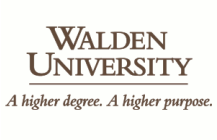

2019

The Use of Dialectical Behavioral Therapy with the Native American Population in the Southwest

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Abstract

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Joseph E. Woodruff

MA, Argosy University, 2003

BS, American Indian College, 1996

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Compared to other races, Native Americans have significantly higher rates of suicide and substance abuse. Dialectical behavioral therapy is an evidence-based program with efficacy for reducing suicidality and comorbid disorders within general populations but may not be effective for Native Americans because it is based in Western ideology. The purpose of this phenomenological study was to explore the lived experiences of Native American therapists who use DBT with Native American populations. Using biosocial theory, I investigated the perceptions and lived experiences of 8 Native American therapists through a phenomenological approach. The research questions encompassed the experiences, including the cultural appropriateness, effectiveness, and treatment barriers and challenges in using DBT. I analyzed data using the interpretive phenomenological analysis. The data displayed 3 superordinate themes from participants: cultural understanding, usefulness of dialectical behavior therapy, and challenges of dialectical behavior therapy. The findings revealed a lack of consensus on how DBT helps Native clients, but participants shared positive experiences using DBT. It was confirmed in the study that knowing the culture, being Native as a provider, understanding generational trauma, and the uniqueness of diversity with different tribes is an asset. The study may have significance for social change by identifying Native American therapists' experiences with using and modifying DBT for Native American clients and potentially providing a pathway for its future use in Native American communities, including current strengths and potential improvements.

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Chapter 1: Introduction to the Study

Introduction

Within Native American populations, suicide and depression are experienced uniquely and at significantly higher rates than among other ethnic groups (Herne, Bartholomew, & Weahkee, 2014; Wexler & Gone, 2012). There is a need for culturally adapted programs that account for traditional, tribal views of medicine and healing (Kinsey, 2014; Kinsey & Reed, 2015; Morris, 2011). In fact, Wexler and Gone (2012) noted that Western models of suicide prevention often lacked cultural consideration. One intervention that has proven effective in treating patients with suicidal ideation is Dialectical Behavioral Therapy (DBT; MacPherson, Cheavens, & Fristad, 2013), which holds, as one of its tenets, that therapists must account for the individuals' backgrounds and beliefs (Swales, Heard, & Williams, 2000). Though a few researchers have examined culturally modified DBT among Native American clients (Beckstead, Lambert, DuBose, & Linehan, 2015; Kinsey, 2014; Kinsey & Reed, 2015), the experiences of Native American therapists in conducting DBT is not known.

The study was designed to explore the perceptions and experiences of Native American therapists who use DBT among the Native American population. Specifically, Native American therapists' perceptions of the cultural appropriateness, effectiveness, and treatment barriers and challenges of DBT were identified. Chapter 1 includes an introduction to the study by providing background, the problem, the purpose, the research questions, the conceptual framework, and the nature of the study. Next, the assumptions, scope and delimitations, and limitations of the study are clarified. The chapter concludes

with a discussion of the significance of the study and its implications for social change. The data may effect social change by helping to address a public health issue among Native American populations in the United States (Sahota & Kastelic, 2012). The study may have significance for social change by identifying Native American therapists' experiences with DBT and potentially providing a pathway for its future use in Native American communities, including its current strengths and potential improvements.

Background

Native Americans have the highest rate of suicide among all races (Herne et al., 2014; O'Keefe et al., 2014). Compared to White populations, Native Americans have 50% more suicides resulting in death, based on data analysis from between 1990 and 2009 (Herne et al., 2014). The characteristics of suicidal individuals are also different; whereas in the general population, men over 45 were more likely to commit suicide; Native American men under 18 were more likely to commit suicide in Native American populations (Herne et al., 2014). Moreover, the United States Surgeon General (Surgeon General; 2012) noted that 14–27% of adolescents in Native American communities had attempted suicide. The increased incidence constituted a significant public health issue, which researchers responded to after the Surgeon General's (1999) call to action to address suicide (DeMartino et al., 2003).

For Native Americans, the research related to suicide prevention demarked the need for culturally appropriate treatment (Doll & Brady, 2013; Morris, 2011; Wexler & Gone, 2012). Western-based interventions often espoused a different worldview than Native American medicine, particularly a lack of focus on communal beliefs of wellness,

which led to a lack of effectiveness among Native American clients (Clifford, Doran, & Tsey, 2013; Mohatt, Fok, Burket, Henry, & Allen, 2011; Sahota & Kastelic, 2012; Wexler & Gone, 2012). Conversely, when therapeutic interventions were adapted for Native American clients, they had significant benefits for Native Americans (Goodkind et al., 2010; Kinsey, 2014; Kinsey & Reed, 2015; Lokken & Twohey, 2004; Morris, 2011).

DBT is an intervention that has demonstrated efficacy for reducing suicidality (Swales et al., 2000), which may be effective among Native American clients. Developed by Linehan (1993a, 1993b) for use among women with borderline personality disorder (BPD), DBT has subsequently been tested among multiple populations and has shown efficacy (Agnew, 2012; Davidson & Tran, 2012; Gado, 2016; Harned et al., 2008; Long et al., 2011; Lothes et al., 2014; MacPherson et al., 2013; Swales et al., 2000). A study by Rathus and Miller (2002) showed how DBT was effective in reducing suicide attempts among adolescents when using both individual and group counseling. Research conducted at a community mental health agency by Blackford and Love (2011) indicated how using DBT skills improved a patient's overall mental health functioning.

Potential strengths of DBT that may underscore its effectiveness for culturally adaptive therapy for Native American clients are the need for self-evaluation (McCabe, 2007), the requirement that the therapist accept and adapt to a client's perceptions while attempting to make a change (Swales et al., 2000), connectedness (Mohatt et al., 2011), and healing from dealing with prior trauma (Goodkind et al., 2010; Kinsey, 2014; Kinsey & Reed, 2015). Kinsey (2014) and Kinsey and Reed (2015) evaluated a single program among the Suquamish tribe in Washington state and noted that the culturally adapted

version of DBT was effective within this population, although the tenure of the program was short and community-based, and the results may not generalize to other settings because of the limited sample. Beckstead et al. (2015) also conducted a quantitative analysis of a DBT substance use program; however, the sample was limited to substance use among adolescents and did not include information about suicide. In addition, Beckstead did not attempt to capture potential differences among the many tribes represented in the population.

Yet, few researchers have examined the use of DBT among Native American therapists treating Native American clients. The unique characteristics of the Native American population, particularly regarding suicide prevention, require evidence-based therapeutic interventions; building the evidence base has been a challenge for Native American communities, which have limited resources to devote to population-specific research (Sahota & Kastelic, 2012). A potential method of building the evidence base for Native American interventions lies in collecting and understanding the perceptions and lived experiences of practitioners who work within Native American communities (Morris, 2011). Therefore, this study addressed a significant gap in the literature regarding the perceptions and lived experiences of Native American therapists who use DBT with Native American populations.

Problem Statement

Native Americans have the highest rate of mental health crises, particularly suicide, among all ethnicities in the United States (Alcántara & Gone, 2007; Herne et al., 2014; O'Keefe et al., 2014). Native American communities require suicide prevention

and interventions that incorporate cultural elements for Native Americans (Alcántara & Gone, 2007; Clifford et al., 2013; Doll & Brady, 2013; Wexler & Gone, 2012). There is evidence that DBT is effective in reducing suicidality and its co-occurring symptoms within multiple populations (Agnew, 2012; Davidson & Tran, 2012; Gado, 2016; Harned et al., 2008; Long et al., 2011; Lothes, et al., 2014; MacPherson et al., 2013; Swales et al., 2000). Yet, little research exists regarding the effectiveness of DBT among Native American populations (Kinsey, 2014; Kinsey & Reed, 2015). The research that does exist was not from the viewpoint of the Native American practitioner, which may be valuable for understanding the holistic experiences and use of DBT among Native American clients (Morris, 2011). Thus, there was a gap in the literature regarding the lived experiences of Native American therapists who use DBT with Native American populations.

Purpose of the Study

The purpose of this phenomenological study was to explore the lived experiences of Native American therapists who use DBT with Native American populations. Eight Native American therapists were interviewed; they worked in the Southwest community, from urban to rural areas on the Native American reservations. Snowball sampling was used to identify potential participants.

Research Questions

Central Research Question: How do Native American therapists describe their experiences of using DBT with the Native American populations?

Research Subquestion 1: How do Native American therapists view DBT as being culturally appropriate with Native American clients?

Research Subquestion 2: How do Native American therapists describe the effectiveness of DBT as a treatment approach for Native American clients?

Research Subquestion 3: What treatment barriers or challenges have been identified by Native American therapists using DBT with Native American clients?

Conceptual Framework

The conceptual framework for the study has a foundation in biosocial theory (Fraser & Solovey, 2007), which holds that the cause of negative behaviors is a result of both biological components and an invalidating environment (Fraser & Solovey, 2007). Biological difficulties that intensely heighten an individual's emotional state can be difficult for a client to regulate; afterward it can be difficult for an individual to return to an emotionally stable state (Linehan, 1993a). An invalidating environment is one where the individual feels disregarded, punished, or neglected (Fraser & Solovey, 2007). For Native American clients, the invalidating environment may include historical cultural trauma (Kinsey, 2014; Morris, 2011).

Nature of the Study

The nature of this study is qualitative. Using a phenomenological approach, I captured participants' experiences in their own words. The aim of phenomenological research is to explore the direct lived experiences of individuals to arrive at the essence of the phenomenon (Stierand & Dörfler, 2012). The phenomenon of interest in this study was the use of DBT as a treatment approach for Native Americans. The data were

collected by conducting in-depth interviews with 8 Native American clinicians who practice DBT. As both mental health professionals and members of the cultural group of interest, Native American therapists may be best suited to provide information concerning the appropriateness of DBT for use with this population (Constantine, 2001). The data were analyzed using the interpretive phenomenological analysis framework (IPA; Smith, Flowers, & Larkin, 2009) and using a NVivo data analysis tool. By exploring the lived experiences of Native American therapists, I examined the phenomenon from their perspective.

Definitions of Key Terms

Native American: Native American is defined by the United States Census Bureau (2010) as a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

Therapists: Therapists are those who have provided mental health treatment for wellness, education, and career goals (American Counseling Association, 2016). They have received licensure from the state that includes, but is not limited to, substance abuse, social work, counseling, marriage and family, or licenses psychologists (American Counseling Association, 2016).

Trained/certified DBT practitioners: Training for a certificate and certification in DBT requires different amounts of trained hours. Being trained or receiving a certificate can require a minimum of 8 hours or more of training. Certification requires both a

completion of education and training with an assessment to display the practice of knowledge and competency in the engagement with treatment (Linehan, 2016).

Assumptions

The present phenomenological study involved interviews with Native American therapists in the Southwest community. It was assumed that the therapists, who were trained and certified in DBT, provided insight into the phenomenon of applying DBT, a Western intervention, in a Native American culture. Per previous research, it was assumed that Native Americans, particularly within tribal settings, experienced therapy uniquely (McCabe, 2007), and that Native American practitioners had some perception of that difference. Moreover, it was assumed that Native American practitioners require specific interventions to address the significant mental health issues among Native Americans, particularly, increased incidence of suicide and co-occurring symptoms (Sahota & Kastelic, 2012; Wexler & Gone, 2012).

Another assumption was that participants were honest and shared their views on DBT. Views may be positive or negative, and it was assumed that the participants had a rationale for their preferences that would become clear through the interview process. It was an assumption of phenomenological research that these experiences can be combined to comprise a unified whole experience (Seamon, 2000).

Scope and Delimitations

The scope of this study involved Native American therapists who use DBT among Native American clients. Participants were delimited to the Southwest United States, enrolled with a Federal Recognized Tribe, working with Native American clients, and

met inclusion criteria. This delimitation was essential, since it clarified the results as related to a specific tribal demographic. Maintaining and understanding the different experiences of different tribes was essential to conducting ethical research among Native Americans (Doll & Brady, 2013; Sahota & Kastelic, 2012; Wexler & Gone, 2012). Because of the limited geographical area in which the study was conducted, the results may not be transferable to other settings.

The scope of the study also included Native American therapists who were trained or certified in DBT. The Native American therapists in this sample have an increased prior understanding of traditional medicine and the tribal worldview in this region. It would be valuable to understand non-Native American therapists' perspectives of applying Western-based therapy among Native American clients, but this purview is beyond the scope of the present study.

Limitations

The present study includes some limitations. Kinsey (2014) observed that DBT has conceptual issues with Native Americans. DBT applies the medical model framework, which may not be fitting for Native Americans (Hwang, 2009; Kinsey, 2014). Moreover, those trained in DBT may have a colonizing or domineering perspective that may overwhelm the voices of Native American clients (Hwang, 2009). I attempted to restrict the influence of the Western medical model by delimiting the sample to Native American therapists.

Another limitation of the study was the small geographic location from which participants were sampled. Participants were recruited from Southwest Community, using

a snowball effect. This limitation allowed for a clear tribal demographic and a similar phenomenological worldview. As noted by Beals et al. (2005), it is essential to examine tribal and regional characteristics of Native Americans when addressing mental health issues, rather than considering Native American culture as monolithic. The results may be limited in their generalizability to other locations.

Significance

The present study has significance for both research and for practice. Currently, researchers hold a consensus that Native Americans require culturally appropriate interventions for suicide prevention and treatment (Doll & Brady, 2013; Sahota & Kastelic, 2012; Wexler & Gone, 2012). There is limited research on evidence-based treatments when treating Native Americans (Gray & Rose, 2012; Sahota & Kastelic, 2012). DBT is a Western intervention that has demonstrated efficacy in multiple populations for reducing suicidality and co-occurring disorders (Agnew, 2012; Davidson & Tran, 2012; Harned et al., 2008; Gado, 2016; Long et al., 2011; Lothes, et al., 2014; MacPherson et al., 2013; Swales et al., 2000). Initial evidence regarding DBT in Native American populations for suicide showed benefits; however, it encompassed only one program in Washington State (Kinsey, 2014; Kinsey & Reed, 2015). The present study expanded study of the use of DBT among Native Americans to an additional population and provided an evidence base for its use, with modifications, among Native American clients.

The present study may also have significance for practice. It is crucial to treat Native Americans with effective models of intervention and cultural competency to build

the treatment rapport (Gray & Rose, 2012). Furthermore, culturally competent treatments and providers are essential for addressing the public health issues among the Native American population (Doll & Brady, 2013; Wexler & Gone, 2012; Wexler et al., 2015). The findings may indicate that DBT is effective and provide a pathway for future treatment; the findings may also demonstrate methods in which practitioners need to adapt DBT to meet the needs of Native American communities. Conversely, the findings may show that therapists should seek out alternative treatments to meet the mental health needs of Native American populations.

This research can contribute to social change by describing a way to treat suicidality within the Native American population. As indicated by the U.S. Surgeon General (2012), Native Americans comprised a significant portion of the suicide epidemic in the United States. By furthering research on DBT among Native Americans, the study may pave a pathway for reducing incidence of suicide and co-occurring disorders within Native American clients through culturally competent treatment. In turn, this study will have significance for the clients, their families, and their communities, which will constitute social change.

To improve the potential significance of the study for social change, the information from the findings of the study will be shared with agencies that work with Native American clients throughout the country. The findings will be shared with these agencies to open discussion on how to build cultural competency, especially when treating Native Americans.

Summary

The rate of suicide among Native Americans is higher than for all other races, necessitating successful modes of treatment and prevention. One means of therapeutic intervention among Western populations is DBT, with demonstrated success in reducing suicidality and comorbid disorders; however, DBT has received little research in the Native American population. The problem statement for this study was that, because Native Americans have the highest rate of psychological disease and suicidality among all races, effective means of providing culture-specific interventions to prevent suicide are needed. The purpose of this qualitative phenomenological study was to uncover the lived experiences of Native American therapists who use DBT with Native American populations. The biosocial theory supported the study, with the assumption that both biology and environment contribute to negative behaviors.

Study findings may have significance for practice and social change. To increase positive therapeutic outcomes, mental health care providers must use effective, culturally competent models of intervention. Additional information on using DBT among Native American populations may illuminate means of treating suicidality among Native Americans.

Chapter 2 will report the literature that supports the purpose and need for the present study. Chapter 3 will describe the participants in the study, present the methods, instruments used, and procedures gathering and the interpretation of the data. Chapter 4 will summarize the data collected. Chapter 5 will discuss the findings, implications for practice, limitations of the research, recommendations, and future research.

Chapter 2: Literature Review

Introduction

Though DBT is effective for reducing suicidality and co-occurring disorders within general populations (Agnew, 2012; Davidson & Tran, 2012; Harned et al., 2008; Gado, 2016; Long et al., 2011; Lothes et al., 2014), little was known about the experiences of Native American therapists in treating Native communities with DBT. This research was important because Native American communities experience greater rates of suicidality (DeMartino et al., 2003), and Native American therapists have unique insights into the Native American community (Morris, 2011). As noted by Clifford et al. (2013), Native American communities may require culturally sensitive and appropriate interventions. It is not yet understood how Native American therapists perceive the cultural appropriateness and effectiveness of DBT, nor if there are any barriers or challenges to its implementation. The purpose of this study was to understand the lived experiences of Native American therapists who use DBT in therapy practice. The following research questions were addressed:

Central Research Question: How do Native American therapists describe their experiences of using DBT with the Native American populations?

Research Subquestion 1: How do Native American therapists view DBT as being culturally-appropriate with Native American clients?

Research Subquestion 2: How do Native American therapists describe the effectiveness of DBT as a treatment approach for Native American clients?

Research Subquestion 3: What treatment barriers or challenges have been identified by Native American therapists using DBT with Native American clients?

Following a discussion of the literature search strategy and the theoretical foundation in which this study is grounded, this literature review is divided into three major sections. The first section consists of a broad overview of research on suicidal behavior in Native American communities. The second section includes the literature regarding culturally sensitive approaches to therapy within the context of Native American communities. The third section highlights studies related to the constructs of interest for the current study, as well as the chosen methodology and methods that are consistent with its scope. The third section will also contextualize the need for this study by noting gaps in the literature related to the examined phenomenon. Finally, the chapter will conclude with a brief review and synthesis of the given studies related to the research questions of this current study.

Literature Search Strategy

My primary strategy for researching literature was searching electronic databases. I used Academic Search Complete, Educational Resources Information Center (ERIC), PsycARTICLES, PsycINFO, Psychology: A SAGE Full-Text Collection, PsycEXTRA, and SocINDEX with Full Text to search for peer-reviewed journal articles. Limiting search options included: full text, English, and peer-reviewed journals. Search terms included: *dialectical behavior therapy, Native Americans, American Indians, suicide treatment outcomes, Alaskan Natives, acculturation, suicide, culture, cultural awareness,* and *cultural sensitivity*. Once key authors were identified, including Cwik, Gone,

O'Keefe, Wexler, and Wingate, the corpus of their work was reviewed to determine any additional articles relevant to the topic.

The scope of this literature review includes current peer-reviewed literature as well as seminal research in the field. However, of the 43 articles reviewed, 30 (about 70%) were published in the past 5 years. This is because several resources about culturally sensitive therapy and interventions for Native American communities were published subsequent to the U.S. Surgeon General's *Call to Action* for programs to prevent suicide among Native American individuals (DeMartino et al., 2003). Therefore, the literature review includes seminal sources regarding the need for culturally competent care among Native Americans. Although these are dated studies, little on this topic has been published within the past 5 years. In addition, five of the outdated sources are key articles supporting the conceptual framework of DBT.

Conceptual Framework: Biosocial Theory

This study built upon the theoretical foundation and literature related to biosocial theory, which underpins DBT. Cloninger (1986) initiated the discussion of biosocial theory by applying a unified theory that suggested anxiety disorders were formed by a combination of genetic personality traits and responses to environmental stimuli. Cloninger attempted to combine the findings of genetic research with the behaviorism trademarked by Pavlov. Developed by Linehan (1993a), biosocial theory emerged as an explanatory framework for emotional dysregulation, specifically applied to parasuicidal adults with borderline personality disorder.

Theorists of biosocial theory posited that emotional dysregulation originates in biological differences and is activated by environmental factors that invalidate emotional responses (Cavazzi & Becerra, 2014; Linehan, 1993a; Shearin & Linehan, 1994; Neece, Berk, & Combs-Ronto, 2013). Emotional vulnerability is characterized by a child's heightened sensitivity to experiencing emotion (e.g., a low threshold for an emotional reaction to an event), increased emotional intensity, and a slow return to emotional baseline (Crowell, Beauchaine, & Linehan, 2009; Neece et al., 2013). In an invalidating home, the child does not know how to regulate or define the biological emotions, leading to dysregulation (Neece et al., 2013). For example, according to biosocial theory, individuals with borderline personality disorder experienced a combination of a predisposition to emotional hyperarousal and invalidating environments in the home (Cavazzi & Becerra, 2014).

Recent findings are conflicted with respect to the explanatory value of biosocial theory to emotional dysregulation and have been mixed. Crowell et al. (2009) reviewed the literature regarding the biosocial model from a developmental psychopathology perspective. Supporting Linehan's (1993a) original theory, Crowell et al. described recent findings showing a transactional relationship between specific biological vulnerabilities (e.g., genetic influences, abnormalities in brain systems, or frontal limbic dysfunction) and environmental risk factors (e.g., invalidation, reinforcement of emotional liability, or inadequate emotion coaching) that contributed to the development of emotion dysregulation, self-harm behavior, and borderline personality disorder. By tying borderline personality disorder to trait impulsivity, Crowell et al. suggested that the

biological component of emotion dysregulation may be even more important. As a result, Crowell et al. suggested that biosocial theory could be applied in genetic research among adolescents and young adults to trace the development of borderline personality disorder. Conversely, Cavazzi and Becerra (2014) determined through a review of literature that biosocial theory did not seem to adequately address the facets of emotional dysregulation present in individuals with borderline personality disorder. Contrary to Crowell et al. Cavazzi and Becerra especially criticized the biological components of biosocial theory.

Some theorists have also suggested that biosocial theory could be used to explain negative outcomes, such as suicide, among individuals with borderline personality disorder (Glenn, Bagge, & Osman, 2013; Neece et al., 2013). Glenn et al. (2013) examined the connections between borderline traits and suicidality among 97 adolescents in two psychiatric inpatient units. Using linear and hierarchical logistic regressions, Glenn et al. attempted to predict suicidality using borderline personality traits. The data revealed that affective instability predicted suicidality within this sample, and greater levels of affective instability predicted the likelihood that an individual would attempt suicide, rather than having suicidal ideation. Neece et al. (2013) furthered the discussion by discussing suicidality among adolescents in general and how biosocial theory might explain suicidality. Neece et al. concluded that biosocial theory had potential for addressing suicide among adolescents, and suggested applying DBT as a treatment among individuals with suicidal ideation.

Literature Review Related to Key Concepts

Dialectical Behavior Therapy

DBT was originally developed by Linehan (1993a, 1993b) and originally created to address parasuicidal behavior in women who had been diagnosed with BPD (Swales et al., 2000). In the development and practice of DBT, Linehan emphasized three main components, all related to a dialectical-based worldview: (a) the belief in a systems perspective of reality; (b) the belief that reality is not static but is instead comprised of opposing forces and tensions; and (c) the belief that, because of the previous tenet, reality is in a process of continuous and ongoing change. DBT is a combination of the dialectical perspective and cognitive behavior therapy (Smith & Peck, 2004).

The three tenets are directly related to the practice of DBT in the following ways. First, the most important system within the context of therapy, in general, is the relationship between the therapist and the patient. More specifically, in the practice of DBT, the therapist must build an understanding and constantly evaluate the influence of the therapist on the client, and the client on the therapist (Swales et al., 2000). Second, building off the belief that reality is comprised of tension, and a constant pull between opposing forces, DBT practitioners note the tension of the impetus to change the client while maintaining acceptance of his or her person (Swales et al., 2000). The importance of this second tenet cannot be understated. Swales et al. explained that the second tenet involved radical acceptance of the client's current circumstances, personality, and wellbeing. In addition, the therapist must accept the present state of the relationship with the client. However, this acceptance contradicts the simultaneous need for the therapist to

demand change from the client (Swales et al., 2000). Therefore, in DBT, Swales et al. noted that strategies are classified as either those that promote change, or those that promote acceptance.

This second tenet leads directly into the third tenet, the emphasis on reality as always in a process of continuous change. Within the practice of DBT, Swales et al. noted it is the therapist's job to help the patient learn to deal with change, not to protect the patient from change. Because of this, DBT does not rely on impersonal logic to force the patient to change. Instead, DBT (and thus the therapist practicing DBT) relies on the dialectical tensions within the relationship between the therapist and the patient to promote change and help the patient cope with such change (Swales et al., 2000).

There are several strategies that therapists practicing DBT utilize in order to help patients successfully work through the four stages of treatment associated with DBT. These four stages include: pre-treatment: commitment; Stage one: stability, connection, and safety; Stage two: exposure and emotionally processing the past; Stage three: synthesis; and Stage four: capacity for sustained joy. A patient progresses from one stage to another through notable changes in his or her pathology (MacPherson et al., 2013; Swales et al., 2000). During each stage, the therapist provides various strategies for understanding and mitigating negative behavioral strategies. For example, during stage one, where most research cases are focused, the therapist works on reducing life-threatening behaviors, like suicidality, therapy-interfering behaviors, like noncompliance, and quality-of-life-interfering behaviors, like homelessness (MacPherson et al., 2013). The tools and strategies that therapists emphasize in treatment include: problem solving

strategies; validation strategies; stylistic strategies; case management strategies; and dialectical strategies (Swales et al., 2000).

Several positive outcomes result from DBT. For example, van den Bosch, Sinnaeve, Hakkaart-van-Roijen, and van Furth (2014) demonstrated that among 71 adults with BPD, a 12-week, intensive DBT program combined with 6 months of standard DBT, significantly reduced suicide attempts and self-harming behavior. According to theory underlying DBT, suicidality is a maladaptive strategy that a client uses to relieve his or her psychological distress (Kinsey & Reed, 2015). A potential limitation of the claim is the need for inpatient treatment, which may discourage Native American clients (Wexler et al., 2015), as well as the application to the traditional population of adults with BPD.

Studies have shown that DBT can prove successful in mitigating suicidality among different populations (Daigle, Pouliot, Chagnon, Greenfield, & Mishara, 2011; Smith & Peck, 2004). Initially, Linehan (1993a, 1993b) initiated treatment trials in urban settings in the United States. Swales et al. (2000) explained that the first controlled trial of DBT demonstrated significant outcomes for suicidal subjects with BPD, including less medically severe and parasuicidal episodes and increased persistence in therapy. Since then, researchers have expanded the examination of DBT practices in reducing suicidality in other cultural settings and with patients other than the specific group on which Linehan focused. In recent years, for example, some researchers expanded the use of DBT beyond adults to adolescents (Groves, Backer, van den Bosch, & Miller, 2012; MacPherson et al., 2013), while others have expanded their scope to include the use of DBT with patients with symptoms of posttraumatic stress disorder (Harned, Jackson, Comtois & Linehan,

2010). Still others have examined the effectiveness and results of training therapists in the use of DBT practices (Herschell, Lindhiem, Kogan, Celedonia, & Stein, 2014). The process of expanding DBT into different populations is like that which occurred with cognitive behavioral therapy, from which DBT takes part of its practice (Bennett & Babbage, 2014).

In a review of the empirical literature, MacPherson et al. (2013) noted that DBT was an evidence-based intervention that could mitigate maladaptive strategies for individuals with emotional and behavioral dysregulation. However, DBT required some adaptation for alternative populations from that which it was intended to address, namely, suicidal adults with BPD (MacPherson et al., 2013). Bennett and Babbage (2014), for example, noted that little work had been done in addressing whether cognitive behavioral therapy, and by extension DBT, is effective among ethnic minorities. In fact, minorities are often left out of such research (Bennett & Babbage, 2014).

The present study will continue the current work that has been done regarding the use of DBT among Native American clients (Beckstead et al., 2015; Kinsey, 2014; Kinsey & Reed, 2015). The current study expands on the theoretical foundation of and existing literature relating to DBT by focusing on the use of DBT specifically within Native American communities to reduce suicidality and co-occurring symptoms. The use will be assessed through qualitative interviews with Native American treatment providers who work primarily with Native American communities.

Suicide in Native American Communities

Suicide constitutes a significant public health issue in the United States, and particularly among Native American communities (Ballard et al., 2014). Alcántara and Gone (2007) and O'Keefe et al. (2014) reported that for Native Americans between the ages 15 to 24 years of age, suicide was the second leading cause of death. The rate of suicide caused an alert on the national level, so much so that the United States Surgeon General issued a *Call to Action* for programs to prevent suicide (DeMartino et al., 2003).

Researchers have noted several differences between Native American populations and others in the United States, including the factors that predict suicide. A few researchers have examined the demographic differences in suicide among Native American populations. Herne et al. (2014) assessed death certificate data and Indian Health Service data from 1999–2009 to compare the rates of suicide among Native American populations and White (non-Hispanic) populations. Results suggested suicide rates per 100,000 people were nearly 50% higher within Native American populations when compared to White in general. Particularly, Native American suicide rates and disparities with White populations were highest in Alaska, where there were 65.4 male deaths and 19.3 female deaths per 100,000 individuals, and in the Northern Plains, where there were 41.6 male deaths and 11.9 female deaths per 100,000 individuals. Conversely, rates of suicide among Native American were less than Whites in the Eastern and Southwestern regions of the United States. In addition, Native American populations older than 45 had lesser rates of suicide when compared to the same age group among White. Herne et al.'s data suggested that the phenomenon of high rates of suicide among

Native American populations is primarily of issue among males under 25 years, and to a lesser extent, females under 25.

Supporting Herne et al. (2014), Wexler and Gone (2012) cited the differences in Native American communities in suicidal clients compared to nonindigenous suicides. Particularly, Wexler and Gone noted that young indigenous men were at a greater risk, and elderly nonindigenous men were at a greater risk in the United States. However, Wexler and Gone compared Native Americans to the general population, whereas Herne et al. compared Native Americans to White. The findings of the two studies were nevertheless supportive of one another.

Additionally, Native Americans may have different impetuses to suicidality than other populations in the United States. Cole et al. (2013) and O'Keefe et al. (2014) studied the utility of the Interpersonal-Psychological theory of suicide. Cole et al.'s sample was of 156 Native American students, whereas O'Keefe et al.'s sample consisted of 171 Native Americans from 27 different tribes. Cole et al. used bootstrapping analysis, and O'Keefe et al. used hierarchical regression analysis. Both groups of researchers tested two factors, perceived burdensomeness and thwarted belongingness, to see whether they affected suicidal ideation. The factors were chosen in accordance with Native American notions of family and community. In O'Keefe et al.'s study, combined, perceived burdensomeness and thwarted belongingness predicted suicidal ideation; however, only perceived burdensomeness predicted suicidal ideation singularly. Cole et al. similarly determined that only perceived burdensomeness indirectly affected the relationship between suicidal ideation and symptoms of depression. Cole et al.'s and

O'Keefe et al.'s research therefore partially supported the notion that suicide had a communal aspect among Native Americans.

Nevertheless, culture remains a significant consideration among researchers in Native American suicide (Wexler et al., 2015). O'Keefe et al. noted that thwarted belongingness may not have predicted suicidal ideation because of the lack of cultural competency in the questionnaire, which asked about disconnection from people in general, rather than a person's significance in the family, community, or tribe. Similarly, Native American differences in suicide led Wexler and Gone (2012) to conclude that culturally-adapted interventions for suicidal clients were necessary. Despite the noted differences, however, Wexler et al. (2015) determined that 90% (18 out of 20) of the recently published studies on Native American suicide focused only on individual factors, rather than on community interventions.

A note of caution is required in referring broadly to suicide within Native American communities (Herne et al., 2014). Beals et al. (2005) found in a study of Indian Health Services data that different tribes had different health-seeking behaviors and different incidences of mental health diagnoses. For example, in the southwest, where the present study took place, Beals et al. determined that women had lower rates of lifetime alcohol abuse compared to the general population of the United States, whereas other tribal populations had increased incidence of alcohol abuse irrespective of gender. Additionally, southwestern Native Americans were more likely to seek out traditional healers (Beals et al., 2005). While the Beals et al. study is dated, the results nevertheless suggested the need for specific, tribally situated research and caution in attempting to

generalize about all Native Americans. The differences also supported Wexler et al.'s (2015) finding that there was a need for cultural sensitivity in therapeutic interventions within Native American communities.

Culturally Sensitive Therapeutic Strategies Within Native American Contexts

Researchers have noted the need for culturally sensitive therapeutic strategies among Native American communities (Clifford et al., 2013; Gray & Rose, 2012; Kinsey & Reed, 2015; Morris, 2011; Wexler & Gone, 2012; Wexler et al., 2015). Gray and Rose (2012) and Sahota and Kastelic (2012) proposed that a lack of a significant evidence base for therapeutic interventions among Native Americans was a pressing issue for researchers and Native American communities. Haring, Titus, Stevens, and Estrada (2012) noted that qualitative methods of inquiry may be more appropriate for capturing cultural diversity and experiences with mental health interventions. Critiquing the monolithic application of Western health paradigms, Wexler and Gone (2012) called for cultural adaptation and consideration of the use of these programs within specific contexts, particularly among Native American communities. Specifically, practitioners need to be aware of the ongoing influences of colonization on Native American individuals and communities (Kinsey & Reed, 2015). The association of Western medicine with colonization and subjugation of indigenous peoples, for example, may lead to distrust of therapeutic interventions among Native Americans (Wexler et al., 2015).

Some researchers have examined best practices for treating Native American clients (Elliott, 2012; Gray & Rose, 2012; Thomason, 2012). Thomason (2012) assessed the therapeutic preferences of Native Americans through an online survey. Mental health

professionals responded to a request on the Society of Indian Psychologists listserv, resulting in 68 usable responses. Approximately half (57%) of participants were themselves Native Americans, 44% were White, and 14% were other; respondents could check more than one race/ethnicity box on the survey. Thomason noted several best practices for therapy with Native American clients, including emphasizing the therapist's and client's background, listening respectfully to the client, and minimizing standardization, such as through intake paperwork and standard beginning questions. In a similar online survey of 50 mental health practitioners, including therapists, social workers, and psychologists, who worked with Native American populations, Elliott (2012) also attempted to determine the utility of spirituality ecograms, diagrams that demonstrate spiritual interconnectedness of family and religious beliefs, among Native Americans in family therapy. Eighty-four percent of the participants were themselves Native American. Elliott's results demonstrated that the mental health workers considered the model of spiritual ecograms to be moderately consistent with Native American worldviews. From this research, the specific best practice for Native American clients that emerged was the emphasis on holistic approaches and on the interconnectedness of all things (Elliott, 2012).

Regarding personal therapy, Morris (2011) determined that culturally adapted therapy strategies increased Native American counselors' perceptions of the outcomes of personal therapy, and that use of traditional practices influenced Native American therapists' counseling. Using qualitative interviews with three Native American mental health workers, Morris developed four themes of participants' responses: (a) personal

history; (b) spirituality and healing; (c) current practices and evolution of practices; and (d) cultural and historical trauma. The findings of Morris' study revealed that the Native American mental health workers came into the practice to bring a traditional worldview to counseling, and because of this background, noted significant differences in the mental health practices that were effective among Native American communities. For example, differences included a relational worldview, like Elliott's (2012) and Mohatt et al.'s (2011) conception of connectedness.

Other researchers have provided overviews of context specific prevention strategies utilized in Native American communities. McCabe (2007) noted that a resurgence in Native American cultural reclamation led to increased emphasis on traditional healing over Western medicine within these communities. Because of this dramatic increase, McCabe assessed that psychotherapists would need to adjust to account for traditional healing in their practices. Participants in McCabe's study included people from both rural and urban areas of Manitoba, and people from the Cree, Ojibwa, Dakota, and Metis communities, all of whom must have been involved in traditional healing methods for at least 3 years prior to their involvement in this study. McCabe discovered 12 different conditions that influenced and explained psychological and spiritual healing among these populations. These 12 conditions included: (a) readiness to heal; (b) understanding inner and unknown experience; (c) lessons of daily living; (d) challenges to change; (e) empathy; (f) acceptance and respect; (g) role modeling; (h) genuineness, credibility, and legitimacy; (i) trust and safety; (j) the sacred teachings; (k) ceremonies and rituals; and (l) belief in the healing spirit (McCabe, 2007, pp. 152-155).

McCabe noted that a primary difference between therapy and Native American healing was the emphasis on the spiritual aspects of healing among Native American communities.

Some therapist characteristics may influence the therapist's effectiveness in treating Native Americans. Elliott (2012) determined that practitioners over 50 were less likely to consider spirituality as central to treatment among Native American clients. It was important that mental health practitioners working among Native American cultures recognize and understand the value of the traditional healing (Morris, 2011). The participants in Thomason's (2012) study also noted a potential ethnic bias in the effectiveness of a therapist when treating Native American clients: 50% said Native American counselors were more effective; 20% reported no difference; 18% determined that it depended on the counselor's cultural competence; 12% reported it depended on the Native American client's extent of traditional beliefs, and no participants said non-Native American counselors were more effective. To minimize the potential influence of ethnicity, the present study was limited to Native American practitioners. Age may nevertheless be a demographic variable among the participants that may influence perceptions of DBT's effectiveness.

Although an ethnic difference in effectiveness for counselors may exist among Native American clients, all individuals working with Native American clients should demonstrate cultural competence (Elliott, 2012; Gray & Rose, 2012; Thomason, 2012). A therapist must develop cultural competence through a process that begins with acknowledgment of cultural differences, which a therapist then develops the skills to

address (Elliottt, 2012). Cultural competence, as reported by the counselors in Thomason's (2012) study, included knowledge of community and tribal concerns, celebration of Native American culture, and acknowledgment of differences. The counselor should also be aware of an individual's tribal background and preferences (Gray & Rose, 2012) and spirituality (Elliott, 2012). If the client wishes, a counselor might work in conjunction with a traditional healer, yet a counselor might also need to recognize that cultural practices, like healing, sweat lodges, and tribal ceremonies, might be private within the Native American community (Gray & Rose, 2012). The constant consideration of culture, and interrogation of Western assumptions of medicine, is essential when providing care to Native American clients (Gray & Rose, 2012; Thomason, 2012; Wexler & Gone, 2012).

Thomason (2012) also noted that counselors preferred certain treatments when treating Native American clients. Contrary to research that suggested that cultural adaptation of treatments was necessary (e.g., Kinsey & Reed, 2015; Wexler et al., 2015), 80% of the participants noted that traditional interventions should be used for Native American clients. However, Thomason also noted that respondents said that theoretical approaches to counseling should be adapted depending on the clients' beliefs. Recommended interventions included client-centered approaches (26%), cognitive behavioral therapy (23%), motivational interviewing (13%), narrative therapy (13%), mindfulness-based approaches (10%), dream analysis (10%), Gestalt (10%), and storytelling (10%). The results of this study may potentially point to the utility of applying a Western intervention, such as DBT, in therapy with Native American clients.

A potential limitation may be the representation of non-Native American therapists (43%) and the Western training of counselors, which may misrepresent the efficacy of treatments for Native American clients.

Culturally sensitive suicide interventions in Native American contexts. Regarding suicide, it is important to acknowledge that suicide rates and various contextual factors underlying suicide risk are different within each specific Native American community. As Wexler and Gone (2012) suggested, many Western models of suicide prevention fail to take these contextual factors into consideration and thus fail to effectively address the issues at hand. The lack of adaptation caused many Native American communities to develop their own methods of suicide prevention and to recommend therapeutic practices that take into consideration these specific cultural contexts (Wexler & Gone, 2012). Because the focus of this current study is on exploring the perceptions of Native American therapists regarding DBT, it is important here to discuss existing literature on culturally sensitive suicide prevention strategies within Native American contexts.

It is helpful to consider why such programs are necessary and important. Wexler and Gone (2012) and Wexler et al. (2015) reviewed the ways that Western assumptions about suicide may conflict with local indigenous understandings about suicide and thus, in many ways, fail to take into consideration cultural contexts. Epistemological tensions between Western scientific conceptions of mental illnesses and suicide are fundamentally different than the conceptions of indigenous populations, and therefore required different

interventions (Wexler et al., 2015). These Western assumptions and indigenous understandings contrasted against one another in many ways, including the following:

- the normative assumption that suicide expresses underlying psychological problems versus the indigenous understanding that suicide expresses historical, cultural, community, and family disruptions;
- the normative assumption that suicide is primarily an agentic expression of personal volition versus the indigenous assumption that suicide is primarily an enacted consequence of social obligation;
- the normative assumption that suicide prevention is best achieved by mental health professionals versus the indigenous assumption that suicide prevention is best achieved by nonprofessional community members; and
- the normative assumption that suicide prevention most properly falls within the purview of formal mental health service delivery systems versus the indigenous assumption that suicide prevention most properly falls within the purview of locally designed decolonization projects. (Wexler & Gone, 2012, p. 800)

Wexler and Gone concluded by calling for culturally based and context-specific collaborative efforts to address suicide. However, Wexler and Gone's research left out specific recommendations for achieving these efforts. Wexler et al. recommended the use of community-based efforts, rather than individual interventions. A potential limitation of programs is self-reporting, which may not intervene in those who need suicide prevention treatment the most (Kinsey & Reed, 2015). There is thus a tension between the

effectiveness of community programs and the potential need for personal-level interventions within Native American clients.

Throughout the literature, the theme of developing treatment models that are respectful of and take into consideration cultural contexts and histories is a common one; in fact, Doll and Brady (2013) cited that cultural adaptation of treatment was a protective factor against suicide. Morgan and Freeman (2009) explored the efforts of researchers to create a new model of diagnosis and treatment, effectively combining the cultural strengths of indigenous people with the technical and treatment skills of more conventional therapeutic strategies. Focusing specifically on alcohol abuse, general substance abuse, and suicide amongst Alaskan Natives, Morgan and Freeman explained Alaskan Natives' rejuvenation of culture, and the requirement for adjunctive therapies that included cultural beliefs. Similarly, Mohatt et al. (2011) developed the Awareness of Connectedness Scale, a measurement tool for assessing risk, resiliency, and change among Native Americans, which was based on cultural notions of disorders, wellness, and healing. Specifically, Mohatt et al. cited the communal beliefs of Native American communities as protective against and benefiting treatment of suicide and substance abuse within these populations. However, both Mohatt et al. and Morgan and Freeman primarily focused on diagnoses, rather than on specific treatment interventions.

Contrary to Mohatt et al.'s (2011) and Morgan and Freeman's (2009) focus on diagnoses for suicidality, Doll and Brady (2013) focused on culturally appropriate treatment for suicide prevention. Doll and Brady evaluated a community-based participatory research intervention, Project HOPE. Project HOPE was a suicide

prevention program developed for a specific Omaha tribal community in Nebraska that utilized occupational therapy to potentially address stress through sensory stimulation. Sensory curricula were utilized in two reservation schools to target youth. To assess the outcomes of the program, Doll and Brady created an instrument to address stress and distributed it to youth in the targeted community, resulting in 635 usable surveys. Results showed an increase in positive feelings after the sensory experience, including 61.8% of students who felt sleepy reporting feeling happy afterwards, 57% of participants who felt stressed reporting feeling happy afterwards, 45% of participants who felt mad reporting feeling happy afterwards, and 42.9% of participants who felt sad reporting feeling happy afterwards. Potential limitations of this research included a lack of generalizability and a reliance on the link between stress and suicide; it may be more effective to examine a suicide treatment with clear outcomes for suicide, such as DBT (Daigle et al., 2011), within Native American populations.

The distrust of Western medicine may reduce the opportunities for and effectiveness of interventions from doctors and practitioners who are not culturally sensitive. For example, Ballard et al. (2014) analyzed 1,424 emergency room visits by 72 Apache adolescents who had attempted suicide and determined that in the year before a suicide attempt, 82% of suicidal adolescents had visited the emergency room, and 26% had visited for a psychiatric reason. Thus, Ballard et al. determined that emergency rooms should conduct suicide evaluations on intake. A potential limitation of the recommendation was that the doctors within emergency rooms may not have cultural competence and may emphasize Western models of healing and denigrate traditional

medicine and worldviews (Gray & Rose, 2012). Alternatively, Cwik et al. (2014) evaluated a community-based surveillance system for intervening in suicide among Native American communities, which had efficacy in increasing reporting and treatment among the White Mountain Apache tribe. When integrating a Western model into a Native American community, it is essential that consideration of existing tribal structures is acknowledged to avoid alienating those who could benefit from treatment (Cwik et al., 2014; Wexler et al., 2015).

In another example, Sahota and Kastelic (2012) reviewed current approaches for assessing tribally based suicide prevention efforts in Native American communities in New Mexico, and highlighted assessment strategies that appeared particularly promising. Assessment of suicide prevention efforts are important to their continuation; without assessment practices that demonstrate their success, it becomes difficult to obtain funding for the programs to develop further. Sahota and Kastelic explained that suicide prevention programs from within the tribe were effective because of their cultural appropriateness, including deference to diverse tribes and their unique experiences with suicide. Utilizing the responsive interview based method developed by Herbert and Irene Rubin, Sahota and Kastelic used qualitative approaches to ask participants about their experiences with suicide intervention programs.

Based on their research, Sahota and Kastelic (2012) developed five policy and practice recommendations for supporting the evaluation and assessment of tribally based suicide prevention programs and strategies: (a) fund evaluations of tribally based suicide prevention programs; (b) provide outside evaluation services to communities; (c) broaden

the definition of acceptable evidence; (d) maintain tribal confidentiality, such as through aggregate data collection; and (e) develop tools for tribes to share data securely with one another, such as a password- protected website (Sahota & Kastelic, 2012, p. 119-122). Like McCabe (2007) and Morris (2011), Sahota and Kastelic concluded that the influence of tribal communities, and adaptation of therapy to meet tribal beliefs and conditions, were essential to addressing the suicide epidemic among Native American communities.

Gaps in the Literature

DBT as culturally appropriate within Native American contexts. Several researchers cited the need for culturally sensitive therapies for Native American clients (Clifford et al., 2013; Morris, 2011; Wexler & Gone, 2012; Wexler et al., 2015), yet little research existed regarding the cultural appropriateness of DBT within Native American individuals to target suicide, depression, and substance abuse (Kinsey, 2014). However, researchers who have examined Native American clients in therapy and their needs have findings that overlap with tenets and stages of DBT (Goodkind et al., 2010; Kinsey, 2014; Mohatt et al., 2011). There was a fundamental intersection between the biopsychosocial theory that underlies DBT and the suicide treatments that Alcántara and Gone (2007) noted were effective among Native Americans. The overlap between the two areas of research suggested further exploration of the cultural appropriateness of DBT within Native American contexts was necessary.

For example, many of the twelve conditions for effective therapy that the healers and client participants cited in McCabe's (2007) study are strikingly like the strategies utilized by DBT, and McCabe, too, acknowledges that there are similarities between

aboriginal traditional methods and mainstream therapy. For example, regarding challenges to change, McCabe explained the need for self-evaluation, akin to DBT. Similarly, regarding acceptance and respect, McCabe demarked the need for acceptance from the practitioner. These two conditions sound remarkably like the tensions and acceptance in DBT, in which therapists are to accept the client even while attempting to intervene in behaviors (Swales et al., 2000). These similarities may underscore that DBT may be a useful option for therapeutic interventions with Native American patients, or, at the very least, it suggests that there are enough similarities between indigenous approaches to healing and DBT that aspects of DBT may be a promising strategy to utilize for culturally sensitive therapy.

An additional intersection of Native American research and DBT is in the second stage of DBT, which involves processing and dealing with prior trauma. Some researchers have noted that addressing cultural trauma inherent in Native American communities was essential to effective therapeutic interventions (Goodkind et al., 2010; Kinsey, 2014; Kinsey & Reed, 2015). Since a therapist practicing DBT meets a client where he or she is (Swales et al., 2000), the second stage of DBT might target such cultural trauma more effectively than an intervention that focused more on individual trauma (Kinsey, 2014). In addition, Smith and Peck (2004) noted the importance of group engagement during this stage, which was consistent with Wexler et al.'s (2015) recommendation for more community-based programs in Native American communities.

A foundational component of DBT, cognitive behavioral therapy, has also shown efficacy in addressing issues of trauma within Native American communities. Bigfoot

and Schmidt (2010) conducted a case illustration of a culturally-adapted cognitive behavioral therapy program. The program blended cultural and spiritual beliefs with cognitive behavioral therapy tools. In the case discussed by Bigfoot and Schmidt, a sexually abused child, Anna, attended therapy with her family to address her healing from the incident. Based on the therapist's use of the program, the family decided to engage in a smudging ceremony, which addressed Anna's spiritual, relational, physical, and mental wellbeing. A limitation of Bigfoot and Schmidt's findings were that the program was new in its inception, and that the case was singular; the purpose of the article was to introduce the program, rather than providing an evaluation. Nevertheless, the study provided initial support for cognitive behavioral therapy among Native Americans, which echoed Thomason's (2012) findings that therapists utilized cognitive behavioral therapy within these communities.

For suicide treatment, the dialectical component of DBT may further the outcomes of cognitive behavioral therapy. Mohatt et al. (2011) noted the need for emphasizing therapies based in Native American culture as essential for designing culturally appropriate interventions. Specifically, Mohatt et al. highlighted connectedness, the collective wellbeing of the individual, his or her family, the community, and nature, as a protective factor against suicidality among 284 Alaskan Native youth. O'Keefe et al. (2014) further noted that disconnection with the community predicted suicidal ideation among Native Americans. The connectedness noted by Mohatt et al. and O'Keefe et al. was like the third and fourth stages of DBT, synthesis and capacity for sustained joy, wherein a client works on solving the problems with his or her

environment and experiencing positive emotions (Swales et al., 2000). In addition, the concepts of connectedness and wholeness are fundamental to the dialectical worldview that underpins DBT (Smith & Peck, 2004).

Effectiveness of DBT as a treatment approach for Native American clients. The review of the literature revealed only two researchers who have examined the use of DBT among Native Americans (Beckstead et al., 2015; Kinsey, 2014). Both researchers evaluated a culturally modified DBT, but Kinsey (2014) utilized qualitative methods, whereas Beckstead et al. (2015) conducted quantitative analyses of a pilot study. Beckstead et al. evaluated individual substance use reduction in a treatment setting, and Kinsey studied a community-based, voluntary program intended to improve community wellness. Below, both studies are reviewed in depth, since they are directly relevant to the present study.

In a doctoral dissertation, Kinsey (2014) attempted to address a gap in the literature regarding DBT as a treatment approach for Native American clients by conducting a critical ethnography of the influence of a culturally modified DBT program, Healthy and Whole, among the Suquamish tribe in Washington State. Qualitative data included in-depth interviews with 13 clinicians and tribe members, as well as participant observations over 10 months. Kinsey found that systemic, intergenerational trauma existed among the tribe, which individuals dealt with in a variety of maladaptive ways, including through suicidality and substance abuse. However, through the DBT provided in the Healthy and Whole program, individuals maintained the cultural values of their tribe and learned emotional management skills that led to positive outcomes in livelihood

and interpersonal trauma. Based on the results, Kinsey concluded that therapists should consider cultural, social, and historical context, a holistic view of trauma, the potential for resilience through cultural identity, and the potential risk of cultural trauma in DBT, particularly among Native American populations.

Beckstead et al. (2015) conducted a pilot study regarding the use of DBT in a residential substance use program. The program utilized DBT in conjunction with cultural modifications, including pre- and posttreatment evaluation among 226 adolescents from 39 tribes using the Youth Outcome Questionnaire-Self-Report demonstrated that DBT was effective in reducing substance use. Specifically, 96% of participants reported being either improved or recovered, with statistically significant outcomes resulting from DBT treatment. While Beckstead et al.'s research demonstrated the effectiveness of DBT within a varied sample of Native American adolescents, it did not address suicidality outcomes; in addition, the emphasis on quantitative measures may limit the ability to capture cultural diversity among Native Americans (Haring et al., 2012).

The limited research on DBT among Native Americans therefore necessitated further exploration. As suicide is a significant health issue within this population (O'Keefe et al., 2014), it is essential to explore if DBT is effective in reducing suicidality. To maintain cultural differences among tribes, I limited the study to a region in the Southwest Area and use a qualitative method of inquiry, as in the Kinsey (2014) study.

Treatment barriers or challenges in using DBT with Native American clients. What little research existed regarding DBT among Native American clients has focused

on the positive aspects of the intervention (Bigfoot & Schmidt, 2010; Kinsey, 2014) or on how to make it work within these communities (Kinsey & Reed, 2015). For example, building on Kinsey's (2014) research, Kinsey and Reed (2015) conducted an evaluation of the development of Healthy and Whole among the Suquamish tribe in Washington State. Based on the motivation of a tribal leader, several modifications occurred in DBT so it would fit the tribal community: a) self-identification, rather than diagnosis, for entry; b) wide diffusion of resources, rather than centralized clinical services; c) facilitative, rather than authoritative, clinicians, who emphasized the importance of cultural influences and communal learning as a result of treatment. Together, Kinsey and Reed argued that these modifications helped the tribe to be more accepting of the intervention. A further strength of the program, as noted by Kinsey and Reed, was the use of data to evaluate the program at four periods during its inception. However, an issue with modifying DBT is that each tribe and its policies must be considered, which may incur significant costs prior to an established evidence base for DBT among Native American clients (Sahota & Kastelic, 2012). Kinsey and Reed did not emphasize the barriers and challenges of integrating Healthy and Whole within the Suquamish tribe.

Researchers have not yet examined the barriers or challenges to using DBT with Native American clients. This is in part because only Morris (2011) and Thomason (2012) conducted a qualitative exploration of Native American mental health workers, and they did not target DBT specifically. Potential barriers identified by Morris were fundamental conflicts between Western conceptions of mental health and traditional healing. For example, this Western worldview may be proliferated by the cognitive

behavioral therapy components of DBT, which includes an emphasis on solving problems and personal achievement (Smith & Peck, 2004). Another potential barrier is the Western view of treatment efficacy, which as demonstrated in Thomason's study, may be perceived as effective by the treatment provider, but not by the client. These Western mentalities may alienate Native American individuals (Wexler et al., 2015).

The lack of exploration regarding application of Western therapies, such as DBT, among Native American clients constituted a significant gap in the literature, as a Western education and theoretical intervention may make it difficult for practitioners to understand Native American clients fully through its lens (Morris, 2011; Sahota & Kastelic, 2012). This gap in the literature may be addressed through the present study.

Summary and Conclusions

Only a small number of researchers have used qualitative approaches when evaluating DBT among Native American communities (Kinsey, 2014; Kinsey & Reed, 2015). The qualitative method was appropriate for capturing cultural diversity among Native Americans (Haring et al., 2012). However, the researchers primarily focused on cultural adaptation in the inception of programs from the clients' perspectives (Kinsey, 2014) or from the developers' perspective (Kinsey & Reed, 2015). Little research exists regarding the experiences of Native American therapists who utilized DBT within these communities, and Clifford et al. (2013) determined that there was a pressing need for additional evaluations of preventative treatments for suicide within Native American communities. Sahota and Kastelic (2012) noted that tribal communities often find it difficult to provide the kind of evidence funding opportunities require. Without funding,

it is difficult for local, context-specific programs to succeed, let alone exist. Understanding the therapists' lived experiences of DBT was essential in providing a next step in understanding its utility within Native American populations.

Several studies reviewed here have concluded with calls for further research in these areas of study. For example, McCabe (2007) called for the further investigation of therapeutic conditions among Native American communities, as did Clifford et al. (2013) and Sahota and Kastelic (2012). Thus, in the present study, I explored perceptions of Native American therapists to provide data regarding practice that may lead to funding for similar interventions (Doll & Brady, 2013; Sahota & Kastelic, 2012). Sahota and Kastelic (2012) noted that such evidence was mandated for funding for mental health programs, and that it was difficult to obtain for Native American communities.

Practice-based evidence is clearly valuable, but during this current study's literature research, no practice-based evidence from Arizona was found. According to the National Conference of State Legislatures, there are 21 federally recognized Native American tribes or groups in the state of Arizona. The lack of practice-based evidence on the Native American communities in this specific geographic area is a gap in the literature that this current study seeks to fill. I will explore DBT as culturally-appropriate within Native American contexts, the effectiveness of DBT as a treatment approach for Native American clients, and treatment barriers or challenges in using DBT with Native American clients. As discussed in the literature review, the unexplored nature of the topic required a qualitative methodology to explore the experiences of Native American practitioners with using DBT. The methodology is expanded upon in the following

chapter. Chapter 3 will outline the research study's methodology and design, the rationale for the chosen research design, the role of the researcher, participant selection logic, and instrumentation before highlighting the procedures of recruitment, participation, and data collection.

Chapter 3: Research Method

The purpose of this study was to understand the lived experiences of Native American therapists who use DBT with Native American populations. This chapter contains a complete description of the study methodology. The sections in this chapter include (a) research design and rationale, (b) role of the researcher, (c) participant selection logic, (d) instrumentation, (e) procedures for recruitment, participation, and data collection, (f) data analysis plan, (g) issues of trustworthiness, and (h) ethical considerations.

Research Design and Rationale

The research questions used to guide this inquiry were as follows:

Central Research Question: How do Native American therapists describe their experiences of using DBT (DBT) with the Native American populations?

Research Subquestion 1: Why do Native American therapists view DBT as being culturally appropriate with Native American clients?

Research Subquestion 2: How do therapists describe the effectiveness of DBT as a treatment approach for Native American clients?

Research Subquestion 3: What treatment barriers or challenges have been identified by therapists using DBT with Native American clients?

The methodology chosen by a researcher to employ in a study is guided by his or her research questions and worldview (Tracy, 2013). In choosing a methodology to guide a study, a researcher makes a statement about the plan to gather, analyze, and interpret data; to report results; and to create knowledge about the phenomenon under study (Petty,

Thomson, & Stew, 2012). The phenomenon explored in this qualitative study was the experiences of Native American therapists in providing DBT to Native American clients. The goal of this study was to explore and understand the lived experiences of the participants through their experiences and perceptions from their worldview using textual responses. The goal of this study was not to measure the effectiveness of DBT or how many therapists use DBT; rather, it was to understand, explore and describe Native American therapists' lived experiences in the use of this technique with Native American clients. Qualitative researchers have an interpretive, critical, or postmodern view of the world, and generally believe that different individuals experience the world in different ways with no absolute reality (Patton, 2015). Because of many different viewpoints included in the category of qualitative research, the best definition of the term is as follows: an overarching term that encompasses many different methods that describe, interpret, or explore the meanings surrounding naturally occurring phenomenon or events (Van Maanen, 1990). The goal of qualitative research is to study phenomena in a naturalistic setting with the goal of exploration based on the viewpoints of the individuals who have experience with the object under study (Denzin & Lincoln, 2013). Qualitative research is inductive, in that the results arise from the gathered data, and contains rich and thick descriptions to fully describe the phenomenon being explored (Merriam & Tisdell, 2015).

The goal of this study was to explore how Native American therapists use DBT with Native American clients. This goal necessitated a qualitative method. When

considering qualitative research, a researcher has a plethora of designs to consider. For this study, an interpretive phenomenological analysis (IPA) method was selected.

IPA is a design arising from phenomenological designs which combines phenomenology, hermeneutics, and ideography (Smith et al., 2009). Phenomenologists seek to understand the lived experiences of participants to understand a specific phenomenon from the worldview of the individuals taking part in the study (Moustakas, 1994). The focus of phenomenological studies is the common, conscious experiences of the participants (Schram, 2003). Hermeneutics is used for the interpretation of meaning as associated with the participants' lived experiences with the focus being language, culture, and any associated meanings (Kvale, 1996). A researcher employs ideography to focus on each individual's unique experiences and the understanding what sets the participant apart from others (Smith et al, 2009). This process requires high level in-depth data analysis and enables the qualitative researcher to employ multiple methods and viewpoints to interpret meaning (Smith et al, 2009).

The goal of qualitative researchers who employ IPA is to understand how people make sense from events, relationships, and processes when examined in the context of their specific lifeworld (Larkin, Eatough, & Osborn, 2011). The focus of this design was to approach the phenomenon under study from the viewpoint of the participants (Smith et al., 2009). An IPA researcher seeks detailed, rich, and thick data from a small number of participants using verbatim individual accounts. Data are typically gathered from interviews or written accounts. The ultimate result of using this design is to use the data gathered for sense making, which is an understanding of what the phenomenon under

study means to the participant (Larkin et al, 2006). The IPA phenomenological approach is most appropriate for the present study's goals and purpose.

Role of the Researcher

A researcher is the key person collecting data and analyzing data from participants, so I was the primary research instrument (Denzin & Lincoln, 2000). By incorporating the technique of interviewing the interviewer, I further established the interview protocol as a dependable instrument (Chenail, 2011). I did not inform participants of my views concerning DBT use or any other issues regarding the study's topic to avoid interfering with their honest responses. To reduce researcher bias, I exercised epoché, or bracketing, to limit the influence of personal biases in the collection, analyses, and interpretation of data in this study (Moustakas, 1994). In my field journal, I recorded my personal reflections about any biases and presuppositions. I used this tool to aid me in insuring that I mitigate any biases as much as possible.

Gold's (1958) typology described the four roles that a researcher may assume in qualitative research: complete participant, participant-as-observer, observer-as-participant, and complete observer. The role of the complete participant entails that the qualitative researcher is a member of the study group but does not reveal to other group members that they are being studied so as not to disturb the usual activity of the group (Tracy, 2013). The participant-as-observer role, however, makes the study known to the participants from the outset of the research (Kitchenham, Budgen, & Brereton, 2010). In this role, the qualitative researcher participates in the activities of the group and observes the group members (Kawulich, 2005; Kitchenham, et al., 2010). In the observer-as-

participant role, the qualitative researcher is not a member and has limited contact with the group members and their activities (i.e., scheduled observations or semistructured interview). The role of the complete observer entails that the qualitative researcher has no direct contact with participants (Kawulich, 2005). The observation of the qualitative researcher is concealed from participants and is unobtrusive in nature (Kawulich, 2005). I conducted the interviews with the participants who were aware of my role. I functioned as a participant-as-observer during this research study.

Methodology

Participant Selection Logic

The target population of this study was Native American therapists who practice DBT with Native American clients. The sampling frame was limited to licensed, trained or certified Native American therapists who practice DBT, and met inclusion criteria. Criteria for inclusion in this study included: (a) the participant must be over the age of 18; (b) the participant must be enrolled a Federal recognize tribe; (c) the participant must be a licensed counselor, licensed substance abuse counselor, licensed social worker, or psychologist; (d) the participant must have practiced counseling treatment under a license for at least two years; (e) the participant must use or have used DBT in therapeutic sessions with Native American clients. The sampling method chosen for this present study is purposive sampling. Qualitative researchers employ purposive sampling to gather participants who have experience with the phenomenon under study and who can express their thoughts, feelings, and perceptions to the qualitative researcher (Patton, 2003). Criterion sampling, a subset of purposive sampling, enables a researcher to set

specific criterion that a participant must match to participate in the study (Suri, 2011). As qualitative research does not require statistical proof, qualitative researchers do not need to employ large sample sizes (Wilmot, 2005). Guest, Bunce, and Johnson (2006) stated that the more homogeneous the sample, the simpler it is to reach saturation, as the experiences of study participants can overlap, which leads to a clear picture of the phenomenon. Saturation occurs when adding more participants to the study does not result in additional perspectives or novel information.

The range of sample size recommendations for phenomenological studies differs. Morse (1994) indicated that phenomenological studies could be conducted with six participants. Guest et al. (2006) conducted a study consisting of 12 interviews. These authors found that many of the codes for the study were created by the sixth interview. Nielsen and Landauer (1993) conducted an analysis of sample sizes in qualitative studies that they employed to create a mathematical model. They found at least 80% of all information that was used in the study was found within 6 interviews, and increasing that number to 12 raised the percentage of found information to 90%. Based on this information, the sample size for this study was 8 participants. Sufficient sampling has occurred when the major themes show depth and variation and the understanding of the case has grown to considerable lengths (Corbin & Strauss, 2008). Francis et al. (2010) indicated that once a researcher has conducted three interviews with no new themes emerging, saturation has been reached. I planned to collect more data if at the completion of the tenth interview, new information still emerged, but this did not happen.

The gathered data must be rich and thick, with these terms defined as quality and quantity (Fusch & Ness, 2015). To aid in the assessment of saturation, a saturation grid was used during analysis. The grid has major topics of interest on the vertical axis and the individual interviews labeled on the horizontal axis (Brod, Tesler, & Christensen, 2009). This representation enabled me to easily track when themes no longer emerged. To assure saturation is met, additional interviews were conducted if new information emerged in the final analysis of the data, but this was not necessary (Fusch & Ness, 2015).

Participants for this study were recruited through snowball sampling, which is a process whereby the participants share information about the study with other potential participants (Patton, 2003). I asked professional associate contacts or those who were referred from peer associates if they know any peer's that met inclusion criteria and to provide their contact information for outreach by this researcher. Recruitment was done by phone and e-mail (Appendix A) and participants were given a brief introduction inviting them to participate in the research study. If willing to participate, I met participants at their location of choice that offered privacy, provided them a copy of the informed consent, allowed them to ask any questions from the consent form, explained confidentiality and the time expectations for interviews, and withdrawal procedures.

Instrumentation

For this study, open-ended, semistructured, interview questions (Appendix B) were created to gather data. I also used an audio-recorder to record the semistructured interviews, which were transcribed by a third-party transcription service. The transcriptionist signed a letter of confidentiality (Appendix C) before beginning

transcription of the interviews. Once transcripts are received, I verified the accuracy of those transcripts by listening to the interviews and comparing the transcripts to the audio recordings. Through these procedures, I established the credibility of the transcripts, and further established credibility throughout the data analysis of the transcripts.

Semistructured interviews are beneficial because the format allows the conversation to naturally navigate through the topics listed on the interview protocol keeping the interview on track (Tracy, 2013). There are two additional types of interviews, structured and unstructured (Merriam & Tisdell, 2015). These names refer to the format in which the interviews are conducted, whereby the structured interview follows the interview protocol explicitly and the unstructured interview does not utilize an interview protocol (Rubin & Rubin 2012). Each has an advantage, where the structured interviews provide the data necessary to answer the research questions and do not deviate from the interview protocol and an unstructured interview allows a researcher to follow where the participant leads (Merriam & Tisdell, 2015). The semistructured interview format lies between the both of those, where an interview protocol is created by listing topics of conversation, yet there is flexibility to deviate from the interview protocol in order to probe for further information (Rubin & Rubin, 2012). I used semistructured interviews based on the structured flexibility inherent to this interviewing style.

Probing is an important aspect of interviewing that allows the qualitative researcher to elicit further information about a topic that may contain thick data. Probing is also important to the interview process when a researcher may not understand the

participants' response, or a response is vague or ambiguous. For these reasons, I used probing questions during the interview process.

Procedures for Recruitment, Participation, and Data Collection

Once potential participants responded to the phone or e-mail requests for participation, I contacted them via telephone. I went over selection criteria to ensure that individual is eligible to participate in the study. To assure privacy and confidentiality, the interview occurred at a mutually selected, private location. The interviews were recorded on an audio recorder to ensure accuracy. To begin the interview, I explained the informed consent to the participants. I answered any questions and reiterated the purpose of the study. Once the informed consent was signed, and the participant was given a copy, the interview began. The interviews were approximately 60 minutes in length. Participants were not offered monetary compensation for their participation. Once the interviews were concluded, I debriefed participants. I thank them for their time, reiterated the purpose of the research study, described how their experiences will help inform future practitioners, and provided my contact information. If participants had any other questions or comments, they were addressed at this time.

Interviews took place over the course of two months and depended on participant availability. Since I audio recorded interviews, I estimated that it would take approximately two weeks to receive the completed transcripts from the transcriptionist. The transcriptionist signed a confidentiality agreement (see Appendix C) per Walden requirements to ensure that participant responses remained confidential.

Once data analysis was completed, I created a summary of the results. I used member checking procedures on the analysis. Member checking involves the participants reviewing the summary to offer feedback about its accuracy in representing their lived experiences (Lincoln & Guba, 1985). The summary was e-mailed to the participants for their review and commentary. The results of member checking were used to edit the analysis.

Data Analysis Plan

Before data analysis begins, a transcriptionist transcribed all interviews. Once the transcripts were completed, the transcripts were uploaded into NVivo. The use of qualitative software aided in the organization of data and assisted me to organize the data as I conducted the analysis and interpretation of the results. Ultimately, all data analysis arose from me.

Smith et al. (2009) explained IPA analysis included (a) movement from what is unique to what is a shared experience among participants; (b) description and interpretation of the lived experiences; and (c) a commitment to viewing and understanding the sense making of the participant. A specific process should be utilized to give a detailed account of steps that should be taken to understand, as well as, interpret the collected data (Smith et al., 1997).

The analysis began with reading and rereading the transcripts repeatedly to gain an understanding of the entirety of the participants' experiences. The transcripts were in my possession. During this time, comments and notes were taken that reflected an increasing understanding of the patterns, words, and thoughts that were observed

(Shinebourne, 2011). Each transcript was read separately and analyzed as a standalone document. During this time, initial codes were identified and named. A code is a short descriptor connected to a word, phrase, or block of text. Once the initial review of the document completed and codes were created, initial themes were identified for that document (Larkin, Watts, & Clifton, 2006).

During this process, coding was conducted on a variety of levels, including (a) descriptive, (b) linguistics, and (c) conceptual (Larkin et al., 2011). The first level coding was employed to identify descriptive comments regarding emotional responses, key phrases, explanations, and descriptions (Smith, 2004). The next level was a review of any linguistic comments to better understand the context in which the language is used (Smith et al., 2009). This can include participants commonly used words and phrases, as well as technical terms or slang (Smith et al, 2009). During the final level of analysis, I employed conceptual commenting, where interpretation from the transcript occurs. At this point, I organized the codes into themes and completed the analysis of the transcript. This process occurred with each transcript.

Once transcripts were analyzed, I gathered the transcripts for an analysis across participants. At this point, I identified superordinate themes, prioritized data, and focused on themes that represented the experiences of the participants of the study (Smith et al, 2009). Themes were not solely chosen by prevalence; instead, factors including richness of information, illumination, novel thoughts or ideas, and increased depth of knowledge were employed to make decisions about the creation of themes (Smith & Osborn, 2007).

As part of this process, I employed Heidegger, Stambaugh, and Schmidt's (2010) adaptation of the hermeneutic circle (or double hermeneutics) to interpret experiences systematically based on answers from multiple perspectives (e.g., the first person, the second person, third person). The process allowed an exploration of the data from various points of view, including some cultural perspectives. Once the final themes were developed, I reported them in narrative and figural fashion and organize them by research questions. Any discrepant cases were discussed. Themes that applied to both research questions were reported in a separate section as overarching themes.

Issues of Trustworthiness

Credibility

Anderson (2010) argued that when performed correctly, qualitative research is "valid, reliable, credible, and rigorous" (p. 22). As Rolfe (2006) explained, validity in qualitative research is referred to by a variety of nomenclature, including the term credibility. Credibility refers to the degree to which the results reflect the true and accurate experiences of the participants. A study is credible when the findings presented are sufficiently accurate in description that an individual with similar experiences would readily express recognition of the presented phenomenon (Krefting, 1991). I established credibility for the research findings through member-checking, reflexivity, prolonged engagement, and saturation.

Member checking occurs when a qualitative researcher presents a summary of the completed analysis to participants and invites them to provide feedback and corrections concerning the accuracy of the description of their lived experiences (Lincoln & Guba,

1985). By completing member checking, I gave the participants an opportunity to add or delete information from the interpretation and offer their opinions. This was an excellent opportunity to receive additional information that could be stimulated by the participants' review of the completed material, which were incorporated as appropriate.

I exercised bracketing, to cast off personal biases and experiences, and to examine the data from a more objective and unbiased perspective (Moustakas, 1994). Bracketing is a process whereby researchers identify any biases or preconceptions to more accurately understand the participant's responses (Tufford & Newman, 2012). To engage in bracketing, I kept a field log where I could note any observations or ideas that occurred during the data collection and data analysis processes. Through keeping this record, I tracked and noted any preconceptions to mitigate any biases that could skew the interpretation. This enabled me to be reflexive about responses to the interview protocol. Reflexivity is of great importance to ensure that the study's findings and concluding statements do not stem from researcher biases.

Saturation increased the credibility of the findings of the study by ensuring that the identified themes were confirmed sufficiently by the data (Morse, Barrett, Mayan, Olson, & Spiers, 2002). There are two different types of saturation, thematic saturation and theoretical saturation. Thematic saturation occurs during the data collection process, where a qualitative researcher collects data until there are fewer surprises in the resulting data and no more themes emerge from the data (O'Reilly & Parker, 2012). Theoretical saturation occurs primarily in grounded theory, where the categories' differences and relationships are explored in a full and detailed manner (O'Reilly & Parker, 2012). Since

I conducted an interpretive phenomenological analysis research study, thematic saturation was employed.

Transferability

Transferability refers to the ability to generalize the findings to other contexts. Several researchers have argued that generalization is not a relevant concern in qualitative research because qualitative studies aim to describe a unique phenomenon or experience, rather than generate broad generalizations (Krefting, 1991). Thus, the degree of transferability of the findings is determined by the reader. Through the provision of thick and detailed description, the reader can make personal judgments concerning the ability of the study's findings to be transferred and applied to other settings (Krefting, 1991). Thick description occurs when a detailed and thorough account of the data collection process and activities is generated, to provide a thorough description of a phenomenon (Lincoln & Guba, 1985). This offers the most depth in making explicit connections between cultural and social relationships to provide a context. As I conducted the interviews, I encouraged thick description to increase the transferability of the study results.

Dependability

Dependability refers to the extent to which the findings are consistent. I enhanced dependability using triangulation and an audit trail. There are four different types of triangulation: methodological triangulation, triangulation of sources, analyst triangulation, and theory triangulation. Methodological triangulation uses multiple different data collection methods to check the consistency of the findings (Lincoln &

Guba, 1985). Triangulation of sources employs multiple sources of information to form a more reliable, impartial, and accurate depiction of reality (Cho & Trent, 2006). Analyst triangulation makes use of multiple analysts to review the findings to highlight blind spots in interpretive analysis (Lincoln & Guba, 1985). Theory triangulation utilizes multiple theoretical perspectives to examine and interpret the data (Lincoln & Guba, 1985). In this study, I used the triangulation of sources since the responses from multiple participants produced a composite narrative, and during this process the individual experiences were compared and contrasted. Themes do not emerge unless triangulation occurs. I provide a transparent description of the research steps to keep an accurate record of what was done in an investigation (Lincoln & Guba 1985). By giving rationale and reasons for pattern recognition during data collection and data analysis, I provided a detailed outline where other researchers can replicate the study and find consistent themes. Because I used both thick description and prolonged engagement, I had a responsibility to record the social setting in sufficient detail, which made the creation of an audit trail an appropriate technique to ensure dependability.

Confirmability

Confirmability refers to the degree to which the findings reflect the participants' overall meaning and intention, rather than those of the qualitative researcher. Confirmability was enhanced using reflexivity, which refers to the continual examination of a qualitative researcher's impact upon the development and construction of knowledge (Malterud, 2001). Because a qualitative researcher is the primary instrument which all data move through, the technique of reflexivity allowed me to acknowledge and record

potential researcher biases in the field log. I examined the ways in which personal experiences and biases affected the research process. Through use of bracketing, personal biases were set aside to examine the data from a fresh and open perspective.

Ethical Considerations

I obtained Institutional Review Board (IRB) approval from Walden prior to data collection The IRB approval number is 12-08-17-00418. I recruited participants through snowball sampling and gave all participants a copy of the informed consent form. I obtained informed consent from all participants prior to collecting data. To ensure this present study met Walden University's IRB ethical standards, participants had to be over the age of 18 and sign the informed consent before the study interview commences. I explained withdrawal steps in the consent letter and reiterated that the study was completely voluntary; no consequences or penalty were given if participants decided to exit. If a participant initially agreed, then rescinded their consent, I removed and destroyed the collected data pertaining to that participant. The responses were confidential, and I did not use any identifying information in the present study. Instead, I assigned either pseudonyms to each participant, which only I knew. All print and digital data are stored in a secured location that only I will have access to for five years, after which, all files will be destroyed. Digital data are secured on a password protected computer and print data will be stored in a locked file cabinet in my home office, to which no one has access.

Although I worked at PIMC for 3 years as a child and adolescent therapist and no longer have any role with Indian Health Service organization, I did not ask any current

therapists or psychologists from Phoenix Indian Medical Center Behavioral Health Department to participate due to avoiding any potential conflicts of interest.

Summary

In this chapter, the research design and the rationale for selecting that design, followed by an in-depth look at the role as a researcher within this study was discussed. Next outlined was the research method—specifically, the participant selection logic and instrumentation—which was proceeded by the procedures for recruitment, participation, and data collection. This is to provide a comprehensive and exhaustive review of the proposed research study and the procedures that will be put in place. An in-depth discussion of that data analysis plan followed, which included a description of comparative framework analysis. A discussion of the issues of trustworthiness was included, breaking down within each section what technique will be used and the rationale for why that was selected. Lastly, a discussion of the ethical considerations that must be considered when conducting qualitative research on human subjects and how it will protect the participant's identity was presented. The resulting analysis will follow in Chapter 4, where a comprehensive breakdown of the data analysis process will provide a succinct rationale of the choices and decisions.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to understand the lived experiences of Native American therapists who use DBT with Native American populations. As such, one central research question and three research subquestions drove the data collection and analysis for this study:

Central Research Question: How do Native American therapists describe their experiences of using DBT with the Native American populations?

Research Subquestion 1: Why do Native American therapists view DBT as being culturally appropriate with Native American clients?

Research Subquestion 2: How do therapists describe the effectiveness of DBT as a treatment approach for Native American clients?

Research Subquestion 3: What treatment barriers or challenges have been identified by therapists using DBT with Native American clients?

In this chapter I present the findings of this research study. I begin by providing a description of the research setting and the participants' demographics. Then, I discuss the process of data collection and analysis, including how I established the trustworthiness of this research study. I then present the results and conclude the chapter with a summary of these results in relation to the research question and subquestions.

Setting

The interviews took place on reservations and in urban areas of Arizona. The interviews were conducted in private locations that were mutually convenient to the

researcher and participant, such as participants' private offices. I interviewed eight participants, and interviews lasted approximately 1 hour each. Before the interviews, participants gave their informed concept and shared they were willing to engage and complete the interview. During interviews, participants did not share any personal issues that could be a distraction to the interview process.

While I interviewed participants, the challenge for me was to remain unbiased. I did this by limiting my responses and feedback to participants' answers. Some answers required more specifics and detail; therefore, I used probing questions. Some participants shared that, despite otherwise meeting qualifications for the study, they did not feel competent with DBT due to a lack of understanding the DBT model. Most participants displayed knowledge of DBT and felt that DBT was a great model to use. Some participants also asked for clarity about the questions, and some felt that some of the questions were redundant.

Demographics

Participants for this research study came from Native populations in the Southwest United States. This is a relatively limited population; therefore, I took extra precautionary measures to ensure the confidentiality of these participants. In this section, I present the participants' demographics broadly and without connecting educational background or licensure to participant numbers, to avoid possible identifying characteristics.

The eight participants included five women and three men. All had master's level education in social work, substance abuse, and professional counseling. One participant

was in the process of obtaining a doctorate in counseling psychology. As for licensure, some had independent licenses in social work, counseling, and substance abuse. Some also had associates licensure in counseling and social work.

All participants were enrolled with federally recognized tribes in the United States. To maintain confidentiality, those tribe names are omitted. The professional field of the southwest Native American population is small, and I took care to maintain confidentiality and privacy of the participants, so that they were not identifiable.

Data Collection

I interviewed eight participants from locations throughout the southwestern United States. Interviews lasted under an hour. I interviewed participants individually at their offices or in another private location free from interruption. Doing so ensured that participants were able to concentrate and focus during the interviews. Participants consented to being recorded with a digital recorder, and once recorded, interviews were transcribed by a transcriptionist who signed a confidentiality form. Data will be uploaded to NVivo software for organization of data.

After bracketing a few of the participants, I noted my thoughts on how much knowledge each participant had with DBT. As I did not want to interfere with participants' knowledge and experience with DBT, I avoided discussing with them my own ideas of DBT. At times, participants discussed how DBT was confusing or that they felt they were incorrectly practicing DBT. However, I avoided teaching or telling them my own thoughts regarding their use of DBT, to ensure they were discussing their own experiences

Data Analysis

IPA is a reductionist process whereby the researcher tries to understand the experiences of participants from their viewpoints (Smith et al., 2009). Smith et al. (1997) suggested a specific process for IPA to provide a detailed account of the data analysis steps for the reader and to enhance understanding of the interpretation of the data. The data analysis began with a full review and thorough reading and re-reading of interview transcripts to familiarize myself with the contents of each. In this first level coding, I analyzed each interview as a standalone document. I moved line-by-line through each individual transcript making notes to myself and highlighting words, phrases, or passages of text relevant to the research questions. In the second level of review, I searched through each transcript looking specifically for linguistic comments such as commonly used words and phrases, highlighting these (Smith et al., 2009). When I completed these two levels of analysis, I moved to the third and final stage of analysis: conceptual coding. At this level, I began organizing the codes from levels one and two into larger themes based on shared descriptive and linguistic features

After I completed this analytic process for the individual transcripts, I performed further analysis across all transcripts. As I did this I compiled the themes generated from the individual interviews, searching for commonalities and shared meaning. I categorized these themes based on similarities, generating the superordinate themes, as Smith et al. (2009) suggested. These superordinate themes were created based on the richness of information and depth of knowledge contained within what I began to supporting themes (Smith & Osborn, 2007). This hierarchy of superordinate and supporting themes is

presented below, as is the number of participants who contributed statements leading to the generation of these superordinate and supporting themes.

Superordinate and Supporting Themes

Superordinate theme	Supporting theme	Participants
Theme 1: Cultural understanding	1a. Native therapists understand generational trauma	3 (P2, P5, P7)
	1b. Native therapists understand unique tribal backgrounds	3 (P2, P5, P6)
Theme 2: Useful aspects of DBT	2a. Mindfulness and wise mind	3 (P4, P5, P7)
	2b. Emotional regulation	4 (P1, P3, P6, P7)
	2c. Targeting the population	3 (P2, P4, P5)
Theme 3: Challenges of DB in Native American populations		6 (P2, P3, P4, P5, P7, P8)

During the data analysis, discrepant case surfaced. One participant met the inclusion requirements and had been trained in the use of DBT and had employed it but had not found it useful for Native American clients and had since stopped using it. This case will be discussed in the results section of this chapter as it provides a counterpoint to other participants' perspectives on the use of DBT for Native American clients.

Evidence of Trustworthiness

Credibility

Practicing accuracy when conducting qualitative research is a form of credibility (Anderson, 2010). This means the data are an accurate measurement of participants' experiences (Anderson, 2010). The accuracy is established when the research findings are verified through transcript review, bracketing, prolonged engagement, and saturation. I used member checking to allow participants to add feedback and corrections to their interviews, therefore their opinions can be viewed more accurately (Lincoln & Guba, 1985). Bracketing helped me reduce personal biases when collecting data (Moustakas, 1994). Through this process I was able to identify any potential biases or perceptions to ensure participants' responses were accurate (Tufford & Newman, 2012). I also established thorough saturation of the data, which increased credibility (Morse et al., 2002). I used thematic saturation, which occurs when further data collection attempts, like more interviews, fail to yield novel ideas and concepts from participants (O'Reilly & Parker, 2012).

Transferability

Transferability is when research findings can be generalized to other frameworks. The findings should be descriptive and detailed such that readers can make explicit connections between cultural and social relationships.

Dependability

Dependability is when the findings are established as reliable. To establish dependability of the data in this research study, I used source triangulation. Triangulation

of data sources takes multiple sources of information to form a credible, accurate, and impartial depiction of reality (Cho & Trent, 2006).

Confirmability

Confirmability is established when participants' views reflect their intentions and meanings without any interference from the researcher's questioning. The researcher is the main instrument when data is collected, observed, and interpreted, therefore the use of reflexivity through bracketing limited the researcher's influence. Reflexivity is a practice of excessive examination of the researcher's impact when collecting data (Malterud, 2001). By using bracketing, confirmability enhanced the accuracy of what the participants stated and did not allow any researcher bias when collecting data (Malterud, 2001). I used reflexive journaling to bracket my experiences before, during, and after interviews when reviewing interview notes. During data collection, I practiced being mindful with personal views that might be different from participants' views. At times, my views were not the same as participants' views regarding the use of DBT. Therefore, I noted the difference, journaled the experience, and continued interviewing so as not to allow bias to interfere with the interview process. Using techniques like bracketing set apart my personal biases from the data collection and analysis processes.

Results

The data analysis yielded three superordinate themes:

1. Cultural understanding
2. Usefulness of DBT
3. Challenges of DBT for Native American populations

Superordinate Themes 1 and 2 contained supporting themes while Theme 3 did not. Superordinate Theme 1, cultural understanding, comprised the supporting themes Native therapists understand generational trauma and Native therapists understand unique tribal backgrounds. Theme 2, usefulness of DBT, contained three supporting themes: mindfulness and wise mind, emotional regulation, and targeting the population. Superordinate theme 3 contained no supporting themes.

Superordinate Theme 1: Cultural Understanding

Participants stressed the importance of Native American therapists working with Native American populations. As Native American therapists using DBT and other treatment modalities, participants recognized that their Native American clients required someone who understood the unique experiences common to Native American populations but who also recognized the heterogeneity that exists within this group. They shared concerns that non-Native American therapists were not acquainted with these experiences and that even if they possessed knowledge of the Native American experience, they had not themselves experienced it. Participants believed that this shared therapist-client experience was essential for building rapport no matter the treatment modality. Participants felt Native therapists could understand the generational trauma that Native populations have endured, as well as their unique tribal backgrounds. As such, two supporting themes established this theme: Native therapists understand generational trauma and Native therapists understand unique tribal backgrounds.

Using terms like “imperative,” “extremely important,” “extremely helpful,” and “need,” participants shared the belief that non-Native American therapists simply could

not understand what it was like to be a Native person, no matter how well-informed or well-intentioned. Though P1 knows a White mental health provider who has worked very well on the reservation with Native American clients, "it is definitely better to have some understanding of the culture and to be respectful of it," P1 reported. P1 continued that this understanding of the culture meant a shared understanding of:

> the past and ongoing struggles, the family structure and how elders are viewed, the vast diversity from one tribe to another, sensitivity to the experience of growing up on a reservation, and checking assumptions based on stereotypes (we all get casino money and handouts).

P4 also found that Native American clients worked best with Native American therapists because these therapists best understood the culture. P4 also believed that while Native therapists were important, Native clients often benefitted from a Native therapist who came from outside the client's immediate community. "It could be a benefit for them," P4 said, "because some folks don't want to talk to anybody from their community or their tribe because of confidentiality, a lot of fear, anxiety, and lack of trust there." Instead, using a therapist who operated in the space between being an insider and an outsider was the most beneficial, according to P4.

P7 drew on personal experience as a client with a non-Native therapist to underscore the value of Native therapists for Native clients. P7 sought therapy as a college student from not only a non-Native therapist, but someone with whom s/he had little else in common as well. "I really felt that she had a hard time relating to me," P7 stated. "We just had a hard time connecting and establishing trust, so within the three

visits, I stopped the counseling. I didn't feel like it was very effective," P7 said. P8 also felt that Native clients cared that their therapists were Native. "I think it matters to my clients and I don't look Native," P8 said. P8 thought that not looking Native indicated an outsider status to those clients, despite clients' knowledge that P8 is of Native background.

In Participant 5's experience, non-Native therapists were unwilling to learn about the culture and history of the Native groups they worked with. "If you have a Native population, you should have a Native practitioner there," P5 stated. P5 believed that having a Native mental health provider was critical because outcomes and diagnoses were reliant on how the providers understood the context of the mental health concerns with which Native clients presented. As an example of this, P5 shared:

> [Non-Native therapists] view [Native clients] as borderline behavior because they're acting out, they're violent, they're doing different things, they're self-harming . . . But when you put the pieces together, you realize it's because they've had extensive history of abuse. And so, they're acting out behaviors as adults and the dysfunctions are even worse.

For accurate diagnoses, having a Native American mental health provider was critical because without the shared understanding of the culture, patients may be misdiagnosed, which could lead to incorrect, and perhaps harmful, treatment modalities and approaches.

P6 shared a similar experience, relating how non-Native therapists may miss important aspects of a Native client's behavior or focus too heavily on other aspects due to a lack of cultural knowledge. P6 described how without an understanding of the

culture, “a lot of clients may be seen as being psychotic,” when those behaviors are, in fact, related to spiritual beliefs. P6 also shared P5’s concern about misdiagnosis of borderline personality disorder, recognizing that the symptoms could be difficult to tease apart from other disorders or the impact of substance abuse. Understanding the culture, background, and history of Native populations was critical for making the right diagnosis for patients, and critical for understanding how DBT could be an effective treatment modality with the correct diagnosis. In other words, DBT is useful but must be applied to correct diagnoses, which may not be possible for a non-Native mental health provider to make given the lack of cultural understanding.

Native American therapists not only understand the history and the culture, but the structural barriers that life on a reservation imposes on Native American clients. The barriers presented real and tangible challenges to effective DBT treatment for Native American clients because of the requirements for proper DBT application. According to Participant 2 (P2), the DBT manual asks if clients can do activities like going to the movies and playing sports, those activities that might provide a pleasant distraction from those concerns for which DBT is being provided. Whereas a Native therapist would understand that barriers such as lack of transportation access could make participating in these activities nearly impossible, a non-Native therapist would not intuitively know this. Lack of transportation can also present a barrier to therapy sessions, which can interfere with DBT specifications for regular, frequent meetings with the therapist.

Recognizing the heterogeneity that exists within Native American populations in North America was another aspect that participants touched upon regarding the role of

Native American therapists. (P3) felt that Native American therapists were best for Native American clients and especially when using DBT. According to P3,

> I think it's important because it, just like any ethnic group, I think there's an advantage in terms of knowing where the individuals are, in terms of possibly the nuances in terms of the culture, the language, aspects of reservation versus not reservation, you kind of know the different demeanors, how they react.

Furthermore, P3 is a Native therapist, and having to "educate myself in terms of the different tribes that are from here," because, "underlining we're all Native people, but culturally, there's difference in terms of their demeanor." Recognizing these cultural differences that exist within and between Native tribes had implications for using DBT as a treatment for Native clients, because DBT could be modified based on these differences. P3 recognized that certain DBT activities, such as mindfulness, would work better in some tribes and not in others. P2 felt similarly, acknowledging the cultural variation that exists within one tribe that non-Native therapists might not recognize. "There's wide variance," said P2. "Not all of us are traditional. Some people are not even traditional, if some people don't even embrace the Christian values," P2 continued. P2 stated people forget all the time that this variation exists and said DBT fails to work when it is applied "mechanically" as a treatment, meaning perhaps when DBT is applied in the same way without consideration for this variation.

P5 also noted how important understanding the differences between tribes was for Native American therapists. P5 stated that, "for each tribe it's different, because the types of trauma each group of people have been through is very different." P5 found this

challenging for DBT treatment because some of DBT was not "specifically formulated" for working with Native clients.

Supporting Theme 1a. Native therapists understand generational trauma. P5 believed that therapists with an understanding of Native American populations are better suited to the treatment of the unique trauma that Native people have incurred. As a Native therapist, P5 focuses on working through this trauma with her/his Native clients. "When I read into the Native population, it's usually been numerous instances of abuse. And it's typically lasted over years during developmental years of childhood into adult years," said P5, "which is why I brought up the focus on trauma because if we can understand. . .and for each tribe it's different because the types of trauma each group of people have been through is very different." That trauma may be related to Catholic school abuse or abuse incurred at a military-style boarding school or may be trauma related to substance abuse in the community or the home. Therapists employing DBT must be sensitive to these traumas, which come from having a greater understanding of the unique trauma historically inflicted on and experienced by Native people.

One reason why having Native therapists for Native clients is because they possess knowledge of Native trauma. "The history, we have multiple trauma, generational trauma, and so we have to take a lot of that into consideration when you're working with individuals," said P7 Being Native American, according to P7, "is really important because we have an understanding of. . .the multiple traumas and Indian people, and the history that we have, and being able to really empathize and understand that is so important."

P8 is a therapist who works primarily with Native clients and their substance abuse problems. P8 has the most experience with Native American clients who have PTSD or other trauma, like historical and personal. “Historical trauma is just being Native, and we’re talking generation after generation,” P8 said. P8 continued:

> So, my opinion on that is so when somebody tells you about the trauma that happened three generations back . . . it’s almost as if it happened to you. I could tell you about the long walk. . . No, I wasn’t there. But I feel like I was there because I was told all of this stuff over and over and over again. That’s historical trauma.

Supporting Theme 1b. Native therapists understand unique tribal backgrounds. One aspect of treating Native American clients that participants believed was important to recognize was the heterogeneity contained within Native tribes and populations. Part of being attentive to the unique cultural background of Native people was recognizing the wide variation that exists within each tribe and between the tribes, because this variation has implications for appropriate treatment modalities. According to P3, this related directly to the significance of having a Native therapist for Native clients. P3 said:

> I think just a basic understanding of their ideas, concepts, their norms. You know, for myself, coming from Navajo down here, I’ve had to educate myself in terms of the different tribes that are here, Salt River, Gila River, and obviously, underlining we’re all Native people, but culturally there’s differences in terms of

> their demeanor, so I think it's important for me knowing, being native, but I need to learn what culture and differences there are.

P5 noted that each tribe was different, and therapists must be cognizant of these differences. According to P5, any therapist working with Native clients should take the time to get to know the specific population they work with. "To go and check out some of these environments . . . as a therapist that's a big deal to me," said P5 of the importance of understanding the unique context in which the individual and tribe lived. Similarly, P6 stated that Native populations were unique, and "we have to take that into consideration, as well."

Superordinate Theme 2: Usefulness of DBT

Participants who were trained on the use of DBT and had experience providing this to their Native clients felt that it was useful and helpful. Many aspects of DBT, with some modification, were particularly helpful for the Native clients of Native therapists. These included aspects like mindfulness and focus, where clients could work through emotion regulation. Participants also suggested that DBT was more effective as a treatment modality for adolescents, though others used it with good efficacy with their adult clients. Some participants had mixed views on the effectiveness of DBT. P1 recognized that "patients who have been through DBT [are] very highly skilled in regulating affect," but found that other Native American patients do not express a lot of emotion, making DBT a challenging therapy practice with these patients.

P2 thought DBT was well-suited for use with families. P2 stated:

> What's worked well with me is the ability to work with the family. To be able to work with the family, because I know that a lot of the adolescent Native American youth that I work with, it seems as though they're not really well informed what the child is doing there, and exactly what we're doing for them. So when we meet up I will tell them that I'm going to try and clarify something.

Supporting Theme 2a: Mindfulness and wise mind. DBT as a treatment modality offers one aspect that participants found particularly useful for Native American clients, that of mindfulness and the wise mind. They felt that these concepts were congruent with many Native spiritual beliefs and, therefore, easy to apply when treating their Native clients. "One thing that I feel works well is the concept of the wise mind. Rational mind," said P2. P2 used this concept with Native clients:

> What I would do is I would reiterate what it really means. Kind of break it down a little bit and I guess the wise mind in a sense could represent the elder . . . I would have them describe, "what are the qualities that you like about the elder? What exactly is it that you think makes them a leader?" Then they would identify certain things about their uncle or somebody like that. The healthy person in their family.

P2 also believed that when applying DBT to Native clients, therapists must be conscientious of the fact that they need to explain what they are doing and why to the clients. "Teach coping mechanisms, do this mindful breathing, mindful walking

approach," P2 said, "We don't really fully explain to them exactly why and what we're doing that for."

P4 saw similarities between mindfulness and Native sweat lodges, a traditional Native spiritual practice. "Another thing that I found . . . was spiritual and cultural counseling and those traditional healing approaches are much, much more powerful than any clinical application that we could ever provide," P4 said. P4 continued, sharing about Native clients:

> Sometimes they just go to a sweat lodge where they would have a little assignment to sit on a blanket and look up at the birds, look at the breeze, feel the sun on their arm. It's kind of a ground mindfulness activity where they'd be involved in a sweat, do some prayer ties or something. Then they'll come out and they have this awakening and they kind of have a breakthrough and, "I need to talk to my mom. I need to tell her something." Whether it was some kind of abuse or something that happened or something they'd been keeping in, repressing.

P5 also believed that there were many ways in which DBT dovetailed with Native American spiritual beliefs, particularly in terms of mindfulness. P5 shared, "I think mindfulness and meditation just because it's so important . . . body scan, some of these other techniques. I think those are very important." P5 felt that these were very important because they were so similar to Native spiritual practices with which Native clients were already familiar. P5 stated:

> I think any kind of mindfulness and meditation, I feel like it's helpful in helping them be able to at least slow things down and kind of bring things

> down. Partly because as a Native person, understanding the peace that comes into our culture, and so a lot of these practices, when it comes with DBT, I think of eastern medicine practices and how much meditation is big in a lot of eastern religions or practices. And I can probably identify more with that because DBT borrows a lot from that because those are indigenous practices from those areas.

P5 thought that these DBT practices were helpful for her/his Native clients because they related to concepts of culture and harmony, and the notion that the physical, mental, and spiritual must be in harmony.

Despite some of the rigidity inherent in DBT, P6 felt that mindfulness could be very easily incorporated into treatment of Native clients. "That mindfulness and how DBT philosophy is really, really centered with our . . . and really tie that in with the Native American belief system," P6 said. P6 believed making these connections between DBT concepts and Native American beliefs for Native clients was helpful when clients felt lost and sought help, because therapists could help them remember how calming the mindfulness is. P7 also believed mindfulness was an important component of DBT and acknowledged that while not all components of DBT were of use with Native American clients, mindfulness and mindful activities were very helpful.

Supporting Theme 2b: Emotional regulation. One useful aspect of DBT when applied to Native clients was that of emotional regulation. In working with Native American youth, P3 found emotional regulation skill-building helpful because often youth did not know how to do this. P3 stated, "I think the skill building coping strategies

work well . . . for some of the youth, lessons, these are skills they might not have been exposed to, or they might have just learned, just emotional regulation, any of that. . .” According to P3, these emotional regulation skills were also effective for suicidality in clients. P3’s experience using DBT with Native American clients was such that in times of crisis, emotional regulation was helpful. P3 shared:

> When I’ve had a crisis call or responded, those skills are there. The emotional regulation, helping explaining these emotions, reverting to those key [aspects] of DBT. Of skill building, coping, mindfulness, all of those play into responding to a suicide crisis event.

Despite reporting limited experience using DBT with Native American clients, P7 has been able to draw on DBT concepts when treating clients. P7 stated, “I’ve been able to use bits and pieces of DBT like the mindfulness and emotional regulation.” P7 acknowledged being impressed with the emotional regulation component of DBT and found it helpful with clients.

P6 has also draw on the DBT concept of emotional regulation with Native American clients, and reports implementing “DBT in my [Native] community.” P6 described her/his interest in using an intervention that dovetailed with the community and found that in DBT. P6 felt that the issues in the community related to identity, stating:

> We don’t even understand who we are as individuals, as Native Americans. And the identity piece was really critical for me to kind of integrate into that type of therapy that I wanted to do. As well as the cognitive deficiencies and the emotional regulation, dysregulation, that they were suffering from.

Supporting Theme 2c: Targeting the population. Participants were in some disagreement as to which populations were better supported through the use of DBT, adults or adolescents. P2 and P3 found youth showed improvement when being treated through DBT. P2 started doing DBT primarily with adolescent psychiatric children. P2 extends this practice to the family level, because DBT helps treat the whole family when an adolescent is psychologically unwell. For P2, DBT is appropriate to bridge the disconnect between an adolescent and their parents. “I know that a lot of the adolescent Native American youth that I work with, it seems as though they’re not really well informed of what the child is doing there and exactly what we’re doing for them,” said P2.

P2 provided an example of a child who is engaging in self-harm and cutting, a scenario in which parents might assume the child is suicidal when, as P2 acknowledge, these are two different things. Despite the success P2 has had with DBT and Native American adolescent clients, P2 acknowledged that in cases where DBT is used for treating personality disorders, this can be a challenge for youth because a correct personality disorder diagnosis cannot be made until the child is 18 years old. P3 felt that DBT had useful aspects but that these were better suited for adults. P3 described the challenge of group DBT therapy for youth who are not always willing to participate in group discussions.

Superordinate Theme 3. Challenges of DBT for Native American Populations

Participants recognized challenges inherent in DBT as a treatment modality for Native American clients, even those participants who used DBT regularly in their

practice. One participant reported no longer using DBT with clients, which will be discussed separately as a discrepant case. The challenges that DBT presented when treating Native clients stemmed primarily from the fact that DBT lacks flexibility for adaptation to different populations.

DBT is relatively inflexible as a treatment modality and therapists to follow its guidelines closely. As a result, participants believed this rigidity to be a challenge for treating Native clients. Some participants ignored these guidelines, modifying useful aspects of DBT to help their clients, but recognized that this was no longer true DBT as prescribed by the treatment approach. P2 was cautioned by a supervisor not to "diverge too far from what the theoretical structure of DBT really is." As P2 stated:

> That's a huge danger, that we deviate from what DBT is supposed to do and we're trying to kind of do our own little thing that we think might be helpful. That usually occurs when I'm trying to be multiculturally competent with native clients and trying to differentiate the difference between tweaking it, modifying it just a little bit, but sticking with the same concepts, and so as to make it work with Native America clients. Differentiating that approach from actually, am I all out just straight up changing the treatment? Treatment modality?

P2 recognized the danger in this grey area while simultaneously acknowledging that DBT should be helpful in multicultural settings even if it requires some adjusting. However, P2 also felt that other than making DBT more multicultural, there was little to change about the approach. This was because of P2's perception that contemporary or younger Native people were less isolated from "mainstream Western values." According

to P2, “95% of the Native American patients that we treat, they’ve grew up in the city life. It’s not, there’s really not much to be changed to be honest with you.” P2 did not think much DBT modification would be required “unless all of a sudden we just had this crazy influx of 60- or maybe 70+ aged individuals that are coming in . . . that are just completely traditional in lifestyle.”

A change that P3 would make to DBT for Native clients would also be “revisiting the strictness in terms of compliance and having other activities that are more, maybe, tribe specific.” P3 recognized the rigidity of DBT treatment and said, “that could be probably one of those challenges.” P3 continued:

> I know they’re pretty strict in terms of following the individual curriculums, even in groups, and I think there’s a lot of factors, like I mentioned, various challenges of getting students to and from the facility. We have families that have to travel great distances and there’s some inconsistency. I know there’s contracts that if you miss two or three then you’re no longer part of it, so I think that weighs heavily on being less strict and more flexible with those situations.

For treating Native clients, this rigidity coupled with structural barriers to regular appointment-keeping creates a challenge for effective DBT treatment. If the DBT treatment schedule allowed greater flexibility, P3 believed Native clients would really benefit from this treatment modality.

P7 was also concerned about this rigidity required of DBT treatment and the barriers that Native clients may face when accessing treatment. P7’s experience of DBT is that “it’s very structured, it’s a very structured model, and I think, for our Native

American population, I think it's really difficult for our clients to have such strict guidelines." Because DBT requires that therapists not deviate from the model, DBT may be impractical for Native clients. P7 continued:

> I'll reemphasize that it's very structured and I don't always think, with our clients, that structure is conducive to . . . I think it might hinder, and it's my personal opinion, it might hinder the process in itself because if everything's structured and you're looking at the structure, structure, structure, and sometimes when things are so structured, you can't see things on the bigger picture.

If P7 could change one thing about DBT, it would be to change the structure required of the approach. "I suppose if DBT was to be effective you would need that structure and, again, for our Native American patients . . . I think we need to tweak it just a bit where it can take into consideration the culture and the background of the individual," said P7 This flexibility would provide Native clients with the best fit because it would allow for cultural adjustments.

According to P8, DBT was "not very good" for use with Native clients. This was "because DBT is using the phone and keeping in constant contact with the therapist too. No, they don't want to do that. Not effective. Not with Natives. And I'm not really up for that either," P8 declared. P8 also felt that the lengthy process required of DBT was a challenge for Native clients because they may not "see progression as quickly as maybe some other things," and so this inflexibility makes DBT an inappropriate therapy method.

Discrepant Case

One discrepant case emerged in the data collection and analysis. P1 was trained on and used DBT with Native clients in the past but no longer used this approach. P1 agreed with other participants on some aspects of DBT use and the importance of Native providers for understanding Native clients. However, P1 believed that core tenets of DBT such as mindfulness and wise mind did not work in Native populations. “I’ve tried to use some DBT skills with a NA client,” P1 said, “but there is a stoicism among NA people that did not blend well with the concept of wise mind, etc.” P1’s experience was that Native clients showed little emotion. This ran counter to statements other participants shared about DBT concepts as congruent with Native beliefs.

Summary

Participants described mixed experiences with using DBT to treat Native American clients. While Native American therapists agreed that there were useful aspects of DBT, there was lack of consensus as to what extent DBT helped their Native clients. On the whole, participants shared positive experiences using DBT in practice, but these positive experiences came with caveats. While aspects of DBT like mindfulness and wise mind, and emotional regulation, were very helpful for Native clients, the rigidity required of therapists employing DBT hindered progress that patients might make. Deviating from DBT guidelines means that a therapist is no longer using true DBT, and the positive experiences reported by participants were usually tied to culturally specific modifications of DBT; therefore, participants did not always believe they were using DBT with the modifications they made. Participants who were willing to overlook this and did believe

that they were using DBT even with modifications believed that this could be a culturally appropriate treatment modality for Native clients. This was particularly true in the case of Native adolescents and those who identified less with their Native cultural background and more with mainstream American society, regardless of tribal affiliation.

In Chapter 5, I will discuss these findings in greater detail and in relation to the literature. This will include a discussion of the applications of this research study. Chapter 5 will also include a discussion of the recommendations for future research on this topic, grounded in the findings of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

DBT has proven to be effective with treating many clinical disorders, including reducing or eliminating suicide or self-harming behaviors. Because Native Americans have had high rates of morbid pathology disorders such as depression, PTSD, and suicide behaviors, Native Americans need treatment models that have efficacy with treating suicide behaviors (Kinsey, 2014; Kinsey & Reed, 2015; Morris, 2011). Researchers also shared the need to have culturally adaptive treatment programs when treating Native Americans (Morris, 2011; Wexler & Gone, 2012). However, a review of the literature revealed that no researchers have assessed Native American providers' experiences when treating Native American clients. After being trained in DBT, I wanted to research other Native providers regarding their experiences when using DBT among Native clients.

Therefore, I developed a qualitative study to analyze Native American providers' experiences using DBT. Semistructured interviews with eight Native American providers were the source of data for addressing the central research question: How do Native American therapists describe their experiences of using DBT with the Native American populations? The results revealed three themes: cultural understanding; usefulness of DBT; and challenges of DBT for Native American populations. In Chapter 5, I discuss and interpret those findings, which are related to the question of the research. This chapter will share the limitations of the qualitative study, and possible recommendations for future studies. Finally, implications of the study are discussed, which leads to the conclusion of the study.

Interpretation of Findings

Interpretation Based on Previous Literature

Based on previous literature, it is important to have Native Americans share their views on what has worked and not worked when using treatment models among Native clients. Bennett and Babbage (2014) shared how minorities have had little input sharing what has been effective. Morris (2011) stated that Natives have insight into their culture and the participants in this study shared that insight. The present study was based on the premise that such unique insight can show how DBT has worked and its challenges with the Native population. The findings revealed a lack of consensus on how DBT helps Native clients, but participants shared positive experiences using DBT. What was confirmed in the study was knowing the culture, being Native as a provider, understanding generational trauma, and the uniqueness of diversity with different tribes.

The first major theme in the present study was cultural awareness. Participants shared that being Native when treating Native clients was important for building rapport, understanding the culture, and knowing the effects of stigmatization with diagnosis. Participants reported that Native American clients trust Native American providers, believing that they genuinely cared compared to a non-Native American providers. Participants also felt that they understood risk factors for Native American clients more than other providers. Participants, as Native Americans themselves, understood the struggles the clients faced, such as living on the reservation, language barriers, generational trauma, lack of resources, and the importance of using sacred traditions

within the tribes. These findings could help explain Thomason's (2012) findings that Native American clients preferred Native American providers.

By understanding the culture, Native American practitioners may also have a better understanding the effects of generational trauma such as suicidality factors within Native American communities. Cole et al. (2013) and O'Keefe et al. (2014) shared how Native Americans have different suicide motivations compared to other populations. Wexler et al. (2015) indicated a specifically indigenous understanding of suicide, which is expressed in historical, cultural, community, and family disruptions. Therefore, the present study supported the idea that culture is an essential consideration with respect to Native American suicide and its higher incidence (Wexler et al., 2015).

The second and third major themes involved the use of DBT. One pivotal finding of the present study was that participants indicated various effectiveness of DBT that related to tribe. Specifically, participants shared the uniqueness that each different Tribe has and it is important to know how each Tribes has different histories, cultures, and traditions when working with that community. One participant shared that DBT will need to be modified due to DBT being effective with some tribes and not with other tribes. Similarly, Beals et al. (2005) highlighted the need for precise studies among each individual tribe. The use of specific interventions and studies among different tribes avoids stereotyping and indicates the need for caution when generalizing Native American communities. This statement confirms the need for culturally sensitive therapeutic interventions when treating Native American communities (Clifford et al.,

2013; Gray & Rose, 2012; Kinsey & Reed, 2015; Morris, 2011; Wexler & Gone, 2012; Wexler et al., 2015).

Another confirmation in theme two was participants sharing modifying DBT can work well with Native clients. These skills were mindfulness, wise mind, and emotional regulation. For example, participants reported that the DBT elements of mindfulness, emotional regulation, and distress tolerance worked with Native populations by being able to adjust DBT to indigenous cultures. Participants saw how some of those skills are used by some tribes' extant traditional practices, such as sweat lodges and prayers. These findings about the usefulness of DBT among Native American clients were consistent with previous studies (e.g., Kinsey & Reed, 2015; Wexler et al., 2015). The idea of modifying DBT based on client needs is also not new; Thomason (2012) also stated that theoretical models can be adapted to the clients' beliefs.

The last superordinate theme was the challenges of DBT for Native American populations. A barrier with DBT that was shared by some of the participants was the rigidity of the program. This has caused some providers to modify and of whether the resultant, modified practice is true DBT. There was no previous research done on the barriers on DBT when being used on Native clients. The- closest to related literature was that previous literature stated using Western models' barriers where Western concepts such as solving problems, personal achievement, and treatment efficacy might disadvantage some clients who came from cultures with different values (Morris, 2011; Smith & Peck, 2004; Wexler et al., 2015). Therefore, the present study indicated some new challenges and opportunities for future study.

Interpretation Based on Conceptual Framework

Biosocial theory holds that negative behaviors result from both biological components and an invalidating environment (Fraser & Solovey, 2007). Under the biosocial theory, an invalidating environment is one where the individual feels disregarded, punished, or neglected (Fraser & Solovey, 2007). Native American clients have an invalidating environment with historical cultural trauma (Kinsey, 2014; Morris, 2011). For example, living on the reservation can impose barriers to treatment, showing invalidated environment. Some of these barriers are not having medical services such as psychiatric care, transportation, and other behavioral support services. These elements display invalidating environment factors.

This invalidating environment was confirmed in the findings that participants shared historical trauma with Native American clients. Further, the findings indicated that considering this trauma was an important cultural concept for practitioners in order to empathize with Native American clients and to fully consider their experiences. This study demonstrated strides towards understanding shared cultural trauma and whether and how it might influence care for clients, particularly those with Native American ancestry.

Another invalidating environment factor from the biosocial theory demonstrated in the data from the present study is not having Native American therapists among Native American clients. Native American providers can understand the mental health concerns with Native clients due to knowing the tribe's history with trauma, the uniqueness of each tribe, and their shared culture. Without this background, for example, a non-Native

provider who does not have any knowledge of the tribe's culture may lead to non-effective use of treatment models or further invalidation of a client's experiences. This lack of understanding may lead to ineffective choices regarding care. For example, a practitioner who did not understand the invalidating implications of cultural trauma might fail to make appropriate modifications to DBT, or to fail to choose DBT as a therapeutic approach. Overall, the findings of the study extended biosocial theory to the practitioner as an actor, particularly among Native American clients.

Limitations of the Study

Limitations were that some of the participants did not use the full model of DBT. For example, some practices, like clients calling their therapists during crisis or participants only using some of the DBT skills, were not consistent with DBT practice. Some participants did not have the resources to practice DBT such as having a DBT consolation team or resources like case managers. Participants failing to use all DBT elements may not fully represent the practice of DBT.

Another limitation was that participants came from different tribes and geographic areas. Participants variously grew up in urban and rural communities, and some previously lived on different reservations. Some participants were from the same tribe, but some shared growing up in traditional home to Christian beliefs. Living and being raised from different locations cannot speak or represent for all tribes. The results also may not generalize to a different geographic region of practice.

Some of the participants had some difficulty answering questions. Some shared some confusion with the questions and some did not feel confident in practicing DBT due

to not receiving enough training. The questionnaire for some had to be explained due to confusion such as “what has worked with Native clients?” That question had to be explained; therefore, it may be that other participants who did not ask for clarification did not understand the question. Participants also shared not feeling adequate using DBT due to only receiving a minimum of 8 hours of DBT training. This discomfort and lack of training might have influenced the results of the present study.

Recommendations

One recommendation would be to have more participants. Having more will gather more details with their experience and improve the amount of information that can be used in the research. Nielsen and Landauer (1993) stated 80% of information was used with six participants and when you reached to 12 participants, 90% information can be used. This study did achieve saturation, but having more participants would share more experiences and potentially provide additional information about DBT use among Native American clients.

A future study might focus specifically on providers’ view of the use of DBT for treating trauma and suicide behaviors among Native American clients. The present study did not elicit specifics on treating trauma and did not get themes on suicide treatment. A follow up study that particularly asked questions about suicide treatment, cultural trauma, and the use of DBT could potentially reveal whether and how practitioners modified DBT to reach clientele with these specific issues. The study might also provide essential information about suicide and generational trauma such as how much culture affects Native American clients having suicide behaviors (Wexler & Gone, 2012).

Future researchers might also examine DBT training hours and what qualifies a practitioner to be adequate practicing DBT. In training for DBT, I have heard from facilitators stating if not using all of DBT's model, then DBT is not being practice. If a practitioner receives eight hours of training, it might be that he or she is not adequately understanding the practice, and therefore might feel uncomfortable integrating it among clients or sharing practices, as indicated by participants in the present study. Alternatively, practitioners might overestimate their knowledge of DBT based on this limited training. As for the recommendation for future studies on this research topic, having providers who had more hours of training and been practicing DBT for certain amount of time should be considered in future studies.

Another recommendation would be a study on specifics on the questionnaire. These specific questions would ask Native American providers what questions to ask when assessing practitioners' experiences using Western models. Therefore, to gather themes on questions to use, I would also recommend expanding the research with other models such as eye movement desensitization reprocessing, cognitive therapy, and using traditional practices.

Implications

Positive Social Change

The study can spur positive social change by leading to more effective treatment among Native American population. Native American have been recorded to have high risks in many areas in mental health and using culturally competent models can improve treating ranges such as suicide intervention with Native American clients, families, and

communities (Wexler & Gone, 2012; Wexler et al., 2015). The findings of the present study may prompt organizational agencies to change their practices for treating Native American clients by reviewing cultural assumptions of traditional practice or adopting a model that allows for flexibility, like DBT. Further, practitioners might make culturally appropriate modifications for Native American clients and cultivate cultural knowledge to provide effective treatment and therefore address mental health issues within this population.

Methodological Implications

The study is important for both research and practice. The present research about best practices when treating Native American clients from a Native American provider's perspective addresses Native American providers' view of Western medical modalities, particularly DBT. The findings regarding cultural sensitivity and modification implied the need to continue research on Native American providers' experiences using evidence based models among Native American clients. It also revealed the importance of using an adaptable model, and understanding and adapting to tribal practices in choosing and applying practice among Native American clientele.

Further, researchers should extend the present study by investigating each tribe's cultural beliefs regarding treatment. Beals et al. (2005) stated that it is important to understand that Tribes are not to be generalize. Future researchers should evaluate specifics with tribe's history, polices, and traditional practices, and whether and how Native American practitioners who come from different tribes than their clients effectively modify their treatment according to clients' beliefs. This additional research

may lead to social change through further development of culturally competent interventions.

Recommendations for Practice

The participants in the present study shared the usefulness and challenges of using DBT. The sharing of the importance of culture and challenges of DBT can improve methods when practicing treatment among Native clients. When treating Native Americans, practitioners can improve efficacy using cultural and adaptive elements in the treatment model. This can cause social change in the future of treating Native American clients, particularly for intergenerational trauma and for population-specific public health concerns, like suicide treatment.

Conclusions

DBT has extensive research on its efficacy and shows to improve mental health such as abating suicide behaviors, which is needed in the Native community. This study has brought out new views when evaluating DBT within Native American clients. The present study revealed different views on how participants saw DBT on its efficacy and challenges. Seeing the themes that emerged will motivate other practitioners, including myself, to appreciate culture with each future client I will work with. Specifically, the three themes revealed in the present study were the need for cultural understanding between providers and their clients, the use and modification of DBT within the Native American population, and some challenges to implementation that in part stemmed from this modification.

This study is a start for future research on this topic that has a gap in literature. When sharing this study in future discussions, it would be important to hear Native providers on their thoughts and challenges with this research. Hearing their views will continue to build this research topic such as the specifics on survey question, the cultural elements to analyze with each tribe, inclusion criteria, and the challenges to name a few. Employing culturally sensitive and specific treatment through DBT may make headway in significant public health issues within the Native American community, and therefore increase wellness among indigenous peoples in the United States.

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Appendix A: Recruitment E-mail

E-mail to Participant

(Date)

Dear Potential Participant,

Hello. My name is XXXX and I am a counseling psychology doctoral student at Walden University. I had the opportunity to work at Phoenix Indian Medical Center as an Adolescent therapist and was trained in dialectical behavioral therapy. For my dissertation study, I would like to speak with licensed, Native American practitioners regarding their experiences using Dialectical Behavioral Therapy (DBT). I am inviting you to participate in an interview by phone or in person regarding your experience using DBT with Native American clients. The interview would consist of a 40-60-minute interview that would be scheduled at your convenience. It is my hope that my dissertation study will provide insight into the Native professional's experience with treating Native Americans. I would like to meet in person to discuss the research, its purpose, obtain consent, and arrange a convenient time for your interview. I am working on my dissertation under the supervision of XXXX. Should you have questions about my study, her contact details are listed below.

If you are interested in participating, please respond to this e-mail at: XXXX

Thank you in advance for your time.

XXXX
Counseling Psychology Doctoral Student

XXXX
Research Supervisor

Appendix B: Interview Protocol

Demographic Question

1. Tell me about yourself: Do you identify yourself with a certain Tribe and enrolled?
2. Current occupation?
3. Education?
4. Licensure
5. Training on DBT and the amount of hours they received the training?
6. How long ago was the training?
7. What population do you practice therapy for?

DBT Providers' Experiences

1. Can you tell me what has worked well with Native Americans clients?
2. What has not worked well in therapy with Native Americans clients and the reasons?
3. What has been your experience using DBT among Native American populations?
4. What have you seen work well with DBT and can you explain how?
5. Have you seen what has not work with DBT with Native American clients and can you explain how?
6. Do you feel a Native American provider is important when practicing treatment with Native American clients and if so or not what are the reasons?
7. Any challenges using DBT and share how it is a challenge?
8. What important culturally elements are needed when treating Native Americans?

Interview Questions

1. Tell me about your use of DBT with Native American Clients?
2. Tell me about your views of the use of DBT?
3. What are your experiences with DBT?
4. Tell me about your training in DBT?

5. What were your experiences with the training in DBT? (What aspects you like, barriers, challenges.)

6. How important is it to follow DBT protocol when using it with Native American clients?

7. Would you make changes in how you use DBT with Native Americans clients and if so what would they be?

8. Do you have any challenges using DBT and explain the reasons?

Appendix C: Transcriptionist Letter of Confidentiality

CONFIDENTIALITY AGREEMENT

Name of Signer:

During the course of my activity in collecting data for this research: The Use of Dialectical Behavioral Therapy with the Native American Population in the Southwest I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:**