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The Relationship between Perceived Cultural Interaction, Client Demographics, and Client Satisfaction of Mental Health Services Providers in the Collaborative Psychiatric Epidemiology Survey (2001-2003): An Exploratory Study

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The Relationship between Perceived Cultural Interaction, Client Demographics, and Client Satisfaction of Mental Health Services Providers in the Collaborative Psychiatric Epidemiology Survey (2001-2003): An Exploratory Study

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Cultural competence is essential to sound social work practice (Boyle & Springer, 2001) and social work professionals are expected to provide culturally competent practice (NASW, 2001). The President's [George W. Bush] New Freedom Commission on Mental Health (2003) called for transforming social service systems to provide culturally and linguistically competent services to facilitate improved quality of life for all Americans, "from *all* communities" to help eliminate disparities in service delivery and to advance a vision for social services for all racial, ethnic, and cultural groups (National Center for Cultural Competence [NCCC], n.d.; italics in original). Studies have shown that practitioners perceive themselves as being culturally competent (Armour, Bain, & Rubio, 2004; Delva-Tauili'ili, 1995). However, the extent to which clients perceive practitioners as culturally competent in their service delivery remains unclear as very few studies have investigated this question (Switzer, Scholle, Johnson, & Kelleher, 1998).

The purpose of the study was to explore the relationships between client's perception of their cultural interaction with mental health provider and the clients' levels of cultural self-awareness, cultural self-determination, and range of assimilation on client satisfaction. To do this, a secondary data analysis was conducted using the Collaborative Psychiatric Epidemiology Surveys (CPES), 2001-2003. The researchers developed composite variables for independent variables: cultural self-awareness, cultural self-determination, range of

assimilation, cultural interaction, and the dependent variable, client satisfaction to determine the relationship between the independent variables and dependent variable. With a sample size of 5,002, it was hypothesized that: Clients with high cultural self-awareness, high cultural self-determination, those at the high range of assimilation, and positive cultural interaction will report higher levels of client satisfaction with their mental health providers.

Findings indicated that cultural self-determination had the strongest relationship with client satisfaction and with the other independent variables, as clients exhibit more cultural self-determination they experience more client satisfaction. Cultural competence strongly influences client satisfaction with mental health services. Further research is strongly suggested to examine more deeply the relationships between the independent variables, the constructs that contribute to each of the independent variables, and enhanced methods to gather such data from cross-cultural clients.

This dissertation by Guileine F. Kraft fulfills the dissertation requirement for the doctor in philosophy in Social Work approved by Karlynn BrintzenhofeSzoc, Ph.D., as Director, and by Frederick Ahearn, D.S.W., and Linda Plitt Donaldson, Ph.D. as Readers.

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Dedication

This dissertation is first and foremost dedicated to my grandparents, Guy and Madeleine Douyon and Benjamin F. Kraft, Sr., Frances Simon-Kraft-Hunter, and Jehu Hunter for the examples they set for me and the love, support, and guidance they bestowed upon me and continue to cast upon me from La Hispaniola and the spirit plane. I dedicate this dissertation to my incredible mother, Yanick Douyon, who has truly loved, supported, and guided my spiritual growth and energy through this process – and throughout of my life. I dedicate this dissertation to my amazing father, Benjamin F. Kraft, Jr., who always encourages me and showed me that diversifying my training, experiences, and dreams can truly allow me to blend my love for music/dance, culture, and social service. I dedicate this dissertation to my inspiriting second-mother, Diane Boudreaux-Kraft, for her ongoing moral support, well-meaning concerns, and empathizing which helped to remind me that everyone has their own experience and story in this process. I dedicate this dissertation to my big brother, Brik Kraft, and little brother, Phillip Kraft who consistently checked on me to make sure I was ok and who, despite their inability to fully relate, always extended their love, support, and advise. I dedicate this to one of my best friends, Varick Baiyina, who supported me and dealt with my anxiety and insanity during the ninth inning stretch and after the end of regulation despite not being in the game during the regular season, thank you for your energy, inspiration, love, and motivation. I dedicate this dissertation to my beloved Haiti, though I have been away for a while, I carry you in my heart always. In the aftermath of January 12, 2010, know that my simple contribution is towards world peace, unity, and unconditional love through the advancement of cultural competence. And, lastly, at the risk of sounding arrogant, I dedicate

this dissertation to myself for the perseverance and strength I showed myself despite the many times I “gave up” and to the children I anticipate having some day, may this serve as an example for you and impetus to follow your dreams and creating your own destiny; remember, *don’t let anyone tell you that the sky is the limit when there are footsteps on the moon* (Unk).

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CHAPTER I

Introduction to the Study

The profession of social work is grounded in the ability of professionals to extend empathy for clients while providing effective and efficient services. The extension of such effective and efficient services to cross-cultural clients is referred to as cultural competence. Thus, the profession of social work must be prepared to encounter a variety of clients, diverse clients who potentially come from any culture, ethnicity, and race around the world. Social work providers should be equipped with the knowledge, skills, and experiences to work successfully with diverse and/or cross-cultural clients. Beyond the preparation of knowledge, skills, and experience, social workers must obtain the self-efficacy to perceive themselves to have the knowledge, skills, and awareness necessary to work with a variety of cultures and ethnicity as well as the confidence to transfer such knowledge, skills, and awareness into application. Consequently, the social work profession must begin to evaluate the degree to which professionals perceive themselves to transmit culturally competent knowledge, skills, and awareness in their practice.

The Council on Social Work Education (CSWE) holds that cultural competence is essential to sound social work practice (Boyle & Springer, 2001; CSWE, 2001). Social work educators are responsible for educating emerging practitioners to be sensitive to cultural and ethnic diversity and to strive to end discrimination, oppression, and poverty, and other forms of social injustice (CSWE, 2001). However, it is not clear if social work education prepares students for cross-cultural practice or effectively helps them to integrate knowledge for culturally competent service delivery. Therefore, there is a need to investigate the level at

which practitioners are transforming knowledge into skills and application while providing services to clients of a different culture.

Social work educators do not universally agree on the methods or implementation of multicultural education (Fellin, 2000). Nor do social work practitioners mutually agree on what constitutes culturally competent practice (Fellin, 2000; Van Soest, 1995). While social work education policies support multiculturalism and culturally competent practice, Van Soest (1995) suggests, in practice, the profession displays ambivalence about its commitment to providing culturally competent service to diverse clients. This ambivalence is evident in the CSWE standards mandating the inclusion of diversity content in social work education. Yet there are inconsistencies in the application across social work academic programs (Van Soest, 1995). Nevertheless social workers and other mental health providers are in need of education and training towards cultural competence, multiculturalism, diversity appreciation, and cross-cultural adaptability, cumulatively referred to as cultural competence in the current study. Notwithstanding, studies have shown that social workers and health care professionals perceive themselves to be culturally competent (Pope-Davis & Ottavi, 1994; Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998; Worthington, Mobley, Franks, & Tan, 2000). Other studies have shown that clients receiving services from cross-cultural providers are not satisfied with the services received (Mori, 2000; Zhang, 2000). The term cross-cultural in the current study refers to the client-provider relationship in the treatment process when such a treatment relationship includes a client of one culture and a provider of another culture. Therefore, the client involved in this treatment process is a cross-cultural client and the provider is a cross-cultural provider. The

client or the client's culture, if different from the provider's, in the treatment relationship defines the relationship as a cross-cultural relationship (Vontress, Johnson, & Epp, 1999).

The Institute of Medicine (IOM, 1993) stipulates cultural competence within health care incorporates the clients' culture, provider skills, client-provider interaction, and clients' perceptions. Whereas client satisfaction is influenced by culture (Sheppard, 1993) and provides information about clients' observations of services (Oliver, 1999), client satisfaction is a central component to cultural competence and cross-cultural service delivery. Thus, the current study seeks to explore the gap between clients' perception of the cultural competence of mental health providers and the actual level of cultural competence of mental health providers.

The current study aims to contribute to the social work knowledge base by using an existing dataset, the Collaborative Psychiatric Epidemiological Study (CPES), for preliminary information on the relationship between cultural competence and client satisfaction. Because there is no universally accepted understanding of cultural competence this study endeavors to catalyze a general discussion of cultural competence through an examination of client satisfaction in cross-cultural practice. This discussion will be initiated through an analysis of cultural self-awareness, cultural self-determination, range of assimilation, and cultural interaction, all used as components of provider cultural competence.

This introductory chapter will describe in detail the presenting problem being addressed: the perceived level of cultural competence in mental health providers. The chapter will then introduce the variables to be analyzed in this study, provide an explanation for the

researcher's personal and professional interest in the problem, state the purpose for the study, and lastly provide a statement for the anticipated implications that the study will have upon completion.

Statement of the Problem

Consensus among social science research indicates a need for helping professionals to be culturally competent (Beckett & Dungee-Anderson, 1996; Boyle & Springer, 2001; Dewees, 2001; Fellin, 2000; Garcia & Van Soest, 2000; Lee & Greene, 2003; Magee, Darby, Connolley & Thomson, 2004; Magee, Darby, Connolley, & Thomson, 2004; Majumdar, Keystone, & Cuttress, 1999; Mildred & Zuniga, 2004; Walker & Staton, 2000). Effective service delivery in health and mental health care incorporates treatment modalities that include the culture of the client, which incorporates the client's environment, family, values, beliefs, and norms. The President's New Freedom Commission on Mental Health (2003) calls for transforming social service systems to provide culturally and linguistically competent services to facilitate improved quality of life for all Americans, "from *all* communities" (National Center for Cultural Competence [NCCC], n.d.; italics in original). The President's New Freedom Commission urges efforts to eliminate disparities within service delivery systems and to advance a vision for health care and social services for populations of all racial, ethnic, and cultural groups. This policy calls for a national commitment to enhancing the emotional and behavioral health of the nation's cultural populations. In providing culturally competent services, the Commission also calls for services to be provided in the client's language.

Studies have shown that practitioners perceive themselves as being culturally competent (Constantine & Ladany, 2000; Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993; Pope-Davis, Reynolds, Dings, & Nielson, 1995; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). However, the extent to which providers offer services in the client's language and clients perceive practitioners as culturally competent in their service delivery remains unclear, as few studies have investigated this question (Switzer, Scholle, Johnson, & Kelleher, 1998).

The underutilization of services by ethnic minorities has largely been attributed to the lack of cultural competence within managed care systems and organizational infrastructures (Cross, Bazron, Dennis, & Isaacs, 1989; Mental Health Statistics Improvement Program, 1996; National Committee for Quality Assurance, 1995; Switzer et al., 1998). While the underutilization of services may be partially influenced by the lack of cultural competence within systems and organizations, it could be reasoned that a significant aspect of the underutilization of services by ethnic minorities is the lack of client satisfaction. This lack of client satisfaction is perhaps influenced by the level of perceived cultural competence of service providers by ethnic clients (Mori, 2000; Zhang, 2000).

The consensus seems to be a need for helping professionals who serve or will potentially serve individuals of cultures other than the culture of the professional, to be culturally competent (Beckett & Dungee-Anderson, 1996; Boyle & Springer, 2001; Dewees, 2001; Fellin, 2000; Lee & Greene, 2003; Mildred & Zuniga, 2004; Walker & Staton, 2000). However, the conceptualization of these ideas varies according to the one to whom one is speaking and according to the topic or issue referenced. Beyond the abstraction of the

concepts, the operationalization of cultural competence is even more ambiguous. Social workers and mental health services providers unquestionably have clients that represent a plethora of cultures, ethnicities, beliefs, norms, and lifestyles. Therefore, mental health providers should be fully prepared to effectively serve such clientele while observing and upholding culturally competent ethical principles while providing services in the client's language, if possible.

While social service and mental health care educational program policies and professional guilds support multiculturalism and the practice of cultural competence (Van Soest, 1995), in practice the professions seem to display ambivalence. This ambivalence is about the commitment to evaluating whether or not cross-cultural clients in fact receive culturally competent services, to their satisfaction. Thus, a driving force in addressing issues previously highlighted is to consider the underlying factors embedded within the issue: the definition of cultural competence, the level of provider cultural competence, and the level of client satisfaction with cross-cultural providers.

Health literacy and cultural competence are two complementary issues that contribute to disparities in health status and health outcomes. Study outcomes have repeatedly suggested that disparities in health care and mental health care may be reduced by addressing cultural competence (American Medical Association [AMA], 2002). However, the scope of the current study is limited to the relationship of clients' perception of the level of cultural competence of mental health providers and client satisfaction. To that end, the presenting problem addressed by the current study involves moving towards a universal understanding of cultural competence. Furthermore, it involves moving towards the implementation of

cultural competence in health care and mental health care service delivery. This could be done through the evaluation of the level of satisfaction of cross-cultural clients with services provided by mental health professionals as impacted by cultural competence such that, implications that arise from such evaluation lead towards the adjustment of service delivery methods. These adjustments will be informed by guidelines set forth by the respective professional guilds, evidenced below, and the contrast between past research indicating professionals believe themselves to be culturally competent and the lack of research supporting these contentions, the current study begins to address this gap in research and literature.

Social Work

The Council on Social Work Education (CSWE, 2008) holds that cultural competence is essential to sound social work practice. The National Association of Social Workers (NASW, 2001) expects social work professionals to provide culturally competent practice. In this increasingly diverse society, social work practitioners have a responsibility to fortify cultural competence in social work practice while striving to deliver such culturally competent practice to an ever-expanding array of clients (NASW, 2001). Indicated in the Preamble of the NASW Code of Ethics (2000), the mission of the profession is to improve the quality of life and well-being of clients by helping clients to meet basic human needs through client empowerment and sensitivity to cultural and ethnic diversity. The importance of cultural competence in social work education and practice is evident and strengthened by implications for the profession and practice.

The importance of cultural competence to the profession of social work is demonstrated through various guidelines and standards embedded in the Standards for Cultural Competence in Social Work Practice (Standards) (NASW, 2001) and the Code of Ethics (2000). The Standards strive to strengthen the awareness of cultural competence in social work practice for the unique ways clients deal with and experience life and social work services as impacted by their culture (NASW, 2001). To improve the quality of services provided by social work professionals, the Standards (NASW, 2001) set forth specific aspects of cultural competence that professionals should use as a guide. Included within the guide are standards for cultural self-awareness and cross-cultural skills, such that social workers are to develop an understanding of their own cultural values, beliefs, biases, and stereotypes, as well as understanding appropriate approaches, communication, and treatment strategies with cross-cultural clients (NASW, 2001). Comparatively, the NASW Code of Ethics (2000) stipulates social work professionals shall have and demonstrate knowledge of the culture of their clients. The Code of Ethics (2000) also specifies professionals are to engage in the promotion of conditions for cross-cultural clients that encourage cultural respect and sensitivity. Thus, the profession of social work emphasizes the magnitude of implementing and fostering cultural competence in practice so clients perceive services as culturally competent.

Psychology

Various endorsements of the American Psychological Association (APA) propose that psychologists participating in clinical practice or delivering services do so in such a way that employs “culturally-appropriate skills” (APA, 2002, p. 43). In such, the APA anticipates

that clients of psychological services perceive that psychologists support cultural diversity and promote an understanding for the role of culture and ethnicity in practice (APA Council of Representatives [Council], 2003). Thus, the Board of Ethnic Minority Affairs of the American Psychological Association (Board) strongly stipulates that among the duties of psychologists are to understand the culture and ethnicity of clients such that appropriate services are provided to cross-cultural clients (Board, 1990). And, the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (Guidelines, 2002), encourages psychologists, in Guideline 2, to "recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals" (p. 25).

The Board (1990) goes on to say that attention to understanding the culture and ethnicity of clients improves the quality of psychological services to culturally diverse populations. The use of such a sociocultural framework, as described by the Board, involves a systematic consideration for the diversity of values, interactional styles, and cultural expectations of clients. Additionally, psychologists have a duty to "help clients increase their awareness of their own cultural values and norms … and facilitate discovery of ways clients can apply this awareness to their own lives…" (Board, 1990, p. 5). Psychologists are charged not only with fostering cultural competence within themselves, but also charged with advancing clients self-determination, impacted by their culture, as they enable clients to discover ways to apply their cultural values and norms in their lives through treatment (Board, 1990). Accordingly, the APA deems it incumbent upon psychologists to be culturally

competent and in so doing to promote cultural self-determination, cultural interaction, and improved client satisfaction.

Counseling

The American Counseling Association (ACA), formerly the American Association for Counseling and Development, outlined the need and rationale for counseling multicultural perspectives. Included in this multicultural perspective in counseling are 31 proposed multicultural counseling competencies, which provide strong impetus for the implementation of developmental and cultural sensitivity into services provided by counselors (Wing Sue, Arredondo, & McDavis, 1992). In tandem with the multicultural counseling competencies suggested by the ACA's Professional Standards Committee, the ACA Code of Ethics (2005) submits a guide for counselors which stipulates the duty counselors have to communicate effectively with *persons of color or others different from them* (emphasis added). Included within the ACA Code of Ethics (2005) are principles pertaining to the counseling relationship, counselor's professional responsibility, and attention to communication with cross-cultural clients.

The ACA Code of Ethics (2005) and the Multicultural Counseling Competencies (Wing Sue, Arredondo, & McDavis, 1992) urges counselors to communicate developmentally and culturally appropriate information, to recognize the impacts of culture on clients, problems and diagnosis of clients, to remain cognizant of the counselor's own cultural background and experiences, and to recognize counselor limitation of their own multicultural competencies and expertise. The guidelines and principles of the ACA emphasize that counselors recognize the cultural and "sociopolitical influences that impinge

upon the life of racial and ethnic minorities" (Wing Sue et al., 1992, p. 482). Thus, counseling professionals, as mental health care providers, are responsible for being acquainted with the helping styles and approaches that are bound and/or impacted by culture, therefore such professionals shall foster the counseling process with persons of color that appreciates cultural sensitivity (Wing Sue et al., 1992), including self-awareness, self-determination, assimilation, and interaction.

Medicine/Psychiatry

Among the medical professionals included under the American Medical Association (AMA) are pediatricians, psychiatrists, family physicians, other professionals with medical degrees, and other mental health professionals. The Institute for Ethics at the AMA (2006) stipulates that many health care system leaders understand the impact of cultural beliefs and values, diversity, and communication on the quality of health care. As such, the AMA, through the *Improving Communication – Improving Care Consensus Report* (2006) and the *Roadmaps for Clinical Practice: A Primer on Population-Based Medicine* (2002) proposed that a portion of enhancing health care for diverse populations is through improved communication and cultural competence.

Through improved communication and cultural competence, medical professionals gain knowledge and understanding of the sociocultural backgrounds of patients in vulnerable populations (AMA, 2002; Health Resources and Services Administration [HRSA], 2001). The goal of cultural competence in medical care includes setting expectations for ethical actions of medical providers so all patients have opportunities to participate in their own health decisions and receive appropriate high-quality care (AMA, 2002). A contribution to

the commitment to cultural competence and improved communication among medical professionals includes regularly monitoring performance of services provided by the medical professionals. This is to be done in conjunction with the utilization of structure, process and outcome measures, and the implementation of appropriate adjustments implied by evaluations (AMA, 2002; HRSA, 2001). The implementation of potential adjustments revealed from evaluations regarding cultural competence are, perhaps, only as effective as the providers' perception of their need for change.

Social Work Compared to Other Providers

As can be seen in the above briefs regarding the standards of the various helping professions, an emphasis on cultural competence is consistent throughout helping professionals. Similar to social work, psychology, counseling, psychiatry, and medicine deem it vital that health and mental health professionals understand not only their own culture, but, more specifically, the culture of the client and the impact of the client's culture on the treatment process and interaction between client and provider.

Provider Self-Perception of Cultural Competence

Studies have shown that practitioners perceive themselves as being culturally competent (Constantine & Ladany, 2000; Pope-Davis & Ottavi, 1994; Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993; Pope-Davis, Reynolds, Dings, & Nielson, 1995; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998; Worthington, Mobley, Franks, & Tan, 2000). Similar studies have shown significant effects of counselor self-reported multicultural counseling competencies (Pope-Davis & Ottavi, 1994; Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993; Pope-Davis, Reynolds, Dings, & Nielson, 1995; Sodowsky, Kuo-Jackson,

Richardson, & Corey, 1998). Therefore, the self-perception of mental health providers' cultural competence has repeatedly been reported despite mixed findings on the level of client satisfaction with cross-cultural providers. Upon further study, research has revealed multiple explanations for the repeated self-perception of provider cultural competence. Constantine and Ladany (2000) and Worthington et al. (2000) determined providers often respond to multicultural counseling competence scales based on what providers anticipate their behavior to be. They provide socially desirable answers, or responded based on their conceptualizations of cultural competence despite the lack of explicit interpretation or implementation of cultural competence or uniformity in the constructs used to assess provider self-perception of cultural competence.

In addition to socially desirable responses or misguided responses to cultural competence self-perception, Pope-Davis, Reynolds, Dings, and Nielson (1995) found that other predictors of such responses include provider's exposure to ethnic group of clients and diverse cultures in general. Neville et al. (1996) found such predictors during provider exposure through educational presentations and Sodowsky, Kuo-Jackson, Richardson, & Corey (1998) found experience with cross-cultural clients as predictive. Mental health care providers, generally speaking, believe themselves to be culturally competent, utilizing multicultural competencies, either because they identify with a culture, race, or ethnicity other than that of the mainstream culture or because they have been exposed to diverse culture, race, or ethnicity through presentations or cross-cultural clients (Pomales, Claibom, & LaFromboise, 1986). Hence, the question of the impact of cultural competence on client

satisfaction remains confounded, perhaps, by the various aspects of service delivery that influence client satisfaction (O'Reilly, Smith, Freeland, & Cernovsky, 1993).

Provider Perception of Provider Cultural Competence.

Despite the consensus among professional guilds that cultural competence is important and should be monitored, there is little agreement on what cultural competence means or how to measure it, specifically with respect to client satisfaction. Conceptual papers on these issues have typically focused either on the service provider or on the mental health professional to the exclusion of the patient, family, or system perspective (Switzer, Scholle, Johnson, & Kelleher, 1998). Therefore, the current study focuses on the gap between the importance of cultural competence in mental health and health care service providers and client satisfaction.

As previously stated, the multifaceted factors included within the presenting problem have traditionally excluded clients to the extent that client satisfaction measures have omitted client perceptions of cultural competence of service providers. Measurement of cultural competence at both the agency and therapist levels has typically been conducted using self-assessment and observer-assessment instruments. These assessment strategies have several limitations including (a) while data are gathered from individuals within the agency itself, there may be strong social pressure for such individuals to overestimate the cultural competence of the agency (Crowne & Marlowe, 1964), and (b) there may be a lack of congruence between agency or therapist reports of cultural competence, and client perceptions about whether the care they receive is culturally competent (Switzer, Scholle, Johnson, & Kelleher, 1998).

Literature has clearly indicated that health care and mental health care providers perceive themselves to be culturally competent. Studies on cultural competence have been completed, utilizing social work faculty and students, medical students, and dental hygiene students (Garcia & Van Soest, 2000; Magee, Darby, Connolley & Thomson, 2004; Majumdar, Keystone, & Cuttress, 1999). While providers determine themselves to be culturally competent and providers of culturally competent services, client perceptions may vary. The current study addresses this gap in assessing the relationship between the various components of cultural competence – cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction – and client satisfaction. This researcher believes these components comprise cultural competence from the client perspective and thus provide strong measures for probing the intricacies of cultural competence from clients' perspective.

Provider Concerns about Client Satisfaction.

Through the understanding of the intricacies of cultural competence from the clients' perspective and in keeping with client-first, client-centered tenets of the mental health and health care professions; providers should be and are expected to be concerned about client satisfaction. Client satisfaction has long been used as an outcome measure, as such (Bjorkman & Hansson, 2001; Graham, Denoual, & Cairns, 2005; Mah, Tough, Fung, Douglas-England & Verhoef, 2006; Spear, 2003); client satisfaction is a central component of service delivery, irrespective of the culture, race, or ethnicity of the client. Consequently, with the added dynamic of culture, race, and ethnicity in the treatment process, client satisfaction, as impacted by cultural competence, becomes an imperative point of assessment when surveying service delivery with cross-cultural clients. Therefore, a parallel concern for

professional guilds and oversight organizations, and health and mental health care providers, is client satisfaction. As the field continues to expand, the impact of cultural competence of service providers on client satisfaction becomes more evident.

Variables in Current Study

The variables included within this secondary data analysis of the Collaborative Psychiatric Epidemiology Study (CPES), include components of the overarching concept cultural competence. While the variables included within this study do not precisely or directly measure cultural competence, these variables are believed to contribute to the understanding of cultural competence. In addition this researcher believes these components of cultural competence will provide the impetus for conceptualizing cultural competence and moving towards a generally agreed upon manifestation of cultural competence within mental health care delivery. The components provided for within this dataset and this study include: cultural self-awareness, cultural self-determination, range of assimilation, and cultural interaction.

Cultural Competence

Cultural competence, according to *The Social Work Dictionary*, refers to the acquiring of "the knowledge, attitudes, understanding, self-awareness, and skills that enable a professional person to serve clients from diverse…backgrounds" (Barker, 2003, p.104). Cultural competence has also been described as a developmental process effecting racial, ethnic, and cultural disparities in health and mental health care (Aponte, 1995; Boyle & Springer, 2001; Cross, Bazron, Dennis, & Isaacs, 1989; Grant & Haynes, 1995). However, scholars have not agreed on a universally accepted understanding and approach to

implementing cultural competence. Literature highlights the need for more practical learning in cultural diversity to increase self-awareness and the capacity for self-evaluation to assess differences and cultural competence (Armour, Bain, & Rubio, 2004).

Cultural Competence through Self-Awareness, Self-Determination, Assimilation, and Interaction.

Researchers, policymakers, and health care professionals have long believed that the centerpiece to accessing quality and satisfactory care in the United States is the elimination of racial, ethnic, and social class health disparities (Cooper, Hill, & Powe, 2002; Penchansky & Thomas, 1981). The Institutes of Medicine's (IOM) Committee on Monitoring Access to Personal Health Services (Committee, 1993), while developing a model for resolving challenges with equitable access to health care, posited that among the strategies for achieving the best health care outcomes, cultural competence within health care must be addressed and implemented. The Committee determined that implementation of cultural competence within health care included clients' culture, the quality of provider skills, communication between client and provider, and clients' perceptions. Similarly, the American Psychological Association and the American Medical Association have included, within their respective guidelines for cultural competence in practice, consideration for the diversity in interaction styles between clients and providers, the cultural expectations of clients, allowing client self-determination (AMA, 2002; Board, 1990), and the implementation of adjustments identified by client evaluations (AMA, 2002; HRSA, 2001). Consistent with the guidelines from professional guilds, scholars and researchers have previously set out to expand the health care field towards adopting a definition of cultural

competence which focuses on clients' perceptions (Switzer, Scholle, Johnson, & Kelleher, 1998). Literature and studies in the past, however, are devoid of assessment of cultural competence from the clients' perspective of client satisfaction and clients' perception of the providers' level of cultural competence.

In keeping with the rationale for the inclusion of self-awareness, self-determination, cultural experience, and interaction styles, the current study is designed to explore the relationship between cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, client satisfaction, and client perception of provider cultural competence.

Cultural Self-Awareness

Cultural self-awareness refers to the understanding a person has of his or her specific culture/ethnicity that influences his or her psychological, social, and emotional attributes (Brown, Parham, & Yonker, 1996). Self-awareness should not be thought of as a concept that one acquires and therefore has mastered indefinitely. Rather, self-awareness is a process relating information from both external realities and internal experiences (Prigatano & Schachter, 1991; Simmond & Fleming, 2003). Thus, self-awareness involves one's ability to recognize the "self" in "relatively objective terms" while maintaining acumen for subjectivity (Prigatano & Schachter, 1991). Self-awareness, according to Brown, Parham, and Yonker (1996), is an essential aspect of the effectiveness of health care providers, consisting of the consciousness an individual has of specific events that impact his/her social, psychological, emotional, and cultural attributes. Furthermore, a key component for cultural competence

alongside cultural knowledge and skills is cultural self-awareness (Pendersen, 1988; Richardson & Molinario, 1996).

Cultural Self-Determination

In its most basic form, self-determination refers to the belief that individuals have the power to reason and should be given the right to determine his or her own actions (Freedberg, 1989). As it pertains to health care and mental health care, self-determination involves providers allowing clients to know the full range of services offered, the alternatives to the offered services, and being given the opportunity to make an intelligent decision about whether or not to accept the offered services (Haas, 1991). The recipient should be allowed to decide what course of treatment is to be taken. Freedberg (1989) stipulates-self-determination grants an individual the inalienable right to actively participate in decisions regarding the treatment process, irrespective of the individual's culture, race, or ethnicity.

Haas (1991) suggests that information transmitted from provider to client in the treatment process should be framed in ways that empower the client. Furthermore, self-determination is only achieved if clients are consistently and honestly apprised of the treatment process (Haas, 1991). This allows the client the right to make decisions about the treatment process thereby allowing culture, race, and ethnicity to be considered in treatment.

Cultural self-determination, then, is a dynamic, active process, whether conscious or unconscious, in which the client is empowered to utilize his or her culture to make decisions about his or her treatment (Kraft & BrintzenhofeSzoc, n.d.). Cultural self-determination plainly implements the traditional concept of self-determination with the addition of allowing the client to consider and implement the impact of his or her own culture, race, and ethnicity

in decisions made regarding the treatment process. The addition of *cultural* to the term places emphasis on the inclusion of culture for the client and primarily for providers.

Range of Assimilation

Culture is understood as the culmination of life patterns shared by a group of people to include language, religious/spiritual ideals, habits of thinking, and patterns of relationships (Lum, 1999). Individuals that immigrate to the United States bring their culture, experiences, and expectations along with them. Such clients, whether voluntarily or involuntarily, go through a process of adjustment to the host culture based on their level of satisfaction with life, knowledge of how the mental health system functions, and difficulties with life (Kilinc & Granello, 2003). This process involves a range of assimilation (Fellin, 2000; Kilinc & Granello, 2003).

Spasojevic, Heffer, and Snyder (2000) stipulate that the psychological problems experienced by immigrants present significant challenges to the mental health community. Thus, mental health providers are faced with providing services to cross-cultural clients at different levels of assimilation. The range of assimilation of a client impacts the degree of receptiveness of mental health services and therefore the level of satisfaction with the treatment (Kilinc & Granello, 2003). Range of assimilation refers to the extent of social integration into the host culture (Fellin, 2000). The process of assimilation involves constructing a *new* culture including aspects of both the native and the host culture simultaneously. Assimilation simply pertains to the extent to which an individual rejects the culture of the United States (Kilinc & Granello, 2003). Range of assimilation is included as a component of cultural competence because of its impact on help-seeking behaviors in cross-

cultural clients (Manheim, 1996). Since cross-cultural clients have the potential to face such challenges along with language barriers, culture shock, social adjustment, and loneliness (Mori, 2000), the inclusion of range of assimilation as a component of cultural competence is warranted as these aspects often impact client satisfaction (Mori, 2000; Zhang, 2000).

Cultural Interaction

The IOM and others have found that one important root cause of unequal treatment and outcomes among minority populations is ineffective communication (AMA, 2006; Taylor & Lurie, 2004). Kaplan et al. (1989) suggested client perceptions are impacted by the interaction between clients and their providers, therefore such communication should reflect *good interpersonal communication* between clients and their health care provider (AMA, 2006; Clark et al., 1999; Gordon et al., 1995; IOM, 2003, Safran et al., 2001; Stewart, 1995; Roter & Hall, 1993; emphasis added). Scholars further propose that communication with clients goes beyond standard or even non-verbal communication, therefore involves taking heed to the interpretation of various words, phrases, gestures, and facial expressions which could be interpreted from various cultural perspectives (Lee, Sullivan, & Lansbury, 2006).

The impact of the cultural interaction between mental health providers and clients should therefore be examined in collaboration with assessments of cultural competence and client satisfaction. Cultural interaction refers to the process of communication between client and provider of same or different cultures (Kelley & Meyers, 1993; Vontress, Johnson, & Epp, 1999). More simply stated, cultural interaction, as it pertains to this study, involves any communication between a provider and a cross-cultural client, whether verbal or non-verbal, which has a culturally laden interpretation and informs the treatment process. Cultural, racial,

and ethnic populations are impacted by aspects of health disparities which include effective communication, provider-client interaction, and quality of care (AHRQ 2004; AMA, 2006; Freimuth & Quinn, 2004; Johnson et al. 2004; Morales et al. 2006). Thus, cultural interaction is another factor in the examination of cultural competence and client satisfaction.

Client Satisfaction

The concept of client satisfaction has been thought of as a concept that is too general to provide substantive information as to the way that clients experience services (Sheppard, 1993). Yet scholars agree that assessing client satisfaction is vital for evaluating health care service delivery (Locker & Dunt, 1978; Sheppard, 1993). Sheppard (1993) suggested that clients in general are liable to see things differently than practitioners. Similarly, Rees and Wallace (1982) point out that satisfaction may be related to service delivery rather than strictly related to interventions (Sheppard, 1993). Client satisfaction, according to Marsden et al. (2000) refers to the extent to which services are perceived to have met an individual's wants and needs related to treatment (Slote Morris & McKeganey, 2007). Gathering information from clients about their perceptions of service delivery is imperative (McPhee, Zusman, & Joss, 1975; Willer & Miller, 1978). Client satisfaction has become critical to health care as an outcome measure and process measure (Bjorkman & Hansson, 2001) and client satisfaction data offer a unique perspective unmatched by data gathered that do not include the client (Davis & Ware, 1988; Kolodinsky, Nam, Lee, & Drzewiczewski, 2001; Mirvis, 1998).

While client satisfaction offers a unique perspective that has said to be unobtainable by other sources (Davis & Ware, 1988; Kolodinsky, Nam, Lee, & Drzewiczewski, 2001;

Mirvis, 1998), it is the primary source of information about client perceptions of experiences, expectations, and effectiveness of services (Oliver, 1999). Insomuch as client satisfaction is obtained and derived from clients, it is, consequently, a measure of perception (Bjorkman & Hansson, 2001); client satisfaction is impacted by culture and related to the way clients perceive services (Sheppard, 1993). Client satisfaction, therefore, adds a dimension to the assessment of care (Buck & Smith, 1998; Graham, Denoual, & Cairns, 2005) from cross-cultural clients. Accordingly, evaluating client satisfaction of services provided by mental health professionals through the lens of cultural competence will extend our understanding of the context within which clients perceive the service delivery, treatment, and individual practitioner. As a result, the interest in analyzing the relationship between cultural competence and client satisfaction has grown for this researcher.

Interest in Problem

The product of a mother born in Port-Au-Prince, Haiti and an African American and part Cherokee father born in Baton Rouge, Louisiana along with an upbringing in Port-Au-Prince, Haiti and Miami, Florida, this researcher has an interest in cultural competence from personal, direct service, and program development perspectives. As a result of living in both a developing country and in the United States of America and being considered a bi-ethnic/bi-cultural individual, this researcher has experienced first hand the need to adjust and assimilate to new cultures, worldviews, and lifestyles. Consequently, as a social worker her interest in the impact of culture and cultural competence on individuals, communities, services, education, and health care arose.

As a multicultural person and professional this researcher began learning at an early age to function within a society that has and continues to implement strategies and practices that are derived from and designed for the mainstream and often Western cultures. While these methods have proven to be effective for many, mainstream and Western strategies and methods are not effective with all clients, especially as this country and the world are increasingly multicultural. Consequently, this social work researcher believes it is incumbent upon helping professionals to advance treatment methods to mimic the advancement in the globalization and expanding cultural milieu of the country and client base.

From a professional perspective, the catalyst for the interest in cultural competence was initiated during this researcher's graduate education at a well-known graduate Social Work institution in the mid-west region of the country which had a limited number of diversity or cultural courses embedded in the curriculum. In fact, at the time of this researcher's matriculation, there was only one required diversity or cultural course required for graduation despite the increasing diversity of the population in this country and thus, the increasing diversity in the client population of social workers and other health care professionals. The lack of academic preparation within what is generally considered the gatekeeping of the profession generated a cause for exploring and perhaps for concern for the level of preparedness of social work practitioners – and other health care professionals – for providing services to cross-cultural clients.

Furthermore, in addition to academic and professional socialization preparedness, the interest in cultural competence and client satisfaction stemmed from the ongoing use of mainstream treatments and methods of treatments that have questionable outcomes with

populations that differ in any way from the mainstream culture and population. Social work education, as well as academic curricula of other health care professionals, has standards for awareness and knowledge of cultural diversity and practice. However, to date, none investigate the degree to which clients feel practitioners are providing appropriate services, from a cultural perspective. Thus, the interest in this topic and study resulted from a paradigm of continuing to advance the field and increase the effectiveness in services provided to any and all potential clients nationwide, cross-cultural clients as well as mainstream clients.

Moreover, an assumption as to the lack of culturally competent academic content and professional socialization in social work and health care stems from the lack of a comprehensive understanding and definition of cultural competence and the implementation of cultural competence in practice. Thus, the study aims to begin to develop a working definition of cultural competence and building a knowledge base of understanding the components of cultural competence and implementation into practice and treatment.

Purpose of Study

The purpose of the study is to explore the relationship between clients' perceptions of the level of cultural competence of mental health services providers by examining the clients' satisfaction with mental health providers. This study is a secondary data analysis. As such this study will isolate concepts believed to contribute to cultural competence – cultural self-awareness, cultural self-determination, range of assimilation, and cultural interaction – and one that is believed to be impacted by cultural competence, client satisfaction. These concepts will be isolated to catalyze a more thorough understanding of the components of

cultural competence towards the development of a social work universally accepted definition and understanding of cultural competence.

Research Question

Is there a relationship between clients' perception of the cultural interaction with mental health providers and the clients' levels of cultural self-awareness, cultural self-determination, and range of assimilation and client satisfaction with mental health professionals?

Hypothesis

Clients with high cultural self-awareness, high cultural self-determination, those at the high range of assimilation, and positive cultural interaction will report higher levels of client satisfaction with their mental health providers.

Significance and Implications

The concept of cultural competence is relatively new to social work. The social work universe does not include a great deal of literature in the area of cultural competence education, training, and client satisfaction. Therefore, this researcher believes this is an area that warrants further investigation and research. Such exploration into this aspect of the social work universe will allow educators, scholars, and professionals to begin to establish an agreed upon understanding, interpretation, and implementation of cultural competence, where one has not previously existed. This study will also allow enhanced research on cultural competence offsetting the deficit in such research. Due to the sparse inclusion of such literature and research studies in the field of social work, articles have been chosen across a myriad of social science and professional disciplines to capture the interpretation

and implementation of cultural competence in comparable professions. Thus, there are multiple implications of the current study for the profession of social work regarding research, practice, and education.

Implications for exploring the relationship between client perception of provider cultural competence and client satisfaction in social work research include probing into the aspects of cultural competence, which effect clients most. Such investigation anticipates providing impetus for the tailoring of cultural competence training, education, and practice. With regard to research, the current study also opens the doors for further research into client satisfaction and further investigation as to whether or not a relationship between client satisfaction and cultural competence exists, if so, what aspects of either may be enhanced to improve the delivery of services to clients. Future research may include studies on the impact of provider cultural competence on health and mental health disparities.

Similarly, exploring the impacts and aspects of cultural competence on clients and client satisfaction may inform practice allowing provider knowledge and edification of cultural competence and culturally competent strategies will increase. Furthermore, service delivery shall improve as knowledge, edification, and strategies are reinforced. The same concepts apply to the implications of the current study for social work education, as research is conducted and the definition, understanding, and interpretation of cultural competence and its relationship to clients and client satisfaction are expounded and clarified, social work curricula may be adjusted or enhanced accordingly. As the gatekeeper to the profession, social work education, research, and practice, can further develop the profession. The profession will also be further enhanced through the implementation of cultural competence

and cultural self-awareness, cultural interaction, and client satisfaction research into practice. The current study serves as a springboard to the advancement of social work research, practice, and education.

Chapter Summary

Haas (1991) stipulates cultural competence involves the framing and transmitting of client information in ways that empower clients while meeting them where they are. Client satisfaction has been noted as an increasingly important dimension of service delivery and client outcome (Donabedian, 1992; Graham, Denoual, & Cairns, 2005; Stallard, 1996). Effective health and mental health service delivery should incorporate treatment modalities that include the culture of the client, which embodies the client's environment, family, values, beliefs, and norms, through the implementation of cultural competence, cultural sensitivity, and effective cultural interaction (AMA, 2006; Council, 2003; NASW, 2001; Wing Sue, Arredondo, & McDavis, 1992). Furthermore, the perceptions of clients have increasingly become important in the process of evaluating service delivery (Graham, Denoual, & Cairns, 2005). Therefore, an assessment of the relationship between client perceptions regarding the cultural competence of health and mental health providers and client satisfaction should be conducted.

The current study is designed to explore the relationship between client perceptions of provider cultural competence and client satisfaction through a secondary data analysis. The measure of cultural competence will be analyzed through components believed to contribute to cultural competence – cultural self-awareness, cultural self-determination, range of assimilation, and cultural interaction – and compared to client satisfaction to determine if

there is a true impact on client outcomes by the client's culture, aspects of cultural competence and client satisfaction that have not been studied in social work. Since provider self-perceptions of cultural competence and the impact of culture on competence have previously been studied, the current study begins to expand the field and the knowledge base. This expansion of the field and knowledge base will allow for the development of a universally agreed upon conceptualization of cultural competence in social work. The next chapter will explore the theoretical framework underlying the current study and expound upon the literature pertaining to each component of the study.

Chapter II

Literature Review

Social problems within the world of social work are customarily placed into a theoretical context. Theoretical context provides information about root causes of behaviors, worldviews, and outcomes. Such information offers a perspective on how to approach the problem or issue at hand, and guidance towards treatment and modalities for addressing the problem. Inasmuch as mental health providers seek a theoretical context for challenges presented by clients, social work research desires a theoretical underpinning for diagnosing and treating social problems. The current chapter provides the theoretical framework for the social problem, of the cultural competence of service providers as perceived by clients, presented in Chapter I. Additionally this chapter will review the literature pertaining to the variables embedded within the current study, conceptually define each variable and connect the variables to the theoretical framework. The variables embedded within the current study are: cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction.

Symbolic Interaction

Symbolic interaction, a social psychological perspective, was derived from the American pragmatist George Herbert Mead at the University of Chicago, Illinois, during the early 1900s. Mead strictly relayed his ideas through oral traditions, leaving his teachings to be posthumously published by his students, as early as 1937 (Kuhn, 1964). The perspective underlines the "*uniqueness* of the human being in nature, especially the fact that human beings *act back* on their environment rather than passively responding to that environment"

(Charon, 2004, p. 26; italics original). Symbolic interaction posits understanding human beings through examining the meanings individuals ascribe to symbols and interpreting interactions. The basic aims of symbolic interaction include determining the types of questions to ask to understand the nature of the relationship at hand and the process whereby self-conceptions change (Kuhn, 1964). Symbolic interaction draws heavily on understanding the use of symbols because human beings craft and rely upon symbols (Charon, 2004; Goffman, 1959). The types of symbols that individuals use include money, hand signals used by Masonic lodges, sororities and fraternities, and gangs, and sacred texts such as The Bible or the Koran. Symbolic interaction emphasizes micro-scale social interaction and how personal identity is created through interaction with others. Of particular interest to symbolic interactionists is the relationship between individual action and group or team pressures (Charon, 2004; Goffman, 1959). An emphasis of symbolic interaction is that people act based on how they define the present situation. The present situation is impacted by the perspective the individual crafts of the symbolic structures that make life meaningful (Charon, 2004).

Along with Mead, Charles Cooley is credited with formulating the theory of symbolic interaction. Herbert Blumer, student and interpreter of Mead, coined the term and submitted an influential summary of the perspective, simply emphasizing that individuals act toward *things* based on the meaning those *things* have for the individual; and these *things* are the result of social interaction and interpretation (Blumer, 1969). Symbolic interaction, according to Blumer (1969), is based on three fundamentals:

- Human beings act toward things on the basis of the meanings that the things have for them;

- Meanings of such things are derived from or arises out of the social interaction that one has with one's fellows; [and]
- Meanings are handled in, and modified through an interpretive process used by the person in dealing with the things [the individual] encounters. (p. 2)

Many scholars agree with these fundamentals; however, others believe the "meaning" of things is often taken for granted and set aside, deemed as unimportant or as a neutral link between human behavior and behavior as a product of factors causing behavior. These behaviors include stimuli, attitudes, motives, and perception (Blumer, 1969). The meaning of things, Blumer (1969) said, is central in their own right, ignoring such meanings and simply focusing on the behavior is to falsify the observed behavior. Since, according to symbolic interaction, meaning arises in the process of interaction, meaning grows out of the ways others act towards the individual with regard to the thing, the action. Meaning is a social product, formed in and through activities and interactions between people. The use of meanings, by the actor, an individual, is acquired through "a process of interpretation" (Blumer, 1969, p. 5).

Ingrained with the three fundamentals of symbolic interaction are five central ideas: (1) the role of social interaction; (2) the role of thinking; (3) the role of definition; (4) the role of the present; and (5) the role of the active human being. The role of social interaction and the role of thinking suggest that symbolic interaction is always central to what individuals do and think. The role of definition proposes that the meanings that individuals ascribe to meaning, similar to perception, is everything; everything refers to reality. The role of the

present indicates the present, rather than the past or future, must be implicit in order to understand cause for certain actions. And the role of the active human being is the basis for conceptualizing individuals as active participants in what individuals do (Charon, 2004). Human beings, as the focal point of symbolic interaction, engage in the development of the self and self-identity as they incorporate these five central ideas into their daily lives, whether consciously or unconsciously (Charon, 2004). As individuals go through life and the world, the world acts on the individual and the individual thus learns to act and define the self through the use of symbols. Each stage of self-development allows individuals to increasingly learn about the world around them, the definitions others have created of them, and then finally one creates a definition of themselves (Charon, 2004). From the symbolic interactionist perspective, individuals "see things not as [things] are but as [the individuals] are…thus [individuals] do not see and then define; [they] define first and then see" (Kuhn, 1964, p. 70).

Mead believed the method by which individuals learn to act toward, ascribe meaning to, and interpret *things*, was cultivated through the development of the self and self-identity. The development of self and self identity, according to Mead, incorporated the five central ideas discussed above, and occurs in four stages:

- the preparatory stage;
- the play stage;
- the game stage: and,
- the reference group stage.

As individuals experience life and the world, they learn to act and define the self through symbols. Each stage of self-development allows individuals to increasingly learn about the world around them, the definitions others have created of them, and then finally one creates a definition of himself or herself (Charon, 2004). An explanation of how this process occurs follows.

The preparatory stage involves an individual, typically a child, imitating those around the individual, mainly adults and figures of authority. The individual imitates the acts of others toward *things*, objects, others, and the child. As long as the individual's act is only imitating it lacks meaning and symbolic understanding. The individual as an object only emerges when the object takes on meaning. Thus the object is defined with words allowing symbolic function to materialize; accordingly the preparatory stage, is strictly imitation (Charon, 2004).

The play stage transpires through the acquisition of language. During the play stage the individual is able to label and define things with words that have shared meaning. With shared meaning objects are ascribed definitions through interaction with others. As definitions occur, individuals assume the perspectives of certain individuals referred to as *significant other(s)*. Interaction with significant others provide patterns of behavior used to regulate one's own behavior. An individual can only see himself through the perspectives of significant others. An individual can only see the perspective of one significant other at a time. This stage is called the "play stage" because the individual and a single significant other make rules according to the situation. The play stage is the real beginning of an individual seeing the self as a social object (Charon, 2004).

The “game,” of the game stage, denotes method and necessity of supposing the perspectives of several *others* simultaneously. Participation in the game stage involves “knowing one’s position in relation to a complex set of others, not just single others” (Charon, 2004, p.76). Progress through the game stage involves taking on the perspective of another as one’s own such that “what was once outside comes to be inside” (Charon, 2004, p.76).

The reference group stage entails interacting with many different group (*generalized other)* perspectives, which allows one to have several reference groups employed to define the self within each group. To be successful in a group one must, at least temporarily adopt a behavior that others use to see and guide the self while in the specific group or team. Participation in the reference group stage causes one to define the self differently according to which group one is interacting with and functioning within (Charon, 2004).

Symbolic interaction is simply a pragmatic approach to the scientific study of human behavior and human group life. The natural world is the empirical world of symbolic interaction, lodging its problems in the natural world, where study and interpretations occur naturally in the social world. Symbolic interaction appreciates that the authenticity of empirical science is respecting the essence of its empirical world (Blumer 1969).

Goffman’s Dramaturgical Perspective

As is customary during the development of a theoretical perspective or framework, scholars and students of theorists often expand upon a theory or aspects of a theory according to their thoughts and beliefs. Such is the case with Erving Goffman, said to be one of the greatest North American sociologists of his time, one who was profoundly influenced by

George Herbert Mead. The study of face-to-face interaction was pioneered by Mead. Taking Mead's work, Goffman developed his own theoretical framework, which elaborated upon symbolic interaction (Kuhn, 1964). Goffman's contribution to Mead's theory is his formulation of symbolic interaction as a *dramaturgical perspective,* presented in his book *The Presentation of Self in Everyday Life* (Goffman, 1959). Goffman alters symbolic interaction by adjusting Mead's social act from traditional symbolic interaction as a complex individual model to a team-of-players model which implies that social action serves as a blueprint for those in society (Kuhn, 1964).

Goffman's dramaturgical perspective holds that social interaction typically follows familiar and anticipated acts and scripts, similar to theatrical productions (Kuhn, 1964). According to Goffman, individuals are recognized as creating, interpreting, and *playing* specific social roles, determined by the team they are a part of (Goffman, 1959). For Goffman, people act based on how they define the present situation as they perceive it based on previous interaction with others and the culture into which the individual was born. Goffman's prolongation of Mead's development of self and self-identity in symbolic interaction is largely centered on interaction and the conduct of individuals involved within the interaction. Whereas Mead focused on the development of the social self pertaining to development throughout childhood and into adolescence, Goffman posits development of the social self continuing throughout adulthood. Goffman (1959) stipulates that individuals continue on a trajectory of developing their social self during ongoing theatrical experiences otherwise understood as life experiences. A significant contribution to symbolic interaction, Goffman equips social scientists with a context for interpreting and evaluating the interaction

occurring within the social world (Goffman, 1959; Goffman, 1967). What Mead refers to as the development of the social self, Goffman considers dramaturgical sociology. Thus, the dramaturgical perspective is not concerned with analyzing the cause of human behavior but the context within which the act occurs (Goffman, 1959).

According to the dramaturgical perspective, human action depends upon time, place, and audience; therefore, the self emerges from the circumstance and situations currently experienced (Goffman, 1959). With the use of a theoretical metaphor, Goffman (1959, 1967) delineates the method by which individuals present themselves to another based on cultural values, norms, and expectations. Actors, Goffman (1959) approximated, perform before an audience. The goal of this presentation of self is acceptance from the audience through guidance. If the actor successfully guides the audience, the audience will view the actor as the actor wants to be viewed (Goffman, 1959). The achievement of the actor's goal results in an intimate form of communication: interaction (Goffman, 1959; Goffman, 1967).

The dramaturgical perspective anchors the individual's identity as performed through role(s) and consensus between the actor and the audience. The consensus between the actor and the audience is what defines the social situations. It is the dependence upon this consensus to define social situations which allows interactions to be defined and redefined continuously, according to the social situation within which the act occurs and the communication between the actor and various audience members (Goffman, 1959). Dramaturgy, thus, emphasizes that the main component of interaction that is *expressiveness*, referred to as a *fully two-sided view of human interaction* (Goffman, 1959, 1967). Consequently, a person's identity, according to dramaturgy, is not an established and

autonomous psychological entity, but rather one that may constantly be remade according to interaction with others (Goffman, 1959).

Within the dramaturgical perspective, social interaction is interpreted as a theatrical performance. Individuals are actors who convey who they are and what they intend through performance to an audience. Similar to their performance on a stage, individuals, in the everyday lives, manage settings, clothing, words, and nonverbal actions, conveying a specific impression to the audience; Goffman (1959) referred to this as *impression management*. Within the theatrical performance of actors, Goffman (1959) made distinctions between *front stage* and *back stage* behavior. Front stage actions are observable parts of the performance, visible by others; back stage behaviors are engaged in when there is no one present (Goffman, 1959). Prior to acting out on a stage, an individual generally prepares a role or impression, which he or she wishes to present to another. These roles are often planned *back stage,* yet may be inadvertently observed by an audience, resulting perhaps, in the act being altered or ignored as flawed, which is then performed *front stage* (Goffman, 1959).

Seven Essential Elements.

Embedded within Goffman's dramaturgical perspective are seven essential elements regarding performance: (1) belief; (2) the front; (3) dramatic realizations; (4) idealization; (5) maintenance of expressive control; (6) misrepresentations; and (7) deception. The first essential element of dramaturgical performance refers to belief. It is important for the individual to believe in the role she is playing. Though others may find it nearly impossible to judge the sincerity or cynicism with which the actor is playing her role, the audience must resort to guessing the performer's real inner state of mind. Such guessing forces the audience

to resign to objectively analyzing the other elements of the performance. The front or *mask* that a performer wears during a performance is an unvarying, generalizable, and transferable mechanism used by the performer to influence the perceptions of the audience.

Dramatic realization refers to the aspects of portrayals of the performer that provides the audience with specific pieces of information. When the performer wants to emphasize something to the audience, she will carry out dramatic realization. It is through dramatic realization that others develop opinions, impressions, and perceptions of the actor. A common aspect of a performance is the presentation of idealized views of the situation presented. Other individuals however, have an *idea* of the given situation (performance) and how it should look. Thus, performers attempt to conduct the performance according to the perceptions of others. Performers have the need to send out appropriate signals while quieting the sporadic compulsion to convey misleading signals that might distract the audience. In order to accomplish this, performers engage in the maintenance of expressive control or *stay in character*.

Despite the performers' attempt to stay in character or present the *idealized* situation, there is a danger of conveying the wrong message or misrepresenting themselves. Often the audience will think of a performance as being either genuine or false, and generally performers wish to avoid the audience disbelieving them, so the performer will avoid misrepresentation of the perception or the impression the performer wishes the audience to develop. The final essential element of dramaturgical performances, deception refers to the suppression of information to either increase the intrigue in the actor or to avoid revealing potential damaging information (Goffman, 1959).

An overarching component of the seven essential elements of dramaturgical performance, according to Goffman (1959), is the performer being allowed *self-determination* to control the information conveyed to the audience. The performer should be empowered to divulge information and *secrets* to the audience without relaying any destructive information to the audience. The performer should have the *self-awareness* to determine which audience or *team* to reveal secrets to and which secrets to conceal. Thus, the performer is empowered to retain a significant level of expressive control over the *interaction* between the performer and the audience (Goffman, 1959).

Teams

When referring to groups of individuals performing in cooperation with each other or solo performances, Goffman (1959) referred to these cooperative arrangements as *teams*. According to Goffman (1959), team members are required to cooperate and share information and secrets with one another. When any one member of the team makes a mistake, the mistake reflects upon the entire team. Trust within the team is critical. Team members have insider knowledge about fellow team members and are not duped by the performance of any other team member. Each member of a team plays a specific role.

Individuals that participate on a team are generally bound by the rules of the team and what may be referred to as ‘familiarity’ among team members. Familiarity constitutes the existence of a formal relationship, which is extended to the individual once the individual joins the team. Those involved in dramaturgical co-operation, therefore, those involved in teams as defined by Goffman (1959), depend upon providing definitions of given situations

as the team defines the situation. Teams depend on mutually accepted understandings and definitions of situations and performances as acted out by team members (Goffman, 1959).

Members of the team play a designated role, with respect to interaction. The individuals' role on the team directs their involvement in an interaction which offers the meaning for their part and their contribution to the interaction. According to Goffman (1959), individuals may hold membership in multiple teams. No matter the number of teams on which an individual maintains membership, the interaction among teammates may be investigated in terms of the cooperative efforts of all members on the team. During the performance of a team, it may be evident that each team consists of leaders or more assertive members of the team who have been given – directly or indirectly – the right to direct and control the progress of dramatic action in which team members are engaged (Goffman, 1959). Teams, Goffman (1959) suggested, vary as to the construct of the team; teams may constitute members of a family, a professional discipline, a gang, and/or cultural or ethnic groups (Goffman, 1959).

Discrepant Roles

Among the roles that individuals play, there are three types of discrepant roles, according to Goffman (1959). The three roles that may be played by individuals include: service specialist, training specialist, and confidant. Service specialists are those individuals who focus on constructing, repairing, or maintaining the performance or performers. Training specialists are those who engage in teaching the performer to develop and maintain control over the impression that the audience has. And a confidant is one to whom the actor discloses her secrets and/or guilt regarding the accuracy or lack of accuracy in the impression given to

the audience. A team member often does not set out to make a business of being a confidant. Usually, she does not accept payment for being a confidant, but instead is usually a family member or friend of the actor, though often an actor will attempt to convert a service specialist into a confidant to ensure discretion (Goffman, 1959).

Goffman (1959) discussed the application of service specialists to mental health and suggested that to engage in multi-services to clients, providers function in intellectual positions, acquiring information, including destructive information, about clients. Providers, according to Goffman (1959), often gain more destructive information about clients than clients intend; providers may obtain more destructive information about the client than the client may know or realize about herself. Clients specialize in the construction, repair, or maintenance of the performance, they offer the provider. Mental health providers become a member of the client's team. As a member of the team, the mental health provider learns the secrets of the client with a backstage view of the client's performance with no risk, guilt, or satisfaction of divulging the secrets – unless divulging secrets are intended or result in the client's condition improving. However, despite the provider becoming a member of the client's team, the client does not learn secrets of the provider, due to professional ethics and the provider maintaining an appropriate level of discretion, and allowing the client self-determination. Additionally, clients as performers may select a certain type of specialist to join their team in order to maintain control over how the client is perceived in the performance, to their family, cultural group, or community. Therefore, as Goffman (1959) articulated, clients may opt to seek services from spiritual healers as opposed to academically trained providers to avoid stigma or shame in their personal life, home, or community.

The application of training mental health specialists involves their acting in the roles of teachers and/or facilitators. Providers as trainers evoke either repressed images or true self-images, empowering clients to control the impressions that the audience develops of the client. While training specialists have been thought of as teachers, parents, and drill sergeants, they may also be social workers, psychologists, or counselors who offer services to clients building up their psychological and emotional self. Training specialists in mental health may be thought of as providing clients with cognitive, psychological, emotional, and personal tools to direct their lives with the autonomy to engage in self-determination (Goffman, 1959). The development of the psychological and emotional self empowers clients to display performances that are higher functioning and more inspiring to the audience (Goffman, 1959).

The confidant role, within the mental health system, provides clients with an outlet for disclosing their thoughts, feelings, and symptoms for any challenge that the clients face. Providers, as confidants, allow clients the self-determination and interaction to divulge their guilt about manipulating an audience into accepting performances that are strictly impressions and performances that are not aspects of reality. Providers as confidants also allow clients to reveal information about the opposition they face from their family, friends, community, and/or culture/ethnicity. Such opposition may include discord in seeking assistance and services from academically trained professionals (Goffman, 1959). Since confidants typically do not accept payment for the assistance or service that is provided, Goffman (1959) suggests client-performers often attempt to revamp service specialists into

confidants to ensure discretion, specifically when the role of service specialists is largely for the purpose of listening and talking.

Superordinate and Subordinate Roles.

Whether the role is a service specialist, training specialist, confidant, performer, or audience member, it is a standard rule of everyday communication that participants contribute to the interaction as either superordinates or subordinates (Goffman, 1959). Goffman (1959) uses the terms superordinate and subordinate to refer to the level of influence an individual has during an interaction. A superordinate refers to one with the most clout during the course of communication, while a subordinate unofficially extends the influence of the communication to the superordinate. Seizing the superordinate position may occur in a variety of ways; it may be given by the subordinate or obtained through academic means, as a doctor over a nurse, or authoritarian means, as a manager over an employee (Goffman, 1959). Goffman (1959) stipulated that superordinate and subordinate roles relate to supervisory relationships as well as interactions between performer and audience.

As superordinate and subordinate roles pertain to interaction, the role that one plays or holds during the course of interaction is contingent upon the topic of discussion and type of relationship between the performer and audience (Goffman, 1959). Thus, a performer may act as a superordinate during one aspect of the interaction with the audience and as a subordinate during another aspect. Similarly, during the course of mental health interaction between a client and a provider, the superordinate and subordinate roles may alternate according to the topic of discussion and the specific treatment under consideration. Therefore, during an assessment the provider may act as the superordinate asking the client,

the subordinate, questions and guiding the client through activities and informative tasks. However, while conversing about the client's culture, the client, offering information about her culture and beliefs, would be acting as the superordinate while the provider is the subordinate, during this part of the interaction (Goffman, 1959).

In everyday interaction, it is assumed that the superordinate will bend to meet the subordinate (Goffman, 1959). Consequently, in order to garner the desired information or interaction with the subordinate, the superordinate will relinquish a portion of the authority. Likewise, a provider will, according to Goffman (1959), surrender the power in the interaction to the client as a means of facilitating interaction by way of fostering empowerment and self-determination in the client.

Applying Dramaturgy

The application of dramaturgy has been said to best be done through the participant as observer perspective during fieldwork (Benford & Hunt, 2007). Benford and Hunt used dramaturgy to portray the communication of power through social movements. According to Benford and Hunt social interactions represent dramas in which performers, both protagonists and antagonists, compete to persuade the impression the audience acquires of power – superordinates vis-à-vis subordinates. As individuals act out their realities in life, a series of social movements which play out as dramas are concerned with instilling the impression to the audience of the acquisition of power.

As it pertains to culture, Goffman (1959; 1967) posited there is an intersection between culture and the dramaturgical perspective. The intersection is most clearly recognized in regard to the maintenance of moral standards. Cultural values, like dramaturgy,

of a team – cultural or ethnic group – determine how individuals feel about certain matters while establishing a framework of appearances that are essential to maintain (Goffman, 1959, 1967).

Critique of Dramaturgical Perspective

Some scholars believe theories should only be applied in settings similar to those where the theory has been tested (Calhoun et al., 2002). The dramaturgical perspective, as an extension of symbolic interaction, applies context to symbolic interaction, connecting the behavior of actors to institutions (Goffman, 1959). As the dramaturgical perspective was designed to be applied to the total institution, Calhoun et al. (2002), state it should not be applied beyond the institution, beyond the circumstances within which the behavior takes place.

In addition to criticism about dramaturgy's application to the institution, some scholars contend dramaturgy does not add to sociology's ambition to understand the legitimacy of certain behaviors (Welsh, 1990). Instead, dramaturgy is said to draw on positivism, which negates reason and rationality, thus is a stretch when used to contextualize human behavior (Welsh, 1990). Yet, according to Goffman (1967), individuals act based on "rules of conduct" which steer actions, whether suitable or just. Individuals are governed by the rules of conduct, which lead to consistency and patterning of behaviors. Rules of conduct compel individuals to moral obligations and expectations allowing for the maintenance of constancy and predictability on teams (Goffman, 1967), thus creating reason and rationality through context.

Dramaturgy Explaining Cultural Competence

Goffman (1959), through the dramaturgical perspective, explains the presenting problem addressed in the current study as a question of performances acted out by individuals towards an audience. The performers in the current study refer to either clients or providers. As the performer concentrates on performing, she does so in such a way so as to emphasize a designated impression upon the audience. Therefore, from the client's perspective, she will act towards the provider according to the impression that she would like to convey. Additionally clients, as a member of various teams, perform according to the rules of the team, while also inviting the provider to join the team by virtue of disclosing information and divulging secrets of the individual and/or the team, thus incorporating the provider into the client's team and culture. As the client interacts with the provider, she utilizes the provider as either service specialist, training specialist, and/or confidant at various points in the relationship as trust has been earned and gained. Similarly, at various points in the interaction between client and provider, the client serves as the superordinate giving the provider information about the client's culture and at other times the client succumbs to the subordinate role accepting direction from the provider. Hence, the interpretation of the interaction between the client and provider molds the interaction moving forward with the provider along with the client's previously held beliefs and experiences. Despite being an "outsider" initially, the provider encompasses a level of power over the client in being involved in the treatment process and administering training, options, and other forms of treatment.

In considering the challenges when a cross-cultural client seeks treatment from a mental health provider, Goffman (1959; 1967) discusses the effect of culture on the interaction; both the client's culture and the provider's culture. While having the power to manipulate the impressions of the provider, the clients use their power to divulge what they choose to divulge about themselves and their culture; the client is thus permitted to exercise self-awareness and reveal his range of assimilation. The client's cultural norms, customs, beliefs, and values play a significant role as a number of cultures maintain strong beliefs and convictions about mental health and help-seeking behaviors. Consequently, the interaction between the client and provider as well as the implementation of the treatment is inspired by the client's culture and expression of cultural convictions. Goffman (1959) indicates that the attention given to understanding the interaction and the components of the interaction between the client and provider reveals the degree to which the client will feel satisfied by the provider and the extent of the provider's aptitude as a specialist in cultural competence.

Interaction between Client and Provider

Both Mead (1934) and Goffman (1959; 1967) have stressed the importance of interaction and appropriately interpreting interactions. Goffman (1959) specifically speaks of medical providers in his discussion of assessing interactions not only between providers but also interactions between provider and client. Direct interaction between provider and client influences the course of the interaction and the perception of the provider held by the client. Therefore, direct interaction between provider and client influences the degree to which the client successfully and positively accepts the services offered and the level of satisfaction that the client experiences with the treatment.

Culture's Impact on Perception, Attitudes, and Experiences

Human behavior, according to White (1974), depends on culture, which dictates how individuals think, feel, and act. As a preceptor to human behavior, culture guides the impressions and perceptions formed by individuals (Goffman, 1959). Culture has been referred to as the macrosystem of society within which individuals exist (Bronfenbrenner, 1979). This notion is influenced by the view that human development is impacted by cultural and family groups with a history of life stages and interactions with the larger society (Bronfenbrenner, 1989; Guan 2004). Therefore, individual human behavior is the result of interactions that individuals have with family, community, and other components of the cultural environment within which individuals reside (Guan, 2004). Similarly, variations in human behavior are the result of cultural variables since behavior is explained in terms of the individual's culture (White, 1947). Consequently, the individual's culture significantly determines her behavior, impressions, attitudes, and perceptions.

Developing and understanding specific behaviors which reveal the influence of culture on behavior according to dramaturgy, Goffman (1959), stipulates individuals use *personal fronts.* This refers to those components of an individual that are relatively fixed, such as social status and race, both cultural aspects which shape an individual's attitudes and experiences. These individual personal characteristics, roles, or fronts are the most influenced by an individual's culture. The influence on one's culture is revealed in expectations, perceptions, and outward behavior that individuals exhibit towards those with whom they interact (Goffman, 1959).

Culture, as a phenomenon of ideas (knowledge and beliefs), sentiments (attitudes and values), and acts (patterns of behaviors based on customs and traditions), which when transmitted from one human to another, results in an interaction process (White, 1947). Culture can only be explained in terms of lifestyle (White, 1947). An individual's or group's patterns of beliefs, values, and norms are determined by lifestyle. Lifestyle also determines the development of expectations and experiences which result from interactions.

Dramatization realization¸ according to Goffman (1959) leads individuals to form opinions and perceptions based on observations and experiences. Dramatization realization involves observation of individual actions of those participating in specific interactions as well as observations of the setting within which the interaction is taking place. The observation of one's actions accompanied by the setting or context within which the interaction occurs provides the audience a framework for deciphering the culture of the performer (Goffman, 1959). Individual perceptions and attitudes emanate from culture and are influenced by the culture of the audience and performer. The culture of the individual serves as a standard for how individuals view and anticipate others' view of the world. Furthermore, the culture of the performer, including the setting within which the interaction occurs, shapes the perceptions and experience of the audience. As they pertain to the current study, the perceptions of the client are shaped by the culture of the client as well as the client's observation of the provider's interaction and the setting within which the interaction takes place. Therefore, the client's performance towards the provider is stimulated by her own culture, based on her values, beliefs, morals, and experiences, as well as the provider's interaction towards the client and the client's expectations of the provider. Likewise, the

provider's attitudes and perceptions are shaped by the provider's own culture, values, beliefs, and experiences as well as the client's performance towards the provider. However, this current study is limited in scope to the perceptions of the client. By observing the client's culture and developing perceptions of the client's culture, the culturally competent provider would allow the client to incorporate aspects of the client's culture into the treatment process, thus allowing the client's self-determination (Goffman, 1959).

As an individual's culture compels her development of perceptions, cultural differences create social constructs within interactions based on the information divulged in the performance. Each individual involved in the interaction and the interaction between those involved in the communication are part of this process (Goffman, 1959; White, 1947). As Goffman (1959) wrote, individuals perform according to the message they would like the audience to receive. Given the deliberate performances of individuals and White's (1947) assertion that culture determines human behavior, it is posited that cultural differences between individuals create social constructs within interactions and between the participation of performer and audience. This culturally-based social construct directs the interaction between individuals influencing the roles the performer and audience in the interaction process. During the interaction process, with the infusion of culture, individuals, performers and audience alike, search for their roles within the interaction. This search for a role within the interaction is influenced by the performance that is being observed as well as the individual's culture. The individual seeks to determine her role either as the service specialist, training specialist, and/or confidant, and performs in that role based on the cultural social construct within which she is accustomed (Goffman, 1959). The individual's role then

directed her attitudes, behavior, experiences, and satisfaction during the interaction and relationship moving forward.

Symbolic Interaction, Dramaturgy, and Variables

Human ecology, according to Bronfenbrenner (1979), views individuals as entrenched within a microsystem of relationships and special roles, mesosytems with external settings, and a macrosystem of culture and teams. This model is influenced by the development of social action in which individuals are viewed in life stages and internal and external interactions and transactions with others in society. Therefore, individual human behavior is the result of interactions with immediate family, community, and culture, including health systems (Blumer, 1969). Thus, individuals are socialized from birth to perform according to those they interact and communicate with. Individuals, through such communications learn to be self-aware, exhibit self-determination, and assimilate with the social world according to their culture(s). These are behaviors and roles that are expected of the individual in her environment.

Culture

According to symbolic interaction, culture is a notion based on how individuals behave, whether deriving from a custom, tradition, norm, value, rules, and the like. (Blumer, 1969). Mead's symbolic interaction sees culture as a derivative of individual behaviors and interpretations (Mead, 1934); while Goffman (1959) relates culture to individual participation in teams. Teams, according to Goffman (1959) refer to various groups of people functioning in partnership with one another in accordance with whatever rules and guidelines that have been established by the leader(s) of the team or the team as a whole. As a member

of a team or cultural group, individuals follow customs, traditions, values, norms, and worldviews, which are thought of and intended to compliment the team and keep the team's secrets (Goffman, 1959). Culture, then, is an organizational phenomenon made up of acts, objects, ideas, and sentiments that are dependent symbols and definitions or interpretations ascribed to the symbols (White, 1947).

Cultural Competence

Cultural competence, posited by Goffman (1959), consists of two components of dramaturgy – deference and demeanor. Deference refers to a demonstration of appreciation; i.e., generally displayed towards an authority figure. Demeanor pertains to an element of an individual's behavior which is typically conveyed through attitude, dress, and posture intended to express qualities that the performer wishes to convey to the audience (Goffman, 1959). Deference and demeanor are determined and based on culture and ethnicity (Goffman, 1959). The significance of culture on deference relates to how authority figures are defined, designated, and regarded; while the influence of culture on demeanor is evidenced in the attire, mannerisms, and how individuals handle themselves in social interactions (Goffman, 1959). Understanding these components and seeking understanding for how individuals ascribe meaning to their actions and performances, to seek such understanding constitutes engaging in a cultural competence.

Cultural Interaction

Interaction refers to the act or process between two or more individuals of performing towards each other such that information is exchanged from one to the other. According to Mead (1934), interaction pertains to conversation with gestures and the use of significant

symbols to convey messages in human society. Interaction is the basis for attitudes, behaviors, and experiences. As the basis for all performances in dramaturgy, cultural interaction is known as the result of behavior with and towards an individual's family, community, and social world (Guan, 2004). Influenced by family, community, and the social world, interaction is subject to cultural stimulus, as such individual actions towards another person are referred to as cultural interactions (Goffman, 1959). Embedded within the essence of symbolic interaction, cultural interaction involves behavior towards others with derived meanings for such actions arising from values, norms, customs, beliefs, and traditions (Blumer, 1969).

Cultural Self-Awareness

A process that engages interaction of information from experiences and reality, self-awareness involves perceiving the *self* in fairly objective terms while retaining an essence of subjectivity. Therefore, self-awareness requires the integration of knowledge of a situation, in an objective sense, and feelings, having an appreciation or individualized interpretation of the situation in a subjective sense (Prigatano & Schachter, 1991; Simmond & Fleming, 2003). Cultural self-awareness, as understood by symbolic interaction and dramaturgy, is hypothesized and found as the integration of one's self-concept from multiple perspectives and multiple domains. Thus an individual understands herself based on the influence of culture, and according to the appraisal of one's self and reflecting appraisals of others¸ specifically the social and cultural groups within which individual matriculates (Cheung & Lau, 2001).

Cultural Self-Determination

Often said to be an inalienable right, self-determination, pertaining to mental health care, involves an individual having full knowledge of what services are being offered as well as the alternatives and that individual having the opportunity to make an informed decision about what services to accept and being fully involved in the treatment process (Haas, 1991). The attachment of culture to *self-determination*, simply enforces the inclusion of culture into the treatment process, allowing individuals to have the authority to hold fast to the norms, values, and beliefs that have guided their lives and lifestyle (Kraft & BrintzenhofeSzoc, n.d.). Dramaturgy along with symbolic interaction emphasized the actor defining the act and performance such that the audience is able to appropriately interpret the performance (Blumer, 1969; Goffman, 1959; Mead, 1934). Additionally, since each individual involved in an interaction has a role, directs her role, and offers meaning for that role, and as a member of a team, each person is expected to sustain the impressions for the audience that hold true to the culture of the team. Each individual in dramaturgy is allowed *cultural self-determination* (Blumer, 1969; Goffman, 1959).

Range of Assimilation

An indication of responding negatively to the culture of a host country and the denial of traditionalism in that same host country indicates a lack of assimilation (Kilinc & Granello, 2003). White (1947) opines that individuals and groups experience disharmonious or conflicting elements with a new or different culture, assimilating by varying degrees into a host culture. Goffman (1959) alludes to the fact that individuals encounter degrees of assimilation as they become members of teams and take on various roles. As individuals earn

secret privileges and higher rankings on the team, their level of acceptance in the team and participation in secrets varies according to the loyalty that they display towards the entire team (Goffman, 1959) and their range of assimilation into the culture of the team.

Client Satisfaction

Client satisfaction, as a rule, is thought of as a comparison of an individual's, or a client's, expectations with the care she receives and her actual experience (Oliver, 1999). More than expectations, however, is an individual's self-awareness and level of assimilation that effects client satisfaction; that is especially influenced by culture (Kilinc & Granello, 2003; Robinson, 1983; Sheppard, 1993). Kilinc and Granello (2003) found an individual's level of assimilation, along with the strength of her conviction for her culture, is directly related with a client's perceptions of services. Dramaturgy's assessment of client satisfaction is based on the client deciphering between a provider that is misrepresenting herself as adequately skilled and a provider that is in fact thoroughly skilled. It may not be easy for the client to disprove the misrepresentation of the provider. Such misrepresentation or impersonation is a *front* put on by the provider, which impacts the client's level of satisfaction (Goffman, 1959).

Mental Health Service Providers

Regarding the standards for ethical practice of the various helping professions, an emphasis on cultural competence is consistent throughout. The importance of mental health professionals understanding their own culture and the culture of the clients, the influence of the client's culture on the treatment process and interaction is clear in social work, psychology, counseling, psychiatry, and medicine. Effective mental health providers are

largely seen by clients as having academic and interpersonal skills (Cooper-Patrick, Powe, Jenckes, Gonzales, Levine, & Ford, 1997). Thus selection process for mental health providers has been reported to be based on client experiences and the hope for high quality care (Saulnier, 2002).

As clients report perceiving mental health providers as having specialty training (Saulnier, 2002), providers of male dominated professions include psychiatrists, psychologists, and medical professionals while social workers and spiritual advisors are seen as humane professionals (Cooper-Patrick, Powe, Jenckes, Gonzales, Levine, & Ford, 1997). Since social workers and spiritual healers are described as more responsive to clients, especially cross-cultural clients (Saulnier, 2002), social workers and spiritual healers are the service provider of preference for clients (Kerssens, Bensing, & Andela, 1997). Providers who relate more to clients on a human level are sought more by cross-cultural clients. As the mental health professionals that are more holistically trained on cultural competence, the reported preference of clients to social workers and spiritual advisors is unique (Goffman, 1959), then treatment outcomes are improved as social workers are described as influencing mental health services more responsively (Saulnier, 2002).

Cultural Competence and the Variables

The next section in this chapter provides a discussion of the variables included in this study; cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction. The section will begin with a discussion on cultural competence as it is understood and implemented in social work education and service delivery.

Cultural Competence

The concept of cultural competence is relatively new to social work. Social work literature does not include a great deal in the area of cultural competence education and training. It would therefore seem this is an area which is in need of further investigation and research. Due to the sparse inclusion of such literature and research studies in the field of social work, articles have been chosen across a myriad of social science disciplines.

According to Armour, Bain, and Rubio (2004) social workers have limited practical guidance to guide the infusion of cultural competence into treatment. Recent literature in social work further highlights the need for more practical learning in cultural competence to increase self-awareness, implementation, interaction, and the capacity for self-evaluation (Armour, Bain, & Rubio, 2004). Previously, cultural competence was referred to as "ethnic-sensitive social work practice" (Lu, Lum, & Chen, 2001). The evolution of terms leading to the use of cultural competence began with the term ethnic sensitive practice. As social work education and training evolved, multicultural sensitivity – which included multicultural education and multicultural competence - replaced ethnic sensitive practice. And multicultural education was ultimately replaced cultural diversity and finally cultural competence (Wallace, 2000).

There are hundreds of conceptual definitions of cultural competence (Boyle & Springer, 2001). For the purposes of the current study, the achievement of cultural competence involves specific objectives: knowledge base, skills base, and value base (Lu, Lum, & Chen, 2004). In order to realize cultural competence, providers and students should undergo training and/or education, including becoming familiar with cultural and cross-

cultural knowledge, skills, values, awareness and affect (Grant & Haynes, 1995; Lu, Lum, & Chen, 2004). Culturally competent education and training, thus, must make a distinction between issues of oppression and the implementation of skills (Aponte, 1995).

Therefore, cultural competence refers to the ability to provide the services needed by diverse groups (Boyle & Springer, 2001). In such, culturally competent services meet the needs of all ethnic groups and specifically those groups who are impacted by racism, classism, poverty, discrimination, and other forms of oppression, while maintaining the values and integrity of the client's culture.

Cultural Self-Awareness

According to Prigatano and Schachter (1991) a simple and universally accepted definition for self-awareness is difficult to come by. Yet, scholars believe self-awareness is critical for the well-being of clients in mental health treatment as they progress towards recovery or well-being (Fleming, & Strong, 1999; Prigatano & Schachter, 1991). And despite the difficulty in defining self-awareness, Simmond and Fleming (2003), in their theoretical analysis of self-awareness, have interpreted self-awareness as a process connecting the interaction of external realities to internal experiences. Similarly, Bardill (2000) explains self-awareness as an individual giving attention to the self while considering the effect of and interaction with others in a cultural context with spiritual realities. Thus, becoming self-aware involves the capacity to discern the self in objective terms while maintaining strong subjectivity (Prigatano & Schacter, 1991). Beckett and Dungee-Anderson (1996) theoretically submit that cultural self-awareness is a critical component in culturally

competent treatment, suggesting cultural self-awareness aids in the avoidance of inaccurate perceptions of groups fostering effective cross-cultural interactions and treatment.

Cultural self-awareness simply pertains to the explicit inclusion or consideration of culture as influencing the development of an individual's self-concept (Beckett & Dungee-Anderson, 1996; Richardson & Molinaro, 1996). Richarson and Molinaro (1996) state that awareness refers to the recognition of the diversity among and between groups. Furthermore cultural awareness specifies recognition of the differences within and between cultural groups (Richard & Molinaro, 1996). In other words, cultural self-awareness recognizes the influence of culture on the development of an individual's perception of the self.

As a developmental process, self-awareness is composed of the integration of knowledge, skills, and feelings (Lucas & Fleming, 2005; Pendersen, 1988; Prigatano & Schacter, 1991). The integration of knowledge involves gaining information about a situation objectively and with understanding the various components of the situation – or culture (Haas, 1991; Prigatano & Schacter, 1991). Skills refer to academic training and experiential professional socialization (Prigatano & Schacter, 1991). Feelings relate to having a comprehension and/or unique interpretation of a situation or cultural/ethnic group in subjective terms (Beckett & Dungee-Anderson, 1996; Prigatano & Schacter, 1991).

The significance of self-awareness and cultural self-awareness is equally important for clients and for mental health service providers (Beckett & Dungee-Anderson, 1996). While a client's development of self-awareness has been empirically linked with emotional distress and enhanced participation and success in treatment (Fleming, Strong & Ashton, 1998; Lam, McMahon, Priddy, & Gehred-Schultz, 1988; Sue, 1977), a provider's self-

awareness is equally as important, especially as it pertains to the provider's development of cultural competence (Beckett & Dungee-Anderson, 1996; Richardson & Molinaro, 1996).

A client's cultural self-awareness contributes to the development of an effective treatment plan tailored to the client's needs *and* culture when addressing a presenting mental health challenge (Simmond & Fleming, 2003). For the client, being culturally self-aware contributes to the client's ability to educate the provider on her culture and cultural convictions (Fleming & Strong, 1997). Regarding providers, cultural self-awareness involves understanding their own cultural group as well as having an awareness of other cultural groups (Richardson & Molinaro, 1996). Providers' cultural self-awareness connects self-awareness with moving beyond one's own culture and worldview that results in having an understanding of appropriate techniques for working with cross-cultural clients, including understanding the underlying core values, norms, beliefs, and customs of cross-cultural clients (Jackson & Meadows, 1991). Scholars, after all, have argued that intentionally becoming aware of one's own culture and worldview is necessary for emerging from potential ethnocentrism or cultural blindness or ignorance (Richardson & Molinaro, 1996; Sue, Arredondo, & McDavis, 1992). Consequently, providers' cultural self-awareness allows them to avoid counter-transference and, more importantly, to appreciate the need to fully understand the client and incorporate the client's culture into the treatment process. Similarly, the client's cultural self-awareness fosters her understanding of self and the weight of culture on one's presenting problem and treatment.

Cultural Self-Determination

Self-determination has its roots in the spirit of benevolence of the 18th century period known as the Age of Enlightenment. Embodied in the spirit of benevolence, self-determination refers to the belief that individuals have and should be granted the power and autonomy to reason to determine their own actions (Freedberg, 1989). The belief in such self-determination gives individual clients permission to actively participate in designing and implementing a treatment process that is thought to be the most beneficial and successful (Freedberg, 1989; Haas, 1991; McDermott, 1975). According to Haas (1991) clients, seeking treatment from any type of provider, must fully understand what they are being offered, know the alternatives to the offered services, and be given the chance to make an informed decision about what service(s) to accept.

The implementation of self-determination does not explicitly exclude the use of culture in the treatment process. However, scholars do believe culture should and perhaps must be intentionally infused into the treatment process (Cross et al., 1989; Goffman, 1959; Haas, 1991); clients then, are to be afforded cultural self-determination (Kraft & BrintzenhofeSzoc, n.d.). Though there is no hard and fast procedure for providing clients cultural self-determination (Haas, 1991), providers should understand it is of instrumental value in the hierarchy of professional mental health values (McDermott, 1975). Since clients manage their own process of change, whether directly or indirectly, providers take the responsibility for helping the change process, which undoubtedly incorporates and emphasizes the client's culture (Kasius, 1950). And, according to Goffman (1967), when clients act with proper demeanor and deference, they must be given the autonomy – self-

determination – to indulge in the performances which they believe will best lead them to their well-being and happiness. Clients thus must be permitted to perform according to the values, rules, norms, and customs of the team – culture – of which they are members.

The degree to which self-determination can be put into practice, whether by providers or clients, is influenced by the level of exploitation, oppression, and lack of available opportunities confronted by clients (Reynolds, 1963). According to McGoldrick, Giordano, and Pearce (1996) culture and ethnicity are major contributors in what clients eat, relate to, celebrate, how they work, worship, and feel about life, death and illness, and thus mental health. Hence, culture affects clients' help-seeking behavior and/or the services clients accept from mental health providers. The acceptance of mental illness and consequently, the freedom – culturally speaking – to accept mental health services may largely be related to an individual's cultural/ethnic beliefs, and the convictions of the authority figures within the individual's community or culture (Haas, 1991). Cultural values may dictate a belief or disbelief in mental illness and subsequently the type of services allowable by an individual within that cultural group (Mori, 2000; Zhang, 2000). Cultural beliefs equally influence the degree to which individuals may divulge challenges they are experiencing, as secrets may not readily be shared, especially with anyone outside of the cultural group (Goffman, 1959).

Similarly culture impacts the way in which providers may implement or incorporate culture into the service delivery and treatment with cross-cultural clients (Haas, 1991). Freedberg (1989) found that providers must recognize the ideological, political, and practice pressures and tensions within self-determination and not to negate the cultural tensions inherent in help-seeking behavior of cross-cultural clients. Scholars have stated that providers

have difficulty with implementing cultural self-determination due to disenfranchised clients (Freedberg, 1989), ie., clients who succumb to authority and do not feel empowered to suggest the integration of culture into their treatment. Likewise, Haas (1991) reported providers' lack of awareness of explicit procedures for implementing self-determination. Furthermore, providers have difficulty promoting autonomy, which in turn perpetuates paternalism (Beauchamp & Childress, 1988). Yet Reynolds (1934) posits that providers must be willing to allow clients ultimate authority in their own matters, a right granted to clients at birth. Moreover, clients are often denied cultural self-determination by providers either improperly informing clients of the therapeutic process or due to providers' unwillingness to forfeit their perceived power. Cross et al (1989) and Haas (1991) reported in their respective theoretical articles that providers improperly informing clients of the therapeutic process is due to a lack of understanding the clients' culture (Cross et al., 1989; Haas, 1991).

Culture influences the clients' quest for mental health assistance and services and their ability to seek or assert autonomy over their own lives. Similarly, appropriate training and professional socialization towards informing clients of their rights and the processes and procedures for executing cultural self-determination influences providers' implementation of cultural self-determination. And, with deficiency of cultural self-determination in mental health treatment, Ben-Sira (1976) found a direct relationship between client's dissatisfaction with treatment and providers and clients' self-determination. Also when clients experienced dissatisfaction with providers, they turned back on their own initiative to seek treatment. Thus, cultural self-determination is most readily activated by the culturally competent provider (Cross et al., 1989).

Range of Assimilation

Assimilation, through acculturation, refers to the extent of social integration into the host culture (Fellin, 2000). The process of assimilation involves constructing a new culture including aspects of both the native and the host culture simultaneously. Acculturation pertains to absorbing the traits of the host culture into one's own cultural identity without relinquishing one's native culture. Degree of assimilation, according to Kilinc and Granello (2003), is evident when an individual rejects a host culture or rejects the observance of traditionalism of a host culture. Thus, range of assimilation is related to the length of time an individual has resided within a host culture and the individual's level of religiosity/ spirituality (Kilinc & Granello, 2003). Empirical studies on assimilation indicate individuals with high assimilation involve themselves into the new life within the host culture while those with lower assimilation are at greater risk for developing mental health challenges (Spasojevic, Heffer, & Snyder, 2000); high assimilation is correlated with better mental health. Studies indicate societies with multiple cultures often put pressure on assimilating individuals, creating a phenomenon of underlying poor physical and mental health (Berry & Kim, 1988; Berry, 1991). Thus, this researcher believes lack of assimilation may contribute to lower cultural self-determination, client satisfaction, and mental health challenges.

Individuals who emigrate from non-English speaking countries often face language barriers, culture shock, immigration challenges, social adjustment, homesickness, and loneliness (Mori, 2000). Social adjustment which translates into various patterns of assimilation is referred to as options of acculturation (Berry, 1991). These patterns include: assimilation (surrendering cultural identity); integration (releasing some aspects of one's

cultural integrity while absorbing aspects of the host culture); separation (holding onto traditional lifestyle and cultural identity); and marginalization (rebelling against host culture). Despite such challenges, immigrants who come from cultures that do not condone or believe in dealing with personal challenges outside of the home often do not believe in seeking assistance for mental challenges (Mori, 2000; Zhang, 2000). The lack of help-seeking behaviors – according to the Western world – has been attributed to a strongly held cultural value orientation, which may discourage seeking professional help and differing cultural perceptions of mental health and mental illness (Manheim, 1996). The lack of help-seeking behaviors may also be attributed to the pattern of assimilation, described by Berry (1991), with which the client identifies. Scholars have noted that individuals from other countries are often unaware of the function of mental health services and are therefore reluctant to seek or use such services when offered (Demir & Aydin, 1996; Guneri & Skovholt, 1999). Furthermore, those from other countries often shy away from mental health services due to a lack of exposure to such services in their country of origin (Kilinc & Granello, 2003).

Findings from Kilinc and Granello (2003) indicate cross-cultural clients prefer seeking assistance from family and friends (informal system) rather than from mental health services and professional resources, which are often associated with stigma. These findings emphasize the importance of professionals offering mental health services to cross-cultural clients that are sensitive and congruent with the client's cultural values and worldviews (Brinson & Kottler, 1995). Most of the time, the first step is to see someone in the informal system of family and friends. Yet, mental health problems in immigrants and cross-cultural clients present a substantial challenge to mental health professionals. Such challenges have

arisen due to mental health providers in the United States, in general, not being trained to provide specialized services to cross-cultural clients, specifically immigrants and refugees (Spasojevic, Heffer, & Snyder, 2000). Therefore, cross-cultural clients, including immigrants and refugees, may not receive the necessary help. This diminishes their ability to assimilate into the mainstream culture (Chambon, 1989; Nann, 1982; Salvandy, 1983) as well as their own individual mental health status. Consequently, the mental health problems exhibited by cross-cultural clients present substantial challenges to the mental health community (Spasojevic, Heffer, & Snyder, 2000).

In addition, other empirical studies indicate mental health providers in the United States are largely not trained to provide specialized services to immigrants and refugees, as a result, many cross-cultural clients do not receive the help they need further diminishing short- and long-term range of assimilation into the host culture (Chambon, 1989; Salvendy, 1983). Accordingly, the literature indicates the range of assimilation and client perceptions of providers are related to client satisfaction (Kilinc & Granello, 2003). Additionally, findings show those with lower levels of assimilation not only show higher levels of psychological distress but also perceive a provider as having lower cultural competence (Adamopoulou, Garyfallos, Bouras, & Kouloumas, 1990; Spasojevic, Heffer, & Snyder, 2000; Westermeyer, Neider, & Callies, 1989). One of the major issues is that many new-comers do not differentiate between health and mental health as mainstream America does; many non-American cultures see the somatic and mental systems as one.

Cultural Interaction

Cultural interaction refers to the process of communication between client and provider of the same or different cultures (Kelley & Meyers, 1993; Vontress, Johnson, & Epp, 1999), that emphasizes perceived difference between individuals engaged in communicating, which accounts for the values, norms, and differences during communication exchanges (Kelley & Meyers, 1993; Vontress, Johnson, & Epp, 1999). Interactions, according to Goffman (1959), are put together as scenes in a play amounting to exchanges of dramatically exaggerated actions, counteractions, and concluding responses. Furthermore, those that witness the action influence the actor and the outcome of such influence and the action itself constitutes the interaction (Wright Mills, 1939). For the purposes of the current study, cultural interaction specifically pertains to communication exchange between client and provider; thus, the client and the provider are seen as performers and audiences while communicating during the treatment process.

Interactions in everyday life are influenced by the culture of those involved in the interaction (Vontress et al., 1999). Interactions with individuals on the same team – cultural group – are often seen as communicating secrets and are to be maintained within the team (Goffman, 1959). Due to the values, beliefs, and customs held within cultures, secrets and interactions with individuals that are not a part of the team may be strictly prohibited. Therefore, clients communicating secrets with mental health providers may be prohibited by the client's culture; such secrets may be revealing mental health challenges in and of themselves and/or revealing information about the client's family, community, and cultural beliefs. Accordingly, barriers in interaction may compound clients seeking or receiving

treatment from cross-cultural mental health providers (Lee, Sullivan, & Lansbury, 2006). The stress of seeking or receiving treatment may also be complicated by the client's perception of the provider's level of cultural competence (Murphy & Clark, 1993). Cross-cultural interaction may be largely ambiguous and open to interpretation due to the meanings ascribed to actions (Goffman, 1959; Mead, 1934) and the rules of the culture guiding its members as to which expressions are required, permitted, preferred, or prohibited (Lee, Sullivan, & Lansbury, 2006). Despite the barriers of verbal interaction, non-verbal communication may also facilitate interaction through gestures and facial expressions, which may be culture specific (Mullavey-O'Byrne, 1994) and thus influence client perceptions, cultural exchanges between the client and provider, and client's satisfaction.

Culture and cultural interaction equally impact the way in which providers obtain information from the client in completing an assessment, identifying the presenting problem, and gathering information about the client's culture, family, and community. To facilitate effective service delivery, it is necessary for providers to obtain information from clients and communicate procedures, explanations, and the implications of treatment with clients. Equally as important is for clients to equip providers with information about their own culture (Murpy & Clark, 1993). Outfitting providers with information about the client's culture allows providers to become aware of the shared meanings of the symbols in the client's culture (Goffman, 1959), resulting in more effective cultural interaction. Providers must develop useful strategies for getting information from clients regarding the presenting problem as well as the clients' culture and the most appropriate use of the clients' culture in the treatment process (Lee, Sullivan, & Lansbury, 2006). The degree of effective cultural

interaction between the actor and observer, or client and provider, determines the extent to which secrets are divulged, misrepresentation occurs, and deception continues (Goffman, 1959; Lee, Sullivan, & Lansbury, 2006). Complicating the problem, service organizations are often on “the other side of town”, the waiting room is not culturally inviting and the provider does not speak the client’s language.

The key to providers for determining how to infuse culture into the treatment process and for providing effective mental health services is through taking direction from the cross-cultural client (Cross et al., 1989; Vontress, Johnson, & Epp, 1999). Clients are the best training specialists to providers for learning the client’s culture. Furthermore, providers must become adept at being the superordinate when necessary and focus on being the subordinate to the client when appropriate (Goffman, 1959, 1967). Through taking heed to client direction, providers will learn, for example, to consult the client’s family and learn who within the family or community to consult regarding mental health treatment. Through becoming culturally competent to the cross-cultural client, providers will learn to engage in effective cultural interaction. With effective cultural interaction, providers can enhance the accumulation of information, which will facilitate cultural self-determination and client satisfaction (Mullavey-O’Byrne, 1994).

Client Satisfaction

Client satisfaction has increasingly become an essential component of assessing quality of care and client outcomes in health and mental health care (Donabedian, 1992; Stallard, 1996). Despite the increasing importance of assessing client satisfaction, knowledge regarding client satisfaction is still largely lacking (Bjorkman & Hansson, 2001). The

concept and meaning of client satisfaction has been poorly defined in clinical terms resulting in inconsistency in measuring client satisfaction and adequately producing findings that represent true client experiences (Tilley & Chambers, 2000). In spite of the limitations in defining client satisfaction in the literature, Oliver (1999) states client satisfaction in general entails contrasting client's expectations with the services provided.

Though a clear definition is rarely provided, scholars have measured client satisfaction in efforts to evaluate the quality of care and to identify implementation challenges for providers. Thus, client satisfaction surveys and studies commonly measure quality of care, identifying gaps in services, (Donabedian, 1988), treatment acceptability (O'Reilly et al., 1993), the process of care, and the outcome of care from the client's perspective (Bjorkman & Hansson, 2001; Bond & Thomas, 1992). These indicators have been associated with having an effect on compliance, efficiency, and efficacy of services for mental health clients (Joe & Friend, 1989; O'Reilly at al., 1993).

Client satisfaction is critical because of the significance it has on enhancing help-seeking behaviors, improving treatment compliance, and preserving relationships with mental health professionals (Haas, 1999). Assessment of client satisfaction potentially contributes to service delivery and treatment assessment. The assessment of service delivery and treatment assessment, through measuring client satisfaction reflects the client's perception of mental health services and the provider of such services (Buck & Smith, 1998; Graham, Denoual, & Cairns, 2005). Measures of satisfaction should take place at various points of the client-practitioner process.

Scholars have noted, both through theoretical suppositions and empirical findings, that client involvement in the treatment process enhances client satisfaction (Calsyn et al., 2003; Rysavy, O'reilly, & Moon, 2001). Similarly, Garfield (1994) reported that positive expectations of services promote client participation in treatment and client satisfaction with treatment providers. Moreover, mental health providers agree that providing clients with treatment options – self-determination (Calsyn et al., 2003; Graham, Denoual, & Cairns, 2005), along with client-centered services that explicitly include culture – cultural interaction (Bjorkman & Hansson, 2001; Calsyn et al., 2003; Harkness & Hensley, 1991), enhances client outcomes and client satisfaction.

Conversely, as there is no consistent reliable and valid measure of the quality of mental health service, there are many critics engaging in such studies (Mah, Tough, Fung, Douglas-England, & Verhoef, 2006) or engaging in measuring client feelings and experiences (Spear, 2003). Concerns about the reliability of client satisfaction surveys and measures involve methodological problems and the lack of conceptual framework within the questionnaires (Bausell, 1985; Nelson & Goldstein, 1989). Furthermore, some scholars indicate challenges with reliable information from client satisfaction measures arise from client characteristics influencing client perceptions, including mental illness and health status, socioeconomic status, and client needs (Sofaer & Firminger, 2005); thus, findings from client satisfaction studies may indicate a link between client mental health as opposed to service quality (Marshall, Hays, & Mazel, 1996). Despite such potential limitations, client satisfaction is considered to be one of the most neglected variables in the evaluation of mental health services (McPhee, Zusman, & Joss, 1975; Urquhart et al., 1986).

As a meaningful representation of clients' experiences, client satisfaction is a significant tool in assessing the helping process (Sheppard, 1993). Along with being a significant tool in assessing mental health care, client satisfaction is largely shaped by the cultural background of the client (Aldana, Piechulek, & Al-Sabir, 2001; Sheppard, 1993). Since clients and providers live in distinct social worlds, the client's cultural background influences the client's views on mental illness, expectations, interaction patterns, and behaviors; clients, therefore, are likely to see things differently from providers (Sheppard, 1993). A client's culture determines her expectations of providers and mental health treatment (DeWilde & Hendriks, 2005; Willer & Miller, 1978) and similar to client needs, the client's culture determines her perception of the degree of helpfulness of the provider and the satisfaction with the services provided. Client culture and client perceptions are highly individualistic and may vary from one encounter to another and from one culture to another (Aldana, Piechulek, & Al-Sabir, 2001). And since satisfaction with services is related to quality of care, client satisfaction is effected by client characteristics, including culture (DeWilde & Hendriks, 2005).

Along with mental health providers having principally been academically trained from a monocultural perspective (Bruni, 1998), mental health services have been organized and largely delivered monoculturally, from an Anglocentric perspective (Khan & Pillay, 2003). Hence, it is no mystery that providers believe they are culturally competent and the services provided are of high quality and not in need of being evaluated for client satisfaction specifically pertaining to culture (Switzer, Scholle, Johnson, & Kelleher, 1998). Additionally, providers are averse to relinquishing any perceived power in the treatment process to clients

or being held accountable for results of client satisfaction surveys (Gionta, Harlow, Loitman, & Leeman, 2005). Yet, research regarding clients' perceptions regarding the level of cultural competence of providers has not been conducted. Research has determined clients prefer to be culturally and gender "matched" with their provider (Fujino, Okazaki, & Young, 1994), however, research has yet to ask or determine the perception of clients regarding the level of cultural competence of mental health service providers, an area that the current study will explore.

Regarding client satisfaction, scholars have found scales to relate to client satisfaction. The Consumer Expectations, Perceptions, and Satisfaction Scale (CEPAS) measures client expectations and client perceptions (Spear, 2003), the Poertner's Client Satisfaction Scales measures worker-client relations (Poertner, 1986), and when engaging in empirical research with clients presenting with major depressive disorder, anxiety disorders, panic disorders, and phobic disorders, scholars have used the Hopkins Symptom Check List-90 (SCL-90) (Derogatis & Fasth, 1977). The current study seeks to determine if there is a relationship between these concepts through assessing cultural self-awareness, cultural self-determination, range of assimilation, and cultural interaction which the researcher believes, based on the literature, begins to unpack client expectations, perceptions, and worker-client relations.

Khan and Pillay (2003) stipulate valuing diversity entails a reflection upon one's individual belonging to unique cultural groups, which is accomplished through self-awareness. Furthermore, it is awareness of the cultural uniqueness of each person that stimulates empathy and enhances interaction between clients and providers. And through

such awareness, Sheppard (1993) posits strong indications of developing interaction skills between providers and clients – both verbally and non-verbally – that facilitates channels for negotiating the meanings of experiences. Such interaction fosters the client feeling empowered to have authority over her mental health treatment, causing the client to experience self-determination (Bockting, Robinson, Benner, & Scheltema, 2004). And, through empirical testing, Kilinc and Granello (2003), found those clients who reported higher levels of satisfaction included those who were more comfortable within the host culture, and who had knowledge and understanding of the mental health system in the United States.

Thus, as a concept of client satisfaction has been found, scholastically speaking, to be too ambiguous and too general to offer intelligible information as to the way clients think and experience mental health treatment (Sheppard, 1993). Locker and Dunt (1978) suggest client satisfaction can be explored from the client's perspective of and experience with the services provided by the professional. Client satisfaction is to be explored. It must include a cultural component, emphasizing the cultural competence of mental health service providers (Goeppinger 1993; Khan & Pillay, 2003). And, more detailed information about the client's experience (Locker & Dunt, 1978) can be incorporated into the treatment process, focusing on the way services are given rather than focusing on positive or negative interventions (Sheppard, 1993).

Chapter Summary

The current chapter presented in detail the theory of symbolic interaction first according to one of its creators, George Herbert Mead, then by a follower of Mead's and

symbolic interaction Ervin Goffman. Goffman largely maintained the integrity of symbolic interaction, of interpreting the actions of an individual according to the meanings the individual ascribed to their actions, and branched off through submitting a context for the actions of individuals. The preceding discussion also presented explanations of the concepts and variables being explored in the current study, from Goffman's dramaturgical perspective and according to scholarly literature over the last seventy-five years: cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction. The discussion sought to provide an innovative way of understanding cultural competence in mental health through considering the level of provider's cultural competence from the client's perspective. To do so, the client's cultural self-awareness, cultural self-determination, range of assimilation, and interpretation of cultural interaction are related to client satisfaction as determinants of the client's perception of provider's cultural competence. The next chapter will discuss the research design and methodology for the current study, including a description of the data set that will be used for this secondary data analysis, the sample population, and conceptualizing and operationalizing the variables.

Chapter III

Methodology

This study explores the level of client satisfaction with mental health service providers specifically as it relates to clients of diverse ethnic, racial, and cultural backgrounds. Using an existing data set, the Collaborative Psychiatric Epidemiology Surveys (CPES), the purpose of this study is to evaluate the extent of client satisfaction, with services provided by mental health professionals.

This chapter presents the study design, the research question, and hypotheses that guide this study. The study design begins with a description of the original study, including a discussion of the study's population and data collection methods. The data collection instrument used for the current study, including information on the reliability and validity, are described. And, lastly, the data analysis plan is presented.

Study Design, Research Question(s), and Hypotheses

The current study is an exploratory study, using secondary data analysis that seeks to determine the relationship between the client's perception of providers' cultural competence, client's cultural self-awareness, cultural self-determination, range of assimilation, and cultural interaction, and client satisfaction with mental health services.

The overarching question that guides this study is: Is there a relationship between client's perception of the cultural interaction with mental health providers and the client's levels of cultural self-awareness, cultural self-determination, and range of assimilation and client satisfaction with mental health professionals? The bivariate testable hypotheses for the present study were as follows:

H_1: Clients with higher levels of cultural self-awareness will have higher levels of cultural self-determination.

H_2: Clients with higher levels of range of assimilation will have higher levels of cultural self-determination.

H_3: Clients with higher levels of cultural self-awareness will have higher levels of range of assimilation.

The overarching multivariate hypothesis for the present study was:

H_4: Clients with high cultural self-awareness, high cultural self-determination, at the high range of assimilation, and positive cultural interaction will report higher levels of client satisfaction with their mental health providers.

The Collaborative Psychiatric Epidemiology Survey, 2001-2003

The current study is a secondary data analysis of data collected from the Collaborative Psychiatric Epidemiology Survey (CPES), 2001-2003. Funded by the National Institute of Mental Health (NIMH), the CPES represents the implementation of three nationally representative surveys, the National Comorbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL), and the National Latino and Asian American Study (NLAAS). Developed in conjunction with one another, the NCS-R, NSAL, and NLAAS, set out to collect data about the incidence of mental disorders, impairments associated with mental disorders, and mental health treatment methods from a sample representative of the United States adult population, 18 years and older. The CPES was the first national dataset with strong statistical power capturing a nationally representative sample of mental health issues associated with various mental health providers. The CPES

also aspired to gain information about support systems, language use and ethnic disparities, discrimination and assimilation to determine whether and how closely various mental health disorders are associated with social and cultural issues (Alegria, Jackson, Kessler, & Takeuchi, 2007; Pennell et al., 2004).

Development of the CPES

The CPES questionnaire was derived largely from the United Nations' World Health Organization's (WHO) extended version of the Composite International Diagnostic Interview (CIDI) expanded for the World Mental Health (WMH) Survey Initiative, the WMH-CIDI (Kessler & Üstün, 2004). It took more than one year for all three studies, the NCS-R, NSAL, and NLAAS, to be fully developed. The process included modifying the WMH-CIDI, with assistance from an international group of collaborators. Modifications and additions to the WMH-CIDI resulted from alterations from the CIDI, which was designed to produce diagnoses in accordance with the American Psychiatric Association's Diagnostic and Statistical Manual (APA DSM). The CIDI expanded the Diagnostic Interview Schedule (DIS), which was the first standardized psychiatric diagnostic questionnaire created for use by lay interviewers. The CIDI was designed to diagnose participants based on the WHO International Classification of Disease (ICD) criteria, rather than strictly diagnosing from the DIS which could only diagnose based on criteria from the APA DSM. The CIDI enhanced the quality of the survey measurement and made methodological improvements through information gathered from debriefing interviews (Pennell et al., 2004).

Upon completion of the core questionnaire, each team of interviewers completed 30-50 pretest interviews. Pretesting revealed problems with wording, interviewer instructions,

and programming errors as well as section timing and other logistical matters, which lead to revisions of the questionnaire content, for all three studies (Pennell et al., 2004). Responsibility for translating the English version of the questionnaire rested with the principal investigators for the NLAAS and the NSAL. Translation of the questionnaire was necessary to collect data from the diverse sample population that each study was geared towards; thus, allowing for national cultural and ethnic representation of the CPES. Once the translated versions of the questionnaire had been drafted, native speakers along with University of Michigan foreign language faculty were hired to review the questionnaire and manage additional testing and evaluating. Appropriate modifications were made by the principal investigators of each study based on reviews provided by native speakers and the faculty (Pennell et al., 2004).

Data were collected using native speakers that were carefully trained in administering the interviews throughout the sampling regions. In addition to training interviewers to properly conduct the face-to-face interviews, interviewers for all three studies were trained in sensitivity to cultural, racial, and socioeconomic diversity that would be encountered during the interviewing. Interviewers were further trained on how to interview on sensitive or potentially embarrassing topics. Lastly, interviewers were trained on their legal obligations regarding information revealed about pending harm to respondents or others; interviewers were instructed on how to handle these perilous situations (Pennell et al., 2004).

Reliability and Validity of the CPES.

As the instrument was developed by CPES investigators for purposes specific to the intended study, the questionnaire was not a standardized instrument that involved testing for

reliability or validity; therefore, there is no known reliability information available. Regarding validity of the instrument(s), the instruments have face-validity as known experts in the field reviewed the questions and determined that the questions would provide the desired data (Pennell et al., 2004). Additionally, face-validity was also determined upon review of the translated questions by foreign language faculty at the University of Michigan and native speakers of the respective languages (Pennell et al., 2004).

Study Population

The sample population of the CPES consisted of 20,130 adult respondents 18 years and older residing in households located in the contiguous United States, Alaska, and Hawaii. Embedded within the population of the CPES universe were Black Americans of African Descent, Black Americans of Caribbean descent, and White Americans (the NSAL universe), Latino American, Asian American, and non-Latino, non-Asian White Americans (the NLAAS universe). The NCS-R universe included a nationally representative sample of English-speaking adults living in non-institutionalized civilian households within the contiguous United States, mainly Latino and non-Latino Whites and Blacks. The three components of the CPES each contributed the following sub samples: 9,282 from the NCS-R study, 6,199 from the NSAL study, and 4,649 from the NLAAS study; which cumulatively account for the total sampling framework of the CPES. The sub sample for each of the three studies consisted of sampling units selected with probabilities proportional to population of the United States (Pennell et al., 2004).

Data collection was conducted in a total of 252 geographic areas of United States and was completed using laptop computers which assisted personal interviews in the

respondents' home from early 2001 to early 2003. The three studies shared 50 of the most densely populated areas of the country. In addition to these shared areas, there were 52 areas exclusive to the NSAL and 18 areas exclusive to the NLAAS; these exclusive areas were included to emulate the specific racial and ethnic focus of those studies while maintaining the appropriate proportions to the larger population of the country.

The sample population for the current study consists of respondents from the primary data population with a diagnosis of major depressive disorder (n=2,842), generalized anxiety disorder (n = 1,220), panic disorder (n=817), and phobic disorders (n = 3,931) according to the APA DSM. Due to the presence of respondents with dual diagnoses, the total sample size for the current study will be 5,002. These diagnoses where selected for use in the current study as these are the conditions that most often receive treatment from social work professionals (Bjorkman & Hansson, 2001).

Conceptual and Operational Definition of Variables

Through the use of the CPES, this investigation begins to explore cultural competence of mental health service providers. Since service providers can not be directly analyzed using this data set, this researcher is using a pseudo triangulation method of examining the cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction of individuals whom have sought mental health services. By way of inspecting these variables this researcher believes an inference can be made about the perceived level of cultural competence of mental health service providers. The conceptual and operational definitions of the variables included in this study follow. The response set for each question can be found in the accompanying appendix.

Cultural Self-Awareness

Scholars agree self-awareness has no agreed upon, universally accepted definition (Lucas & Fleming, 2005; Prigatano & Schachter, 1991; Simmond & Fleming, 2003). Nevertheless, self-awareness is said to be a process that develops over time, involving the communication of information from internal experience and outward reality, which allows an individual to perceive the 'self' (Fleming & Strong, 1997; Prigatano & Schachter, 1991; Simmond & Fleming, 2003). Self-awareness involves giving attention to self, to others, to the context, and to spiritual realities (Bardill, 2000).

Cultural self-awareness, then, refers to the understanding a person has of her specific culture/ethnicity that influences her psychological, social, and emotional attributes. Additionally, cultural self-awareness pertains to the consciousness maintained by an individual of events that impact that individual's daily experiences and behaviors (Brown, Parham, & Yonker, 1996). Furthermore, it has been suggested that a single individual may experience fluctuations in her self-awareness according to the individual's experiences and realities (Fleming & Strong, 1997; Simmond & Fleming, 2003).

Scholars agree self-awareness is difficult to measure (Fleming & Strong, 1995; McGlynn, & Schacter, 1989; Prigatano & Klonoff, 1998; Prigatano & Schachter, 1991). And, although scholars indicate there is no consensus on the best way to measure self-awareness (Abreu et al., 2001; Sherer et al., 1998), due to the variations in client satisfaction, mental health, and cultural competence, this study will measure cultural self-awareness using 61 questions from the CPES (See Appendix A).

Cultural Self-Determination

Self-determination is signified in the belief that humans undoubtedly have the ability to determine their own actions and behavior, and the power to reason (Freedberg, 1989). The self-determined client has inalienable rights to actively participate in decisions regarding her treatment process (Freedberg, 1989), whether the client is considering the use of medical, mental health, or other professional services (Haas, 1991). Therefore, through self-determination, clients are empowered to know what is being offered and the alternatives to the offered service(s), so as to make knowledgeable, informed decisions about whether or not to accept the offered services (Haas, 1991).

Cultural self-determination, thus, is a dynamic, active process, whether conscious or unconscious, in which the client is granted the autonomy to utilize her culture to make decisions about her treatment process (Kraft & BrintzenhofeSzoc, n.d.). The use of cultural self-determination in treatment simply involves asking clients to provide their perspective on the potential effect of their culture on the treatment process (Lee, Sullivan, & Lansbury, 2006; Murphy & Clark, 1993). Self-determination cannot be achieved unless clients are honestly apprised of their options, according to Haas (1991), therefore, clients cannot be afforded self-determination without the inclusion of culture.

Based on this understanding, cultural self-determination, for the purposes of this study, will be operationalized using 76 questions from the CPES (See Appendix B).

Range of Assimilation

Assimilation, according to Kilinc and Granello (2003), refers to evidence of rejection of host culture or the observance of an individual maintaining traditionalism. Thus, the level

of assimilation is thought of as an indicator of how much an individual has thrown herself into a new life, new culture, and level of religiosity/spirituality without looking back, according to the length of time the individual has been in the host culture (Kilinc & Granello, 2003; Spasojevic, Heffer, & Snyder, 2000).

Thus, range of assimilation, through acculturation, refers to the extent of social integration into the host culture (Fellin, 2000). The process of assimilation involves constructing a *new* culture including aspects of both the native and the host culture simultaneously. Acculturation pertains to absorbing the traits of the host culture into one's own cultural identity without relinquishing one's native culture. Range of assimilation centers around the level of an individual's social adjustment to a host culture (Fellin, 2000) according to the individual's construction of a *new* culture consisting of aspects of both the native and the host culture. Accordingly, range of assimilation will be measured using 19 questions from the CPES (See Appendix C).

Cultural Interaction

Cultural interaction, according to Pettegrew and Turkat (1986), refers to a dynamic process involving the transmitting of bi-directional information with no specific beginning, middle, or endpoint. Interaction is transactional, occurring between two or more individuals simultaneously using actual words, language, gestures, and facial expressions to communicate. Such communication emphasizes the content of the information exchanged as well as the nature of the relationship dimension exhibited in the interaction (Gionta, Harlow, Loitman, & Leeman, 2005).

Cultural interaction refers to the process of communication between individuals of the different cultures (Kelley & Meyers, 1993; Vontress, Johnson, & Epp, 1999). The emphasis in cultural interaction, as it relates to the current study and mental health, is with the client's perception of cultural differences between the client and provider (Vontress, Johnson, & Epp, 1999). Cultural interaction refers to verbal communication as well as non-verbal communication, which may also facilitate the transmitting of information through gestures with culture specific indicators (Mullavey-O'Byrne, 1994). From the client perspective, cultural interaction pertains to educating mental health providers of the client's culture and the ramifications of the client's culture on understanding the client's presenting mental health challenges and the treatment process. From the provider perspective, cultural interaction refers to the professional communicating procedures, explanations, and implications of mental health treatment on the client and the demonstration of cultural competence (Lee, Sullivan, & Lansbury, 2006). Cultural interaction, then, provides a stimulus for the client's perception of the provider's level of cultural competence and the client's satisfaction with mental health treatment.

Cultural interaction, for the purposes of the current study, will be comprised of 23 questions from the CPES (See Appendix D).

Client Satisfaction

Client satisfaction offers a unique perspective unobtainable from other sources (Davis & Ware, 1988; Mirvis, 1998; Kolodinsky, Nam, Lee, & Drzewiczewski, 2001), generally involving an assessment of client's expectations contrasted to the care received (Oliver, 1999). As a concept, client satisfaction is said to be elusive due to the measuring of client's

feelings, perceptions, and attitudes about mental health treatment (Davis & Ware, 1988). Client satisfaction has become important both as an outcome measure of mental health care and as a process measure for how care is provided (Bjorkman & Hansson, 2001); therefore the treatment provided may be impacted by the level of cultural competence of the practitioner and indirectly by the cultural interaction with the client. Accordingly, evaluating client satisfaction of services provided by mental health professionals through the lens of the client's cultural self-awareness, cultural self-determination, range of assimilation, and the cultural interaction with the provider will extend our understanding of the context within which clients perceive the service delivery, treatment, and individual practitioner.

Some scholars believe client satisfaction is too general a concept to yield meaningful information as to the way clients think (Locker & Dunt, 1978; Sheppard, 1993). Yet, for the purpose of this study, client satisfaction pertains to an assessment of a client's approval of the services delivered by mental health providers to be used to evaluate and improve the quality of service delivery (Clark, Scott, Boydell, & Goering, 1999). Client satisfaction has also been identified as a predictor in the clients exhibiting empowerment behaviors and client perceptions of their quality of life and treatment provider (Barker & Orrell, 1999).

Previously, client satisfaction has been measured using client expectations, attitudes, and perceptions in Poertner's Client Satisfaction Scales (Poertner, 1986). Additionally, Barker and Orrell (1999) have measured client satisfaction using client views of the general quality of services, professional qualities and competence, and communication. And, Garland and Besingei (1996) found a relationship between client satisfaction and provider competence. Thus, the current study measures client satisfaction by examining provider

helpfulness and client-provider interaction. Client satisfaction in the current is operationalized using 26 questions from the CPES (See Appendix E).

Data Analysis Plan

The data analysis plan for this study includes descriptive statistics to describe the sample population, specifically pertaining to cultural, racial, and ethnic characteristics. Upon the development of the scales representing the specific variables for this study, cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction, this researcher is evaluating these for reliability. Pearson's correlations will be used to test the bivariate hypotheses and multiple regression analysis will be used to test the final hypothesis.

Human Subjects Concerns

This study is an analysis of secondary or previously collected data. All identifying information regarding the respondents has been removed. The original study received Institutional Review Board (IRB) approval from each of the participating institutions respective to each of the three studies, NCS-R, NSAL, and NLAAS. This study received Institutional Review Board approval from The Catholic University of America.

Strengths and Limitations

Embedded within most research studies are strengths and limitations, the current study is no exception. This investigation was limited by being a secondary data analysis which hampered the operationalizing of the variables, that were restricted to questions, data, and variables constructed for the purposes of the original purpose of data collection. Therefore, the research was limited in how the variables were defined. Conversely, the

analysis benefited from the large, random sample population of the original study, allowing the findings to be generalized to the population of the United States.

Chapter Summary

This chapter on methodology presented the research question and research design which guided the investigation. This chapter also presented the primary dataset which will be customized to suit the current study, the statement of the hypothesis, and sample population. A discussion of the conceptual definitions of each of the variables was included along with how each variable will be measured and analyzed. The chapter concluded with brief discussions on the concerns to human subjects and the strengths and limitations of the study. The next chapter will discuss the sample in descriptive terms and statistical findings.

Chapter IV

Findings and Analysis of Data

The current study set out to test the overarching hypothesis that clients with high cultural self-awareness, high cultural self-determination, those at the high range of assimilation, and positive cultural interaction will report higher levels of client satisfaction with their mental health providers. The findings of the analysis of data are examined in this chapter. In addition to the overarching hypothesis, numerous other bivariate hypotheses are also examined. Consequently, this chapter presents the findings and data analysis of the current study using descriptive statistics to describe the sample population and multiple regression analysis was used to analyze the hypotheses.

Description of Sample

A nationally representative study of the incidence of mental disorders, impairments associated with mental disorders, and mental health treatment methods, the Collaborative Psychiatric Epidemiology Survey (CPES), 2001-2003 (Alegria, Jackson, Kessler, & Takeuchi, 2007; Pennell et al., 2004) was selected for a secondary data analysis. The first dataset of its kind, the CPES includes data about mental health support systems, language use and ethnic disparities, discrimination and assimilation to determine the association between mental health disorders and social and cultural issues. The CPES collected data from individuals of the Caribbean, Asia, Latin America, and the United States. The composite CPES includes data from the National Comorbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL), and the National Latino and Asian American Study (NLAAS).

The sample population for this analysis includes 5,002 participants of which 34.7% were male (*N* = 1,734) and 65.3% female (*N* = 3,268). With an inclusion criterion that study participants be legal adults according to US standards, the age range of the sample population was 18-93; with a mean age of 41.6 (*SD* = 14.9) and modes of 30 and 37 (see Table 4.1). The sample population represented racial and ethnic diversity which

Table 4.1:

Basic Demographics of Study Participants (N = 5,002)

		n	%
Gender			
Male		1,734	34.7
Female		3,268	65.3
Age			
18-25		772	15.4
26-35		1,139	22.7
36-45		1,223	24.5
46-55		982	19.6
56-65		509	10.1
66-75		255	5.0
76+		122	2.4
Mean 41.6	*SD* 14.9	Range 18 - 93	
US Citizen			
Yes		3,470	92.2
No		295	7.8
Education			
Less than HS		964	19.3
High School		1,446	28.9
Some College		1,393	27.8
College Degree or Greater		1,199	24.0

mirrors that of the proportions of the greater United States including 82.5% American born (*N* = 4,050) and 17.5% participants born in a country other than the United States (*N* = 86) (91 cases or 1.8% did not respond to this question). Within this racial and ethnic diversity of the sample population, 49.6% identified as White (Non-Latino), 19.6% African American,

17.5% Latino, 6.4% Asian, 4.6% Caribbean, and 2.4% “Other” (see Table 4.2). Of these participants, 77.2% had at least one parent born in the United States (*N* = 2,890) and 22.9% of the participants had neither parent born in the US (*N* = 856). Thus, 70.3% of the sample population is not first generation American (Table 4.3).

Table 4.2:

Racial/Ethnic Demographics (N=5002)

			n	%
Race				
	Asian			
		Vietnamese	58	1.2
		Filipino	73	1.5
		Chinese	93	1.9
		All Other Asian	98	2.0
	Latino			
		Cuban	125	2.5
		Puerto Rican	138	2.8
		Mexican	354	7.1
		All Other Latino	254	5.1
	Caribbean			
		Haitian	36	0.7
		Jamaican	73	1.5
		Trinidad & Tobago	29	0.6
		All Other Caribbean	77	1.5
	African-American		978	19.6
	White (Non-Latino)		2,480	49.6
	All Other		119	2.4
Country of Birth				
	United States		4,050	82.5
	Other		861	17.5

With the current study analyzing client satisfaction regarding client perceptions with mental health service providers, the sample population involves individuals with diagnosed mental health conditions as determined by the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV). Of the many disorders included in the DSM-IV and in the CPES, this study focuses on those disorders which are readily treated by social work professionals:

Social Phobia (38.2%; *N* = 1,909), Major Depressive Disorder (56.8%; *N* = 2,842), Generalized Anxiety Disorder (18.1%; *N* = 906), Agoraphobia without Panic Disorder

Table 4.3:

Familial Demographics (N = 5,002)

	n	%
# of parents born in US		
No parents born in the US	856	22.9
1 parent	258	6.9
2 parents	2,632	70.3
# of grandparents born in US		
0	826	24.6
1	119	3.5
2	452	13.4
3	202	6.0
4 or more	1,763	52.4

(9.9%; *N* = 495), Agoraphobia with Panic Disorder (6.6%; *N* = 329), Panic Disorder (16.3%; *N* = 817), and Specific Phobia Disorder (39.9%; *N* = 1,198) (Table 4.4).

Table 4.4:

*Demographics of Conditions (N = 5,002)**

	n	%
Social Phobia	1,909	38.2
Major Depressive Disorder	2,842	56.8
Generalized Anxiety Disorder	906	18.1
Agoraphobia (w/o Panic Disorder)	495	9.9
Agoraphobia (with Panic Disorder)	329	6.6
Panic Disorder	817	16.3
Specific Phobia Disorder	1,198	39.9

* % greater than 100% due to respondents with dual diagnoses

Summary Statistics of Variables

The CPES, the first nationally representative data set of mental health services, was selected to investigate the relationship between clients' perception of cultural competence of mental health service providers. Since data regarding the level of cultural competence of

mental health providers is not available in the CPES, this study considered cultural competence in mental health providers through exploring the clients' cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction. These variables were investigated based on the related literature in the field of cultural competence which identify significant components that impact cultural competence, one's perception of cultural competence of service providers, and clients' level of client satisfaction. As the CPES includes several hundred questions that contribute to the major aspects of each of the variables, the questions were aligned with each of the variables and Cronbach's alpha was analyzed to reveal those questions which were best suited to represent cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction. Those groups of questions that resulted with the acceptable Cronbach's alpha values were retained.

Interested in the type of mental health providers, the current study includes comparisons across disciplines. The mental health provider types included in this study include: psychiatry, general practitioner/medical doctor, psychology, social work, counseling, spiritual adviser, and traditional healer.

Independent Variables

As a reminder, cultural self-awareness refers to the insight individuals have of their own culture/ethnicity that influences their psychological, social, and emotional lifestyle (Brown, Parham, & Yonker, 1996). Cultural self-determination is a dynamic, active, and autonomic process in which an individual utilizes her culture to make decisions about her health and mental health treatment (Kraft & BrintzenhofeSzoc, n.d.). Range of assimilation

refers to a cultural exchange which resulted from contact with a host culture whereby an individual relinquishes her cultural identity and adjusts to the mainstream society (Berry, 1991; Fellin, 2000; Redfield, Linton, & Herskovits, 1936). Cultural interaction involves the communication exchange between clients and providers in which clients perceive cultural differences from the culture of the providers during the treatment process (Kelley & Meyers, 1993; Vontress, Johnson, & Epp, 1999). Following is the operationalizing of each of the independent variables discussed.

Cultural Self-Awareness.

The first independent variable, cultural self-awareness has been operationalized through variables which constitute aspects of individual clients. These aspects include cultural facets which pertain to the clients' micro, messo, and macro systems. Therefore, cultural self-awareness includes questions regarding the values, beliefs, and norms embedded within the client's lifestyle, character, and culture. These questions also include facets of the clients' perceived family support, respect received, and family cohesion.

The group of questions which were compiled to create the cultural self-awareness variable include: family-support, ethnic-group, religion-level, respect, family-cohesion, goals, spirituality/pray, and worth. To see the full list of questions included in this variable, see Appendix A. Family support refers to assistance and encouragement clients felt they received from family members. Family-support was calculated on a 4-point Likert type scale (4 = *a lot*, 1 = *not at all*). Ethnic-group considered the degree to which clients related to their ethnic group and was computed on a 4-point Likert type scale (4 = *very closely*, 1 = *not at all*). Religion-level considered the extent to which clients sought support from religion.

Religion-level was developed on a 4-point Likert type scale (4 = *often*, 1 = *never*). Respect refers to the client's perception of respect they receive from others which influences the client's level of confidence and self-awareness; respect was enumerated on a 6-point Likert type scale (6 = *almost everyday*, 1 = *never*). Spirituality/Pray considers the importance of spirituality/ pray in the client's life and it was tallied on both a 6 and 4-point Likert type scales (6 = *nearly everyday*, 1 = *never*; 4 = *very important*, 1 = *not at all important*). Goals was considered based on goals as a determinant of client's confidence and foresight into the future and was computed on both a 3 and 4-point Likert type scale (3 = *often*, 1 = *hardly ever/never*; 4 = *strongly agree*, 1 = *strongly disagree*). The worth questions were included to signify the client's perception of her qualities and was calculated on a 4-point Likert type scale (4 = *strongly agree*, 1 = *strongly disagree*). The family-cohesion questions indicate the extent to which the client feels close to family and abides by the culture of the family or her ethnicity. Family-cohesion was assessed on a 4-point Likert type scale (4 = *strongly agree*, 1

Table 4.5:

Cultural Self-Awareness Variable Groups

	$\bar{x}$	SD	Range	α
Family Support	2.6	0.6	0.0-4.0	.63
Ethnic Group	3.4	1.2	0.3-8.5	.44
Religion Level*	3.2	1.0	0.5-4.0	.75
Respect	2.5	1.2	0.5-6.0	.86
Family Cohesion	3.0	0.4	1.0-3.6	.80
Spirituality / Pray	4.1	0.8	1.0-5.0	.61
Worth	3.3	0.6	1.0-4.0	.66

* Cronbach's alpha for all three items is not available as two are asked of one group and one of the other two groups. The alpha presented represents the two items.

= *strongly disagree*). These cultural self-awareness domains each result in numerical estimates which are interpreted according to their corresponding score; the higher the score

the higher the clients' level of cultural self-awareness. The Cronbach's alphas for these questions along with the mean, standard deviation, and range are listed in Table 4.5.

Cultural Self-Determination.

The variable cultural self-determination was operationalized through the use of questions pertaining to aspects of the client's life which indicate the client's autonomy, willingness, and drive to overcome challenges. These indicators are also related to the client's ability to persevere while retaining and promoting her culture and ethnicity. Questions from the CPES compiled to create the cultural self-determination variable include the total professionals seen for treatment, the attempt to get help for various symptoms, the number of different providers types treatment was obtained from, the extent symptoms interfered with daily living, reasons for not seeking treatment, and the number of times the client sought treatment.

To obtain a cultural self-determination level, total professionals seen for symptoms and help-seeking behaviors was computed based on each type of mental health provider. The professional-seen variable was calculated numerically, in whole numbers. The tried-get and seen-professional-sad variables were enumerated using dichotomous variables, *yes* (1) and *no* (5). Extent-interfere questions inquired about how much mental health symptoms impacted the client's tasks of daily living and was tallied numerically on a scale of 1-10 with 10 meaning symptoms interfered the worst. The time-needed-help variable considered the length of time the client believed she needed assistance. Time-needed-help was assessed numerically in time segments of days, weeks, months, and years. And the professional-for-mental-health variable inquired about the type of provider clients sought treatment with.

These domains are contrasted to reasons for the client delaying treatment, which is coded to allow a higher number of delays to treatment to refer to the more clients persevered over challenges to seek treatment. Delay is counted for each type of delay on a dichotomous scale (0 = *no*, 1 = *yes*). The professional-for-mental-health domain provides information regarding the number of provider types clients sought treatment from. This domain is analyzed numerically. Cultural self-determination domains are interpreted such that the higher the score the higher the client's level of self-determination. The Cronbach's alphas for each of the variables included in this composite were observed and displayed in Table 4.6.

Table 4.6:

Cultural Self-Determination Variable Groups

	$\bar{x}$	SD	Range	α
Professional Seen	1.7	2.5	0-30.0	----
Tried To Get Help	0.2	0.2	0-0.9	.77
Seen Professional Sad	0.4	0.2	0-1.0	.40
Extent Interfere	5.5	3.5	0-20.0	.90
Delay	0.4	0.3	0-1.9	.82
Time Needed Help	8.0	7.0	0-68.0	----
Professional for Mental Health	0.4	0.4	0.1-2.8	----
Goals*	1.8	1.0	0.5-4.0	.65

* Cronbach's alpha for all three items is not available as two are asked of one group and one of the another group. The alpha presented represents the two items.

The provider type domain provides information as to the various provider types clients sought treatment from, allowing for comparisons between provider types. The full list of questions included in the cultural self-determination variable may be seen in Appendix B.

Range of Assimilation.

Cultural assimilation includes concepts embedded within it which pertain to an individual either modifying her own culture, in some aspects, or holding fast to her own culture and potentially experiencing challenges with navigating the systems of the

mainstream culture. Either way, range of assimilation includes behaviors and relationships which allow or disallow an individual to more smoothly traverse society. Some of these relationships include interaction with neighbors and the surrounding community one lives in, the language one communicates in, and spiritual support.

The operationalizing of the independent variable range of assimilation includes the combination of questions revealing information about the client's level of comfort and identifying with neighbors, language, and church. Neighbors questions explore the relationship between clients and those in their immediate geographic community. Thus, these questions calculate how much clients relate to and have positive relationships with their neighbors; this scale is computed on a 4-point Likert type scale (4 = *very true*, 1 = *not at all true*). The domain language queried clients about the language they speak with friends and family and what language clients think in. These questions provide information about the client adjusting to the host culture as she is communicating in her daily life. Language is recorded in linguistic categories. The final group of assimilation questions focuses on the extent to which clients perceive their relationship with the church and people in the church is positive, this is enumerated on a 4-point Likert type scale (4 = *very close*, 1 = *not close at all*; 4 = *very satisfied*, 1 = *very dissatisfied*; and 4 = *often*, 1 = *never*). Each of the assimilation domains is interpreted based on high scores constituting high range of assimilation. The

Table 4.7:

Range of Assimilation Variable Groups

	$\bar{x}$	SD	Range	α
Neighbors	3.0	.7	0.6-4.0	.82
Language	2.6	1.4	1.0-5.0	.92
Church	2.4	.6	0.1-3.9	.72

range of assimilation domains, unlike the other four variables, include data strictly from the National Survey of American Life (NSAL) and the National Latino and Asian American Study (NLAAS). The Cronbach's alphas for each of the variable groups included in this composite were observed and displayed in Table 4.7. See the full list of range of assimilation questions in Appendix C.

Cultural Interaction.

The effectiveness with which clients communicate with their providers is largely influenced by the varying values, beliefs, traditions, and verbalizations expressed by both parties engaged in the interaction. Thus, when clients and providers understand one another cross-culturally and appropriately interpret the symbols and somatic symptoms, effective cultural interaction results. Such interpretation is provoked by the degree to which clients feel the professional was helpful, the client feels confident about communicating with the provider, and the challenges felt with interacting with professional are minimized.

To determine the extent to which clients felt they received helpful treatment from mental health providers, questions investigating whether or not the professional-(was)-helpful were included in the cultural interaction variable using a dichotomous (0 = *no*, 1 = *yes*) response set. A means of exploring the impact of language on the treatment process,

Table 4.8:

Cultural Interaction Variable Groups

	$\bar{x}$	SD	Range
Professional Helpful	0.1	0.3	0-1.0
Language Quit	0.1	0.2	0-0.7
Challenges	2.0	0.9	0-5.0

clients were asked if language was related to reasons for discontinuing treatment and if they communicated with the care provider in their own language. And challenges with interaction were examined through inquiring as to barriers clients felt with obtaining direct service from providers using the dichotomous responses (0 = *no*, 1 = *yes*) and one 4-point Likert type scale (4 = *not at all comfortable*, 1 = *very comfortable*). These responses in the interaction domains indicate the higher the score the higher the cultural interaction. The full set of questions included in the cultural interaction questions, see Appendix D.

Dependent Variable

The sole dependent variable, client satisfaction, pertains to the assessment of an individual's approval of treatment from mental health professionals (Oliver, 1999). As an independent variable each of the independent variables relate to client satisfaction with respect to the impact of culture on client satisfaction. An individual's beliefs, values, and customs influence their worldview, lifestyle, communication style, and understanding of how mental health challenges should be addressed. Therefore, considering the moderating effect of culture on client satisfaction allows for a more holistic impression of client perceptions of provider cultural competence. The following describes how client satisfaction was operationalized.

Client Satisfaction.

As an assessment of an individual's approval of treatment services received by mental health service providers cross-culturally, client satisfaction was explored. This assessment includes what this researcher believes are core to the analysis of client satisfaction: satisfaction with treatment, amount of help, and quality of services. The variable group

satisfaction seeks the level of approval a client had with various mental health providers on a 5-point Likert type scale (5 = *very satisfied*, 1 = *very dissatisfied*). To determine the extent to which mental health providers were helpful to cross-cultural clients or the extent to which clients felt mental health providers were helpful, clients were asked the amount each type of provider helped. The amount providers were helpful was computed on a 4-point Likert type scale (4 = *a lot*, 1 = *not at all*). With amount providers helped a strong indicator of client satisfaction, an assessment of the quality of services is equally as robust a domain, clients

Table 4.9:

Client Satisfaction Variable Groups

	$\bar{x}$	SD	Range	α
Each Professional Past Year	0.9	0.6	0.1-4.3	.50
Amount Helped	0.6	0.4	0.1-3.0	.64
Quality Service	0.04	0.2	0-3.9	.72

were asked about the quality of services they received from each provider type. Quality of services received was rated on a 5-point Likert type scale (5 = *excellent*, 1 = *poor*). Within each of the client satisfaction domains, the higher the number of professionals, amount provider helped, and the quality of service the higher the client satisfaction. The full list of questions may be found in Appendix E. The Cronbach's alphas for each of the variables included in this composite were observed and displayed in Table 4.9.

Provider Type.

A significant premise in this study, clients' perception of which provider(s) supplies the best quality, most satisfying, and culturally competent treatment, basic statistics on provider type must be considered, see Table 4.10 for provider type statistics. The processing of frequency statistics reveals those included in the 5,002 sample visited a psychiatrist 1,268

times, psychologists 947 times, social workers 436 times, and religious/spiritual advisors 640 times. While the frequency of these visits may indicate psychiatrists and general practitioners were the preferred provider type, upon reviewing the median number of visits, i.e., the provider type that respondents most often sought treatment from are social workers (median = 16) and religious/spiritual advisor (median = 16), when compared to the remaining provider types. As a result of the method with which the original data were collected by the CPES, no further analysis pertaining to provider type is possible.

Table 4.10

Basic Statistics on Provider Type (N = 5,002)

	n	$\bar{x}$	Median	SD
Psychiatrist	1,268	10.59	7	10.14
General Practitioner	1,356	9.55	6	9.73
Psychologist	947	13.10	10	10.14
Social Worker	436	18.08	16	10.70
Counselor	933	15.21	12	9.68
Religious/Spiritual Advisor	640	18.55	16	9.32

Bivariate Analysis

A series of bivariate statistical analyses were conducted to determine the similarities and differences between the composite variables. In such, the researcher completed a string of independent t-tests, analysis of variances, and Pearson's correlations; the results of those comparisons are reported in the following Tables. Of the 24 composite variables, the following seven domains resulted in statistically significant differences (Table 4.11). These bivariate findings from independent t-tests indicate females experience more family-support, religion-level, spirituality/pray, and goals attainment than males. And males experience more respect, a greater extent of interference with daily living, and more challenges with interaction with mental health providers.

Table 4.11

Bivariate Statistics by Gender(N = 5,002)*

	Males		Females	
	n	$\bar{x}$	n	$\bar{x}$
Family Support Awareness	1,633	2.54	3,099	2.70
Religion Level Awareness	1,562	3.00	3,107	3.40
Respect Awareness	654	2.69	1,329	2.51
Spirituality/Pray Awareness	346	3.93	807	4.22
Goals Determination	658	1.74	1,335	1.84
Extent Interfere Determination	289	5.95	699	5.30
Challenges Interaction	1,339	2.00	2,395	1.91

*statistical significance determined according to ≤ .05

ANOVA's: Race/Ethnicity vs. Composite Variables

A sizeable aspect to the current study, race/ethnicity as a demographic variable provides information as to similarities and differences based on cultural variation between race/ethnic groups. The *Variables by Race/Ethnicity & Cultural Self-Awareness* table (Table 4.12) presents the mean scores of the cultural self-awareness composite variables determined to be statistically significant at the .05 level. These variables specify the cultural groups that reported self perception of the distinct facets of cultural self-awareness. More to the point, the table depicts the influence of race/ethnicity on features that contribute to an individual identifying with the specific group.

It is important to note, the respect, worth, and spirituality/pray composites were also concluded to have statistical significance when comparing the means across race/ethnic groups, however since at least one of the groups has fewer than two cases a post hoc test was not performed. Within the respect composite, African Americans (*N* = 642) and Latinos (*N* = 594) had the largest *N* value reinforcing this researcher's ideas that respect is an integral part of one's personal identity, cultural identity, and awareness in the world. Comparing mean

scores across race/ethnicity, however, two (Asian and Other) of six groups had fewer than two cases, and thus no post hoc test was performed. The sentimentality of self-worth relates to positive feelings one has about themselves and their deservingness of treatment. Similarly, spirituality/pray, the cultural groups of color (Latino, Caribbean, and African American) had the largest *N* values (*N* = 906), with the White group including 247 cases. Thus,

Table 4.12

Variables by Race/Ethnicity & Cultural Self-Awareness (N = 5,002)

	N	$\bar{x}$	F	Post hoc *p*
Family Support				
Asian	317	2.51		c,d,e
Latino	847	2.61		c,d
Caribbean	232	2.82	13.59	a,b,e,f
African American	932	2.73		a,b,e,f
White	2,303	2.63		a,c,d
Other	101	2.54		c,d
Ethnic Group				
Asian	320	4.57		b,c,d,e,f
Latino	830	4.25		a,c,d,e,f
Caribbean	11	3.15	288.76	a,b
African American	316	3.13		a.b
White	2,152	2.99		a,b
Other	114	2.90		a,b
Religion Level				
Asian	314	2.62		b,c,d,e,f
Latino	850	2.97		a,c,d,e,f
Caribbean	232	3.64	98.43	a,b,e
African American	956	3.71		a,b,e
White	2,210	3.14		a,b,c,d,f
Other	107	3.43		a,b,e

[a] Difference with Asian
[b] Difference with Latino
[c] Difference with Caribbean
[d] Difference with African American
[e] Difference with White
[f] Difference with Other

spirituality/pray is found to be another important factor of cultural self-awareness. This finding is not an indication that Whites do not consider spirituality/pray important in their lives, it simply denotes what scholars have believed, that spirituality and a connection to a higher power is essential to cultural identity and self-awareness.

Race/Ethnicity vs. Cultural Self-Determination.

Cultural self-determination in the current study involves the amount effort, purpose, and fortitude an individual exhibits to the end of seeking and obtaining treatment for mental health challenges. This research operationalized cultural self-determination through persevering over various aspects of daily living that individuals are faced with which if handled differently may be barriers to treatment. Of the eight composites of cultural self-determination included in the study, two were found to have statistically significant differences across race/ethnic groups. The remaining composites not found to have statistical significance include professional-seen, time-needed-help, and professional-for-mental-health. Those variables found to have statistical significance but had at least one group with fewer than two cases include: goals, tried-get-help, and seen-professional-for-sadness.

Goals determination has a fairly even spread of cases across the race/ethnic groups. This finding indicates goals, striving for goals, and achieving goals are focal aspects of individuals and their feelings of positive self-awareness. Analogous to goals, tried-to-get-help determination is a composite which post hoc analysis was not performed due to the lack of cases in one of the groups. Tried-to-get-help refers to an individual's attempt to seek assistance from a mental health symptom from family and friends. These questions resulted in very few responses as compared to the number of individuals that responded to other

questions included in composite variables and were not responded to at all by either Asians or Others. And, seen-professional-sad questions mirror tried-get-help questions, few overall responses and no responses from Asians or Others. Seen-professional-sad details the type of provider individuals sought treatment from when experiencing sadness. The low response rate is not surprising to this researcher as peoples of color, as well as White, do not typically

Table 4.13

Variables by Race/Ethnicity & Cultural Self-Determination

	n	$\bar{x}$	F	Post hoc *p*
Extent Interfere				
Asian	79	6.84		c,d,e
Latino	232	6.33		c,e
Caribbean	33	3.82	10.31	a,b
African American	177	5.41		a
White	440	4.85		a,b
Other	27	6.12		----
Delay				
Asian	36	0.44		----
Latino	151	0.52		c,d,e
Caribbean	31	0.33	14.75	b
African American	129	0.37		b
White	376	0.32		b
Other	16	0.42		----

[a] Difference with Asian
[b] Difference with Latino
[c] Difference with Caribbean
[d] Difference with African American
[e] Difference with White
[f] Difference with Other

seek assistance for “sadness” and don’t discuss these matters outside of the home. Additionally, the terms “sadness” may have differing definitions or manifestations across cultures as language is an important part of mental health treatment and interaction.

Race/Ethnicity vs. Range of Assimilation.

One of the most interesting findings of this bivariate analysis is revealed upon reviewing the analysis of variance of the Range of Assimilation composite variables. None of the three composite range of assimilation variables resulted in a statistically significant mean score when compared across race/ethnic groups. While at first look this finding appears incomprehensible, upon more careful consideration the range of assimilation that individuals experience is perhaps as distinct and diverse as cultural groups themselves. Each composite, language, neighbors, and church, may be thought of in different terms within each cultural group thus the conceptualization of the influence of language, neighbors, and church on individuals within each race/ethnic group may vary widely. Statistically speaking, these composite variables could not be used for comparing mean scores across groups as each variable included at least two groups of which no responses were recorded, thus post hoc analysis could not be performed.

Race/Ethnicity vs. Cultural Interaction.

In a series of analysis of variance bivariate tests executed using race/ethnic groups as the point of comparison and the composite cultural interaction, the following table (Table 4.14) reports the results of two of three variables, professional-helpful and challenges. The third variable amassed of multiple questions related to the client's perception of her ability to communicate and be understood by mental health providers. The language-quit composite variable could not be analyzed in these bivarate analyses because the questions were solely asked of Asians and Latinos, thus comparisons could not be drawn across all six race/ethnic groups. Despite the lack of statistical significance of the variable, there is substantive

significance which speaks to the degree of effectiveness of communication between clients and mental health providers. The substantive significance of testing the efficacy of interaction between clients and their providers is evidenced in client's lack of confidence in providers' ability to communicate with and understanding the problems of the individuals before them. The perception of providers' lack of communicating with and understanding clients exceeds vocabulary and common language. Communication between cross-cultural

Table 4.14

Variables by Race/Ethnicity & Cultural Interaction

	n	$\bar{x}$	F	Post hoc *p*
Professional Helpful				
Asian	17	0.24	12.88	----
Latino	114	0.27		c,d,e
Caribbean	111	0.07		b,e
African American	394	0.06		b,e
White	361	0.18		b,c,d
Other	12	0.25		----
Challenges				
Asian	319	1.92	9.48	b
Latino	827	2.09		a,e
Caribbean	11	1.81		----
African American	318	1.97		----
White	2,145	1.86		b,f
Other	114	2.18		e

[a] Difference with Asian
[b] Difference with Latino
[c] Difference with Caribbean
[d] Difference with African American
[e] Difference with White
[f] Difference with Other

clients and providers extends to providers comprehending how providers express symptoms and the variation in terminology between the client's host language and American English. In this analysis, however, language as a purpose for pursuing mental health treatment cannot be

determined bivariately using analysis of variance, other determinants of interaction are presented below.

Race/Ethnicity vs. Client Satisfaction.

In tandem with the independent composite variables, client satisfaction with mental health service was assessed comparing mean scores of race/ethnic groups. Of the three aggregate client satisfaction variables, amount services helped is the sole statistically significant analysis of comparing mean scores; these results are reported below (Table 4.15). The two remaining variables, satisfaction with providers and quality of services do not have information to provide. Satisfaction with providers was not found to have statistical

Table 4.15

Variables by Race/Ethnicity & Client Satisfaction

	n	$\bar{x}$	F	Post hoc *p*
Amount				
Asian	67	0.53		----
Latino	243	0.63		[c]
Caribbean	54	0.44	2.50	[b]
African American	233	0.59		----
White	674	0.56		----
Other	24	0.60		----

[a] Difference with Asian
[b] Difference with Latino
[c] Difference with Caribbean
[d] Difference with African American
[e] Difference with White
[f] Difference with Other

significance and quality of services has too few cases to produce a post hoc test. Despite the lack of reportable findings, the importance of client satisfaction with various providers and quality of services is clear. A major determinant in the effectiveness of services provided to

clients, specifically with mental health challenges, is client satisfaction; services provided to cross-cultural clients is no different.

The overall finding from the comparisons of means of composite variable scores of race/ethnic groups largely confirms the suspicions of this researcher and of literature in the area of cultural competence. Simply stated, culture and ethnicity influence client perceptions of mental health treatment and client perceptions of mental health service providers. There is evidence of differences in cultural self-awareness, cultural self-determination, cultural interaction, and client satisfaction across cultures; individuals of color, as a whole, show more mean differences than Whites. Also, there are mean differences between cultural groups of individuals of color. The influence of these differences is not evident in the aforementioned analysis of variances and independent t-tests; further interpretation of the differences is presented below upon reviewing the various results of correlation statistics. Next this researcher reports on results of mean differences of level of education of each of the composite variables.

ANOVA's: Level of Education vs. Composite Variables

As was previously stated, analysis of variance is a comparison of mean scores. In the following section, mean scores of each of the composite variables included in the current study will be assessed according to level of education. The following tables outline those mean scores that have been determined to be statistically significant.

Level of Education vs. Cultural Self-Awareness

The influence of level of education on cultural self-awareness, overall, may be seen in

Table 4.16

Variables by Level of Education & Cultural Self-Awareness

	n	$\bar{x}$	F	Post hoc *p*
Family Support				
Less than HS	915	2.55	13.05	[h,i,j]
High School	1,365	2.64		[g,j]
Some College	1,313	2.67		[g,j]
College Degree or Greater	1,139	2.70		[g,h]
Ethnic Group				
Less than HS	677	3.79	28.63	[h,i,j]
High School	1,038	3.34		[g]
Some College	1,094	3.29		[g]
College Degree or Greater	934	3.37		[g]
Religion Level				
Less than HS	928	3.19	4.03	----
High School	1,350	3.28		[j]
Some College	1,293	3.24		----
College Degree or Greater	1,098	3.15		[h]
Respect				
Less than HS	540	2.41	3.84	[h]
High School	559	2.66		[g]
Some College	464	2.56		----
College Degree or Greater	420	2.58		----
Spirituality/Pray				
Less than HS	274	4.21	4.45	[j]
High School	384	4.17		[j]
Some College	261	4.15		[j]
College Degree or Greater	234	3.97		[g,h,i]
Worth				
Less than HS	274	3.00	30.12	[h,i,j]
High School	384	3.26		[g,j]
Some College	261	3.37		[g]
College Degree or Greater	234	3.44		[g,h]

[g] Difference with Less than HS
[h] Difference with High School
[i] Difference with Some College
[j] Difference with College Degree or Greater

Table 4.16 outlining the mean scores of those composite variables with a statistically significant difference in level of education; this includes six of the seven variables. The lone variable not found to be statistically significant, family-cohesion, indicates, like several of the significant variables, that one's level of education is not a clear determinant of one's level of cultural self-awareness. While family-support and worth show the more education one has, the more family-support and self-worth that individual experiences, the data indicate, the less education the more spiritual/pray an individual experiences. The remaining variables do not show a clear relationship between one's level of education and the cultural self-awareness composite variables; see Table 4.16 for the influence of each level of education on cultural self-awareness variables. These findings do not stipulate those with more education have less cultural self-awareness. These findings suggest that those included in the sample typically had levels of cultural self-awareness comparable to those of the general population. Generalizations to the larger society beyond the sample may be made due to the overall sample size and the categorical proportions paralleling the population at large.

Level of Education vs. Cultural Self-Determination.

As it pertains to cultural self-determination, the samples mean scores denote having less education results in having more self-determination to seek and/or obtain treatment for mental health challenges. While this finding may seem to imply that those with more education do not have as much drive, effort, or inclination towards pursuing assistance from mental health providers, this finding is understood differently by this researcher. This finding may indicate that those with more education were more successful in obtaining effective and satisfying treatment early in their endeavor for assistance. Those with less education were not

as successful in obtaining effective treatment early in their endeavor and therefore needed to continue to seek treatment and thus seemed to exhibit more self-determination than those with more education.

Table 4.17

Variables by Level of Education & Cultural Self-Determination

	n	$\bar{x}$	F	Post hoc *p*
Goals				
Less than HS	542	1.90	6.86	i,j
High School	566	1.89		i,j
Some College	463	1.73		g,h
College Degree or Greater	422	1.67		g,h
Tried to Get Help				
Less than HS	217	0.27	6.23	h,j
High School	293	0.23		g
Some College	184	0.23		----
College Degree or Greater	158	0.20		g
Extent Interfere				
Less than HS	255	5.99	6.12	j
High School	283	5.53		j
Some College	255	5.51		j
College Degree or Greater	195	4.60		----
Delay				
Less than HS	136	0.51	18.21	h,i,j
High School	184	0.38		g
Some College	221	0.34		g
College Degree or Greater	198	0.32		g
Time Needed Help				
Less than HS	130	9.67	4.69	j
High School	152	7.80		----
Some College	154	8.02		----
College Degree or Greater	110	6.31		g
Professional for Mental Health				
Less than HS	568	0.37	7.17	i,j
High School	870	0.42		j
Some College	945	0.45		g
College Degree or Greater	768	0.47		g,h

[g] Difference with Less than HS
[h] Difference with High School
[i] Difference with Some College
[j] Difference with College Degree or Greater

Of the eight total domains included in the cultural self-determination variable, six were determined to have statistical significance at the $p = .05$ level when comparing mean scores of level of education; thus two of the domains did not result in statistical significance. The two domains that did not produce statistical significance when comparing mean level of education scores were professional-seen and seen-professional-sad. The results of the six statistically significant domains are included in Table 4.17.

Level of Education vs. Range of Assimilation.

Questions included in the range of assimilation composite variables inquire about the respondents comfort with their geographic community, language use, and church

Table 4.18

Variables by Level of Education & Range of Assimilation

	n	$\bar{x}$	F	Post hoc *p*
Neighbors				
Less than HS	268	2.84		[j]
High School	182	2.91	7.15	[j]
Some College	203	2.99		----
College Degree or Greater	188	3.16		[g,h]
Language				
Less than HS	248	1.90		[h,i,j]
High School	154	2.56	42.95	[g,i,j]
Some College	166	3.20		[g,h]
College Degree or Greater	170	3.08		[g,h]

[g] Difference with Less than HS
[h] Difference with High School
[i] Difference with Some College
[j] Difference with College Degree or Greater

environment. The analysis of variance run on these three domains reported statistically significant results in two of the domains. The non-significant domain was the church domain. The neighbors and language domains indicate increased education assist individuals in

adjusting to a new cultural environment more smoothly. An explanation of these findings may assert that those with more education are prepared to negotiate the social construct and mental systems of the host country. Thus, those with more education have the educational advantage to obtaining the desired treatment and outcomes. These results are reported in Table 4.18.

Level of Education vs. Cultural Interaction.

Conversely, of the three cultural interaction composite variables, two were found to lack statistical significance when comparing mean level of education leaving challenges with interaction as the sole cultural interaction domain with statistical significance, see Table 4.19. The professional-helpful and language-quit domains provided unclear findings as it pertains to level of education. An interpretation of the challenges domain offers, those with less education experience more challenges interacting with mental health providers. This finding falls in line with past research and the inclination of this researcher, reinforcing that those with more education are more familiar with language and vocabulary used in mainstream society for communicating with mental health providers.

Akin to the comparisons with the race/ethnicity groups, level of education produced a variable which included no domains with statistical significance. Among the dependent satisfaction variables, neither the satisfaction with treatment, amount of treatment, and quality of services domains resulted in statistically significant findings. Of interest to note is that level of education is not a clear determinant of an individual's level of satisfaction with mental health services or mental health providers. As is resolved by the use of the Tukey's rotation during analysis of variance, any differences from these results in the groups, or in the

general population, is due to chance. The following explores results from a series of Pearson's correlations.

Table 4.19

Variables by Level of Education & Cultural Interaction

	n	$\bar{x}$	F	Post hoc *p*
Challenge				
Less than HS	671	2.08	28.21	[i,j]
High School	1,033	2.07		[i,j]
Some College	1,094	1.87		[g,h,j]
College Degree or Greater	936	1.76		[g,h,i]

[g] Difference with Less than HS
[h] Difference with High School
[i] Difference with Some College
[j] Difference with College Degree or Greater

Pearson's Correlations

The observations made of the aforementioned bivariate statistics allowed this researcher and the reader to become more acquainted with the data set and the population included in the current study. The following is the next step in enhancing the understanding of the data set and the relationship of the variables to each other. Thus, a look at the linear relationships between composite variables included in the study which provoke discussion on the hypotheses presented in Chapter III of this dissertation. Responses and discussion pertaining to the first three of four hypotheses follow.

Age.

To determine the linear relationship between the age demographic and each of the composite variables, Pearson's correlations was completed. The results of the statistically significant findings are displayed in Table 4.20. When compared to age, religion-level, family-cohesion, spiritual/pray, seen-professional, time-needed, neighbors, and church have

positive linear correlations. Older individuals experience higher religion-level, family-cohesion, spiritual/pray, and church, and seen-professionals and time-needed-help. Conversely, family-support, respect, professional-for-mental-health, language, professional-helpful, and challenges had negative linear relationships with age. Therefore, older clients reported less family-support, respect, language assimilation, and challenges assimilation than younger clients; and older clients reported seeing fewer professionals-for-mental-health and feeling professionals as less helpful.

Of particular interest is the lack of a linear relationship between age and any of the client satisfaction domains. The suggestion of this finding is that age is not a factor in the level of satisfaction an individual perceives from mental health service providers.

Table 4.20

Correlation Matrix of Age vs. Composite Variables

	n	*r*
Cultural Self-Awareness		
Family Support	4,732	-.099**
Religion Level	4,669	.164**
Respect	1,983	-.149**
Family Cohesion	841	.136**
Spirituality/Pray	1,153	.107**
Cultural Self-Determination		
Seen Professional Sad	452	.117*
Time Needed Help	538	.180**
Professional for Mental Health	3,151	-.073**
Range of Assimilation		
Neighbors	841	.098**
Language	738	-.351**
Church	894	.109**
Cultural Interaction		
Professional Helpful	1,009	-.087**
Challenges	3,734	-.137**

**Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Cultural Self-Awareness vs. Cultural Self-Determination.

Examining the relationship between the composite variables for cultural self-awareness and cultural self-determination, the findings are revealed in a correlation matrix and displayed in Table 4.21. The findings from this statistical analysis contribute to answering the first hypothesis presented in this dissertation:

H_1: Clients with higher levels of cultural self-awareness will have higher levels of cultural self-determination.

Of the seven cultural self-awareness domains and eight cultural self-determination domains, there are 15 statistically significant correlations of the 56 total potential correlations. Although there is not an overwhelming affirmative response to $H_{1,}$ there were 15 correlations that support for this hypothesis and 41 correlations that do not support this hypothesis. These correlations that do not support the hypothesis provide indications of areas for further exploration, beyond the scope of this dissertation.

There is support for H_1, nine positive linear relationships between cultural self-awareness domains and cultural self-determination and six negative linear relationships. The more religion, respect, family-cohesion, and worth individuals report, the more determined to reach their goals the individuals are. The more religion awareness clients report, the more clients tried- get-help. The more spirituality/pray, the more professionals clients saw for their sadness. Of particular interest is the positive linear relationship between ethnic-group awareness and delay determination. This finding responds to a considerable portion of the premise for this study. Directly interpreted, those who identify more with their culture/ethnicity delay mental health treatment more. Thus, the more cultural self-awareness

clients have the more cultural self-determination. While a definitive conclusion to this hypothesis cannot be made within the current study, there is ample evidence to support the hypothesis with implications for further research.

Range of Assimilation vs. Cultural Self-Determination.

To ascertain the relationship between range of assimilation and cultural self-determination statistical correlations were completed using the Pearson's method and a correlation matrix examined (Table 4.22). Included in this analysis are eight domains of cultural self-determination composite variables and three domains within the range of assimilation composites. The relationship between cultural self-determination and range of assimilation was sought to answer the second bivariate hypothesis in this study:

H_2: Clients with higher levels of range of assimilation will have higher levels of cultural self-determination.

Included in this matrix are 24 possible correlations there are eight statistically significant linear relationships. Overall, three of these linear relationships support the hypothesis and five of the statistically significant relationships do not support the hypothesis. Based entirely on the number of positive versus negative linear relationships H_2 is not supported by the findings in this study. Those who are more determined to reach their goals and readily talked to professionals for mental health treatment also readily spoke English with their family and friends and thought in English, thus experiencing more assimilation to the host culture. And, those who sought more treatment from mental health professionals perceived themselves to have adapted more to church and more satisfied with their relationship with people in the

Table. 4.21

Correlation Matrix: Cultural Self-Awareness vs. Cultural Self-Determination

	Cultural Self-Awareness						
	Family Support	Ethnic Group	Religion Level	Respect	Family Cohesion	Spirituality /Pray	Worth
Cultural Self-Determination							
Goals	----	----	.147**	.119**	-.249**	----	-.496**
Professional Seen	----	----	----	----	----	----	----
Tried Get Help	-.068*	----	.127**	----	----	----	-.123**
Seen Professional Sadness	----	----	----	----	----	.139**	----
Extent Interfere	-.093**	.131**	-.077*	----	----	----	----
Delay	----	.340**	----	----	----	----	-.244**
Time Needed help	-.109*	----	----	----	----	----	----
Professional for MH	----	----	.082**	----	----	----	----

**Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Table. 4.22

Correlation Matrix: Range of Assimilation vs. Cultural Self-Determination

	Range of Assimilation		
	Neighbors	Language	Challenges
Cultural Self-Determination			
Goals	-.093**	.151**	----
Professional Seen	----	----	----
Tried Get Help	----	----	----
Seen Professional Sadness	----	----	----
Extent Interfere	-.151*	----	----
Delay	-.228**	-.311**	----
Time Needed help	----	-.348*	----
Professional for MH	----	.138**	.091*

**Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

church; these findings support the hypothesis. Conversely, those who delayed mental health treatment and felt they needed more time receiving mental health treatment believed themselves to be less assimilated to the host language, English. Those who are more determined to reach their goals feel daily living tasks interfere with their mental health, and are more inclined to delay treatment and feel less comfortable and assimilated to their neighbors; these results fail to support this hypothesis.

Cultural Self-Awareness vs. Range of Assimilation.

The third bivariate hypothesis investigates the relationship between cultural self-awareness and range of assimilation, through another correlation analysis. Between the seven cultural self-awareness domains and the three range of assimilation domains, there are 21 possible correlations, of which 10 are statistically significant. These ten statistically significant findings provide insight into this third hypothesis:

H_3: Clients with higher levels of cultural self-awareness will have higher levels of range of assimilation.

With seven positive linear relationships and three negative linear relationships resulting from the cultural self-awareness and range of assimilation match-up, it is perhaps safe to assume that H_3 is largely supported. These seven positive linear relationships support the hypothesis and the three negative relationships do not support the hypothesis. Along with supporting H_3, these findings emphasize impact of culture and cultural self-awareness on an individual's journey of assimilation. It also underscores the variation in culture and ethnicity but also the similarities in immigrating to the United States and learning to navigate the various systems in society.

Individual interpretations of the bivariate correlations involving cultural self-awareness domains and range of assimilation domains which support H_3, begin with those experiencing high family-support and high family-cohesion also feel closely assimilated to their neighbors and geographic community. Those who perceive

Table. 4.23

Correlation Matrix: Cultural Self-Awareness vs. Range of Assimilation

	Range of Assimilation		
	Neighbors	Language	Church
Cultural Self-Awareness			
Family Support	.097**	.265**	.189**
Ethnic Group	----	-.411*	----
Religion Level	----	----	.336**
Respect	-.147**	.254**	----
Family Cohesion	.184**	-.169**	----
Spirituality/Pray	----	----	.346**
Worth	----	----	----

**Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

themselves to have high family-support also perceive themselves as being respected, thus these individuals communicate using a universal language and communicate with family

and friends accordingly. And those with high family-support, high religion awareness, and high spirituality/pray awareness have positively adjusted to their church community. The findings that fail to support H_3 include those who have high respect, high ethnic-group identity, and high family-cohesion have assimilated less to the mainstream culture.

Multiple Regression Analysis

Multiple regression analysis was used to determine the existence of a relationship between a series of independent variables and each dependent variable. This analysis was used to test the fourth and final hypothesis of the current study:

H_4: Clients with high cultural self-awareness, high cultural self-determination, at the high range of assimilation, and positive cultural interaction will report higher levels of client satisfaction with their mental health providers.

To accomplish the determination about the relationship between cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction, a series of regression analyses were run using the Backward method regression including all of the domains with valid cases to complete the analysis against each of the three dependent variable domains (amount provider helped, quality of service, and satisfaction with treatment/provider).

Amount Providers Helped

When including all seven domains of the cultural self-awareness composite variables, it was determined that there is no relationship between cultural self-awareness and the amount providers helped; none of the regression models produced statistically

significant findings. Religion level was trending towards significance in the model so a Pearson's correlation was run to see if there was a linear relationship between this one domain of cultural awareness and this dependent variable. There was a statistically significant strong, positive linear relationship between religion level and amount providers helped ($r = .60$, $p < .05$). The higher the religion level the greater the amount providers helped. Thirty-six percent of the variance in amount providers helped was explained by religion level.

Table 4.24

Multiple Regression for Amount Provider Helped

	B	Beta	t	Sig
Cultural Self-Determination				
Professional Seen	.596	.332	2.857	.007
Professional for MH	4.574	.459	3.900	.000
Delayed	2.181	.190	1.914	.062
Constant	.473		.518	.607
$R^2 = .660$ $F = 27.156$ $p < .000$				

To investigate the influence of cultural self-determination on amount providers helped another MRA using the Backward method was conducted. Of the eight cultural self-determination domains three in the final model remained statistically significant ($F = 27.156$, $p <. 001$, $R^2 = .660$). Having seen a professional for mental health was the strongest predictor ($\beta = .459$), professionals seen was the next strongest ($\beta = .332$) followed by delay ($\beta = .190$). Sixty-six percent of the variance in amount provider helped can be explained by the more professionals seen for mental health, the more professionals seen in general, and the more delays the client experienced. (See Table 4.24)

The remaining two independent variables, range of assimilation and cultural interaction were not found to be statistically significant predictors of amount providers helped. Thus H_4 in terms of amount providers helped was partially supported.

Satisfaction with Treatment/Provider

Similar to the amount providers helped, the satisfaction with the treatment/ provider dependent variable does not produce linear relationships with the cultural self-awareness domains over all. The religion level awareness composite variable was significant in a number of the models so a Pearson's correlation was run to determine if there was a linear relationship between religion level and satisfaction the treatment/ provider. There is a statistically significant weak, positive linear relationship between religion level and satisfaction with treatment/provider ($r = .056$, $p < .05$). The higher the religion level the higher the satisfaction with treatment/provider. Just over 3% of the variance in satisfaction with treatment/provider can be explained by religion level. Consequently, the more religion awareness a client experiences, the more the client felt providers were helpful and the more clients felt satisfied with each provider type over a 12-month period.

With the eight domains of cultural self-determination entered using the Backward method with satisfaction with treatment/provider as the dependent variable two remained in the model ($F = 24.157$, $p < .001$, $R^2 = .547$). The two domains of cultural self-determination were professionals-seen-for-mental-health ($\beta = .625$, $p < .001$) and delay determination ($\beta = .222$, $p = >061$). Just under 55% of the variance in satisfaction with

treatment/provider can be explained by the more professional seen for mental health and the greater the delay experienced by clients. (See Table 4.25)

Table 4.25

Multiple Regression for Satisfaction Treatment/Provider

	B	Beta	t	Sig
Cultural Self-Determination				
Professional for MH	5.900	.625	5.424	.000
Delay Determination	2.496	.222	1.929	.061
Constant	2.520		2.427	.020
$R^2 = .547$ F = 24.157 $p < .000$				

The remaining two independent variables, range of assimilation and cultural interaction were not found to be statistically significant predictors of satisfaction with treatment/provider. Thus H_4 with satisfaction with treatment/provider was partially supported.

Quality of Services

Regarding the quality of services received the cultural self-awareness domains do not provide adequate information to predict client perceptions of the quality of services within the current sample.

Table 4.26

Multiple Regression for Quality of Services

	B	Beta	t	Sig
Cultural Self-Determination				
Goals	-2.248	-.193	-2.020	.050
Professional Seen	.662	.299	2.475	.017
Professional for MH	6.889	.562	4.637	.000
$R^2 = .621$ F = 22.895 $p < .000$				

Within the analysis of the quality of services multiple regressions cultural self-awareness, range of assimilation, and cultural interaction no statistically significant findings were found. Using the Backward method with the eight domains of cultural self-determination with quality of services three of the domains were statistically significant ($F = 22.895$, $p < .001$, $R^2 = .621$). The three domains, in order of strength, were professionals-seen-for-mental-health ($\beta = .562$), professionals-seen ($\beta = .299$), and goals ($\beta = -.193$). Just over 62% of the variance in quality of services is explained by more professionals-seen, more professionals-seen-for-mental-health, and lower goals determination. (See table 4.26)

One domain with cultural self-determination, extent of interference, was found to be significant in some of the preliminary MRA's a Pearson's correlation was run to see if there was a statistically significant linear relationship between this variable and quality of service. There was a statistically significant weak, positive linear relationship between extent of interference and quality of services ($r = .303$, $p < .01$). The greater the extent of interference the higher the quality of services. Just over 9% of the variance in quality of services is explained by extent of interference.

Chapter Summary

The current chapter provided the findings and data analysis revealed in the current study examining the relationships between cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction. Overall findings indicate none of the hypotheses presented were definitively supported, however, a robust quantity of statistically significant findings support the need to explore client

perceptions of provider cultural competence compared to client satisfaction and provide impetus for further research. Through content discussion and a series of tables, the statistical analyses are presented. The next chapter provides an overview of the study in its entirety and provides discussion for implications for these findings, suggestions for further research, the limitations of the study, and contributions to the field of social work and mental health care.

Chapter V

Summary and Conclusions

The concept of cultural competence is relatively new to social work. The social work universe does not include a great deal of literature in the area of cultural competence practice, education, and training. The social work universe consists of even less literature on the relationship between cultural competence and client satisfaction. It would therefore seem this is an area in need of further investigation and research. Due to the sparse inclusion of such literature and research studies in social work, the following reports on an exploratory study examining the relationship between client perceptions of mental health provider's level of cultural competence.

The President's [George W. Bush] New Freedom Commission on Mental Health, in 2003, called for the social service system to transform into providing culturally and linguistically competent services to provoke improved quality of life for all Americans, "from *all* communities" (National Center for Cultural Competence [NCCC], n.d.; italics in original). The President's New Freedom Commission, thus, urged the social service delivery system to eliminate disparities and to advance a vision for health care and social services for populations of all racial, ethnic, and cultural groups. This policy called for a national commitment to enhancing the emotional and behavioral health of the nation's cultural populations.

The profession of social work, through the National Association of Social Workers and the Council on Social Work Education charge professionals with providing culturally competent practice (Boyle & Springer, 2001; CSWE, 2001; NASW, 2001). The American

Psychological Association (APA) (2002) expects clinical psychologists to provide ‘culturally-appropriate’ services. Through ‘culturally-appropriate’ services the psychological profession expects clients to perceive the services they receive as promoting cultural diversity. And through the promotion of cultural diversity it is accepted that culture is incorporated into treatment (Council, 2003). Similarly, licensed counselors are urged to include developmentally and culturally appropriate skills and techniques in their practice. These skills and techniques should realize the influence of culture on clients, diagnosis, and the presenting problem. These skills and techniques should also consider the counselor’s own cultural background and experiences and the counselor’s limitations of their own cross-cultural competencies (Wing Sue et al., 1992). The American Medical Association (AMA) anticipates that the medical health care system will be governed by an understanding of the importance of cultural beliefs, values, diversity and interaction; this should improve the quality of health care. The AMA therefore, projected the most effective method for enhancing health care with diverse populations is through cultural competence (AMA, 2002, 2006).

Social work professionals and other helping professionals share similar standards for emphasizing the importance of cultural competence in mental health care. A part of incorporating culturally competent practice into mental health treatment, clinical practitioners are obliged to understand their own culture and the culture of the client and the influence of culture on the treatment process as well as communication between the client and the provider.

Research in matters of cultural competence has reported that mental health care providers believe themselves to be and practice cultural competence (Armour, Bain, & Rubio, 2004; Delva-Tauili'ili, 1995).Yet, the degree to which clients agree that providers are culturally competent and deliver culturally competence services continues to be uncertain. This uncertainty looms due to the lack of studies that have truly investigated client perceptions of mental health providers' cultural competence (Switzer, Scholle, Johnson, & Kelleher, 1998).

The literature of social work and other helping professions reflect an ambiguity about the definition(s), conceptualization, and application of cultural competence. A contribution of this dissertation, therefore, is the development of a universal definition of cultural competence and an application of this definition to practice. Thus, cultural competence, as it is interpreted by this author and according to literature, refers to knowledge, attitudes, self-awareness, and skills that enable a professional person to more efficiently serve clients from diverse populations (Barker, 2003). Cultural competence is a developmental process allowing interaction and mental health treatment to be enhanced and incorporate the racial, ethnic, and cultural nuances of diverse clients (Aponte, 1995; Armour et al., 2004; Boyle & Springer, 2001; Cross, Bazron, Dennis, & Isaacs, 1989; Grant & Haynes, 1995).

Client satisfaction, similar to cultural competence, offers a unique perspective about client perceptions of mental health treatment, that if not specifically sought is unobtainable from other sources (Davis & Ware, 1988; Mirvis, 1998; Kolodinsky, Nam, Lee, & Drzewiczewski, 2001). Client satisfaction involves an assessment of expectations clients have of services contrasted to the care received (Oliver, 1999). Client satisfaction is

important as an outcome measure of mental health treatment and as a process measure for how care is provided (Bjorkman & Hansson, 2001). As such the treatment provided to clients with mental health concerns may be affected by the level of cultural competence of the provider and indirectly by the cultural interaction with the client. Accordingly, evaluating client satisfaction of services provided by mental health professionals through the lens of the client's cultural self-awareness, cultural self-determination, range of assimilation, and the cultural interaction with the provider extends our understanding of the context within which clients perceive the service delivery, treatment, and providers.

Symbolic Interaction and Dramaturgy

Symbolic interaction (SI), a social psychological perspective, introduced by George Herbert Mead, underlines the *uniqueness* of how individuals interact with their environment and those in their environment (Charon, 2004; italics in original). Further, symbolic interaction posits to be complete, human beings must be social. It is through social interaction that the self emerges (Hensarling & del Carmen, 2002; Mead, 1934). Understanding of human beings unfolds through examining their interactions, through translating and interpreting the actions of individuals. Symbolic interaction holds that it is in an individual's interactions with others where the self and personal identity is developed.

Symbolic interaction is used in this study to support the importance of the interaction between mental health provider and client, and how the culture of the client and provider impacts the client's interaction with the provider (Berger & Luckmann, 1967; Blumer, 1969; Goffman, 1959, 1967; Guan, 2004). According to SI, cultural traditions play a significant role in shaping individual perceptions, attitudes, and experiences (Guan, 2004). SI insists that

the differences in culture are in fact unique social constructs that are created within interaction based on the meaning of a given situation (Berger & Luckmann, 1967; Guan, 2004). This socially constructed reality of culture motivates how individuals view their relationships. This cultural reality effects how individuals' views affect their attitudes, desires, behaviors, and level of satisfaction (Guan, 2004). This interaction, shaped by culture, influences the process of socialization and acculturation (Guan, 2004). This interaction influences mental health treatment.

Dramaturgical Perspective

Grown out of symbolic interaction, Ervin Goffman developed the dramaturgical perspective. Dramaturgy refers to theatrical arts involved in bringing productions to life. While being involved with the language and music of the theatrical stage, dramaturgy also involves staging itself, i.e., blocking of actors, setting, and the visual composition of theatrical production. Beyond being concerned with set designing, dramaturgy also encompasses choreography and place of aesthetic elements. It is due to these elements and the core of dramaturgy that it may be referred to as a multidimensional view of human interaction (Goffman, 1959). Goffman alters symbolic interaction by adjusting Mead's social act from traditional symbolic interaction as a complex individual model to a team-of-players model which implies that social action serves as a blueprint for those in society (Kuhn, 1964).

The dramaturgical perspective stipulates a person's identity is constantly remade as a result of the individual's interaction with others. According to dramaturgs, human action depends upon time, place, and audience. Thus, the self is discerned through who one is, a

dramatic result from the current scene (Kuhn, 1964). Goffman extends symbolic interaction into a theatrical metaphor defining the process by which individuals present themselves to others based on cultural values, norms, and expectations (Goffman, 1959; Goffman, 1964). The goal of such presentations of the self is creating specific impressions and gaining acceptance from the audience through manipulation. If the individual is successful, the audience will view the individual as he/she wants to be viewed. This form of manipulation or behavior is nothing more than an intimate form of interaction and communication (Goffman, 1964).

According to the dramaturgical perspective, social interaction is dissected as a theatrical performance. Thus, individuals as actors must convey their personal characteristics and their intentions to others through performances. As individuals do on stage, individuals in everyday life manage settings, clothing, words, and nonverbal actions to create a particular impression in others. An important distinction is made between ‘front stage’ and ‘back state’ behavior. Front stage refers to actions visible by the audience that are part of the performance. Back stage behaviors are engaged in when no audience is present. Individuals are likely to behave one way in front of audiences but engage in unseemly behaviors back stage, thus attempting to hide certain behaviors from the audience (Goffman, 1964).

Embedded within dramaturgy are seven essential elements which pertain to the behavior of the actor in a performance. These seven essential elements include (1) belief; (2) the front; (3) dramatic realizations; (4) idealization; (5) maintenance of expressive control; (6) misrepresentations; and (7) deception. Belief refers to the actor trusting in his/her performance. The front is a *mask* used by the performer to manipulate the audience into

perceiving that which the performer wants the audience to perceive. A dramatic realization is used to emphasize specific pieces of information. Through dramatic realizations, others develop opinions, impressions, and perceptions of the performer. Idealizations involve the *ideas* or perceptions the audience has of the performer; performers attempt to behave according to audience perception as opposed to based on the performer's intentions. Staying in character, or engaging in maintenance of expressive control, is done to avoid conveying misleading information which might distract the audience. When a performer does not successfully maintain expressive control and/or successfully presents the idealized situation, misrepresentation occurs whereby the performer provides the audience with inaccurate information. Misrepresentation gives the audience the opportunity to derive the wrong impression or opinion of the performer. And, deception refers to the suppression of information to either increase the intrigue in the performer or avoid revealing potentially damaging information (Goffman, 1959).

Along with carefully crafting behaviors and the impressions to audience members, Goffman (1959) posits that each individual in the dramatic interaction plays a specific role either as service specialist, training specialist, or confidant. Service specialists engage in a specific task, performing as assistants of a sort. Training specialists provide the audience with lessons and/or guidance. And, confidants serve as sounding boards and sponges of information not to be released.

While actors and audience persons engage in the aforementioned roles, there is a second tier role that individuals play in interactions in everyday life. This second tier involves subordinate and superordinate roles, which refer to the level of influence an

individual has during the interaction. The superordinate within the interaction refers to the individual with the most clout while the subordinate assumes a more submissive and passive function. The superordinate role is either given by the subordinate or it is obtained via academic or authoritarian means. The subordinate role occurs either by default or is readily accepted (Goffman, 1959). Goffman (1959) stipulated superordinate and subordinate roles refer to interactions between performer and audience equally as to supervisory relationships. And, superordinate and subordinate roles may fluctuate during the course of a single interaction; one may be superordinate during one aspect of the interaction with the audience and subordinate during another aspect (Goffman, 1959).

Applying Dramaturgy to Mental Health

Though Goffman's dramaturgical perspective was developed from a sociological viewpoint, he specified application to other situational aspects was appropriate and imperative (Goffman, 1959). The dramaturgical perspective, as an extension of symbolic interaction, applies context to symbolic interaction, connecting the behavior of actors to institutions (Goffman, 1959). As the dramaturgical perspective was designed to be applied to the total institution, Calhoun et al. (2002), state it should not be applied beyond the institution, beyond the circumstances within which the behavior takes place. However, Goffman (1959, 1964) destined dramaturgy applied to everyday life and mental health alike.

Similar to actors in a theatre performing for an audience, client's experiencing mental health challenges and seeking or obtaining treatment behave dramatically for providers. While clients behave in ways they believe is most appropriate for the situation they do so taking on various roles and providers accept other roles. Clients in mental health treatment

perform based on their culture or ethnicity. Likewise, providers giving mental health treatment interpret the performances of clients through the cultural lens of the provider. Also, providers perform according to their culture and in keeping with their role(s) at that particular time.

Clients engage in superordinate roles while giving providers information as to the presenting problem and the client's culture. During interactions with mental health providers, clients assume the subordinate role while answering questions and following directives during assessments or treatment. Inasmuch as clients assume both the superordinate and subordinate role in the treatment process, providers also accept the superordinate and subordinate role. Providers behave as the superordinate while facilitating the treatment process and accept the subordinate role while learning from the client about the client's culture and the client's presenting problem.

In addition to subordinate and superordinate roles, clients and providers also act as service specialists, training specialists, or confidants. As service specialists providers offer clients assistance towards improving their experience with mental health challenges. Clients as service specialists construct, repair, or maintain the premise of the treatment and cross-cultural interaction. As training specialists providers guide and direct clients on making behavioral shifts and lifestyle changes towards improving their experience with mental health challenges. Clients as training specialists educate providers on the clients' culture and how to consider incorporating the clients' culture into the treatment process. And, as confidants, providers allow clients to use them as sounding board and vault for secrets and confidential information. Clients as confidants allow providers to learn the secrets of the clients' culture,

the clients' team; as confidants clients agree to maintain the integrity of the treatment and methods used in the treatment process.

Dramaturgy may readily be used in mental health treatment through unpacking the presenting problem and the culture(s) involved in the treatment process. Such unpacking allows the client to perform as the client desires and the provider to grasp the information the client has presented to the provider. Understanding mental health through the lens of dramaturgy guides mental health providers to examine, understand, and appreciate the client's culture, the client's behavior, and the influence of the client's culture on her performance and the treatment process.

Dramaturgy and Cultural Competence

Goffman (1959), through the dramaturgical perspective, explains the presenting problem as a question of performances acted out by individuals towards an audience. The performers refer to either clients or providers. As the performer concentrates on performing, he or she does so in such a way so as to emphasize a desired impression upon the audience. Therefore, from the client's perspective, he or she will act towards the provider according to the impression that he or she would like to convey. Hence, the interpretation of the interaction between the client and provider is molded partially by the previously held beliefs and experiences of the client. The interaction between the client and provider as well as the implementation of the treatment is determined by the client's culture and expression of cultural convictions. Goffman (1959) indicates that the attention given to understanding the interaction and the components of the interaction between the client and provider reveals the

degree to which the client will feel satisfied by the provider and the extent of the provider's aptitude as a specialist in cultural competence.

As it pertains to culture, Goffman (1959; 1967) posited there is an intersection between culture and the dramaturgical perspective. The intersection is most clearly recognized in regard to the maintenance of moral standards. Cultural values, like dramaturgy determine how individuals feel about certain matters while establishing a framework of appearances that are essential to maintain (Goffman, 1959, 1967). In the current study, the intersection is evident in the concepts being investigated: cultural competence, cultural interaction, cultural self-awareness, cultural self-determination, range of assimilation, and client satisfaction.

Cultural competence consists of two components of dramaturgy – deference and demeanor, which are determined and based on culture and ethnicity (Goffman, 1959). The significance of culture on deference relates to how authority figures are defined, designated, and regarded; the influence of culture on demeanor is evidenced in the attire, mannerisms, and how individuals handle themselves in social interactions (Goffman, 1959).Understanding the components of deference and demeanor and seeking understanding for how individuals ascribe meaning to their actions and performances constitutes engaging in a cultural competence.

Interaction is the basis for attitudes, behaviors, and experiences. According to Mead (1934), interaction pertains to conversation with gestures and the use of significant symbols to convey messages in human society. As the basis for all performances in dramaturgy, cultural interaction is the result of behavior with and towards an individual's family,

community, and social world (Guan, 2004). Interaction thus, is subject to cultural stimulus; therefore individual actions towards another person are referred to as cultural interactions (Goffman, 1959). Embedded within the essence of symbolic interaction, cultural interaction involves behavior towards others with derived meanings for such actions arising from values, norms, customs, beliefs, and traditions (Blumer, 1969).

Self-awareness involves perceiving the *self* in fairly objective terms while retaining an essence of subjectivity. Therefore, self-awareness requires the integration of knowledge of a situation, in an objective sense. Self-awareness also requires feelings and having an appreciation for subjective interpretations of the situation (Prigatano & Schachter, 1991; Simmond & Fleming, 2003). Cultural self-awareness, as understood by symbolic interaction and dramaturgy, assumes the integration of one's self-concept from multiple perspectives and multiple domains. Therefore individuals understand the self based on the effect of culture, based upon self-assessment and reflecting on judgments of others, especially the social and cultural groups within which individuals reside (Cheung & Lau, 2001).

Self-determination involves clients' full involvement and knowledge of services rendered and alternatives to mental health treatment which allows the individuals to make an informed decision and being fully involved in the treatment process (Haas, 1991). Cultural self-determination infuses culture into the treatment process allowing clients to hold fast to the norms, values, and beliefs that have guided their lives and lifestyle (Kraft & BrintzenhofeSzoc, n.d.). Dramaturgy along with symbolic interaction emphasized the actor defining the act and performance such that the audience is able to appropriately interpret the performance. And based on the role each individual plays in the interaction and the

impressions conveyed, cultural self-determination is upheld as performers and audience members hold true to the culture of the team (Blumer, 1969; Goffman, 1959; Mead, 1934).

There is evidence that responding negatively to the culture of a host country and the denial of traditionalism in that host country indicates an individual's lack of assimilation (Kilinc & Granello, 2003). Goffman (1959) alludes to the fact that individuals encounter degrees of assimilation as members of teams and the acceptance of various roles. As individuals earn secret privileges and higher rankings on the team, their level of acceptance in the culture and participation in secrets varies according to the loyalty that they display towards the entire cultural group (Goffman, 1959) and their range of assimilation into the culture of the team.

Client satisfaction, as a rule, is thought of as a comparison of an individual's, or a client's, expectations with the care he receives and his actual experience (Oliver, 1999). More than expectations, an individual's self-awareness and level of assimilation affects client satisfaction; that is especially influenced by culture (Kilinc & Granello, 2003; Robinson, 1983; Sheppard, 1993). Dramaturgy's assessment of client satisfaction is based on the client's ability to distinguish between a provider misrepresenting himself as adequately skilled and a provider that is in fact thoroughly skilled. It may not be easy for the client to disprove the misrepresentation of the provider. Such misrepresentation or impersonation is a *front* put on by the provider, which impacts the client's level of satisfaction (Goffman, 1959).

Methodology

Using an existing data set, the Collaborative Psychiatric Epidemiology Surveys (CPES) (2001-2003), the purpose of the current study was to explore the relationships

between client's perception of her cultural interaction with mental health provider and the client's levels of cultural self-awareness, cultural self-determination, and range of assimilation on client satisfaction. The overarching research question that guided this study was: Is there a relationship between client's perception of the cultural interaction with mental health providers and the client's levels of cultural self-awareness, cultural self-determination, and range of assimilation and client satisfaction with mental health professionals? The bivariate hypotheses for the present study were:

H_1: Clients with higher levels of cultural self-awareness will have higher levels of cultural self-determination.

H_2: Clients with higher levels of range of assimilation will have higher levels of cultural self-determination.

H_3: Clients with higher levels of cultural self-awareness will have higher levels of range of assimilation.

The multivariate hypothesis was:

H_4: Clients with high cultural self-awareness, high cultural self-determination, at the high range of assimilation, and positive cultural interaction will report higher levels of client satisfaction with their mental health providers.

The Collaborative Psychiatric Epidemiology Survey, 2001-2003

This secondary data analysis of the CPES is a composite of three nationally representative surveys: the National Comorbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL), and the National Latino and Asian American Study (NLAAS). Developed in conjunction with one another, the NCS-R, NSAL, and NLAAS,

collected data about the incidence of mental disorders, impairments associated with mental disorders, and mental health treatment methods from a sample representative of the United States adult population. The CPES, the first national dataset with sufficient statistical power, also aspired to gain information about support systems, language use and ethnic disparities, discrimination and assimilation to determine whether and how closely various mental health disorders are associated with social and cultural issues (Alegria, Jackson, Kessler, & Takeuchi, 2007; Pennell et al., 2004). The full sample for CPES includes 20,130 adult respondents; 9,282 from the NCS-R study, 6,199 from the NSAL study, and 4,649 from the NLAAS study. The sub-sample that used in this study included those with a DSM-IV diagnosis of major depressive disorder (*n*=2,842), generalized anxiety disorder (*n* = 906), panic disorder (*n*=817), and phobic disorders (social phobia, agoraphobia without panic, agoraphobia with panic, specific phobia) (*n* = 3,931). Due to the presence of respondents with dual diagnoses, the final sample size is 5,002. The sample includes English-speaking adult respondents 18 years and older residing in households located in the contiguous United States (Alaska and Hawaii from the NLAAS study). The NSAL universe included: Black Americans of African descent, Black Americans of Caribbean descent, and White Americans, and the NLAAS universe included Latino American, Asian American, and non-Latino, non-Asian White Americans. The data were collected using laptop computer assisted personal interviews in the respondents' home over a period from early 2001 to early 2003.

Variables

Wide ambiguity in the understanding of cultural competence has led to the interchanging terms. Thus, studies surveying providers' self-perception of cultural

competence have equally used *multicultural counseling competencies* to be interpreted as cultural competence in service delivery. This study recognizes cultural competence as the acquiring of "the knowledge, attitudes, understanding, self-awareness, and skills that enable a professional person to serve clients from diverse…backgrounds" (Barker, 2003, p.104). Cultural competence is a developmental process effecting racial, ethnic, and cultural disparities in health and mental health care (Aponte, 1995; Armour et al., 2004; Boyle & Springer, 2001; Cross, Bazron, Dennis, & Isaacs, 1989; Grant & Haynes, 1995). With no direct access to cultural competence within the CPES, the study investigated aspects of cultural competence believed to encompass the whole.

Independent Variables.

The independent variable cultural self-awareness refers to the understanding a person has of her own culture/ethnicity that impacts her conception of the world, her thinking, and her behavior (Brown, Parham, & Yonker, 1996). The variable cultural self-determination is conceptually defined as the autonomy a client uses regarding her mental health treatment which is impacted by the client's culture (Kraft & BrintzenhofeSzoc, n.d). Range of assimilation is conceptually defined as the level of an individual's social adjustment to a host culture (Fellin, 2000) according to the client's construction of a *new* culture consisting of aspects of both the native and the host culture. The final independent variable, cultural interaction, is conceptually defined as an emphasis on perceived cultural difference between the client and provider which accounts for the values, norms, and differences in the client's culture during communication exchanges in the treatment process (Kelley & Meyers, 1993;

Vontress, Johnson, & Epp, 1999). All of these variables are operationally defined from variables taken from the CPES (See Appendix A-D).

Dependent Variable.

The dependent variable, client satisfaction, is conceptually defined as an assessment of a client's approval of the services delivered by mental health providers. Client satisfaction is operationally defined from variables taken from the CPES (See Appendix E).

Findings and Discussion

Scholars have strongly suggested individuals from other countries experience challenges with understanding the American mental health systems due to the lack of exposure to such services in their home country (Demir & Aydin, 1996; Guneri & Skovholt, 1999). With the increasing racial/ethnic diversity in the United States, evolving the mental health system and enhancing services to reach and offer culturally competent services to cross-cultural clients is medically and ethically responsible. Thus, as Brinson and Kittler (1995) stipulate, it is essential to provide mental health services to cross-cultural clients that are sensitive and congruent with racial/ethnic/cultural values and worldviews. Research and literature has shown that as one is involved in the development of the self (Charon, 2004; Goffman, 1959), the development of cultural self-awareness, cultural self-determination, and assimilation to *any* new culture is inevitable (Bond, 1984; Simmond & Fleming, 2003).

While the mental health care system is developing services that are culturally competent its responsibility extends beyond the implementation of services to evaluating and assessing the effectiveness of such services. Though there have been studies evaluating client satisfaction with mental health services, few studies have infused cultural competence or

cross-cultural service delivery. Other studies have been conducted on provider perceptions of their own cultural competence; few studies have explored client perceptions of provider cultural competence. And, no studies have been found to assess the relationship between client satisfaction and client perceptions of provider cultural competence. The current study began to explore these very issues.

Taking a closer look at the components believed to comprise cultural competence, an investigation was conducted on pairs of the overarching variables in an attempt to dig deeper into the concepts and dynamic of cultural competence. Bivariate analyses were completed using Pearson's correlations to determine if there are linear relationships between cultural self-awareness and cultural self-determination, range of assimilation, cultural self-determination, and cultural self awareness and range of assimilation. These analyses also served to address H_1, H_2, and H_3.

Though cultural self-awareness has been said to be a broad and challenging concept to evaluate, it requires the integration of knowledge and feelings (Prigatano & Klonoff, 1998; Simmond & Fleming, 2003). It has also been said that cultural self-determination requires an honest understanding of culture/race/ethnicity and the treatment process (Haas, 1991). Therefore, a comparison of the relationship between cultural self-awareness and cultural self-determination is connected to the need for mental health and helping professionals to conceptualize cultural competence.

Of the seven cultural self-awareness domains and eight cultural self-determination domains, 15 of a possible 56 linear relationships were made. Eight of these pairs were negatively correlated and seven positively correlated. While the researcher's preference

would be 15 positive linear relationships, these findings indicate further investigation into these aspects of both cultural self-awareness and cultural self-determination is warranted. Furthermore, as this study involved a secondary data analysis, the wording of questions and structuring of interview surveys provided valuable information and would need to be more closely correlated. As such, the researchers consider H_1 to be effectively supported with further research suggested.

Kilinc and Granello (2003) conducted a study which indicated range of assimilation related to length of time in the United States. In addition to cultural self-determination requiring understanding the treatment process (Haas, 1991); it also requires understanding the mental health care system and navigation of the system. It may be inferred that the longer an individual has resided within the United States the easier it would be able to negotiate the mental health care system, thus, range of assimilation would be statistically correlated to cultural self-determination, as hypothesized in H_2. Despite this rationale, the comparisons of the range of assimilation composite variables against the cultural self-determination variables fail to support H_2. While the analysis in the current study does not support a direct relationship between range of assimilation and cultural self-determination what is revealed is the need for further exploration regarding the specific aspects that comprise range of assimilation and cultural self-determination.

Just as range of assimilation of an individual may be subject to increasing over time, Fleming and Strong (1997) found that cultural self-awareness tends to fluctuate within the same individuals. As individuals consistently evolve and continuously experience new things, it stands to reason their range of assimilation and cultural self-determination would

grow and each aspect would influence the other. With the ten statistically significant correlations between cultural self-awareness and range of assimilation, of the possible 21 correlations, there is strong evidence of a durable relationship between the two concepts. Thus, in addition to significant support for H_3, further examination into the various facets of cultural self-awareness and range of assimilation is strongly recommended.

The overall purpose of this secondary data analysis was to determine if there is a relationship between cultural self-awareness, cultural self-determination, range of assimilation, cultural interaction, and client satisfaction. Client satisfaction was measured by three composite variables: amount provider helped, satisfaction with treatment/provider, and quality of service.

Of the eight cultural self-determination domains three remained in the final statistically significant model with amount provider helped ($F = 27.156$, $p <. 001$, $R^2 = .660$). Having seen a professional-for-mental-health was the strongest predictor ($\beta = .459$), professionals-seen was the next strongest ($\beta = .332$) followed by delay ($\beta = .190$). Sixty-six percent of the variance in amount provider helped can be explained by the more professionals seen for mental health, the more professionals were seen in general, and the more delays the client experienced. The domains of cultural self-determination with satisfaction with treatment/provider as the dependent variable two remained in the model ($F = 24.157$, $p < .001$, $R^2 = .547$). The two domains of cultural self-determination were professionals-seen-for-mental-health ($\beta = .625$, $p < .001$) and delay determination ($\beta = .222$, $p = >061$). For cultural self-determination with quality of services, three of the domains were statistically significant ($F = 22.895$, $p < .001$, $R^2 = .621$). The three domains, in order of strength, were

professionals-seen for mental health ($\beta = .562$), professionals-seen ($\beta = .299$), and goals ($\beta = -.193$). One additional domain of cultural determination, extent of interference, was found to have a statistically significant weak, positive linear relationship with quality of services ($r = .303$, $p < .01$).

Further, there was a statistically significant strong, positive linear relationship between religion level and amount providers helped ($r = .60$, $p < .05$). There is a statistically significant weak, positive linear relationship between religion level and satisfaction with treatment/provider ($r = .056$, $p < .05$). Religion level was not related to the third aspect of client satisfaction, quality of services.

The results of the overarching hypothesis (H_4), through multiple regression analysis, reveal further research is needed to determine the relationship between the independent composite variables and client satisfaction. The observances of statistically significant models indicate there is a relationship between the independent variables and client satisfaction. However, a more detailed review reveals those specific aspects that influence client satisfaction. These aspects include: religion level (cultural self-awareness); professional-seen for treatment (cultural self-determination); extent-interfere (cultural self-determination); and professional-for-mental-health (cultural self-determination). Since these variables do not cumulatively produce statistically significant regression models it cannot be inferred that these variables, as developed, specifically determine client satisfaction, however, it does begin to cast light on future research. Ultimately, the multivariate hypothesis is partially supported in terms of the influence of cultural self-determination on all three satisfaction dependent variables.

Significance and Implications

The concept of cultural competence is relatively new to social work. The social work universe does not include a great deal of literature in the area of cultural competence education, training, and client satisfaction. Therefore the current study accepted the charge of further investigation and research. Such exploration into this aspect of the social work universe will allow educators, scholars, and professionals to begin to establish an agreed upon understanding, interpretation, and implementation of cultural competence, where one has not previously existed. Due to the sparse inclusion of such literature and research studies in the field of social work, articles have been chosen across a myriad of social science disciplines to capture the interpretation and implementation of cultural competence in comparable professions. Thus, there are multiple implications for the current study to the profession of social work with regard to research, practice, and education.

Implications for exploring the relationship between client perception of provider cultural competence and client satisfaction on social work research include probing into the aspects of cultural competence that influence clients the most, such that cultural competence training, education, and practice can be tailored, accordingly. With regard to research, the current study also opens the doors for further research into client satisfaction and further investigation as to whether or not a relationship between client satisfaction and cultural competence exists, if so, what aspects of either may be enhanced to improve the delivery of services to clients. Future research may include studies on the effect of provider cultural competence on health and mental health disparities. Research may also incorporate the

specific components of cultural competence, i.e., family support, religion awareness, spirituality, goals, self-determination, language, and assimilation.

Similarly, exploring the impacts and aspects of cultural competence on clients and client satisfaction may increase provider knowledge and edification of cultural competence and culturally competent strategies. Furthermore, service delivery shall enhance as knowledge, edification, and strategies are fortified. The same concepts apply to the implications of the current study for social work education, as research is conducted and the definition, understanding, and interpretation of cultural competence and its relationship to clients and client satisfaction are expounded and clarified, social work curricula may be adjusted or enhanced accordingly. As the gatekeeper to the profession, social work education, as well as research and practice, can further develop the profession. The implementation of cultural competence and self-awareness, cultural interaction, and client satisfaction would also be improved. Thus the current study serves as a springboard to the advancement of social work research, practice, and education.

Contribution and Originality

This study enhanced social work knowledge of client perceptions of the cultural competence of practitioners and thus the importance of the development of cultural competence in mental health providers. The study begins to help social work practitioners to identify the behaviors and treatment methods needed to produce client satisfaction in cultural interactions and in treatment with clients. This study gave attention to the importance of cultural interaction and cultural competence in social work practice. The study revealed the lack of data collection and measures which serve to clearly investigate provider cultural

competence and the effect of cultural competence on mental health treatment. And, the study creates the impetus for further research in cultural competence and social work.

Limitations

As a secondary data analysis, this study revealed more than a few limitations to the use of the CPES and similar data sets. An overarching limitation to this study was the compilation of three data sets though developed in collaboration with one another did not universally gather the same information. Therefore, this study was unable to conduct data analysis across all three data sets or obtain findings from the included racial and ethnic groups. In addition to not asking all questions or gathering the same information across all three subsets, aspects that were included within two or three of the subsets may not have asked the questions in the same way, thus also limiting data analysis and obtaining statistical consistency across the data subsets and racial and ethnic groups.

An additional limitation of conducting a secondary data analysis is the data that are available to operationalize the variables are only those which were collected and included in the original study. The process of developing the composites scores that were used as the independent variables did not always include the full range of the concepts that guided the research.

Conclusion

Mental health professionals need an awareness and understanding of the various cultural groups of clients as well as their own cultural group (Richardson & Molinaro, 1996). Though it is well documented that mental health problems experienced by cross-cultural clients present a significant challenge to mental health providers (Spasojevic, Heffer, &

Snyder, 2000), research regarding client perceptions of cultural competence among professionals is absent from scholarly literature. Jackson and Meadows (1991) advise mental health professionals *in training* and those currently in practice should move beyond their own culture towards fully appreciating and understanding the culture of their clients. Therefore, mental health professionals should not only strive to learn techniques for how to work with cross-cultural clients but also aspire to understand the underlying, core value structure of such clients (Richardson & Molinaro, 1996).

Despite the limited research and literature on client perceptions of the cultural competence of mental health providers, findings have indicated that mental health providers can improve overall client satisfaction by providing culturally competent services (Martin, Petr, & Kapp, 2003). And, as is expected, higher levels of client satisfaction predict favorable mental health treatment outcomes (Slote Morris & McKeganey, 2007). Therefore, the current study of client perceptions juxtaposed against provider cultural competence measured against client satisfaction is a rationale exploratory analysis moving towards the development of a universally accepted, understood, and implemented definition of cultural competence.

The current study initiated the exploration of client perceptions of provider cultural competence as well as the specific factors that determine cultural self-awareness, cultural self-determination, range of assimilation, and cultural interaction, concepts believed to lead to and measure cultural competence. Though the secondary data analysis conducted during this study did not definitively determine the specific facets of the overarching variables nor did it definitively determine undeniable relationships between the variables, it is clear through the correlations and multiple regressions that there exists ample justification for the

existence of statistical relationships between the variables which warrant further examination. Thus, the current study was successful in exploring the relationship between the dynamics of cultural competence (cultural self-awareness, cultural self-determination, range of assimilation, and cultural interaction) and client satisfaction and suggesting next steps towards developing research questions and developing studies.

Appendix A:

Questions used to measure Cultural Self-Awareness

CPES Label	**Response Set**	**Subset**
Family Support		
Frequency rely on relatives who don't live with you for serious problem*	1-4	NCS/NLAAS
Frequency can rely on relatives who don't live with you to disc worries*	1-4	NCS/NLAAS
How often relatives make too many demands on you*	1-4	NCS/NLAAS
How often your relatives argue with you*	1-4	NCS/NLAAS
Frequency family helps you out*	0,1-4	NSAL
Frequency you help family out*	0,1-4	NSAL
How close do you feel to family members*	1-4	NSAL
Closeness in feelings of family members to each other*	1-4	NSAL
Frequency family makes you feel loved excluding spouse*	1-4	NSAL
Frequency family listens to your problems*	1-4	NSAL
Frequency family expresses concern for well-being*	1-4	NSAL
Frequency family makes too many demands of you*	1-4	NSAL
Frequency family criticizes you*	1-4	NSAL
Frequency family takes advantage you*	1-4	NSAL
Frequency see/write/phone friends *	0,1-7	NSAL
Frequency friends help you out *	0,1-4	NSAL
Frequency you help friends out *	0,1-4	NSAL
Closeness you feel toward friends *	1-4	NSAL
Ethnic Group		
Identify with others of same racial/ethnic descent*	1-4	NCS/NLAAS
Feel close in your ideas/feelings with people of same racial descent*	1-4	NCS/NLAAS
Amt time would like to spend with people of same racial/ethnic group*	1-4	NCS/NLAAS
Treated unfairly due to race*	1-4	NLAAS
Treated badly due to poor/accented English*	1no,5yes	NLAAS
Religion Level		
During difficult times-seek comfort in religion*	1-4	NCS/NLAAS
Importance of religion in your life*	1-4	NSAL
Look to God for strength*	1-4	NSAL
Respect		
Frequency treated with less courtesy than others*	1-6	NLAAS/NSAL
Frequency treated with less respect than others*	1-6	NLAAS/NSAL
Family Cohesion		
Family shares values*	1-4	NLAAS

Things work well as family*	1-4	NLAAS
Family trusts and confides in each other*	1-4	NLAAS
Family loyal to family*	1-4	NLAAS
Proud of family*	1-4	NLAAS
Express feelings with family*	1-4	NLAAS
Family likes to spend free time with each other*	1-4	NLAAS
Family feels close to each other*	1-4	NLAAS
Family togetherness is important*	1-4	NLAAS
Argue with family over different customs	1-3	NLAAS
Lonely and isolated due to lack of family unity	1-3	NLAAS
Family relations less important to people close to you	1-3	NLAAS
Spirituality/Pray		
Frequency of praying*	1-6	NSAL
Frequency of asking someone to pray for you*	1-6	NSAL
Importance of spirituality in your life*	1-4	NSAL
Importance of prayer in dealing with stressful situations*	1-4	NSAL
Worth		
I am person of worth/equal to others*	1-4	NSAL
I have a number of good qualities*	1-4	NSAL
I sometimes feel useless*	1-4	NSAL
My future seems hopeless/not changing for better*	1-4	NSAL
I feel helpless dealing with life problems*	1-4	NSAL

*Recoded so responses to original "1" become "4" or "5"; e.g., Original coding: 1 = strongly agree, 4 = strongly disagree; New coding: 1 = strongly disagree, 4 = strongly agree.
Abbreviations of Subsets:
NCS: National Comorbidity Survey Replication
NSAL: National Survey of American Life
NLAAS: National Latino and Asian American Study

Appendix B:

Questions used for measuring Cultural Self-Determination

CPES Label	**Response Set**	**Subset**
Professionals Seen		
Total professionals seen for sadness including helpful treatment	None#	NLAAS
Total professionals seen about sadness	None#	NLAAS
Total professionals seen for irritability including helpful treatment	None#	NLAAS
Total professionals seen for panic including helpful treatment	None#	NCS/NLAAS
Total professionals seen for social fear including helpful treatment	None#	NCS/NLAAS
Total professionals seen for fear including helpful treatment	None#	NCS/NLAAS
Tried Get		
Tried to get professional help for sadness*	1yes,5no	NSAL
Tried to get help for sadness from family/friends/acquaint*	1yes,5no	NSAL
Tried to get professional help for panic attacks*	1yes,5no	NSAL
Tried to get help from family/friends/acquaint for attacks*	1yes,5no	NSAL
Tried to get professional help for social fear*	1yes,5no	NSAL
Tried to get help from family/friends/acquaint for social fear*	1yes,5no	NSAL
Tried to get professional help for fear*	1yes,5no	NSAL
Tried to get help from family/friends/acquaint fear*	1yes,5no	NSAL
Tried to get professional help for worry*	1yes,5no	NSAL
Tried to get help from family/friends/acquaint for worry*	1yes,5no	NSAL
Seen Professional Sad		
Seen psychiatrist about sadness*	1yes,5no	NSAL
Seen other mental health professional about sadness*	1yes,5no	NSAL
Seen family doc about sadness*	1yes,5no	NSAL
Seen other med doc about sadness*	1yes,5no	NSAL
Seen other health professional about sadness*	1yes,5no	NSAL
Seen religious or spiritual advisor about sadness*	1yes,5no	NSAL
Seen other healer about sadness*	1yes,5no	NSAL
Extent Interfere		
Extent to which irritability interfered with home mgmt	1-10 high worst	NCS/NLAAS
Extent to which irritability interfered with work	1-10 high worst	NCS/NLAAS
Extent to which irritability interfered with form/maintain close relations	1-10 high worst	NCS/NLAAS
Extent to which irritability interfered with social life	1-10 high worst	NCS/NLAAS

Extent which severe worry interfered with home mgmt	1-10 high worst	ALL 3
Extent which severe worry interfered with ability to work	1-10 high worst	ALL 3
Extent which severe worry interfered with form/maintain relations	1-10 high worst	ALL 3
Extent which severe worry interfered with social life	1-10 high worst	ALL 3
Delay		
Reason delay treatment-insurance*	1yes,5no	ALL 3
Reason delay treatment-problem get better by itself*	1yes,5no	ALL 3
Reason delay treatment-problem didn't bother you at 1st*	1yes,5no	ALL 3
Reason delay treatment-handle problem on own*	1yes,5no	ALL 3
Reason delay treatment-think treatment not work*	1yes,5no	ALL 3
Reason delay treatment-treatment didn't work before*	1yes,5no	ALL 3
Reason delay treatment-too expensive*	1yes,5no	ALL 3
Reason delay treatment-worry what people think*	1yes,5no	ALL 3
Reason delay treatment-conflicts/hard to get to treatment*	1yes,5no	ALL 3
Reason delay treatment-unsure who/where to see/go*	1yes,5no	ALL 3
Reason delay treatment-time consuming/inconvenient*	1yes,5no	ALL 3
Reason delay treatment-could not get appointment*	1yes,5no	ALL 3
Reason delay treatment-scared of hospital against will*	1yes,5no	ALL 3
Reason delay treatment-dislike service options*	1yes,5no	ALL 3
Reason delay treatment-other reason*	1yes,5no	ALL 3
Reason delay treatment-treated unfairly race/ethnicity*	1yes,5no	NLAAS
Reason delay treatment-language barrier*	1yes,5no	NLAAS
Reason delay treatment-unable get same race provider*	1yes,5no	NLAAS
Reason delay treatment-could not choose provider*	1yes,5no	NLAAS
Reason delay treatment-not comfort discuss with professional*	1yes,5no	NLAAS
Time Needed Help		
Amt of time thought needed professional help	None+	ALL 3
Unit time thought need professional help	1-4	ALL 3
Professional for Mental Health		
Talked to professional about mental health:1st mention	1-10 & 13	ALL 3
Talked to professional about mental health:1st mention	1-10 & 13	ALL 3
Talked to professional about mental health:10th mention	1-10 & 13	ALL 3
Talked to professional about mental health:10th mention	1-10 & 13	ALL 3
Talked to professional about mental health:2nd mention	1-10 & 13	ALL 3
Talked to professional about mental health:2nd mention	1-10 & 13	ALL 3
Talked to professional about mental health:3rd mention	1-10 & 13	ALL 3
Talked to professional about mental health:3rd mention	1-10 & 13	ALL 3
Talked to professional about mental health:4th mention	1-10 & 13	ALL 3

Talked to professional about mental health:4th mention	1-10 & 13	ALL 3
Talked to professional about mental health:5th mention	1-10 & 13	ALL 3
Talked to professional about mental health:5th mention	1-10 & 13	ALL 3
Talked to professional about mental health:6th mention	1-10 & 13	ALL 3
Talked to professional about mental health:6th mention	1-10 & 13	ALL 3
Talked to professional about mental health:7th mention	1-10 & 13	ALL 3
Talked to professional about mental health:7th mention	1-10 & 13	ALL 3
Talked to professional about mental health:8th mention	1-10 & 13	ALL 3
Talked to professional about mental health:8th mention	1-10 & 13	ALL 3
Talked to professional about mental health:9th mention	1-10 & 13	ALL 3
Talked to professional about mental health:9th mention	1-10 & 13	ALL 3
Goals		
Being too close to family interfered with goals	1-3	NLAAS
Personal goals conflict with family	1-3	NLAAS
Impossible to reach my goals*	1-4	NSAL

*Recoded so responses resulted in 0 = no, 1 = yes.
[#]Response recorded in whole numbers
[+]Response set: Select days, weeks, months, years

Abbreviations of Subsets:
NCS: National Comorbidity Survey Replication
NSAL: National Survey of American Life
NLAAS: National Latino and Asian American Study

Appendix C:

Questions used to measure Range of Assimilation

CPES	**Response Set**	**Subset**
Neighbors		
People in neighborhood can be trusted*	1-4	NLAAS
People in neighborhood get along w/ each other*	1-4	NLAAS
People in neighborhood help in emergency*	1-4	NLAAS
People in neighborhood look out for each other*	1-4	NLAAS
I feel safe alone in neighborhood at night*	1-4	NLAAS
Language		
Language spoken with friends	1-5	NLAAS
Language spoken with family	1-5	NLAAS
Language in which you think	1-5	NLAAS
Church		
Closeness to church people*	1-4	NSAL
Satisfaction w/ quality of relations w/ church people*	1-4	NSAL
Church people make you feel loved*	1-4	NSAL
Church people listen to problems*	1-4	NSAL
Church people express interest in well-being*	1-4	NSAL
Church people make too many demands on you*	1-4	NSAL
Church people criticize you*	1-4	NSAL
Church people take advantage of you*	1-4	NSAL

*Recoded so responses to original "1" become "4" or "5"; e.g., Original coding: 1 = strongly agree, 4 = strongly disagree; New coding: 1 = strongly disagree, 4 = strongly agree.

Abbreviations of Subsets:
NCS: National Comorbidity Survey Replication
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NLAAS: National Latino and Asian American Study

Appendix D:

Questions used to measure Cultural Interaction

CPES Label	Response Set	Subset
Professional Helpful		
Professionals were helpful – sadness*	1yes,5no	NSAL
Professional(s) were helpful – mania*	1yes,5no	NSAL
Professional(s) were helpful - panic attacks*	1yes,5no	NSAL
Professional was helpful - social fear*	1yes,5no	NSAL
Professional was helpful – fear*	1yes,5no	NSAL
Professional was helpful – worry*	1yes,5no	NSAL
Received helpful/effective treatment for fear*	1yes,5no	NCS/NLAAS
Language Quit		
Reason quit treatment-could not communicate*	1yes,5no	NLAAS
Reason quit treatment-provider not comprehend problems*	1yes,5no	NLAAS
Communicate with care provider in own language*	1yes,5no	NLAAS
Challenges		
Difficult to get doctor appt over phone in last year*	1yes,5no	NLAAS
Difficult getting referral to specialist*	1yes,5no	NLAAS
Provider spends limited time*	1yes,5no	NLAAS
Long waits of 1+ hour in waiting room*	1yes,5no	NLAAS
Difficulty getting info or advice over phone*	1yes,5no	NLAAS
Difficulty getting to assigned clinic*	1yes,5no	NLAAS
Difficulty getting prescribed meds*	1yes,5no	NLAAS
Comfort level of talking to professional about personal problems*	1-4	NCS/NLAAS

*Recoded so responses resulted in 0 = no, 1 = yes.
Abbreviations of Subsets:
NCS: National Comorbidity Survey Replication
NSAL: National Survey of American Life
NLAAS: National Latino and Asian American Study

Appendix E:

Questions used to measure Client Satisfaction

CPES Label	Response Set	Subset
Each Professional Past Year		
Satisfaction with treatment/service from psychiatrist past year*	1-5	ALL 3
Satisfaction with med doc treat/services past 12 months*	1-5	ALL 3
Satisfaction with psychologist treat/services past 12 months*	1-5	ALL 3
Satisfaction with social worker treat/services past 12 months*	1-5	ALL 3
Satisfaction with counselor treat/services past 12 months*	1-5	ALL 3
Satisfaction with spirit advisor treat/services past 12 months*	1-5	ALL 3
Satisfaction with treatment/services from healer past 12 months*	1-5	ALL 3
Amount Helped		
Amount psychiatrist helped*	1-4	ALL 3
Amount medical doctor helped*	1-4	ALL 3
Amount psychologist helped*	1-4	ALL 3
Amount social worker helped*	1-4	ALL 3
Amount counselor helped*	1-4	ALL 3
Amount professional helped*	1-4	ALL 3
Amount non-MD health professional helped*	1-4	ALL 3
Amount spiritual advisor helped*	1-4	ALL 3
Amount healer helped*	1-4	ALL 3
Quality Service		
Quality of service received rating for psychiatrist	1-5	NLAAS
Quality of service received rating for medical doctor	1-5	NLAAS
Quality of service received rating for psychologist	1-5	NLAAS
Quality of service received rating for counselor	1-5	NLAAS
Quality of service received rating for professional	1-5	NLAAS
Quality of service received rating for non-MD health professional	1-5	NLAAS
Quality of service received rating for spiritual advisor	1-5	NLAAS
Quality of service received rating for healer	1-5	NLAAS
Quality of service received rating for social worker	1-5	NLAAS
Lack of continuity of care/high turnover of providers	1yes,5no,7na	NLAAS

*Recoded so responses to original "1" become "4" or "5"; e.g., Original coding: 1 = strongly agree, 4 = strongly disagree; New coding: 1 = strongly disagree, 4 = strongly agree.

Abbreviations of Subsets:
NCS: National Comorbidity Survey Replication
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