

# Caregivers' Views on the Cultural Appropriateness of Services for Children with Emotional or Behavioral Disorders

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*ABSTRACT: While there is growing consensus on the need for cultural competence in children's mental health services, research has thus far provided little concrete information about what culturally competent service provision looks like in practice. This study is a secondary analysis of quantitative and qualitative data regarding caregiver perceptions of the cultural appropriateness of services to children with severe emotional and behavioral disorders. The data were gathered from a diverse sample of caregivers for 286 children. Analysis of the qualitative data yielded a set of coding categories which reliably capture the dimensions of caregiver experience contained in descriptions of specific instances of satisfaction or dissatisfaction with services. Caregivers from diverse backgrounds were equally likely to express satisfaction or dissatisfaction with services; however, the distribution of these satisfactions and dissatisfactions across the coding categories was not the same for caregivers of different ethnic or racial communities, or for higher- versus low-income caregivers. For minority caregivers, having experienced a dissatisfaction related to respect for community/ethnic cultural values contributed significantly to overall dissatisfaction with services.*

The demand for cultural competence in children's mental health services has gained momentum from a steadily accumulating body of research which suggests that the current system is in many ways inequitable and ineffective in meeting the mental health needs of children and adolescents from ethnically and culturally diverse minority populations. Minority children are more likely than children from the majority culture to be diagnosed with serious emotional disorders, yet they also have limited access to mental health services (Isaacs-Shockley, Cross, Bazron, Dennis, & Benjamin, 1996). When these children do receive treatment, they are more likely than their white counterparts to be placed in restrictive environments and/or removed from their homes or communities (Gibbs & Huang, 1989; Lewis, Shanok, Cohen, Kligfeld, & Frisone, 1980; Singh, Ellis, Oswald, Wechsler, & Curtis, 1997). For example, an African American child with a severe emotional or behavioral disorder is more likely to be placed in a restrictive school setting (Singh et al., 1997), or to end up in the juvenile justice system rather than in a treatment setting (Isaacs-Shockley et al., 1996). Similarly, Native American children with behavioral or emotional disorders are likely to be removed from home and tribe (Blum, Harmon, Harris, Bergeisen, & Resnick, 1992).

Difficulties arise when providers mistakenly assume that the practices and values embodied in their own culture can be applied universally. This can lead providers to label as abnormal, unhealthy or maladaptive behaviors which, within a client's culture, are actually normal, healthy, and/or adaptive (Aponte, Rivers, & Wohl, 1995; Sue, 1998). In turn, this sort of ethnocentrism increases the likelihood that, in working with people from diverse backgrounds, service providers will: misinterpret symptoms; pursue unnecessary, ineffective, or even destructive treatments; undervalue alternative treatments; or misunderstand the cultural dynamics of caregiving and support (Corey, Corey, & Callanan, 1993; Fernando, 1988; Sue, 1998). Interpersonal relationships between service providers and clients are also affected by the interracial, interethnic, and interclass dynamics which are evoked in interactions between members of different cultures and subcultures within American society. Service providers, particularly those from the majority culture and/or from affluent backgrounds, may have had neither the opportunity nor the motivation to gain a sensitivity to issues related to historical and ongoing discrimination and exploitation of people from poor and minority populations (Singleton-Bowie, 1995).

While the literature on cultural competence in children's mental health has focused on the problematic experiences of children of color in mental health systems, there are of course other ways in which services can be culturally inappropriate. Children and caregivers can experience misunderstanding and prejudice, and consequently receive services that are inappropriate or ineffective, when providers fail to understand behavior and values deriving from religious affiliation, being poor or disabled, or belonging to other types of social groups. Even a child from the majority culture who

receives services within a large community of color may legitimately feel that the system has misunderstood or discriminated against her.

When focusing on the cultural competence of services provided to children with emotional and behavioral disorders, the perspective of family caregivers is also of particular importance. This is not just because family caregivers represent the cultural beliefs and values that must be incorporated if the principles of cultural competence are to be put into practice in treating the child. Caregivers are also increasingly being called on to act as decision-makers and collaborators in treatment planning and implementation. If caregivers feel that their beliefs and values are not being respected, there is little chance that the desired types of collaboration will occur.

Existing research demonstrates the need for greater cultural competence in services; however, it is not all that helpful as a source of information about what exactly is problematic (or exemplary) in interactions and relationships between service providers and children and their parents or other caregivers. The purpose of this study is to highlight the diverse voices of caregivers to children with emotional or behavioral disorders as they describe specific occasions when they were particularly satisfied or dissatisfied with the extent to which service providers respected their cultural beliefs and values. A broad definition of "culture" was used in the study, in order to encourage caregivers to think about possible occasions when the beliefs or values at stake were not just those associated with ethnic or racial communities, but also with religious communities, economic status, perceived educational background and/or other social groupings. This study also examines whether caregivers from different cultural backgrounds tend to experience different sorts of satisfactions and dissatisfactions with services. In making these comparisons, the study is not limited to examining differences in experience between Caucasian and ethnically or culturally diverse (primarily African American) caregivers, but also between caregivers whose educational backgrounds and economic circumstances more closely resemble those of "typical" service providers versus those who have disparate economic or educational levels.

## **METHOD**

This study is a secondary analysis of data collected from families who participated in an evaluation of the Robert Wood Johnson Foundation's Mental Health Services Program for Youth in Multnomah County, Oregon (Friesen et al., 1996). Multnomah County includes the city of Portland, and is the major metropolitan county in the state. The current study makes use only of data collected at admission to the project when no intervention had yet taken place.

## **Participants**

Families were eligible for participation in the evaluation if their child was between 5 and 18 years old, had a DSM-III diagnosis, had received more than one service in the previous 6 months, and had experienced substantial limitation in at least two major life areas (e.g., school performance, relationship development, family life, and self-care). Data from a total of 286 families were used in the analyses presented below. Most of the caregiver/respondents were women (90%), and most (69%) were biological or adoptive parents, although 21 % were foster parents and 6% were other relatives. Just over half of the caregiver respondents were employed (56%), and 51 % had at least some college or trade school education. Household income for 44% of the families was below \$15,000, and for 22% of the families was above \$25,000. The majority of the children in the study were boys (69%), and the children's ages ranged from 6 to 18 years, with an average of 11.9. Sixty-seven percent of the children were white, 22% African American, and 9% Native American, while representation from other races was less than 3%.

Data for the evaluation were collected through structured interviews with parents or other caregivers and through written questionnaires completed at the time of the interview. Responses or ratings were recorded verbatim. The interviews were conducted by graduate-level social work students who had attended eight hours of training in data collection and who received regular supervision and follow-up training. The entire interview process took from two to two and a half hours and was generally conducted in the parent's or caregiver's home. At the completion of each interview, the respondent was paid \$25.

## **Measures**

The study focused on the analysis of responses to a series of closed- and open-ended questions about caregivers' views of the extent to which the services their children received were culturally appropriate. The questions were prefaced by a statement designed to encourage caregivers to think about culture in a broad sense, as structuring beliefs and values around issues such as how children are raised and disciplined, how families interact, how decisions are made, and how emotions are expressed.

Responses to two of the forced-choice questions were used in the analyses for this study. Caregivers were asked how important they thought it was for their culture to be considered in the creation of the child's service plan, and the extent to which the child's culture had been taken into account in the activities and services provided under the plan. Caregivers were then asked to provide specific examples

of the ways in which their cultural values either had or had not been considered in the assessment of their child's behavior, in the development of the service plan, and during the course of the activities and services that were provided to the child. Responses to these open-ended questions consisted of caregiver descriptions of occasions during which their cultural values either had or had not been respected. Caregivers' answers to the open-ended questions were transcribed for analysis.

Since one of the goals of the study was to learn more about what caregivers included in the broad definition of "culture," a coding system was developed to reflect the types of values that were at stake on the occasions described in the interview responses. Because of the similarity in the range of the types of responses provided to the open-ended questions, the same coding categories were used for all of them.

After numerous passes through a subset of the interview responses, the author developed a series of categories to represent the types of beliefs and values most frequently invoked by caregivers in response to the interview questions. For each occasion when one of these beliefs or values was invoked, a second coding was also made to reflect whether the value had been accommodated or supported by service providers (referred to from here on as a "satisfaction" with services), or whether the value had been disregarded or violated by service providers (representing a "dissatisfaction" with services). The author then coded all the interview responses. Because the responses to the four open-ended questions referenced a similar range of beliefs and values, the whole block of four answers was considered to be the unit of analysis. The number of codings associated with each set of responses to the interview question was thus variable, and ran from 0 to 8, with an average of 2.2. A third researcher then independently coded roughly half of the responses to the interview questions. Interrater reliability was quite high, with agreement ranging from 82% to 98%. The kappas for interrater agreement were .88 (type of value) and .93 (satisfaction/dissatisfaction), indicating "strong agreement" between raters (Fleiss, 1981). The author's codings were retained for all respondents. For two of the categories, subcategories reflecting the most common subtypes of responses were also developed. The categories and subcategories are described in detail in the results section, below.

In addition to the interview data on the cultural appropriateness of services, family and child demographic characteristics were collected, as were measures of child problem severity, family participation in planning, and caregiver satisfaction with services. Problem severity was assessed using the total problem score from the Child Behavior Checklist or CBCL (Achenbach, 1991). The extent of caregiver participation in planning was measured using the Family Participation in Planning measure, which is based on ratings that caregivers provided concerning how involved they were in the development of their child's primary plan (Friesen et al., 1996). Finally, caregiver satisfaction was measured with an adaptation of the Client Satisfaction Questionnaire developed by Larsen, Attkisson,

Hargreaves, and Nguyen (1979).

## **RESULTS**

When provided with the broad definition of culture described above, 81.8% of family caregivers responded that it was of at least some importance that their culture be considered by the people who provided services to their children. This rate was significantly higher ( $\chi^2(181), p < .05$ ) among minority caregivers, with 100.0% of African Americans placing at least some importance on the consideration of culture. The rate among Caucasians was still relatively high at 80.0%. However, when asked whether or not their culture had been considered when the primary service plan was developed, there were no significant differences between these groups in the proportion saying yes (48.8% overall). When the responses to these same questions were examined for differences by other demographic variables, no significant differences were found. The overall percentages for responses thus held regardless of whether the caregiver: was a high school graduate or a non-graduate; was employed or unemployed; lived in a low or moderate income household; or parented alone or with a spouse or partner.

### **Themes in Caregivers' Responses**

The results presented so far indicate that, for most caregivers, it is important that the child's culture be considered when services are planned and provided. The results are also clear in indicating that providers are only partially successful in accommodating culture in service delivery. What remains unclear, however, is exactly what sorts of situations caregivers are referencing when they respond to these questions. The responses to the open-ended questions present caregiver perceptions about the specific ways that culture was or was not considered in the planning and delivery of services, and in the assessment of their child's behavior. The coding categories applied to these responses are presented below, and in Table 1.

#### *Community/Ethnic Values*

This category was coded when caregivers' responses to the interview questions invoked beliefs or values shared within their ethnic or racial subculture or geographical community. Within this category, subcategories were coded to reflect the most common types of responses. The first subcategory was most frequently coded when caregivers expressed a satisfaction or dissatisfaction regarding the

availability of therapists who were an ethnic match to the children being served, or of educational programs which focused on the viewpoints and achievements of people of color.

They see all kids as the same, but I see it different. I see each race in its own mode. There should be more diverse psychologists and service providers to meet those races' needs. Personally, I see it as a matter of gut feelings—black psychologists can better help black children.

Her therapist was also of mixed Asian background, therefore they have similarities in backgrounds. This therapist knows how my daughter is feeling because she has been there.

A second subcategory was coded when caregivers provided examples of satisfactions or dissatisfactions regarding whether providers understood that norms of behavior could differ between communities:

Some things which the school identified as behavior problems, I didn't. For example, [child] was braiding classmates' hair and the teacher said this was inappropriate. Blacks are more touchy and I thought it was OK. She is also loud and boisterous in the hall, and that is normal for black culture but not at her white school.

He was in a majority white school. Some of his behavior would not have caused as many problems as in an urban black school as they did in his school. The child stands out more and gets picked out more due to his behavior and being black.

A third subcategory was coded when caregivers complimented services for supporting or reflecting values which, rather than being ethnic- or community-specific, were instead universal or "color-blind."

They treated her like all children regardless of her culture, so they took her culture into account by not being prejudiced.

Mostly it didn't matter what culture the therapist was, it depended more that the individual therapist had knowledge, skill and attitude. . .

A fourth subcategory coded for satisfactions or dissatisfactions related to whether or not there was racism, hostility, prejudice or bias in service provision.

Table 1. Categories and Subcategories of Caregivers' Responses

Coding system: Categories and subcategories	General description of caregivers' responses reflecting...	
	...satisfaction with services	...dissatisfaction with services
Community or ethnic values	Service providers respect and/or understand values or beliefs shared within an ethnic or racial subculture, or values common to a geographical locality such as a neighborhood; providers/system treat people from different communities equitably	Service providers fail to respect these values and beliefs; providers are racist; providers/system are inequitable
Ethnic match/targeted	System provides services reflecting or supporting values of the family's community	System fails to provide these services
Understanding of cultural norms	Providers understand that norms of behavior can differ between communities	Providers disparage or fail to understand norms of other communities
"Color blind" services	Services are the same for all rather than being ethnic- or community-specific	System provides community-specific services which are inferior or inappropriate
System equity/bias	System allocates resources and opportunities equitably across communities; providers are not racist, prejudiced	System fails to be equitable; providers are hostile, racist, prejudiced
Religious values	System/providers respect and accommodate family's religious or spiritual beliefs and values	System/providers fail to respect or accommodate
Parenting values	Providers respect caregivers' parenting, knowledge of the child	Providers fail to respect caregivers' parenting
Caregiver ideas and input	Providers respect caregivers' knowledge about the nature of child's disability and appropriate treatment	Providers do not respect caregivers' knowledge in these areas
Strict discipline	Discipline advocated/practiced by providers is appropriately strict; incorporates physical punishment when appropriate	Discipline advocated, practiced by providers fails to include punishment (including physical) and/or strict consequences for inappropriate behavior
Liberal discipline	Discipline advocated, practiced by providers is child-centered; precludes physical punishment	Discipline too harsh, strict, physical
Respect for child	Providers respect child as a unique person with a disability	Providers fail to respect child as such
Respect for caregiver	Providers respect caregiver regardless of potential stigmas	Providers fail to respect caregivers

Absolutely there was prejudice in many cases of their treatment of me and my kids. White counselors don't have any interest in seeing a black child succeed.

By my being an Indian, a lot of the time they just did not take me seriously. What I had to say was not acknowledged.

They were unfair on a racial problem. The school did not do a darned thing when my grandchild was attacked by black kids because she is white.

In addition, this final subcategory was also coded when caregivers argued that the service system as a whole unfairly privileged children from certain communities or ethnic groups, or allocated disproportionate resources to them:

The schools are set up to rear non-color middle class Americans. Everything—math questions, multiple choice questions—it's all geared toward white America. In particular, minority race kids are more likely to be classified as emotionally disturbed.

The schools seem to acknowledge other cultures more. They celebrate African and Indian holidays and they didn't celebrate Christmas....They should teach white culture more.

[Providers] in general could be more sensitive and conscious of the struggles or racism in this culture. Don't say, "Just put it behind you." That does not validate the reality of what people of color experience with racial prejudice.

### *Religious Values*

This category included caregiver satisfactions and dissatisfactions regarding the extent to which the family's religious or spiritual values had been respected by service providers.

I'm Pentecostal and everything I believe in as far as parenting is based on biblical principles. But they treat things like religious beliefs like they are not important or applicable.

I liked that prayer, church, the importance of schoolwork and proper behavior are all affirmed at her school.

### *Parenting Values*

This category contained several sub-categories related to the extent to which providers respected caregivers' knowledge of the child and ability to parent effectively. Responses coded into the first subcategory dealt with the extent to which service providers took into account caregiver's ideas regarding the source or nature of the child's disorder or disability or the appropriate treatment or services

for the child.

I feel they were not compassionate or cognizant of the fact that the child has a biological, emotional disability. I feel it stems from prenatal factors but the school does not take this into account.

We wanted the school to be more open to preparing him for college. They were not giving him that option.

Discipline was a concern expressed by many caregivers. Two subcategories within the parenting values category were developed to reflect the extent to which caregivers felt that their values about discipline were, or were not, respected. One subcategory, "strict discipline" was coded as a satisfaction if caregivers mentioned that the discipline provided in services reflected their own values in being appropriately strict or conservative. The large majority of caregivers' dissatisfactions in this subcategory stemmed from feelings that service providers condemned caregivers' valuing of physical punishment as a legitimate means of discipline:

ABC Center has their own methods of discipline which I don't agree with. They say no physical discipline but my culture values some spanking. . . . [Also] in my culture parents speak more harshly. The ABC Center parenting classes didn't promote this. They said easy going and consistent would get the job done.

I believe in spanking but the school and [state children's agency] don't believe in spanking,

The second discipline-related subcategory was called "liberal discipline," and reflected the opposite orientation from the "strict discipline" category.

[Disagreement over] discipline wasn't really an issue. XYZ Center is a pretty liberal place, and so they never counteracted anything I taught my son.

Their discipline wasn't a nurturing, self-esteem type discipline in which a child could grow.

### *Respect for the Caregiver*

This category was coded when a caregiver expressed satisfaction or dissatisfaction with the extent to which service providers respected her, regardless of her apparent membership in a stigmatized social group (e.g. having limited income, receiving public aid, or having limited formal education).

[Service worker] was inappropriate and cruel to me. She called me a liar in front of my kids and let me know she didn't like me because I'm fat.

Services at ABC Center were respectful, especially of someone using a medical card.

### *Respect for the Child*

Often, dissatisfactions in this category revolved around a provider's failure to see the child as a unique person—with promise and potential—rather than as a "problem," a "label," or a "case":

They see him as a syndrome and treated him like that, not taking into account that he's a person with his own individual needs.

### **Distributions of Satisfactions and Dissatisfactions**

The next stage of data analysis focused on the relative importance of different types of satisfactions and dissatisfactions, and whether the frequency of occurrence of particular types of satisfactions and dissatisfactions varied between caregivers from different demographic groups (Table 2). To examine this question, the analytical strategy was to look at the data cross-classified in order to see if significant differences between groups existed in the likelihood of citing examples of satisfactions or dissatisfactions falling into a certain category. For most of the analyses, the statistic of interest was a simple chi square, since there were no instances in which there were significant interactions between race and the other personal and demographic variables examined. African Americans, whites, and Native Americans in this sample were, for example, equally likely to be employed, members of low-income households, or graduates of high school.

Family caregivers of African American and Native American children were more concerned with issues of community and ethnic values than were their Caucasian counterparts, offering significantly more examples of both dissatisfaction ( $\chi^2(224), p < .01$ ) and satisfaction ( $\chi^2(224), p < .01$ ) with the extent to which these values were taken into consideration in assessment and planning. Almost half of the African Americans and two-fifths of Native Americans gave examples of dissatisfactions in this area, as compared to fewer than one in ten Caucasians. However, minority caregivers were far from being unilaterally critical. Slightly more than a third of the African American caregivers, and almost a quarter of the Native Americans provided examples of occasions when they felt that service providers had done a good job of accommodating their ethnic and community values in their child's assessment, planning, or treatment.

Table 2. Type of Value by Race

Type of value or belief: Categories and subcategories	Percentage of family caretakers expressing . . .					
	. . . satisfaction with services			. . . dissatisfaction with services		
	African American <sup>a</sup>	Caucasian	Total	African American <sup>a</sup>	Caucasian	Total
Community or ethnic values	35.1***	3.7***	9.6	48.6***	7.5***	15.2
Ethnic match/targeted	24.3***	0.6***	5.1	27.0***	1.9***	6.6
Understanding of cultural norms	2.7	0.6	1.0	21.6***	0.6***	4.5
"Color blind" services	16.2***	0.6***	3.5	0.0	0.0	0.0
System equity/bias	0.0	0.6	0.5	18.9**	3.7**	6.6
Religious values	2.7	5.0	4.5	8.1	7.5	7.6
Parenting values	5.3	10.3	9.9	42.1	23.9	25.6
Caregiver ideas and input	0.0	6.8	6.2	15.8	14.6	14.8
Strict discipline	5.3	3.5	3.7	26.3*	10.3*	11.8
Liberal discipline	0.0	0.0	0.0	0.0	2.2	2.0
Respect for child	18.9	30.4	28.3	29.7	26.1	26.8
Respect for caregiver	0.0	6.5	5.9	10.5	13.0	12.8
Any category	42.1	56.5	55.2	68.4	51.6	53.2

NOTE: Total percentages within subcategories may add up either to less (due to some responses not clearly belonging to any sub-category) or to more (due to multiple responses by caregivers) than the category total percentage.

<sup>a</sup>Caregiver's race used except when the caregiver was explicitly focusing on the experiences of the child, i.e. in the categories related to community or ethnic values and respect for the child as an individual with a disability, child's race was used.

\*Differences between African Americans and Caucasians significant  $p < .05$ .

\*\*Differences between African Americans and Caucasians significant  $p < .01$ .

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Breaking these results down by subcategories shows both African Americans and Native Americans expressing the greatest degree of dissatisfaction in two areas: lack of ethnic-targeted programs or therapist match, and service providers' lack of understanding of cultural norms or specific elements or values characteristic of members of a community or ethnic group. Bias or discrimination on the part of providers or the system was the third-ranked subcategory for African Americans. This was also the most frequently cited type of dissatisfaction by the small percentage of Caucasians whose responses fell into the category of ethnic/community values. Most frequently, these Caucasians were concerned with what could be called reverse discrimination in the system.

For caregivers of African American children, the issue most frequently at stake in the satisfactions was also the availability of targeted programs and therapists from similar backgrounds. However, the other major area of satisfaction for African American caregivers was for having been provided with

services that were "color blind." In some cases, these caregivers expressed satisfaction that their child had *not* been matched by ethnicity with a provider, or that he had *not* been automatically placed in programs presumed to appeal to him because of his race or ethnicity.

Regarding issues other than those related to community and ethnic values, the overall pattern was one of shared similarity of experiences across ethnic groups in terms of the types of satisfactions and dissatisfactions encountered. About a quarter of caregivers across ethnic groups were dissatisfied due to a perceived lack of respect by service providers of their child as a unique and valuable individual with a disability. Similarly, about a quarter of caregivers were dissatisfied due to service providers' lack of respect for caregivers' parenting values and practices. One in nine was dissatisfied with service providers' level of respect for the caregiver. Within the category of parenting values, however, there was a significant difference by caregiver ethnicity in the distribution of dissatisfactions: African American family caregivers were significantly more likely than their Caucasian counterparts (26.3% versus 10.3%,  $X^2(203), P < .05$ ) to express the specific dissatisfaction that service providers were too lenient in the discipline they prescribed or used, or that they unfairly condemned caregivers for using forms of discipline that were too strict.

Satisfactions with service providers were for the most part relatively infrequent. There were two exceptions to this generalization, yet in each case, the percentage of caregivers expressing dissatisfaction was still higher than the percentage expressing satisfaction with services in the same category. The first exception, noted above, was the mentioning of satisfaction by more than a third of the African American caregivers and about a quarter of the Native American caregivers with the ways that community and ethnic values were accommodated by service providers. The other exception was a relatively high frequency of examples of satisfaction with service providers' respect for the child as a unique individual with a disability, with about a quarter of caregivers providing examples of satisfaction with services in this area. In no other category were satisfactions cited by more than one caregiver in ten.

Neither low educational attainment nor unemployment nor single parenthood was associated with elevated levels of dissatisfaction with service providers' understanding of family caregivers' personal situations; however, a significantly higher proportion of low-income family caregivers did provide examples of dissatisfactions of this sort (19.3% of low-income family caregivers versus 6.9% of family caregivers of higher income provided examples of dissatisfactions ( $X^2(187), p < .01$ )). Loglinear analyses showed that this effect was indeed a function of income, not education or employment status (simple chi square analyses showed that these categories were interrelated).

## **Cultural Appropriateness and Overall Satisfaction**

The final step in the analyses of the data on cultural appropriateness was to examine whether or not having experienced a dissatisfaction in this area would have a significant effect on overall satisfaction with services for family caregivers. An analysis of covariance model was developed using SPSS 8.0 (SPSS Inc., 1997), with caregiver satisfaction as the dependent variable and problem severity and family participation in planning as covariates.

The analyses described in the earlier sections of this paper indicated that dissatisfactions related to a lack of respect for or understanding of community or ethnic values occurred with relative frequency among minority caregivers. The model was therefore constructed to test both for a main effect of minority racial/ethnic status and for an interaction of minority status with community/ethnic dissatisfaction. In addition, analyses performed on the same data (e.g., Friesen et al., 1996) suggested that the caregiver's relationship to the child—as a foster parent or as a relative—also had an effect on satisfaction. Furthermore, previous analyses also indicated that participation in planning had a greater impact on satisfaction for kin caregivers than for foster caregivers.

A model was thus constructed with four fixed factors and two interaction terms, in addition to the two covariates. The first of the fixed factors had two levels indicating whether the caregiver was a relative of the child or a foster parent. The second factor also had two levels, indicating caregiver race as either majority or minority. The third factor was a two level variable indicating whether or not the caregiver had provided an example of a dissatisfaction which had been coded as being related to community or ethnic values, and the fourth factor was another two level variable indicating the presence or absence of any dissatisfaction from the other coded categories. The two interaction terms which were entered into the model represented the interaction of caregiver race and community/ethnic dissatisfaction and the interaction of kin/foster caregiver status and family participation in planning.

Results from the analysis of covariance showed an overall adjusted  $R^2$  of .405. A large and significant portion of the explained variance was due to the covariates. Three of the four factors—the exception being caregiver minority/majority race factor—were significant ( $p \leq .01$ ), as were both of the interaction terms. Overall satisfaction with services thus tended to be lower when caregivers: were kin of the child receiving services; provided at least one example of a situation coded as a dissatisfaction related to ethnic or community values; and/or provided an example of a dissatisfaction from any of the other coded categories. Overall satisfaction with services was not significantly related to caregiver minority/majority status. However, satisfaction with services was significantly lower ( $p \leq .01$ ) for minority caregivers who had voiced a complaint related to community or ethnic values, while minority caregivers who did not voice such a complaint had mean satisfaction not significantly different from that

of majority caregivers.

## **DISCUSSION**

Results from this study show that about half of caregivers—regardless of race, education, or other personal variables—felt that service providers had done at least a fairly good job in accommodating their beliefs and values during treatment planning and service delivery; however, the remaining half of caregivers felt that service providers were not particularly respectful of culture. Caregivers from all backgrounds were highly concerned with whether or not service providers respected the belief that each child is a unique individual, irreducible to a syndrome, a label, or a problem. Relatively large numbers of caregivers across all demographic and personal categories also commented on the extent to which service providers failed to appreciate caregivers' knowledge of the child, and caregivers' ability to parent effectively.

There was little evidence of higher levels of dissatisfaction with service providers among caregivers whose education and socio-economic status could be thought of as placing them in a different subculture from the "average" provider. The one significant exception was that low-income caregivers were more likely to provide examples of dissatisfactions with service providers' understanding of their personal situation. A large proportion of low-income caregivers felt disrespected in this manner, saying that providers viewed them, for example, as "loser[s]" or "trash." Caregivers' descriptions of dissatisfactions suggest that many service providers are insufficiently sensitive to the numerous ways in which having limited income places additional burdens on already-struggling caregivers as they interact with the mental health system. Caregivers' words, as reported here, indicate a need for further attention to this issue.

The analyses indicated that minority family caregivers were more likely than their majority counterparts to describe service providers' failures to accommodate community and ethnic values. Furthermore, the results of the analysis of covariance indicate that such failures had highly significant effects on overall satisfaction for minority caregivers. While close to half of minority family caregivers described a dissatisfaction of this sort, over one third expressed a specific satisfaction with the way that their community or ethnic values were respected by service providers. In sum, while there is evidence, in a significant number of instances, of services supportive of community and ethnic cultures, the overall results reinforce the words of minority caregivers who pointed to instances of racism or prejudice.

Caregivers' voices also warn against seeing members of minority cultures as homogeneous, desiring and needing the same kinds of services. For example, while some minority caregivers adamantly

asserted that children from minority cultures needed therapists from the same background or targeted programs to support their culture, others caregivers insisted just as adamantly that the best treatment was one which was color-blind. What is needed from service providers is a sophisticated cultural competence which can see people simultaneously as members of a culture or community (or of several overlapping cultures or communities), and yet also as individuals who reflect culture and community in unique ways. Promising research in cultural competence is beginning to examine what Sue (1998) calls "cognitive match"—shared conceptions between consumers and providers of mental health services regarding the goals for treatment, the means for achieving these goals, and the preferred means of resolving disagreements. While sharing an ethnicity may well contribute to cognitive match, it does not insure it.

Another theme that emerges clearly from both white and minority caregivers' voices is the dissatisfaction related to diverging ideas about parenting, and particularly what constitutes appropriate discipline. Caregivers in this study distinguished between spanking and abuse, and in a number of cases were adamant that spanking is an important part of an effective discipline scheme. In making these claims, these caregivers are supported by research which supports the idea that non-abusive spanking, *judiciously* used, can be a very effective means of discipline (Lazelere, 1996; Lefkowitz, Eron, Walder, & Huesmann, 1978), and that physical discipline is not necessarily inconsistent with the kind of warm, authoritative parenting that has previously been linked to good outcomes for children (Baumrind, 1997; Sears, 1961).

Results of the current study also support findings from previous research in suggesting that culture makes a difference in terms of what disciplinary practices are endorsed by caregivers (Deater-Deckard, Dodge, Bates, & Pettit, 1996). A number of studies have shown that spanking in particular seems to be more widely condoned in the African American community (see Jackson, 1997, for a review). However, in contrast to the majority population, the use of physical discipline among African Americans does not seem to be associated with negative effects in children (Baumrind, 1997; Deater-Deckard et al., 1996). Researchers have interpreted these findings as follows: because physical discipline is more acceptable in the African American community, African American parents may be more likely than white parents to use it within a parent-child relationship which is, overall, characterized by parental warmth (Jackson, 1997). Failure to understand these cultural differences, and the propensity to pathologize them, gives credence to black caregivers' perceptions that the system is biased in its evaluation of their culture and their parenting competence. It seems there is a need for providers to be more flexible and more sophisticated in working with caregivers around these issues.

While the results of this study point to genuine areas of caregiver satisfaction and dissatisfaction

with the service delivery system, the study should be viewed as exploratory. The data analyzed for this study were among many collected for the program evaluation. Thus the questions regarding the cultural appropriateness of services was not given special attention, and there was no opportunity built into the interview for follow-up questions or probes. It therefore seems likely that the responses obtained were fewer in number and contained less detail than they would have had cultural appropriateness been a central focus of the data gathering effort. What is more, since the types of incidents that respondents were being asked to describe are very sensitive, and since the interviewers were mostly white and middle-class, the possibility of underreporting in these areas is significant. The results may thus represent a low-end estimate of the extent to which these types of situations were experienced.

The broad definition of "culture" used in gathering data is both a strength of this study and yet also a limitation. While the coding categories seem to have captured quite effectively the range of responses provided by caregivers to this broad definition of "culture," there were also a number of instances in which it seemed that respondents were confused by the definition, claiming that they had no culture and that the questions were therefore not relevant to them. Other researchers may find the results presented here useful in minimizing this sort of confusion in future studies, since this study points to various discrete themes contained in people's everyday understanding of the idea of "culture."

Taken together, the limitations enumerated above indicate that this study likely underestimates the frequency with which caregivers encounter dissatisfactions with the cultural appropriateness of services. It is clear that much needs to be done both in educating and training service providers in cultural competence, and in enlarging the research base in this area. We need to remember to ground these efforts in the experiences of families, so that caregivers, children, and youth will more frequently encounter services that are flexible and responsive to diverse value systems. What is more, there is a need to explore, and to evaluate, ways to build into systems structures and processes—third-party-neutral mediators or ombuds come to mind as possibilities—which can serve both to resolve specific dissatisfactions and to increase the capacities of providers and families to work together. In providing these kinds of opportunities to address dissatisfactions constructively, a system of care would express a real commitment to helping family members find alternatives beyond the unsatisfactory admonition to "just put it behind you."

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