Community Health Workers and Social Proximity: Implementation of a Parenting Program in Urban Poverty

BY

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THESIS

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This thesis is dedicated to my parents, Luz and Richard Gustafson, whose endless love, support, and encouragement keep me motivated and forever grateful.
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<tr>
<td>AA</td>
<td>African American</td>
</tr>
<tr>
<td>CHW</td>
<td>Community health worker</td>
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<tr>
<td>PASS</td>
<td>Partners Achieving Student Success</td>
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<td>SFL</td>
<td>Student-Family Liaison</td>
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SUMMARY

Community health workers (CHWs) offer many advantages for effective dissemination of mental health interventions, and thus a potential means through which to mitigate the many barriers to treatment faced by minority youth and their families. However, studies using CHWs have mainly focused on whether interventions implemented by this workforce are effective, while leaving much unknown about the nature of CHWs’ role and the key elements that make them effective.

The primary aim of the present study was to better understand one of the central components defining the CHW role: their shared community membership with the population served. We used the term social proximity to refer to this closeness to the population served, and to encapsulate the shared characteristics, background, and experiences that could comprise defining features of community membership. In order to better characterize and understand social proximity, we interviewed 16 CHWs (called Student-Family Liaisons, or SFLs) implementing a school-based early intervention program (Partners Achieving Student Success, or PASS) in Latino and African American communities of urban poverty. The program targeted promoting child and parent engagement in schooling as a protective factor for children’s mental health. SFLs were interviewed about the strategies, characteristics, and elements of their role that they leveraged in connecting with and engaging families.

Thematic analyses of semi-structured interviews with these 16 SFLs revealed four main themes defining social proximity for this CHW workforce: (1) experiences of parenthood or caring for children, (2) knowledge and understanding of practices or experiences related to ethnicity/race, (3) familiarity with and understanding of the neighborhood community, and (4) experiences of life hardships and struggles. These elements of social proximity were featured
SUMMARY (continued)

most prominently in the engagement strategy of relating. SFLs’ accounts illustrated how their experience of social proximity was informed by specific typologies of similarities (experiential and deep-level), contextually relevant similarities, and program-based similarities. Additionally, these accounts highlight the need for supporting, promoting, and celebrating the natural traits and lived experiences of CHWs, for these are the defining features that make this workforce unique and also what CHWs consistently draw upon when connecting with community members during service delivery.
I. INTRODUCTION

A. Background

Large unmet mental health needs of youth have persisted over the last several decades despite longstanding calls to better provide services to youth in need (U.S. Office of the Surgeon General, 1999). Estimates indicate that anywhere from 60 to 80 percent of children and adolescents in need of mental health services do not receive treatment (U.S. Office of the Surgeon General, 1999; Kataoka, et al., 2002, Merikangas et al., 2011). This need is particularly marked for minority youth who have even poorer odds of receiving services, and who face more risk factors that contribute to mental health vulnerabilities given their overrepresentation in vulnerable populations such as those in the child welfare system, those living in poverty, or homeless (U.S. Department of Health and Human Services, 2014; Alegria et al., 2010; Alegria & Green, 2015; Costello et al., 2014; Marrast et al., 2016; Xue et al., 2005).

The mental health disparities between youth of color and their white peers can be attributed to various causes. However, several factors are worth highlighting for the present discussion. Cultural differences in help-seeking attitudes, clinician bias and/or client distrust, disparities between clinicians and clients in treatment expectations and preferences all contribute to disparities in service use by minority populations (Holm-Hansen, 2006). These barriers to treatment are often compounded by environmental and societal forces commonly faced by minority families. Specifically, poverty, neighborhood violence, poor educational resources, systemic racism, and language and legal barriers make for not only a difficult lived experience, but also engender difficulties in accessing, navigating, and continuing with services (Alegria & Green, 2015).
These barriers to treatment for minority youth intersect with the difficulties facing contemporary child mental healthcare, most critically, challenges with sustained family engagement in services as well as a shortage of service providers. It is well established that an integral component of mental health services for children of any background is parent involvement in treatment (Nock & Ferriter, 2005). Consistent with ecological theory of development (Bronfenbrenner, 1979), interventions aiming to effectively promote healthy psychological development target not only the individual child, but also the key players and systems in a child’s environment, particularly parents. However, a ubiquitous challenge in youth mental health services is the difficulty of attaining consistent parent engagement and participation in interventions. At least one third of children and families fail to attend an initial intake appointment, and 40%-60% drop out after a few sessions (Gopalan et al., 2010). These participation challenges are particularly marked for minority families and those living in urban, low-income communities (McKay et al., 2005; Kazdin & Mazurick, 1994). Furthermore, underlying the discussion of participation challenges is the assumption that services are available in the first place, an assumption that cannot always be made given significant shortages in service providers, especially in urban communities with large ethnic/racial-minority populations (Vander Wielen et al., 2015). Shortages exist across the spectrum of mental health providers (e.g. psychiatrists, psychologists, counselors, etc.), with fewer than half of U.S. counties containing a specialty mental health facility with programs for youth with severe emotional disturbances (Koppelman, 2004; Cummings et al., 2013; U.S. Department of Health and Human Services, 2013). Such provider shortages disproportionately impact marginalized communities that are often already under-resourced. Minority youth with mental health needs thus face barriers to treatment not only due to their sociocultural status, but also due to inadequacies in the provision
of mental health services. The pressing need to better address these barriers and provide services to minority children and families necessitates the development of innovative service models extending beyond traditional clinic-based services and providers (Kazdin & Rabbitt, 2013).

B. Paraprofessionals & Mental Health

In face of provider shortages, environmental and sociocultural barriers for minority youth and families’ access to mental health care, paraprofessionals, also referred to as community health workers (CHWs), offer a potential means through which to mitigate some of the barriers to services for this population. The American Public Health Association (2001) defines CHWs as “frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.” Reinschmidt et al. (2006) describe how CHWs “play a wide range of roles in education, outreach and advocacy work, and have an equally wide range of socio-cultural and personal characteristics” (p. 257). Thus, this is a versatile workforce that is well suited for a variety of health prevention and intervention programs for minority populations. Here we will consider the use of a paraprofessional workforce within the domain of child mental health services, specifically in the prevention of emerging mental health needs.

With appropriate supervision, CHWs have been shown to be effective in disseminating psychoeducational programs, detecting mental health disorders, as well as providing referrals and follow-up care (Kakuma et al., 2011; Patel et al., 2011). Additionally, they can be used to provide health education, case management, and outreach services (Swider, 2002). Using this workforce for minority mental health promotion has several advantages: (1) given that CHWs
are embedded within the community, they can more effectively reach difficult-to-access populations (i.e. minorities), thus helping address the disparity in access; (2) given CHWs’ familiarity with the culture of the community they serve, they are able to incorporate local knowledge into services, thus addressing cultural barriers to service use, such as stigma or cultural competence; (3) given their community-peer status they can develop more trusting relationships with these populations, which can help increase service use; (4) given that paraprofessionals require less specialized training, CHWs help reduce costs while increasing the capacity of mental healthcare; and (5) CHWs can contribute to community empowerment ownership of mental healthcare by serving as an advocate for their community members and linking them to services (U.S. Department of Health and Human Services, 2007; Swider, 2002; Love et al., 1997; Giblin, 1989; Witmer et al., 1995; Gilkey et al., 2011).

While the paraprofessional workforce offers many advantages for effective dissemination of mental health interventions, studies using CHWs have mainly focused on whether interventions implemented by this workforce are effective (Swider, 2002; Andrews et al., 2004), while leaving much unknown about what specific elements make CHWs effective. Swider (2002) aptly captures this issue:

*If CHWs are going to be used with these populations, further work is needed on what characteristics make the CHW effective with these groups. Does the CHW need to live in their community, be of similar class or ethnicity, or share behavioral risk factors, or are the most effective CHWs any person who works in roles requiring little skill, but who takes time to reach out and listen to underserved groups on a regular basis?* (p. 19)

Although the emergence of CHWs to expand healthcare access for the underserved can be traced back to the 1950s and 1960s (Perry et al., 2014), it was not until the 1990s that they began to be conceptualized as a distinct workforce, and only recently were they recognized as such by the
U.S. Department of Labor in 2010 (Love et al., 1997; Gilkey et al., 2011). Therefore, much still remains to be explored and understood about this workforce, particularly regarding the characteristics and processes that allow for CHWs’ to promote access to mental healthcare for marginalized children and families.

C. The Unique Role of Community Health Workers

The role of a CHW can be likened to several other professions, such as health educators, mentors, and mental health workers, as it encompasses some similar functions (Eng & Young, 1992). CHWs share commonalities with health educators and mental health providers in that their role can involve disseminating psychoeducational information, implementing low intensity interventions, or providing psychosocial support (Kakuma et al., 2011; Patel et al., 2017). They also share commonalities with mentors, particularly peer-mentors, in that community health workers are near-peers (Rogers, 1995) providing guidance to the population with whom they work. Much like mentors, they can provide both instrumental and psychosocial support (Eng & Young, 1992, Reinschmidt et al., 2006; Eby et al., 2013). However, despite sharing some common aspects with other professions, CHWs occupy a distinct role and function that may make them uniquely positioned to serve traditionally marginalized communities.

To better understand the idiosyncrasies of the CHW role, a closer examination of its definition is warranted. The previously noted American Public Health Association’s (2001) definition can be distilled into two main components: the central characteristics of CHWs, and the central functions of CHWs. Specifically, regarding characteristics, CHWs are defined by their status as a “trusted member of the community” and/or as “having an unusually close understanding of the community” (American Public Health Association, 2001). We will refer to this closeness to the community served as social proximity. Regarding CHWs’ function, their
social proximity is leveraged to (1) “facilitate access to services”, and (2) “improve the quality and cultural competence of service delivery” (American Public Health Association, 2001). In this way, a CHW’s social proximity can be conceptualized as their “active ingredient,” on which their ability to effectively perform their functions is predicated.

Because of their social proximity, CHWs’ role rests upon shared commonalities with those they serve, which differs from more traditional mental health workers whose roles are not defined by nor contingent upon their social positionality. It is generally understood that a clinician, counselor, social worker, or psychiatrist can effectively function in their role irrespective of the commonalities or lack thereof between provider and client. For example, in their review of therapist characteristics impacting the therapeutic alliance, Ackerman and Hilsenroth (2003) found that important personal attributes included trustworthiness, experience (with regards to training and years of practice), confidence, clear communication, accurate interpretation, and warmth/friendliness amongst others. Factors relating to therapists’ social positionality or proximity to clients (e.g. their community membership as defined by shared ethnicity/race, area of residence, experience within a particular socioeconomic class, etc.) were not discussed or even considered as potentially relevant to their relationship with clients. In addition, whereas a meta-analysis of 81 studies examining ethnic matching in mental health services found relatively strong effects for client preferences for therapists of one’s own race or ethnicity, there was almost no benefit to treatment outcomes from racial or ethnic matching (Cabral & Smith, 2011). Thus, the ability of mental health providers to perform their functions rests upon their training, mastery of content, and development of expertise, as well as general interpersonal skills, such as being empathic and non-judgmental. However, what distinguishes CHWs from these other mental health professions is the nature of the preparation for their role.
Gilkey et al. (2011) conceptualize CHWs’ role as that of an “experience-based expert” to reflect the fact that this workforce is not only knowledgeable about a particular health issue, but they understand the particular health issue in a “socially contextualized way” via their commonalities and shared experiences with the population they serve. As Eng and Young (1992) note, the distinction between paraprofessionals and other mental health providers does not necessarily lie in the content they provide, but in the manner in which they do so. Hence, while CHWs may also undergo training and mastery of content, it is the intersection of this specialized health knowledge with their set of lived experiences as members of a particular community that defines their unique role (Gilkey et al., 2011).

D. Social Proximity & Engagement

By definition one of the primary purposes of a CHW is facilitating access to services (American Public Health Association, 2001), which we propose closely maps onto the various components of engagement. Additionally, CHWs’ shared community membership (i.e., social proximity) is framed as that which enables them to perform this function of access facilitation (American Public Health Association, 2001). Thus, we can broadly conceptualize one of CHWs’ primary functions as facilitating engagement in services via leveraging their social proximity.

Engagement can refer to a variety of forms of participation in services, including attendance (Ingoldsby, 2010) and adherence to program content (Nock & Ferriter, 2005). Therefore, engagement includes the concrete logistics of attending services and implementing intervention content (e.g. transportation, time, etc.), as well as the client’s attitudes and receptiveness towards services (e.g. motivation to attend, willingness to implement intervention content, beliefs about the necessity or effectiveness of treatment, etc.) (McKay & Bannon, 2004). The engagement process also involves dynamic relationship quality factors that develop
throughout the course of the service provider and client’s interactions, such as building rapport and trust, as the client-provider relationship is a significant predictor of client attendance and outcomes (McKay & Bannon, 2004; Karver et al., 2006). All of these facets of engagement represent factors that can either help or hinder a client’s ability to access and utilize services, and in this way the process of engagement reflects CHWs’ work of facilitating access to services.

In drawing from the CHW definition we can conceptually make the case for social proximity being leveraged to facilitate engagement in services, but much remains unknown about CHWs’ experiences of both the construct of social proximity and the process of engagement. As previously discussed, we use the term social proximity to refer to a closeness to the population served either through community membership (i.e., being of the same ethnicity, a part of the same cultural group, neighborhood, or religious community) or through intimate knowledge and understanding of the community (i.e., familiarity with cultural norms, practices, and experiences). However, the construct remains ambiguous, for there is no clear delineation as to the specific boundaries of community membership or the specific extent of community understanding that is necessary. We do not know which characteristics and experiences are most salient, and which specific elements enable paraprofessionals to effectively engage community members and connect them to services. Equally unclear is how these elements are leveraged to promote engagement. These questions are of particular importance for better understanding the mechanisms and relevant factors in CHWs’ ability to increase mental health service access, use, and overall engagement for minorities. Because little is known about the specific elements of social proximity associated with engagement in community health work, we draw from the mental health and mentorship literatures to guide our understanding of this phenomenon in CHWs, given the overlapping nature of these roles.
When thinking about elements that may contribute to engagement, the mentorship literature frequently cites Byrne’s similarity-attraction paradigm. The paradigm proposes that the more similar someone perceives another person to be, the more they like, are receptive towards, and are drawn to that person (Byrne, 1971). Applied to CHWs, this framework suggests that through social proximity the population served perceives paraprofessionals as similar to themselves, and therefore are more receptive to the CHW and by extension, the services they provide. The similarity-attraction paradigm can further be understood through a framework of three broad categories of similarity: surface-level, deep-level, and experiential. Surface-level similarities refer to readily observable demographic characteristics such as age, gender, or ethnicity (Harrison et al., 1998), deep-level similarities refer to personal characteristics such as attitudes, beliefs, and values (Harrison et al., 1998), while experiential similarities refer to experience-based factors such as educational background and geographic location (Eby et al., 2013). In a large meta-analysis across youth, academic, and workplace mentorship, Eby and colleagues (2013) found little support for surface-level similarities impacting mentee relationship satisfaction or instrumental and psychosocial support, while deep-level and experiential similarities emerged as significant antecedents in relation to these domains. The authors proposed that deep-level similarities were associated with increased engagement in the form of longer relationships and more frequent contacts. When considered in relation to social proximity, these results suggest that deep-level and experiential similarities may define particularly important elements of social proximity.

Within the mental health treatment literature, antecedent factors (also referred to as pretreatment characteristics) are discussed as relevant to engagement. These factors consist of more static elements or characteristics that exist before the program is implemented and the
relationship building process is underway, such as the individual’s demographic characteristics and past experiences (Karver et al., 2005). There are clear parallels between antecedent factors and elements of social proximity. Both concepts refer to a set of pre-existing characteristics, traits, and experiences that a service provider brings to treatment. However, what distinguishes social proximity from antecedent factors is that social proximity is defined as a shared characteristic or experience in relation to the population served. Such shared provider-client identification is not requisite in antecedent factors. The study of therapist antecedent factors has instead mostly focused on the provider’s characteristics independent from the client’s (e.g. clear communication and warmth; Ackerman & Hilsenroth, 2003), and when shared clinician-client characteristics have been examined, studies have focused only on surface-level similarities. As noted previously, across several meta-analyses, surface-level similarities such as therapist-client race or ethnic match have not been found to significantly influence engagement or overall client outcomes (Cabral & Smith, 2011; Maramba & Nagayama Hall, 2002). This is consistent with findings from the mentorship literature indicating that surface-level similarities do not seem to play a prominent role in client engagement, thus supporting the notion that this type of similarity may not be a particularly meaningful form of social proximity.

While these literatures provide a body of evidence to guide our thinking around the phenomenon of social proximity in CHWs, there are important differences between paraprofessionals relative to mentors and mental health professionals; namely, the fact that the latter two roles are not defined by their social proximity, whereas for paraprofessionals social proximity is a central component. Thus, while we draw from these literatures – particularly the similarity-attraction paradigm and typologies of different levels of similarity from mentorship
research – to frame our research, a primary goal for this study is to understand social proximity as experienced and leveraged by CHWs.

E. Present Study

The present study aims to explore what characterizes social proximity for CHWs, and how it manifests in CHWs’ work with children and families in the context of mental health promotion. Our research questions include:

1) What is the nature of social proximity as experienced by paraprofessionals? What are the salient similarities arising from shared community membership and knowledge?

2) How does social proximity play a role in paraprofessionals’ work engaging families in services? What are the processes through which social proximity is utilized to facilitate engagement?

Because so little is known about what characterizes social proximity in CHWs’ experiences and how it manifests CHWs’ work with clients, qualitative methodology was deemed most appropriate as it allows for a descriptive and exploratory understanding of the phenomena. The present study took a deductive approach through drawing from existing research in related fields (e.g. mentorship and mental health) to inform interview questions and a priori expected codes, as well as an inductive approach to iteratively refine codes throughout the data analysis process. It employed thematic analysis (Braun & Clarke 2006) to identify, analyze, and interpret patterns across the narratives of participants. Given that thematic analysis does not inherently subscribe to one specific theoretical paradigm (Braun & Clarke, 2006), we situate the present study in the spectrum between positivist and constructivist paradigms, where positivism adheres to the belief that there exists an objective true reality that is apprehendable, and constructivism posits that reality is relative, socially constructed, and can exist in multiple
equally valid forms (for review see Ponterotto, 2005). Between these ends, our approach is aligned with postpositivism (or critical realism) in that ontologically we subscribe to the belief of a true reality that exists independently of our perceptions, while epistemologically we recognize that our ability to apprehend this reality is imperfect, and thus our understanding of the world is a construction based on our perspectives, allowing for multiple valid perspectives on reality (Maxwell, 2012).
II. METHODS

A. Setting

Participants were recruited from the paraprofessional staff at four social service agencies implementing a newly developed school-based prevention and early intervention parenting program, Partners Achieving Student Success (PASS), across 16 public elementary schools in Chicago communities of concentrated poverty. PASS was grounded in empirical research supporting parent and child engagement in learning as a protective factor for children’s mental health. It was developed through a collaboration between the research team and community social service agencies, with researchers serving in a consultation role throughout program implementation.

PASS served approximately 600 predominantly Latino and African American students in kindergarten through third grade who were beginning to show evidence of pending emotional, behavioral, social, and academic problems. While paraprofessionals targeted both the child and parents, their intervention efforts emphasized working with parents as the most effective means through which to make meaningful and lasting improvements in the child’s environment. Paraprofessionals provided behavioral, emotional, academic, and social skill building support to students, and worked closely with parents to implement positive parenting strategies, facilitate engagement in their child’s learning, and connect them to concrete community resources and services to meet basic needs.

The paraprofessional staff consisted of trained community members (CHWs), referred to as School Family Liaisons (SFLs). SFLs worked for one of four social service agencies, with two operating in ethnically diverse neighborhoods but serving a predominantly Latino population, and the other two serving predominantly African American communities. While SFLs worked
for social service agencies, they were mainly situated within the schools and spent the majority of their time either at school or in the community. There were two SFLs assigned to each school, each with a caseload of approximately 20 students, and they were supervised by a master’s level mental health professional employed by their agency and assigned full-time to PASS.

B. Procedures

University review board approval was obtained prior to beginning the study, and written consent was obtained from all participants. This study was one component of a larger mixed-methods project examining different types of roles and supports provided by paraprofessionals. The other component of the larger study included focus groups with SFLs and parents as well as quantitative questionnaire data. Therefore, ten of the SFL participants in the present study also participated in other data collection (focus group and quantitative questionnaires). The present study only presents the SFL interview data.

Prior to beginning data collection, interview questions were developed and edited via an iterative process. The first author developed an initial set of questions and then consulted with two SFLs and a supervisor to gather feedback about their understanding of the questions as well as question relevance and acceptability. Questions were edited as appropriate, and then two pilot interviews were conducted to gather additional feedback. Staff members who were consulted for question development were not participants in later interview data collection, and information from pilot interviews was not recorded nor included in the present data set. Incorporating PASS staff feedback, interview questions were then finalized and prepared for data collection. Interview questions addressed SFLs’ strategies and forms of engagement with parents as well as the role of shared similarities in their work with parents. The semi-structured interview consisted of ten central questions, each with 2-3 optional follow up probes (see Appendix).
C. **Participants**

Participants were recruited through informational sessions held at SFLs’ agencies. A member of the research team presented SFLs with a description of the study, and later followed up with SFLs who expressed interest in participating to complete the consent process. Participants in the present study completed one audio-recorded face-to-face interview lasting approximately 60-90 minutes. They were compensated with a $20 gift card. Sixteen paraprofessionals participated in the present study. As noted in Table I, the sample consisted of 15 females, 6 of whom were Latina and 9 of whom were African American, and 1 Latino male. SFLs ranged in age from 23-58 years old (M=34). Half of the sample had a four-year college education, while the other half ranged from a high school or GED to a two-year college education. Time working for the PASS program ranged from 6-62 months (M=29 months). At least one SFL participated from 11 of the 16 schools in which PASS was implemented. All but one SFL completed the demographic questionnaire.
TABLE I SFL AND SCHOOL DEMOGRAPHICS

<table>
<thead>
<tr>
<th>SFL</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Parent</th>
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<tr>
<th>School</th>
<th>Racial/Ethnic Composition</th>
<th>Low-Income</th>
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<tbody>
<tr>
<td>A</td>
<td>98.2% AA, 1.6% Latino</td>
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<td>K</td>
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</table>

*School demographic data from Chicago Public Schools’ “School Profiles”
AA: African American
NA: Not available

D. Data Analysis

Interviews were audio-recorded and professionally transcribed. The transcripts were checked against audio recordings for accuracy, and then segmented into smaller units for coding. The first author segmented transcripts via thematic criteria, in which meaningful, complete, coherent and independently understood coding units were demarcated (Schreier, 2013; Saldaña, 2015). Given that the interviews were informed by the mental health and mentorship literature on engagement antecedents, an initial list of provisional a priori codes based on anticipated categories and types of responses was generated by the first author prior to transcript review and analysis (Saldaña, 2015; Schreier, 2013). This initial codebook was modified and refined via an iterative process as transcripts were reviewed and coded.
Interviews were analyzed with qualitative software Dedoose (Dedoose Version 7.5.9, 2016). Thematic analyses followed Braun and Clarke’s (2006) structured guidelines for analyzing themes, including identifying themes, reviewing themes and revising as needed, and refining themes and subthemes. The coding team was comprised of one female graduate student (first author) and one male advanced undergraduate student. The lead author and second coder began coder training by reviewing and practicing code applications on two randomly selected transcripts. Lead author and second coder then trained to develop reliability using random representative subsamples from the transcripts for pilot testing. Discrepancies were addressed by clarifying, discussing, and reestablishing consensus on operational definitions or determining whether revisions or clarifications of the coding scheme were needed, followed by additional independent coding until a pooled Cohen’s Kappa for all codes of .9 was reached (Lombard et al., 2010). Once adequate reliability was achieved, the full sample of interviews was then independently coded. The first author coded all the interviews, and following the guidelines offered by Lombard et al. (2010), 40% of interviews were coded by the second coder.
III. RESULTS

Qualitative interviews examined SFLs’ strategies and forms of engagement with parents, and the role of shared similarities in the process of engagement. Analyses revealed four main themes that characterized relevant factors of social proximity for SFLs: (1) experiences of parenthood or caring for children, (2) knowledge and understanding of practices or experiences related to ethnicity/race, (3) familiarity with and understanding of the neighborhood community, and (4) experiences of life hardships and struggles. These themes are described in detail below, with accompanying exemplar quotes. Following the thematic characterization of the elements of social proximity, we present themes pertaining to the ways SFLs utilized their social proximity to engage parents. These themes are summarized in Table II.

<table>
<thead>
<tr>
<th>TABLE II SOCIAL PROXIMITY &amp; ENGAGEMENT THEMES</th>
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<tbody>
<tr>
<td>Umbrella categories, themes, and subthemes</td>
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<tr>
<td>Defining elements of social proximity</td>
</tr>
<tr>
<td>Parenthood</td>
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<tr>
<td>Ethnicity</td>
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<tr>
<td>Neighborhood</td>
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<tr>
<td>Challenges</td>
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<tr>
<td>Engagement strategies utilizing social proximity</td>
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<tr>
<td>Relating</td>
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<tr>
<td>Normalizing</td>
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<td>Equality</td>
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<tr>
<td>Buy-in</td>
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<tr>
<td>Incentives</td>
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<td>Positivity/Praise</td>
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</table>

Themes and subthemes are indented; subthemes are italicized.
A. **Defining Elements of Social Proximity**

1. **Parenthood.**

SFLs described being a parent as one of the primary similarities and ways in which they identified with parents in PASS, citing various aspects of parenthood as common ground. SFLs indicated frequently sharing their own parenting practices and strategies with PASS parents. Additionally, SFLs described establishing common ground through their familiarity with certain parenting practices used by PASS parents. Specifically, SFLs reflected on their conversations with parents regarding disciplinary physical punishment, which was a core component addressed in the PASS curriculum. Some SFLs’ noted that although they did not use physical discipline with their own children, corporal punishment was very familiar to them as it was common practice when they were growing up and/or how they themselves were raised, hence citing their familiarity and understanding of the practice as a similarity with PASS parents. One SFL described her reaction to parents sharing their use of physical punishment:

> [N]ot being shocked, and also being grateful that they’re willing to say that – “I’m gonna whoop him,” type of thing. And just let him [parent] know, “Yeah, I got whooped, too” […] So it’s like, “Okay, so I can say this.” Because you do tell them you’re a mandated reported. So they’re like, “Okay.” But they’re able to, if it slips out, they say it. You’re like […] “let’s try something else,” or “I got whooped, too.” Something, to make it seem like it’s not the end of the world. So it’s just, okay. So we’re kind of on the same page. We know what that is. We understand there’s a difference between spanking and completely like child abuse.

SFLs also identified various parenting challenges as shared commonalities with parents. For some paraprofessionals these challenges were described as general difficulties in raising children, while for others the challenges of parenthood were described in relation to other
circumstances, such as parenting as a single mother, while working, and/or going to school. For example, one SFL described how she relates to the parents on her caseload:

My parents know that I struggle as a parent. I am no different from you. There may be something that you can say to help me. My kids are not angels, so your kid is not the only one that’s acting out in school. I have a 16-year-old son that acts out at school. I have a 5-year-old son that drives me crazy. I have an 18-year-old daughter who is going through the flux. I tell them all of that. So, we have a lot of similarities. You are not different. We are not different from one another. So, I tell them about all of that, just so they can know that it’s okay. It’s gonna be okay.

While another SFL expressed,

[The] majority of the time you see single parents going to school, working, being involved with your children. Just every day – yeah, you run across some parents that you be like, “Okay, we’ve been through similarities – the same thing.”

Although the majority of SFLs were parents (see Table 1), three SFLs did not have children. Despite not being a parent, however, the experience of caring for a child still emerged as a prominent theme for these SFLs. They emphasized their prior roles as caretakers for siblings or nieces and nephews, and related these to the experience and challenge of parenthood through that role:

[T]he parents see me, and I don’t think they think I have kids. And I make a very good point to mention I have little brothers and sisters, and I mention to some moms, “I don’t have kids myself, but I saw the way all my siblings were raised after us.” And I guess I mention my own experiences when I’m with my mother, and I’m like, “You know my mom used to work two jobs so I would have to go from high school directly to go pick up these kids.” So it’s like I would have to take a bus to the daycare center. I would have to
pick up from elementary school to the daycare and then take a bus. I share my own experiences.

2. **Ethnicity/race.**

In this theme we use ethnicity/race to refer to “groups of people who share common cultural traits, such as language, history, religion, ancestry, traditions, and beliefs” (Sanchez, Colón-Torres, Feuer, Roundfield, & Berardi, 2014, p. 147). Interestingly, Latino SFLs, but not African American SFLs, explicitly cited ethnic/race-related factors as commonalities with parents. Hence the excerpts described here only represent the experiences of the seven Latina/o SFLs.

With regards to ethnicity-related factors, these SFLs identified discipline practices, language, and the immigrant experience as similarities with parents. As discussed above, SFLs (both Latino and African American) indicated familiarity with disciplinary physical punishment as a commonality with parents. However, only the Latino SFLs related the practice of corporal punishment to their ethnic background, as one SFL described, “with a majority of Hispanic families, that’s how they discipline.” The cultural elements of physical discipline also emerged in the way SFLs described parents discussing the practice, at times highlighting the use of specific language:

[I]f you talk to him [parent] about time out, he’ll be like, “yeah, that’s not how we were raised.” They will grab the *chancla* [slipper], or the cord, or the *chingada*. The words that they use, just for them talking like that, they feel comfortable, just for me knowing what that means, because that’s something growing up too, that’s the way we were also disciplined […] [B]y me telling them, yeah, that’s how we were raised too, but that’s not how I’m raising my son. And, just explaining that things are different now. So yeah, I think, like, when you share the same culture, and the same language, it’s easier for them.
Language was another relevant component within the theme of ethnicity for these Latino SFLs. They described the importance of speaking Spanish given their primarily Latino caseloads, indicating that, as one SFL put it, “knowing their [parents’] language is really big.” Some SFLs reflected on more nuanced commonalities with parents afforded by their shared language beyond simply know Spanish, such as familiarity with particular Spanish sayings (or *dichos*) as well as familiarity and comfort with speaking in particular tones or registers with parents. As one SFL shared,

> With Latinos I’m extremely confident because I can get to them by talking in a way like them. A lot of what I use in CPP [parent groups] when I’m teaching is I use a lot of our sayings that we use in Latino – *dichos* – that we use in Latin-American. That’s one way for me to say that I’m teaching them about helping their kids at home, because they need to learn rules at home because society has rules. And then I’ll say something like “*como decían nuestros abuelos o nuestros papas, lo que no te enseñan en la casa te lo enseñan en la calle*” [as our grandparents and parents said, what they don’t teach you at home you’ll learn in the streets]. And those are big things that I use to relate.

Another of these SFLs described how as she began her job as an SFL, she learned to use her interactions with her own family as a reference framework for how to speak with the parents on her caseload:

> [O]nce I got to meeting one or two of the parents, I was just like, “Wow! These people are just like my family” because most of my – all of my caseload is Latino or has some Latino in them. So I’m like, “This is just like my mom. This is like talking to my aunt. This is like talking to my uncle.” Since I know how to talk to them, that’s kind of how I would talk to them.
In addition to cultural parenting practices and language, the immigrant experience was featured prominently within the theme of ethnicity. Some of these SFLs were immigrants themselves, while others expressed familiarity with the experience due to their parents having immigrated. Most SFL discussions of immigration centered on the challenges accompanying being a newcomer to the country, which included not knowing the language, long work hours, and being unfamiliar with American school systems. One SFL described,

[P]arents are immigrants and either from Mexico or South America. So I’m able to […] have a sense of where the parents are coming, or the families are coming from. The work schedule, having two jobs, or having a lot of kids, and not being able to like give attention to every single one, because their moms are busy and they’re tired. Yeah, so and just coming from countries, like from Mexico, like I lived there, so I know how hard life can be.

3. **Neighborhood.**

As previously stated, none of the African American SFLs specifically discussed race-related commonalities with parents, instead focusing on similarities arising from shared neighborhood membership and familiarity. We coded and conceptualized these factors as distinct themes to reflect their different underpinnings (i.e., similarities attributed to ethnicity versus area of residence). While three Latina SFLs briefly mentioned being from the same neighborhood as parents, these were isolated statements and SFLs did not endorse this commonality as something they shared or found relevant to their work with parents. Therefore, the excerpts presented here are only from the nine African American SFL accounts of neighborhood-based commonalities with parents.

Several of these SFLs reflected on how their neighborhood membership allowed them to speak in a more casual and personal manner that engaged parents. As one SFL put it, “they like
that sister girl attitude.” Another expressed how initially she struggled to connect with parents in her role as a paraprofessional until she acknowledged her community membership and started speaking in a way that reflected that:

I grew up right down the street from here [...] My mom and them and I stayed on that block all their life. My father’s church is right there. My kids go there. We are in the community. I know everything that they’re talking about. I already know what they’re talking about. So that’s why I was like, “Why am I talking to them like I don’t know what they talking about?” I’m like, “Girl, I stay in [neighborhood].”

The familiarity and understanding of the neighborhoods’ persistent violence and poverty was a central element of these SFLs’ descriptions of neighborhood-based similarities with parents. One SFL expressed how “people that grew up in [neighborhood], it’s a lot of death around them, it’s a lot of poverty,” while another stated, “you have to think about our neighborhood, it’s a lot going on so that [violence] is huge. That is huge. I mean a child [...] was killed at the gas station across from the school.” Because of these difficult circumstances faced by the community, SFLs indicated that being from the community and understanding these experiences was important to parents:

Interacting with my parents, and letting them know that I don’t think I’m above them – living in [neighborhood] is a great asset to being an SFL [...] [Parents are] more open to listen and respond if you live where they are versus you living outside of the neighborhood. Because to them, they don’t think you understand what they’re dealing with because you don’t live where they live, but I do.

This same SFL went on to describe how some parents were surprised to know that the SFL lived in the neighborhood:
[Parents are] so used to people that work in areas not living in the areas that they work in.

In most jobs, you have a lot of people that don’t live in the area where they come from, which means they either live in the suburbs somewhere because they’re trying to get away from where – all of this [violence] that they’re dealing with. But once they realize I’m in their neighborhood, I’m not goin’ nowhere, so it’s easy for them to talk to me.

In addition to a shared understanding of the difficulties of living in the neighborhood, SFLs also described the benefits of shared connections with members of the neighborhood:

The pastor I grew up with and the pastor that’s currently at the church […] this man married me. He came over and spoke to me and so the parents are like, “Oh, you know him?” I’m like, “Yeah, that was the pastor I grew up [with].” […] And that immediately opened up doors […] having that community connection.

4. Challenges.

The theme of challenges was ubiquitous throughout all SFLs reflections on their shared commonalities with parents. We describe it separately here not as a means to convey its status as a theme distinct and independent from the others, but rather, we present it separately due to its prominence. Within the theme of parenting, SFLs expressed identifying with parents through similar challenges in raising or caring for children, being a single mother, or parenting while working and going to school. Within the theme of ethnicity, SFLs described the familiar challenges arising from being an immigrant, including not knowing the language, working long hours, and difficulty understanding and getting involved in their child’s education. Within the theme of neighborhoods, SFLs indicated having common ground with parents in their shared challenges of facing community violence. Thus, topics of shared difficulties were pervasive in SFLs’ accounts of their conversations with parents. In addition to these difficulties, SFLs also discussed economic hardship as another common challenge they shared with parents:
We wasn’t rich when we grew up. My momma had ten kids in a three-bedroom apartment. Just imagine. We was all sleeping in the same rooms together. So when I see – if I go in the house – some people may go in somebody house and see beds on top of beds and be like, “Oh.” No, I know that. I’ve seen that before. I have. I was living in something like that before, so it doesn’t affect me. I go in they house like, “This is where they sleep at? Oh, okay.” It’s nothing. Then they can tell.

Hardships were at times also discussed in relation to the neighborhood:

I identify because I came from an impoverished neighborhood, as they say. I identify with all the crisis that went on because I grew up with the crisis. The dependency on public services. I identify with a lot of the children not having a father. So, I identify with a lot of different things. I came from the neighborhood where I honestly didn’t know I was gonna go to college because I didn’t know how that worked.

B. **Engagement Strategies & Social Proximity**

SFLs reported several strategies for engaging parents in PASS in which they either relied upon or referenced their shared similarities (i.e. social proximity). The extent to which the elements of social proximity played a role in these strategies varied from being central and necessary, to more indirectly informing in the strategy. Below we discuss the role of social proximity in the strategies of relating, as well as incentives and positivity/praise, and conclude with SFLs’ reflections on the importance of shared similarities.

1. **Relating.**

SFLs described several ways in which they used their commonalities with parents (i.e. social proximity) to relate. They discussed sharing their own experiences and background to normalize difficulties parents were facing, to set a tone of equality between them and their parents, and to promote buy-in and give legitimacy to intervention content. What follows is a
description of social proximity in the process of relating through the lens of each of these three subthemes (normalizing, equality, and buy-in). It should be noted that while these represent different functions, SFLs frequently described these processes to be in the service of the same underlying goal: to build parent trust in and openness with them, in order to facilitate overall engagement in the program.

a. **Normalizing Challenges.**

The sharing of personal challenges was a common form of relating discussed by SFLs. Through sharing their own difficulties, SFLs used relating as a means to convey an understanding of parents’ hardships, to indicate that “[parents] are not the only ones going through a rough time,” and to engender parent trust in and comfort with the SFL. These challenges included experiences of parenting difficulties:

I think [parents] feel more comfortable opening up. Because […] for example, when we have to do an assessment, one of the questions is, why do you think your child would benefit? Where would you like to see some improvement in your kid? […] A lot of the times, that’s the very first question. They don’t feel comfortable answering that to someone they just met. But when we get into a little conversation, and they start sharing, for example, he has a really hard time getting started on homework, and it drives me crazy, and I’m like, “oh, I get it. I have a 10-year-old, I get it.” And I open up to them, that’s like, an introduction. Like, hey, you can open up. If I feel comfortable opening up to you, that we’ve never met –You could feel comfortable opening up to me as well. And then, just explaining this is what I do. I don’t know if it’ll work for you, but you can try it, and then just let me know how it works. And so, like, whenever I open up, they open up too.
Other SFLs reported connecting with parents over shared economic hardships to build trust and help the parent feel comfortable opening up to them, as one SFL described,

> [E]veryone has struggled before. Everyone will continue to go through things. You know, some people fall on hard times, some don’t. And it’s understandable. So one thing I do, I try to relate. You know. I do. I try to relate, and once I relate with my parents, that’s my way of getting them to open up, and that’s my way of building their trust. So they was like, “Well, I don’t have it.” Look, we didn’t all – there’s time when I didn’t have gas money either, and I had to ask my mom, my dad, my uncle, or such and such for some gas money just so I can get [to work] – stop, don’t let your pride get in the way.

In addition to connecting over shared struggles to develop trust with parents, SFLs reflected on the process of relating to parents’ difficulties as a way to make parents feel understood:

> They're like, "Oh, wow, you do understand." You say you do, but you really have experienced this, so you know what it's like. So just making those connections or whether it's, like I said, the first-generation immigrant families, just knowing that I can relate to them in that aspect, too. Knowing that I had parents who English wasn't their first language, so I understand how their child feels when they're doing homework or whatever the case may be and just that language barrier. So parents feel like “wow, you've really been through it, so you really know what it's like,” so just any connections that I can make with the family really does help the family feel like I do understand what they're saying.

b. **Equalizing.**

Another prominent function of relating was creating a sense of equality between the SFL and parent. Several paraprofessionals discussed the importance of presenting themselves such that parents did not feel as though the SFL was “above them.” One SFL described how “I try to really relate to them because I don’t want families to think of me as bougie, like, “Oh,
she’s better than me.” I don’t want that.” Another SFL shared her use of relating to establish that she was not different from parents, and as a way of creating a sense of togetherness and peer-like conversations:

I always said to my parents, I’m no different than you. I sit in the group with my parents. I don’t facilitate outside of the group. I sit there, and I share stories, and I share struggles, and it becomes everybody’s outlet […] I just try to relate. I do. I just try to relate and just show them I’m no different. So that’s the biggest strategy I can use, is just to not be different. Not try to make myself be the ultimate professional in the room. No, I’m with you. We’re together. So, I just make them feel like it’s just us. I’m your girlfriend and we’re just having a conversation, and it won’t go no further. So, I just try to let them know that this is a safe space and engage them that way.

c. **Buy-in.**

The strategy of relating was also utilized to facilitate parent buy-in in the parenting practices promoted by the PASS intervention. For example, one SFL described a conversation with a mom about the use of time-out in which the SFL referenced her own ethnicity to indicate that the strategy could be applied in Latino families:

[W]hen I said time out, one mom was like, “Oh the gueros do that, the white people do that.” And I’m like, “Well, I do it and I’m not white!”

Another SFL described how she shared with parents her experience of losing her eldest son and how this impacted her youngest son. She reflected on how she would have benefited from a program like PASS to better support her son, thus leveraging her personal experience as a way of vouching for the importance of the services provided by the intervention:

I tell everybody that. Even when I first started this, when we had to present this at the schools, I told them the story, and I told them, “I wish they had a program like PASS
back then because I would’ve been able to try to get him some type of help – some type of socioemotional –,” because I was like 24. I had no idea about social and emotional lessons or that kids even needed that, and now, I tell the parents, “Yeah, they do need – it’s like guidance to help them maneuver through they feelings.

Other SFLs discussed how by virtue of their social proximity and relating with parents, they were able to make information more accessible and legitimate:

It makes it easier because then [parents] feel like, “Oh, you understand, instead of you just saying stuff out of a book or you just reading the script.” “No, I’m actually telling you something that I went through that is something what you’re going through or could be possibly going through.”

Similarly, another SFL distinguished between teaching parenting strategies to parents versus “passing along” information that they themselves use:

Those are the things that I tell them. I’m telling you this; I’m not teaching you. I’m telling you what I do and so I’m just passing along the information.

2. Incentives and positivity/praise.

In addition to the engagement strategy of relating, some SFLs referenced social proximity in their use of incentives and positivity/praise. However, the role of social proximity in these strategies was somewhat less clear. SFLs described utilizing incentives and positive news/praise in order to motivate and encourage parents’ engagement in PASS. Paraprofessionals discussed using incentives as a way to motivate parents to attend in-person meetings either at school or in the community. Some also described using incentives with the children to reward positive behaviors or to promote children encouraging their parents to come to meet with the SFL or attend a school event. These descriptions primarily centered on the various types of incentives SFLs provided (e.g. gift card raffles, cleaning baskets, school supplies, food, etc.), and how the
use of incentives facilitated parent engagement. However, a few SFLs also discussed some elements of social proximity in relation to incentives. For example, one SFL reflected on how some parts of her social positionality (being a parent) informed her decisions in implementing the usage of incentives as an engagement strategy:

I will bribe a parent [...] And I’m a mom. I’m giving you what you need, not what you want. I’m bringing bleach, fabric softener, detergent, dish washing liquid, toothpaste, toothbrushes, soap deodorant and stuff like that, whatever.

Paraprofessionals also discussed leading with positive news about a child or praising the parent to motivate parents to be receptive to the program. While most descriptions of this strategy were about framing positivity as an important motivational counterpoint to parents’ typical experience with the school – given that parents were accustomed to only receiving bad news when they heard from the school – some SFLs also referenced elements of social proximity in their accounts of understanding and utilizing the strategy of positivity. Specifically, some SFLs referenced their own position as a parent informing their understanding of the need for praise and good news. In a discussion of praise, one SFL reflected, “sometimes you need that as a parent, who doesn’t need praise?” Another SFL shared,

[B]ecause I’m a parent, so I think parents are [appreciative], when you call and say, “I’m not calling to give you a bad report. I’m giving you a positive report. This is what’s been going on,” [...] give positives so they outweigh the negative when you call.

Thus, both SFLs referenced elements of social proximity as a way of informing and contextualizing their rationale for utilizing the strategy.

3. Importance of social proximity.

SFLs’ reflections on the role and value of leveraging social proximity with parents revealed somewhat of a paradox in their views toward the strategy. On the one hand, several
paraprofessionals emphasized the importance of social proximity in order to successfully perform their work with families in PASS. One SFL expressed,

I think life experiences are important. I can’t go and get someone from the [affluent] neighborhood and tell them to come to [SFL’s neighborhood] and do a parenting class. You live in a six bedroom house with three bathrooms, and you’re gonna come and parent someone who’s lived in a one bedroom with five kids and one bathroom with three towels […] I think that having children in what we do is important also. I think those two things are the biggest things.

Here the SFL highlighted the importance of parenthood and being from a similar community, framing these specific forms of social proximity as essential to performing the work of an SFL. Similarly, another SFL underscored the importance of shared experiences with parents, describing social proximity as necessary to their work:

[I]f I didn’t have those shared experiences, I don’t think I’d be efficient because if you can’t sympathize with these families, then there’s no understanding. It’s so easy for a person that has never even heard of any of what they’re going through to just be like “Well, you need to bring your kids to school.” Period. “Your kid needs an education.”

But once you know you’ve had those experiences, you’ve heard your family, you’ve seen your family have to juggle – you’ve seen your own mom have to juggle two jobs and she can’t pick up a kid from daycare. I had to do that. And, if you can’t sympathize with that, if you can’t understand that, you’re – it’s not gonna work.

Other paraprofessionals discussed the value of social proximity in more general terms, not framing similarities as necessary or specifying any particular similarities as requisite, but still emphasizing the importance of some form of similarity as facilitative to work with parents. For example:
It [similarities] definitely has helped just with the whole being open and comfortable with me. I think that because at first when you meet anybody, you're kinda like offensive. You're not really gonna open up to anybody, and you kinda wanna get to know this person, but once you start noticing some similarities, it's like, “Oh, well, this person's kinda like me,” and they start feeling more comfortable, and they wanna open up.

It should be noted that within discussions emphasizing the importance or necessity of social proximity, most SFLs still attempted to establish a boundary between over sharing details of their personal life and relating with a parent. As one SFL expressed,

[B]eing able to talk and just relate, and just share some things. [But] always have a boundary. If you’re one that just shares everything, then that’s not gonna work for you, either, because it might backfire.

On the other hand, there were other SFLs who indicated that they did not view having a shared background or experiences with a parent as important to their work:

I don’t think it’s important to have a similar background. It just goes back to just being able to help, being able to help that family. If I didn’t have no kids, I think I still can relate to them because I’ve worked with kids before and parents before. So I can kinda relate to the different things that they go through or anything. So you don’t have to necessarily really have to have a similar background as them, no.

While this SFL began by stating that she did not view shared similarities as important, she went on to discuss how in the absence of a personal shared similarity she could still find another way of relating with parents. This was a common theme in accounts that did not place importance on shared similarities, emphasizing that even without social proximity, it was important to find some way to relate with parents. For example:

It’s not a bad thing if you don’t have, can’t relate to them one-on-one, hand in hand. But then you just find – use a celebrity, use something […] Try to relate in some type of way.
because, for me, if I put myself in another shoe – say for instance, I was a parent and I was talking, talking, and the SFL never had any experience, and she didn’t know where I was coming from, why would I continue to tell her things, if she doesn’t know where I’m coming from? You know, so that’s like I said, whether you can or you can’t relate, you know somebody. I’m pretty sure you know somebody, whether you remember them twenty years ago or five years ago […] So that’s a big piece, because for some reason, I found me relating help them talk a little bit more.

Additionally, those who stated that commonalities with parents were not necessary to function in their role still acknowledged that having similarities facilitated their work:

If anything, it’s a plus. So if you do have some of the same, same backgrounds, maybe you could share how you were able to get through it, or what you’ve learned. That might work for those families. But it’s not necessary. It’s always a plus.
IV. DISCUSSION

The primary aim of the present study was to better understand one of the central components defining the CHW role: their shared community membership with the population served. We used the term social proximity to refer to this closeness to the population served, and to encapsulate the shared characteristics, background, and experiences that could comprise defining features of community membership. Thematic analyses of semi-structured interviews with a group of CHWs implementing a mental health early intervention prevention program for children and their parents revealed four main themes defining social proximity for this SFL workforce: (1) experiences of parenthood or caring for children, (2) knowledge and understanding of practices or experiences related to ethnicity/race, (3) familiarity with and understanding of the neighborhood community, and (4) experiences of life hardships and struggles. These elements of social proximity were featured most prominently in the engagement strategy of relating. What follows is a discussion of these findings and their significance in characterizing social proximity for paraprofessionals, understanding CHW engagement strategies in relation to social proximity, as well as implications for practice.

A. **Characterizing Social Proximity**

1. **Typologies of similarities in social proximity.**

Of the typologies within the similarity-attraction paradigm (Harrison et al., 1998; Eby et al., 2013), the themes that defined social proximity for SFLs most closely mapped onto the experiential-level of similarity. Paraprofessionals described emphasizing their experiences of being a parent or caring for children (e.g. siblings or cousins if not a parent themselves), their experiences of living within the neighborhood comprised of familiarities with community circumstances and events (e.g. violence and poverty) as well as community networks (e.g.
knowing community figures such as the pastor), and their experiences of overall life hardship including economic and parenting challenges.

For the Latina SFL’s, the theme of ethnicity also fell within the scope of experiential-level similarities given that the immigrant experience was a prominent component of their accounts of ethnic-based commonalities. However, this theme also appeared to include factors that could be characterized as deep-level similarities. Specifically, these SFLs discussed physical disciplinary practices in relation to cultural attitudes and beliefs in which physical punishment was considered normative, thus describing a deep-level similarity. With regards to surface-level similarities, demographic similarities such as being Latina/o or a mom were discussed but almost always embedded within descriptions of the experiences stemming from these characteristics. Thus the main emphasis was on experiential-level commonalities.

The one form of surface-level similarity that did emerge as important to engagement, specifically for Latina/o SFLs, was shared language with parents. Being able to speak Spanish was consistently discussed as a core component of connecting with Latino/a parents. Aside from language, however, surface-level similarities did not emerge as a particularly central form of social proximity for SFLs’ work in PASS. These findings are consistent with the mentorship literature indicating that experiential-level similarities were significant antecedents to the mentor-mentee relationship (Eby et al., 2013), and with mental health literature indicating that aside from language (Griner & Smith, 2006), surface-level similarities were not significantly predictive of client engagement or outcomes (Cabral & Smith, 2011; Maramba & Nagayama Hall, 2002).
2. **Contextual influences on social proximity.**

While across SFL accounts experiential-level similarities emerged as an overarching common typology of similarity, there were also differences amongst SFLs with regards to the themes of social proximity. Specifically, all seven Latina/o SFLs cited ethnic-related factors as commonalities with parents, whereas none of the nine African American SFLs referenced ethnic/race-related factors. Conversely, neighborhood-related commonalities with parents were featured prominently in all African American SFLs’ reflections, whereas four Latino SFLs did not reference neighborhood membership, and the three who did only discussed it briefly. However, the elements comprising these two themes demonstrated some similar patterns as manifestations of culture. Both neighborhoods and ethnic groups are social ecosystems, containing and enacting their own sets of beliefs, values, and practices, with culture as their common denominator. Thus, both of these themes reflect relevant cultural elements defining social proximity for SFLs. African American SFLs discussed how neighborhood membership allowed for a familiarity in how to speak to parents as well as a familiarity with the challenges of community violence and poverty facing parents, which paralleled Latino SFLs’ descriptions of shared culture and language informing the way in which they spoke with parents and their familiarity with the challenges of immigration. These separate yet parallel accounts demonstrate the importance of considering culture in a variety of manifestations when attempting to define community membership for CHWs.

Given the qualitative nature of this study, we do not seek to generalize these forms of social proximity as true for all CHWs of specific ethnic or racial backgrounds, instead, we aim to contextualize this pattern of findings to better understand how different forms of social proximity become relevant to CHWs. To this end, it is important to note that SFLs at agencies serving
predominantly African American communities were situated in neighborhoods which were 96-98% African American, whereas SFLs at agencies serving predominantly Latino communities were situated in neighborhoods which were around 50% Latino (Farooqui, 2016). It is therefore possible that SFLs’ characterization of relevant factors of social proximity was in part influenced by their neighborhood context. Social psychological studies have demonstrated how context can impact the salience of various in-group/out-group characteristics, such that, for example, an African American woman surrounded by Caucasian people perceives her race as most salient, whereas when surrounded by men she perceives her gender as most salient (McGuire & Padawar-Singer, 1976). Had African American SFLs been working in neighborhoods with a slightly more diverse composition, perhaps ethnic/racial elements of social proximity would have been more frequently cited. These patterns of salience illustrate the importance of contextualized experience in defining social proximity between CHWs and the population served. Dimensions of race/ethnicity, neighborhood, gender, and other demographic variables are only as meaningful as the context within which they are situated and the other factors with which they intersect.

3. **Content-driven social proximity.**

In addition to characterizing social proximity by typologies of similarities and contextual factors, we can also better understand the construct by considering its characteristics in relation to program content. Some programs utilizing CHWs have employed paraprofessionals who have specific experience with the program’s target disease, disorder, or challenge (e.g. CHWs having diabetes or being a parent with experience navigating social services; Norris et al., 2006; Koroloff et al., 1994), thus requiring a more specific form of social proximity characterized beyond general community membership (O’Brien et al., 2009). In the case of PASS, the social service agencies implementing the program did not set parenthood as a required criterion to be
an SFL. However, despite not requiring specific experience with parenting, thirteen of sixteen SFLs in this study were parents, and all SFLs discussed parenthood as a prominent form of program-specific social proximity. Specifically, the three SFLs who were not parents found ways to relate to the experience of parenthood by leveraging past experiences of caring for children (such as siblings or cousins), which suggests that this specific form of social proximity – shared commonalities in the domain of the program’s target challenge – was an integral part of engaging parents in PASS. It should be noted, however, that the present study cannot speak to whether program-specific forms of social proximity are relevant to all community health work. CHWs work across a large number of health issues (for review see Perry et al., 2014), and programs that require previous experience with the target issue are only a subset of studies (O’Brien et al., 2009). It may be that experience with the specific program target is more important and relevant to certain health issues than others. Future research with paraprofessionals will have to consider questions such as whether a CHW must have experienced hypertension, malaria, or depression in order to implement programs intervening upon these issues. That said, the present study’s findings illustrate how even in the absence of requiring program-specific forms of social proximity (as was the case in PASS), paraprofessionals still naturally generated and relied upon shared commonalities with parents within the program’s target challenge of parenting.

B. Leveraging Social Proximity & Implications for Practice

Paraprofessionals’ discussions indicated several ways in which social proximity was used in their work engaging parents. Specifically, elements of social proximity played a role in strategies of relating, incentives, and positivity/praise. SLFs described leveraging social proximity in order to relate with parents, through which they normalized parents’ challenges,
created a sense of equality, and promoted program buy-in. Within the strategies of incentives and positivity/praise, beyond defining these strategies by their primary purpose – motivation for participation in the case of incentives, and receptiveness to PASS by counterbalancing negative news from the school in the case of positivity – some SFLs cited elements of social proximity (mainly parenthood) as informing and providing additional understanding of the strategy. However, compared to the use of social proximity in the strategy of relating in which it served to normalize, equalize, and promote buy-in, it was less clear how social proximity influenced the use of these other strategies beyond informing SFLs’ understanding of the strategy.

The importance SFLs attributed to shared similarities with parents appeared to range from helpful but not necessary, to necessary and essential to their job. However, regardless of where along this spectrum an SFL’s opinion of social proximity stood, all acknowledged that in the absence of shared personal similarities, it was crucial to find a means through which to relate to parents in order to connect with them and engage them in PASS. The centrality of relating and social proximity reflects the unique near-peer positionality of CHWs that shapes the way they connect and convey information such that although they are a service provider, they engage in a personal and relational manner (Mlotshwa et al., 2015). This defining feature of social proximity and its use in relating has important implications for programs utilizing a CHW workforce.

Recent research has found that although community based organizations (CBOs) have traditionally been the most common employer of CHWs (U.S. Department of Health and Human Services, 2007), hospitals and other health systems now lead more CHW programs compared to other settings such as CBOs and social service agencies (Malcarney et al., 2017). The shift in employment settings from CBOs to hospitals has significant implications given that health systems were more likely to use educational/training requirements in hiring CHWs (Malcarney et
Our research suggests that this prioritization of formalized education or training may have unintended negative consequences given the importance of CHWs’ natural characteristics and experiences. By virtue of their very definition, CHWs are always navigating the tension between being an “insider” or near-peer to the population served while also being an “outsider” as a health professional (Mlotshwa et al., 2015). It is this duality that distinguishes them from other health providers and is credited with CHWs being able to expand access to services for traditionally underserved populations. To successfully perform their role, it is critical that both of these components – their natural characteristics, e.g. social proximity, and their health knowledge – be supported.

C. Limitations & Future Directions

There are several limitations that are important to note for interpretation of the findings. This study was specific to a parenting intervention in urban high poverty communities. Recruitment relied on a convenience sample, and participants were almost entirely female. Thus, the findings may not be relevant to other CHWs in other settings and communities. Given that not all of the PASS SFL staff agreed to participate, there may have been self-selection effects wherein only those SFLs who felt competent and confident in their role participated; although this is unlikely given that the SFLs who did participate freely discussed their challenges and frustrations in trying to connect with parents. Additionally, we do not have data from the parents participating in PASS regarding their experiences and perceptions of social proximity, as we only interviewed SFLs. Therefore, we cannot know whether the specific elements of social proximity cited by SFLs (parenthood, ethnicity, neighborhood, and challenges) would also be cited by parents or whether they would indicate different relevant factors.
As a qualitative study, we did not set out to demonstrate any causal link between social proximity and parent or child outcomes. Instead, our goal was to illuminate CHWs’ experience of social proximity – what factors they viewed as relevant and the ways in which they leveraged these factors in their work with parents. This is but an initial step in better understanding social proximity. Future research should further examine how social proximity manifests for other sets of CHWs, in other settings and programs, and from other perspectives (e.g. clients) in order to better determine what defining factors are relevant in community health work. Additional research should also study the impact of CHWs’ social proximity on participant outcomes. Both qualitative and quantitative methodologies will be necessary to develop a full understanding of the construct.

D. Conclusion

The present study provides insights into the phenomenon of social proximity within community health work, the relevant components as experienced by CHWs, and the ways in which social proximity was leveraged in their work. The specific elements of social proximity presented (parenthood, ethnicity, neighborhood, and challenges) do not necessarily represent universal factors within the construct that are true for all CHWs. Instead, we propose that these elements of social proximity point us toward factors that meaningfully shape the ways in which CHWs perform their role as both a near-peer and service provider. SFLs’ accounts illustrated how their experience of social proximity was informed by specific typologies of similarities (experiential and deep-level), contextually relevant similarities, and program-based similarities. If the trend continues for CHWs to become more integrated within the healthcare system, these considerations will become increasingly important in order to fully support and optimize the potential of this workforce.
The SFL accounts presented here illustrate the need for supporting, promoting, and celebrating the natural traits and lived experiences of CHWs, for these are the defining features that make this workforce unique and also what CHWs consistently draw upon when connecting with community members during service delivery. Therefore, our study suggests that, beyond formal education and training, considerations of a CHW’s social proximity to the population served through typology of similarities (experiential and deep-level), contextually relevant similarities, and program-based similarities should be prioritized so as to ensure that this critical feature of CHWs is promoted.
CITED LITERATURE


APPENDIX

PASS PROGRAM SFL INTERVIEW SCRIPT

Welcome

“Good afternoon/evening and welcome. Thank you for taking the time to join talk to me about the PASS program. My name is Erika, and, as you know, I am a graduate student at UIC and am working on the PASS Program. Today I will be asking you some questions about your experiences on PASS.”

Overview of the Topic

“I am interested in learning about how you connect with families, some of the challenges you experience in trying to connect with families, and what you think makes you effective in your work as an SFL.”

Ground Rules

“There are no “right” or “wrong” answers. I just want to hear your thoughts, opinions, and experiences.

As stated in the consent form that you signed, you agreed to participate in this interview for approximately one hour. I am recording the session so that we don’t miss any of your comments, and I will send this recording to a company so that it can be professionally transcribed. Then I will be able to summarize what I’ve learned from your feedback. This recording will remain confidential and will not be shared with anyone outside of the UIC team. No names will be included in any of our summaries; codes will be used to protect your identity and the identity of anyone else you mention. To make sure we keep all information private, please do not use the names of any parents or children so that we can best protect their confidentiality.

I’m here to ask questions, to listen and to make sure I get the most accurate account of your experiences that’s true to you. If there any questions that you don’t feel comfortable answering that is completely fine, just let me know and we can skip on to the next question. Or if further along in the interview you think of something else you want to add to a prior question, that’s okay too. Again, just let me know and we can go back and talk about it. Additionally, feel free to let me know if any of the questions are unclear and I’ll be happy to clarify.

If you have a cell phone, it would help if you could put it on quiet or vibrate, and if you need to answer the phone please step out to do so. Do you have any questions before we get started?

Alright, we are going to begin recording and start our interview now.”

Guiding Questions

“I’d like to start off by hearing a little bit about your work on PASS.”
1. What are some of your roles and responsibilities as an SFL? Tell me what you do on a typical day.
   Cued:
   a) What made you interested in being an SFL?
   b) What are some of the things you enjoy the most about working on PASS?
   c) Have you had experience with similar types of jobs in the past? If so, what were they?

2. What are some of your responsibilities in your work with kids in PASS?
   Cued:
   a) What are some of the things you enjoy most about working with kids in PASS?
   b) Can you describe an experience with kids that seemed to you especially meaningful?
   c) In what ways does your work with kids relate to your work with parents?

   “Now I would like to ask you some questions about your relationships with the parents in PASS and ways in which you connect with them.”

3. An important part of your role as an SFL is connecting with families. Tell me about how those experiences have gone for you. In what ways have you connected with families?
   Cued:
   a) What are some strategies you use to engage families?
      a. What are strategies do you use when you are first getting to know a family and trying to engage them versus once you know them better? Are the strategies the same? Different?
   b) What kinds of conversations have you had with parents that have helped them open up to you?
   c) Without using any real names, tell me about a time when a parent has really connected and engaged with you [Or: a case where engagement happened easily]

4. We’ve heard from other SFLs that there are some families who are more difficult to connect with. Have you experienced that?
   Cued:
   a) What has made it hard or gotten in the way of connecting with parents?
   b) Have there been experiences or topics that have turned off a family from participating in PASS?
   c) Some SFLs have found that some parents avoid interacting with them. Have you had this experience? Why do you think this happens

5. Tell me about some of the similarities you have noticed between you and the parents you work with.
   Cued:
   a) Are there any similarities in terms of life experiences? (such as education, parenthood, immigration, language, etc.)
   b) Are there any similarities in terms of your beliefs or the things you value?
6. Does being similar to a parent affect the way you interact/connect with them, or how they interact/connect with you? In what ways?  
   Cued:  
   a) Are there specific similarities that make it easier or harder to talk to or connect with a parent? If so, how?  
   b) Without using any real names, give me an example of a time that you used a shared similarity to connect with a family. Or an example of a time when a shared similarity got in the way of connecting with a family.  

7. Tell me about some of the differences you have noticed between you and the parents you work with.  
   Cued:  
   a) Are there any differences in terms of life experiences? (such as education, parenthood, immigration, language, etc.)  
   b) Are there any differences in terms of your beliefs or the things you value?  

8. Does being different from a parent affect the way you interact/connect with them, or how they interact/connect with you? In what ways?  
   Cued:  
   a) Are there specific differences that make it easier or harder to talk to or connect with a parent? If so, how?  
   b) Without using any real names, give me an example of a time that a difference between you and a parent made it hard or kept you from connecting with a family. Or when a difference helped you connect with a family.  

9. Without using any real names, what are some of the personal experiences that families have shared with you? And why do you think they shared this with you?  
   Cued:  
   a) Have any of the experiences that a parent has shared affected you on a personal level? How?  
   b) Have any of the experiences that parents have shared with you been particularly hard for you to handle or respond to? In what ways?  

10. I’m interested in hearing about any other experiences you think have prepared you for your work with families on PASS. For example, any educational experience or training (either through PASS or in the past), community roles you’ve held, etc.  
   Cued:  
   a) Have you felt prepared for the task of reaching out and connecting with families?  
   b) If you had to train people to work as an SFL on PASS, what would you give as advice?  
   c) What are some ways we could shape new training experiences to provide you more support in your work with families?  

11. We’ve talked a lot about your role as an SFL and the work you do with families. With that in mind, what characteristics, attributes, skills, abilities, etc. do you think are necessary to be a good SFL?
Cued:
a) Describe what a good SFL looks like – what characteristics does s/he have, how does s/he act?
b) Do you think it is important to have similar experiences as the families you work with? Why or why not?
c) Do you think it is important to have a similar background as the families you work with? Why or why not?

Closing

“This ends our interview today. Do you have any questions for me?

Thank you very much. I truly appreciate the time you have taken to discuss these questions and your honest feedback about PASS. Your feedback and opinions will help us better understand the different ways SFLs connect with Latino families in PASS, and how these factors can help engage Latino families in the future.”
VITA

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