

2019

# THE EXPLORATION OF CLINICIANS' LIVED EXPERIENCES IN CULTURALLY ADAPTING EMPIRICALLY SUPPORTED TREATMENTS FOR AMERICAN INDIAN AND ALASKA NATIVE POPULATIONS

Maegan Rides At The Door

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THE EXPLORATION OF CLINICIANS' LIVED EXPERIENCES IN CULTURALLY  
ADAPTING EMPIRICALLY SUPPORTED TREATMENTS FOR AMERICAN INDIAN AND  
ALASKA NATIVE POPULATIONS

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Dissertation

presented in partial fulfillment of the requirements  
for the degree of

Doctor of Philosophy  
in Counselor Education and Supervision

The University of Montana  
Missoula, MT

May 2019

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# CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

Dr. Bart Klika  
Prevent Child Abuse America

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# CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

*Rides At The Door, Maegan, PhD, Spring 2019*

*Counselor Education and Supervision*

Abstract

Chairperson or Co-Chairperson: Lindsey Nichols

Co-Chairperson: John Sommers-Flanagan

This study investigated the lived experiences of clinicians who have culturally adapted Empirically Supported Treatments (EST) for American Indian/Alaskan Native (AI/AN) populations. The central research question for this investigation was: What is the experience of mental health providers in culturally adapting empirically supported treatments for American Indian and Alaska Native populations? A guided semi-structured interview protocol was used to interview eight participants. Giorgi's descriptive phenomenological psychological method was used to develop a general psychological structure representing eight essential constituents. They are: developing an understanding of cultural adaptation, focusing on building and maintaining therapeutic relationships, immersion and engagement with community, experiencing conflict between Western and Indigenous epistemology, navigating the use of empirically supported treatments, supporting traditional and culturally developed ways of healing, clinicians' ability to embody cultural humility and increase cultural competency, and coping with external factors. Implications for practitioners, treatment developers, funders, academic programs, clients, and the counseling field are provided. Lastly, recommendations derived directly from the data, arising from limitations of the study, based on delimitations, and those relevant to the research problem are discussed.

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## Acknowledgement

There are many people that have supported me professionally and personally as I completed the research and writing of this dissertation.

Professionally, I would like to thank Dr. Lindsey Nichols, for being the primary chairperson on my committee. You kept me on track with a realistic timeline, was always willing to meet with me, and provided great guidance along the way. Thank you, Dr. John Sommers-Flanagan, for agreeing to be my co-chair. It was important for me to have you in this role as you have been my academic advisor since 2009 and have been encouraging me to pursue a doctorate degree for many years. Although they have many responsibilities, I am grateful for my other dissertation committee members who provided their input and gave me reassurance. Dr. Bart Klika, thank you for introducing me to articles on cultural adaptation and sparking my interest in this topic. I appreciate research assistants', Megan and Bridget, for doing a great job with the tasks you were given. I would like to acknowledge Dr. Chuck Harris for allowing my research assistants to use your lab to transcribe the interviews and check out equipment. I would also like to thank my expert informants' for helping me develop my interview protocol. You are all inspiring American Indian women, Ph.D., rockstars!

Personally, I would first like to thank my husband, Jonas Rides At The Door, and my daughter, Maleah Rides At The Door, for your love, understanding, and encouragement. Thank you to my mom, Darnell Day, for your weekly phone calls filled with laughter and reminding me to take care of myself holistically. It was rejuvenating to visit Poplar, MT on the Fort Peck Reservation several times throughout the completion of this dissertation. Although I haven't lived there in quite a few years as I have been on a long academic journey, I still consider it my home away from home. A special thank you to my dad, Robert Hopkins, and my step mom, Janell, for our long visits around the dining table drinking coffee and for always sending me back to Missoula with a large can of Tim Hortons coffee. It was much needed! Dr. Karla Bird, thank you for paving the way and showing me that this really is possible! Corinna, for always laughing at all my jokes. Tiana, for your unwavering life-long friendship. Clover, for cheering me on. Lauren, for giving me food and a place to stay to and from visiting home. Dr. Marilyn Bruguier-Zimmerman, for your good advice. I'd also like to thank my many other clinical supervisors, colleagues, family members, and friends who have supported me in various ways.

Last, and definitely not least, I would like to thank the participants' who gave their time and expertise. Interviewing you was the most enjoyable part of this process. Thank you for your willingness to share openly and honestly. I felt a responsibility to make sure your experiences were accurately and sensitively captured and synthesized. Your collective experiences shed light on this topic in an important way. Thank you for all that you do for American Indian and Alaska Native clients and the communities you serve. I hope we will continue to work together to further this work.

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## CHAPTER 1.

### INTRODUCTION

Mental health disparities between American Indian and Alaska Native (AI/AN) populations and White Americans are a topic of increasing concern. Many researchers have been trying to conduct research within AI/AN communities in an effort to reduce mental health disparities and improve service provision (Gone & Trimble, 2012; Warne, 2006). Despite the difficulty of conducting accurate prevalence studies, the available data paints a grim picture of American Indian mental health, and general health overall.

Statistics related to AI/AN mental health reveal high prevalence rates of depression, substance use disorders, suicide, anxiety, post-traumatic stress disorder, intimate partner violence, and psychological distress (Beals, Manson, Whitesell, Spicer, Novins, & Mitchell, 2005; Centers for Disease Control and Prevention, 2016; Indian Health Service, 2015). American Indians experience a lower life expectancy than the general population and disproportionate health conditions (Indian Health Service, 2017). One report revealed the life expectancy of AI/AN living in Montana to be 20 years less than the general population (Montana Department of Public Health and Human Services, 2013).

As we know from the landmark Adverse Childhood Experiences (ACE) study conducted by the Center for Disease Control and Prevention (2016) with help from Kaiser Permanente, childhood experiences are correlated with the adoption of health risk behaviors. Those behaviors in turn can have a negative influence on mental health and health outcomes later in life, including early death. Studies of the prevalence rates of adverse childhood experiences among AI/AN populations indicate that they are higher than the general population (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015; De Ravello, Abeita, & Brown, 2008; Koss, Yuan,

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Dightman, Prince, Polacca, Sanderson, & Goldman, 2003). Given the need to reduce mental health disparities among AI/AN populations, it has become a race against time to find effective mental health and substance use treatments. Identifying effective treatments could lead to reduced mental health, substance use, and health disparities and increased life expectancies among AI/AN populations.

### **Statement of the Problem**

One prominent strategy for improving mental health among AI/ANs is to increase access to empirically supported treatments (EST) within tribal communities. Federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the Administration for Children and Families (ACF) fund grants, cooperative agreements, and contracts for tribal communities. Many tribal communities rely on this funding to operate mental health programs. After finding that ethnic minorities have unequal access to empirically supported interventions, these funding agencies began to encourage empirically supported treatments or programs (U.S. Department of Health and Human Services (DHHS), 2001). In grant proposal solicitations, there has been guidance to select empirically supported approaches and promising practices from lists developed by federal agencies and organizations (Lucero, 2011). Examples of these lists include the Office of Juvenile Justice and Delinquency Prevention Model Programs Guide, the National Child Traumatic Stress Network's (NCTSN) Empirically Supported Treatments and Promising Practices fact sheets, the First Nations Behavioral Health Association (FNBHA, 2009), Catalogue of Effective Behavioral Health Practices for Tribal Communities, and a list developed by the Society of Clinical Psychology, a division of the American Psychological Association (APA Presidential Task Force on Evidence-Based Practice, 2006).

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It is logical for programs to shift to using what works. However, the criteria treatments need to meet to qualify as an empirically supported approach or a promising practice vary among different entities and agencies. Conducting double blind, randomized control trials (RCTs) with representative sample sizes is the most common method for validating treatments. However, RCT's are less feasible for psychotherapy in general, as it is time consuming and costly. Other challenges associated with RCT use include: (a) establishing inclusion criteria, (b) standardizing interventions, (c) determining outcome measures, and (d) ensuring the generalizability of results (Bothwell, Greene, Podolsky, & Jones, 2016). Furthermore, with so many confounding variables in psychotherapy, even when RCTs are conducted, it is difficult to make casual inferences about the results of these trials (Gone & Alcantára, 2007) or determine whether the results will generalize to practice settings with specific populations. More often than not, it is difficult to obtain adequate representation from minority groups in RCTs, making generalizations of positive outcomes to minority populations impossible. Similar issues are present when researching treatment modalities among AI/AN populations (Gray & Rose, 2012). Therefore, most treatments included on the lists of empirically supported treatments have not demonstrated effectiveness for AI/ANs in particular.

Encouraging empirically supported treatments for all clients is a one-size-fits-all approach. Treatments that meet research criteria and are listed as empirically supported must be carried out with fidelity (Cohen et al., 2008); the idea being that any deviation from the treatment approach could interfere with effectiveness and decrease positive outcomes (Chu & Leino, 2017). Prioritizing fidelity means that practitioners are unable to modify empirically supported treatments to take into account the cultural identity of individual clients. This can also interfere with treatment outcomes; however, we do not know whether modifying treatments to fit client

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culture is for better or for worse, due to the absence of rigorous evaluation studies (Chu & Leino, 2017). Regardless of outcomes, mental health providers are still encouraged by their professional associations and accreditation bodies to apply multicultural competencies in their clinical practice (ACA, 2014). This leads us to try to figure out how to resolve the tensions between treatment fidelity and cultural fit.

### **Rationale for the Study**

In the context of historical and intergenerational trauma, AI/AN mental health disparities among American Indian and Alaska Native (AI/AN) disparities began long ago as a result of a volatile history with the U.S. government and citizens implementing, at times, policies and strategies for AI/AN eradication and, at other times, forced assimilation of AI/AN people (Braveheart, 2003). This cumulative history, including the U.S. government's failure to fulfill its treaty obligations with tribes, has created a persistent rift between the U.S. government and AI/AN communities continuing to the present day (Grandbois, 2005; National Congress of American Indians, 2018). This rift has created an overall mistrust by AI/ANs of the Indian Health Service (i.e., a federal agency within the Department of Health and Human Services responsible for providing health care, including mental health services for AI/ANs) and mental health systems (Gray, 2012).

Mental health and substance abuse issues are often conceptualized by mental health providers through a Western perspective that relies on a categorical model of psychopathology. This categorical model has several characteristics, including: (a) emphasizing underlying diagnosis rather than on presenting signs and symptoms, (b) concern about the biological etiology of psychopathology, (c) focus on pathology, and (d) assumptions that medication is better than psychotherapy (or that mental disorders should be treated by physicians as opposed to

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mental health providers), or that individuals who struggle with mental illness are not fully responsible for their behavior (Lilienfeld, Sauvigné, Lynn, Cautin, Lutzman, & Waldman, 2015). These philosophies are in stark contrast to a holistic perspective of wellness often ascribed to by AI/AN's. Interventions that have been developed to treat individuals from the dominant culture may be causing unnecessary harm due to the lack of cultural sensitivity for the target population. For example, it may cause undue psychological distress if an intervention requires a male youth to discuss a topic that is not permitted for him in his culture to discuss with a female therapist. This lack of cultural sensitivity further creates a systemic barrier among service providers and the population being served. These instances can discourage AI/AN youth and their families from seeking or providing permission for their children to participate in treatment. In fact, it has been documented that AI/ANs generally avoid initiating therapy with a mental health professional or limit their participation by attending few sessions (LaFromboise, Trimble, & Mohatt, 1990; Gray, 2012; Gray & Rose, 2012 Sue, Allen, & Conaway, 1978). The potential negative effects of not providing culturally adapted empirically supported treatments may be especially unfortunate for small rural AI/AN communities where service providers and programs are already lacking and community member opinion is strong.

Given that substantial funding is being given to tribal programs to implement empirically supported treatment models, it makes logical sense to explore the dynamics of how mental health providers are ensuring cultural fit. This area of research is a hot topic considering the potential implications for tribal communities. It is imagined that many mental health providers already culturally adapt treatments to their populations to some extent. However, this study would help determine the complexities with this process.

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Because this study is focused on the lived experience of mental health providers, it will help provide information as to how empirically supported treatments are currently used with AI/AN populations. This study is relevant for treatment developers and funders as they prepare the mental health workforce to ensure empirically supported treatments are a good cultural fit for minority populations generally, and AI/AN populations in particular.

The purpose of this study is to investigate mental health provider experiences of culturally adapting empirically supported treatments for American Indian and Alaska Native populations. This study will use phenomenology, a qualitative method of inquiry, to examine in more depth mental health providers' lived experiences of using and adapting empirically supported treatments. The focus will be on describing the meaning and essence of these lived experiences, not on developing or validating a coherent grounded theory from multiple data sources (Hays & Wood, 2011). This study is exploratory, due to the limited research on cultural adaptation of empirically supported treatments with AI/AN populations.

### **Research Question**

Data will be gathered on clinicians' lived experiences of adapting empirically supported treatments to AI/AN populations. The central research question is:

What is the experience of mental health providers in culturally adapting empirically supported treatments for American Indian and Alaska Native populations?

**Sub-questions.** Three sub-questions have been developed to understand mental health provider decision-making, methods of cultural adaptation, and implementation. These three sub-questions are:

- What rationale and/or circumstances lead to choosing to culturally adapt an empirically supported treatment?



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- What methods have been used to culturally adapt empirically supported treatment for this population?
- What are mental health providers' experiences in implementing the culturally adapted treatment with this population?

These research questions may help fill the gaps of knowledge between the developers of empirically supported treatments and AI/AN clients who receive them. Since research has largely focused on studying the efficacy and effectiveness of empirically supported treatments, mental health providers are often viewed as an objective party in implementation even though there is a lot of variability that can occur on the part of the mental health provider (Westen, Novotny, & Thompson-Brenner, 2005). Studying mental health provider experiences can help us more deeply understand one specific perspective on how cultural adaptation is perceived and how cultural adaptation can influence implementation. It is acknowledged that mental health provider experiences are one perspective. Other perspectives include but are not limited to: funders, treatment developers, academic departments, licensing boards, insurance companies, professional associations, accreditation and most importantly the client's themselves. Mental health providers are situated directly between treatment developers and clients. Their position means they are the most important stakeholder navigating the process of adapting treatments to fit individual client's needs and this is why this study explores this perspective.

### **Definition of Terms**

To clarify the meaning of terms used in this study, definitions are provided.

**American Indian and/or Alaska Native.** These terms refer to an individual who has "origins in any of the original peoples of North and South America (including Central American) and who maintains tribal affiliation or community attachment" (Norris, Vines, & Hoeffel, 2012,

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p. 2). This definition includes those who self-identify as being American Indian and/or Alaska Native.

**Constituent.** Constituents are synthesized meaning units that represent the essence(s) of participant's lived experience of culturally adapting ESTs for AI/AN populations (Giorgi, 2009). Constituents (also called "wholes") are interdependent meaning units shared by several or all participants and consist of parts (independent meaning units) and moments (interdependent and descriptive meaning units) (Overenget, 1996). An analogy explaining wholes, parts, and moments is described in chapter four.

**Culture.** Culture is the "expression of language, behavior, customs, knowledge, symbols, ideas, and values which provide people with a particular world view and guidelines for living life" (Berryhill, 1998, p. 2). In this study, culture is in context to AI/AN tribes in the United States.

**Culturally sensitive intervention.** For the purposes of the current study, a culturally sensitive intervention is defined as "the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation" (Rescinow, Soler, Braithwaite, Ahluwalia, & Butler, 2000, p. 272).

**Cultural adaptation.** The term "cultural adaptation" has been used across disciplines to refer to the process of incorporating the target population's culture into an existing intervention. Bernal, Jiménez-Chafey, & Rodríguez (2009) define it as "the systematic modification of an empirically supported treatment (EST) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (p. 362). This study will only be focused on ESTs and not all intervention protocols.

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**Deep structure adaptation.** In an attempt to further describe adaptations, Rescinow and colleagues (Rescinow, Baranowski, Ahluwalia, & Braithwaite, 1999; Rescinow et al., 2000) have defined and delineated deep and surface structure adaptations. Deep structure adaptations are defined as “incorporating the cultural, social, psychological, environmental, and historical forces that influence the target behavior in the proposed target population” (p. 273-274). For example, enlisting the help of elders to develop and provide psychoeducation would be a deep structure adaptation.

**Surface structure adaptation.** Surface structure adaptation is “matching intervention materials and messages to observable, ‘superficial’ characteristics of a target population” (Rescinow, Baranowski, Ahluwalia & Braithwaite, 1999; Rescinow, et al., 2000, p. 273). An example of a surface adaptation would be changing a manual to include images relevant for the target population. Another example specific to AI/AN populations is using a feather to focus on in the implementation of Eye Movement Desensitization and Reprocessing Therapy (Gray, 2012).

**Empirically supported treatment.** An empirically supported treatment (EST) is a treatment that has been determined to have an established base of evidence for the treatment of a particular mental disorder and can be found by searching the National Registry of Evidenced Based Programs and Practices (NREBPP). This term is differentiated from an evidence-based program, which could potentially be implemented by paraprofessionals, or evidence-based practices, which is more general and refers to therapeutic practice as a whole rather than the implementation of an empirically supported treatment in particular (Schlosser & Sigafos, 2008).

**Federally recognized tribe.** A federally recognized tribe is a tribe is "an American Indian or Alaska Native tribal entity that is recognized as having a government-to-government

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relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the Bureau of Indian Affairs" (BIA, 2018).

**Mental health provider.** This term is used interchangeably with the word clinician. It is meant to be broad to include Licensed Clinical Professional Counselors (also referred to as Licensed Professional Counselors), Licensed Clinical Psychologists, Licensed Clinical Social Workers (including Licensed Independent Social Workers and Academy of Certified Social Workers), Licensed Addiction Counselors (also referred to as Licensed Clinical Alcohol & Drug Abuse Counselors), and Licensed Marriage and Family Therapists.

**Non-Federally recognized tribe.** A non-recognized tribe is tribe that is not recognized as having a government-to-government relationship with the United States. This is because of the absence of formal documentation of this relationship, such as treaties between the United States and the tribe. The United States government makes this determination; therefore, this study will not exclude tribal members from non-federally recognized tribes.

**State Recognized Tribe.** State recognized tribes are non-federally recognized tribes that have gained recognition by the state of their residence. The Little Shell Chippewa Tribe in Montana is an example of a state recognized tribe. This study will not exclude tribal members from state recognized tribes.

### **Summary**

The systemic cultural barrier between mental health service agencies and AI/AN communities could increase if the federal government's encouragement of the use of empirically supported treatments also means there is no room for cultural adaptation. It is logical to assume that tailoring empirically supported treatments to fit individual clients' needs and culture would

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seem more effective, however, it is not known how exactly this process should best occur given that this largely occurs informally. Despite the complexities and challenges associated with the cultural adaptation of ESTs, what everyone wants is to find approaches that work. This phenomenological study would help provide foundational context in exploring clinicians' lived experiences in implementing empirically supported treatments that have been culturally adapted.

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## CHAPTER 2.

### REVIEW OF THE LITERATURE

To set a foundational understanding of culturally adapted empirically supported treatments that have been developed for AI/ANs, several topics will be explored. This chapter provides a literature review on the following areas: AI/AN populations and AI/AN peoples perspectives on wellness; the prevalence of mental health and substance abuse disorders; the state of the mental health service delivery in AI/AN communities; culturally sensitive interventions (including the benefits of, establishing an evidence base for, empirically supported treatments, conflict between fit and fidelity); and a review of cultural adaptations as related to ethnic minority groups generally, as well as AI/AN populations specifically. Gaps and deficiencies in the literature will be discussed to illuminate areas for further research.

#### **Limitations of the Literature Review**

Because this literature review is primarily focused on cultural adaptation of empirically supported treatments, it is not focused on other culturally sensitive interventions, such as traditional healing practices or contemporary interventions originating from tribal cultures. For example, while searching the literature, three original interventions that were developed by tribal communities were identified (Fisher & Ball, 2003; Petoskey, Van Stelle, & De Jong, 1998; Goodkind, LaNoue, & Milford, 2010). It is possible that there are more interventions such as these that have been developed but not yet analyzed via research methods or permitted to be published. According to the articles reviewed, various methods are being used to culturally adapt ESTs. It is not suggested there should be only one process for cultural adaptation; however, there may be more effective methods that would allow for making meaningful cultural adaptations to better serve AI/AN populations.

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It is not within the scope of this study to explore culturally adapted therapy as a whole, or specific therapeutic tasks, such as culturally adapting assessment. Some work has been done on these issues as they pertain to counseling AI/AN populations (Heinrich, Corbine, & Thomas, 1990; Thomason, 2011). Specific and existing cultural adaptations and specific therapy tasks are important and needed; however, this study is focused on the cultural adaptation of ESTs in particular.

It is also not the scope of this paper to incorporate prevention interventions or curricula that can be delivered by non-licensed paraprofessionals. There are AI/AN-specific curricula that are on lists of empirically supported treatments. They include Project Venture, Zuni American Indian Life Skills Development (also American Indian Life Skills Development), and the Red Cliff Wellness School Curriculum (Carter, Straits, & Hall, 2007; LaFromboise & Howard-Pitney, 1995; Petoskey, Van Stelle, & De Jong, 1998).

### **The AI/AN Population**

There are approximately 2.5 million people who self-identify as AI/AN, according to the U.S. Census (2010). There are over 700 federally recognized, state recognized, and non-federally or state recognized tribes in the United States (Gone, 2004). AI/AN people are a very diverse group of people who have their own creation stories, worldviews, and practices. AI/AN people may ascribe to different religious beliefs and reside in communities both off and on reservations (Gone, 2004). According to the U.S. Census (2010), 78% of AI/AN live off reservation, which is a significant proportion of the population. Many AI/AN reside in urban areas. This is largely due to historical events such as the U.S. government's relocation program, the purpose of which was to entice AI/AN to move to urban areas, or the mass removal of AI/AN children to out-of-state foster homes, prior to and even after the implementation of the Indian Child Welfare Act (1978).

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Undoubtedly, most urban areas and some reservation communities have AI/AN residents representing a variety of different tribes as evidenced by the diversity of representation in Urban Indian Health Organizations service provision estimates (UIHI, 2012). Furthermore, AI/AN people are also becoming increasingly multi-racial as evidenced by the last U.S. Census (2010). The growing diversity of AI/AN populations is relevant to the purpose of this study.

**Prevalence of mental health and substance use disorders.** The prevalence of mental health and substance abuse disorders among AI/AN have been difficult to accurately estimate, due to the lack of and limited ability to conduct large-scale studies, culturally accurate assessment and diagnosis, and the differences in defining who is American Indian or Alaska Native. However, existing research supports disproportionately high rates of mental health issues in this population (Gone & Trimble, 2012). A review conducted by Gone and Trimble (2012) found, more specifically, that alcohol and marijuana abuse and dependence, PTSD, childhood conduct disorder, and suicidal behaviors occur at a high prevalence among AI/ANs.

Despite the difficulty in conducting large-scale studies of a relatively small population, literature regarding AI/AN substance use and mental health in smaller samples do exist to help illuminate this issue. Marijuana use in American Indian youth is also higher compared to other ethnic groups with the results of one study showing nearly 50% of American Indian students in 7<sup>th</sup> through 12<sup>th</sup> grade using marijuana on at least one occasion (Beauvais, 1996).

The rate of mental health problems among American Indian youth is likewise notable. American Indian youth are at a higher risk of suicide than any other racial or ethnic group (Gray & McCullagh, 2014). In a study of 349 youth tribal members across three separate assessment periods with different samples, 41.3%, 41.7%, and 31.4% of the sample met criteria for at least



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one psychiatric disorder based on the Young Adult Psychiatric Assessment (Costello, Erkanli, Copeland, & Angold, 2010).

Another contributing factor to the decline of mental health and increased psychological distress among AI/AN populations is the propensity to experience many losses over short periods of time. Overall, AI/ANs have a 5.5-year lower life expectancy than the general U.S. population (Indian Health Service, 2018). The primary causes of death in AI/AN populations are due to health conditions such as heart disease, cancer, and diabetes, unintentional injuries such as automobile accidents, and suicide (Kochanek, Xu, Murphy, Minino, & Kung, 2012). For AI/AN youth, the two leading causes of death are due to unintentional injuries and suicide (Indian Health Service, 2003). This means that many of the losses experienced by AI/ANs are unexpected and may be perceived as traumatic. This finding is supported in a study where 28% of 8-11<sup>th</sup> grade American Indian students reported the sudden loss of someone close or witnessing a death (Jones, Dauphinais, Sack, & Somervell, 1997).

**Concept of wellness from AI/AN perspectives.** Each tribe has their unique perspectives on wellness. It is difficult to describe the concept of wellness of each tribe from their perspective given the number of tribes in the United States. In addition, experiences with the U.S. federal government have affected how traditional views on wellness may have changed over time to present day (Gray & Rose, 2012). When describing wellness from AI/AN perspectives, it is often described as a holistic view encompassing physical, mental, spiritual, and emotional domains including a connection to the earth and sky (Gray & Rose, 2010). Cross-cultural traditional concepts of AI/AN wellness, also include an emphasis on relationships to extended family members, practices about respect, beliefs regarding the circle of connectedness among all people and to all living things, and the interconnectedness between spirituality and healing (Bigfoot &

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Schmidt, 2010). The circle is seen as an important symbol because life is considered as operating in a circular way. Examples include, change in the seasons, phases of the moon, phases of the sun, rotation of the earth, rotation of the stars, and life cycle (infant, child/adolescent, adult, elder) (Bigfoot & Schmidt, 2010). AI/AN perceive wellness to include mind, body, spirit, and relationship to all things (Gone, 2017). Maintaining wellness is not linear, but is about achieving a balance between all of these things (Bigfoot & Schmidt, 2010).

**Incongruence between service delivery and AI/AN perspectives.** Often there is incongruence between AI/AN beliefs on the concept of wellness and service delivery in mental health systems. This is partly because mental health service delivery is primarily based on a Western-based medical model. Because of the way mental health systems are set up, “Forcing AI/ANs to use non-AI/AN specific practices challenges their epistemology and promotes a system that is based on a hierarchy of Western knowledge” (Lucero, 2011, p. 322).

An AI/AN elder articulates this quite clearly when he says,

“...If you look at the big picture, you look at your past, your history, where you come from...and you look at your future where the Whiteman’s leading you, I guess you could make a choice. Where do I want to end up? And I guess a lot of people...want to end up looking good to the Whiteman, I guess. Then it’d be a fine thing to do: go to the White psychiatrists, you know, in the Indian Health Service and say, ‘Well go ahead and rid me of my history, my past, and brainwash me forever so I can be like a Whiteman.’ And I don’t know. I guess that’d be a choice each individual will have to make....I don’t like it myself.” (Gone, 2007, p. 294).

The incongruence between mental health service delivery and AI/AN community needs and wants is vast, but not unsolvable. Over time, mental health systems have evolved and diversified the provision of services. Specifically, tribes have been supported in securing oversight of behavioral health programs and substance abuse treatment programs.

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### **State of MH Services in Indian Country**

The federal government has been given the responsibility of providing health services, including mental health, for all federally recognized AI/AN individuals residing in the United States. The federal government assumed responsibility through Article 1, Section 8 of the constitution in 1797, laws, treaties, supreme court decisions, congressional acts (e.g., Snyder Act of 1921, Indian Health Care Improvement Act of 1976, Patient Protection and Affordable Health Care Act of 2010) and executive orders often times in exchange for land (Indian Health Service, 2018). The Indian Health Service, a government agency under the Department of Health and Human Services, is the agency responsible for this provision.

The Indian Health Service's Division of Behavioral Health is responsible for providing mental health and substance use services for AI/AN populations living in both tribal and urban areas (Indian Health Service, 2018). The Indian Health Service headquarters are in Rockville, MD and it oversees 12 regional offices geographically located throughout the United States. According the Indian Health Service website, there are 161 health centers including reservation and Urban Indian Health Organizations (Indian Health Service, 2018).

Urban Indian Health Organizations (UIHO) are the primary point of contact for health care for AI/ANs living in metropolitan areas. There are currently 34 urban American Indian health organizations across the United States, which provide an array of services encompassing health and behavioral health including substance use treatment (Pomerville & Gone, 2017). Urban American Indian health organizations serve a diverse population. At least 76.8% of service provision is to AI/AN individuals (Pomerville & Gone, 2017).

If AI/AN individuals do not receive mental health services through the Indian Health Service or tribally operated programs, they might utilize services that non-AI/ANs use, such as

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state and county public health clinics, health maintenance organizations, private service providers or agencies who accept Medicare/Medicaid, or less frequently pay out-of-pocket through sliding fee scales (Gone, 2004). It is commonly noted that AI/ANs often do not have their own insurance, but this may have improved after the passing of the Patient Protection and Affordable Health Care Act of 2010.

In 2011, David Levinson, at the Office of Inspector General (OIG), completed a government report on AI/AN access to mental health services at the request of a congressional representative. The report is based on services provided by the Indian Health Service and tribal behavioral health programs between January 2008 and June 2009. Although this report is dated, another report has not been completed on this topic by the OIG since 2011 to present date. The major findings from this report are as follows: most programs provide some kind of mental health service, but at some facilities this is limited to referral; there are also frequently staffing shortages of licensed mental health providers, and challenges such as lack of transportation, childcare, and employment that affect access to mental health services.

As evidence of the increasing self-determination of tribes to take over the provision of mental health and substance abuse treatment, currently more than 50 percent of mental health programs and more than 90 percent of alcohol and substance abuse programs are tribally operated (Indian Health Service, 2018). This has allowed tribes more flexibility in being able to incorporate traditional healing into service provision. However, less is known about how this is being accomplished if so and whether this movement has increased access to mental health services. Currently, there is no hub in which to identify service provision across the nation in these locations. It is believed that there is an increased emphasis in these programs as well as in

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the Indian Health Service (due to its mission statement) to increase the cultural sensitivity of services.

### **Culturally Sensitive Interventions**

Cultural sensitivity has typically involved counseling practice in general. Hoop et al, (2008) describe cultural sensitivity as an “awareness and appreciation for cultural diversity” (p. 355). They further explain that mental health providers achieve cultural competency by using cultural sensitivity, cultural knowledge, and cultural empathy. Therefore, cultural sensitivity is a broader construct. In contrast, cultural adaptation has been used in referring to modifying specific treatments (Bernal et al., 2009). There has been more research on culturally sensitive interventions in general as opposed to culturally adapted empirically supported treatments in particular. Evidence-based treatment has been sometimes used in the literature interchangeably with empirically supported treatment, but overall has taken a broader definition that includes treatments showing research evidence to support their use. In contrast to empirically supported treatment, empirically supported treatment specifically refers to treatments that have supporting RCT outcomes or tightly controlled and replicated single case design research (Chambless et al., 1998). Because the research on culturally adapted, empirically supported treatments for AI/AN populations is scarce, this literature review is broad to include culturally sensitive interventions and other ethnic minority populations.

**Benefits of culturally sensitive interventions.** Although research in this area is lacking, there is preliminary evidence demonstrating the benefits of using CSIs. For example, it has been shown to improve rapport building by mental health providers and contribute to better client engagement (Jackson-Gilfort, Liddle, Tejada, & Dakof, 2001; Jackson & Hodge, 2010); CSIs are also associated with improved retention and treatment outcomes (Gone & Alcantára, 2007;

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Hodge, Jackson, & Vaughn, 2012; Jackson, 2009; Jackson & Hodge, 2010; Miranda et al., 2003).

Each CSI exists on a continuum of how much culture is informing the intervention (i.e., how culturally sensitive it is). CSIs may be more relevant and effective and may prove to be more beneficial to the target population than interventions that are not as culturally sensitive.

Although additional examination of the unique beneficial aspects of using CSIs is warranted, improving cultural sensitivity is considered best practice in many fields of study. The number of recent literature reviews found while searching for culturally sensitive mental health interventions for AI/ANs provides evidence of the increasing interest in providing CSIs for ethnic minority populations including AI/ANs (Griner & Smith 2006; Gone & Alcantára, 2007; Jackson, 2009; Jackson & Hodge 2010; Hodge, Jackson, & Vaughn, 2012).

**Establishing an evidence base for culturally sensitive interventions.** According to Goodkind, Lanoue, and Milford (2010), there are three ways to establish an evidence base for culturally sensitive interventions. These three avenues are to: (a) study existing traditional healing practices, (b) co-develop and study interventions that have combined both traditional healing and empirically supported interventions, and (c) test adaptations of existing empirically supported treatments.

Although studying traditional healing practices would be a significant contribution to research, it is controversial. Consistently, tribal communities have guarded against research focusing on traditional practices. Studying traditional healing would be interfering with the sacredness of these practices with the potential for exploitation (Lucero, 2011; Struthers & Eschiti, 2005). This is a justified concern considering that some non-Indians have taken on these practices without being given the right or proper training, and have caused harm as a result (Dalal, 2011). Although this is technically a potential path, it is not considered the best viable

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approach (from a tribal perspective) to take at this time. Instead, a tribal perspective is that AI/AN traditional healing practices have existed for many generations and this longevity is evidence of helpfulness in and of itself (Gray & Rose, 2012).

Gone and Calf Looking (2015) proposed developing indigenous interventions as an alternative to studying existing traditional healing practices. One example of such intervention is a seasonal cultural immersion camp that was developed for Substance Use Disorders (SUD). In the description of the cultural immersion camp, the components of this intervention included traditional healing practices. However, it is surmised that the emphasis of this particular approach is the importance placed on the development of the intervention arising from an indigenous perspective as opposed to arising from a western perspective and therefore requiring adaptation. This approach seems to be a viable way to develop potentially empirically supported treatments, however, the researchers acknowledged the difficulty in designing a formal evaluation plan for this type of intervention.

The second option, according to Goodkind, Lanoue, and Milford (2010), would be to co-develop, with communities, interventions that have combined both traditional healing and empirically supported interventions. This avenue is less controversial although it would require some decision making to determine what traditional healing practices are appropriate to combine with empirically supported interventions and how to go about evaluating this approach. This approach would require great care for writing about these traditional healing practices and consideration for who is able to carry out these practices if they are combined with empirically supported interventions. It would be inappropriate for a non-Native mental health counselor to use traditional healing practices in combination with empirically supported interventions most of the time. In order for a non-Native to be able to provide traditional healing practices in a tribal

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community or with American Indian clients in an urban setting would require great dedication, learning, tribal community approval, and time, with no guarantees of obtaining permission.

Traditional protocols would make it complex for individual interventions but a viable avenue for group or family interventions would be to include a traditional healer as a co-facilitator. Given the shortage of American Indian counselors and the fact that organizations would have to find a way to compensate co-facilitators that is culturally and mutually acceptable, this avenue may be limited by resources. Traditional healers may also differ in their views about whether traditional healing can be combined with empirically supported treatments or where it is appropriate and not appropriate to conduct certain traditional healing practices.

The third option is to develop cultural adaptations for existing empirically supported treatments. Identifying critical intervention components, while flexibly changing less critical intervention components to be more culturally suitable is how this approach could meet the need for cultural sensitivity and utilize established empirically supported treatments (Cohen et al., 2008). One main question that needs to be determined in order to use this approach effectively is, “Culturally adapting to whom?” With over 560 federally recognized tribes and a number of non-federally recognized tribes who have rich and diverse histories, cultures, and belief systems it seems unrealistic and impractical for all ESTs to be culturally adapted to each individual tribe (Bernal et al., 2009; Bureau of Indian Affairs, 2017). Given there is evidence that developing interventions for specific cultural groups is more effective than developing interventions for a broader and more diverse target population (Griner & Smith, 2006), this would be the ideal approach. However, it would take at least 100,000 studies to be able to culturally adapt a number of empirically supported interventions for all of these unique tribes (Bernal et al., 2009). A fact that makes this question even more difficult to answer is the growing diversity within the



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American Indian and Alaska Native populations. It is more commonplace for individuals to identify with more than one tribe or ethnicity. Culturally adapting to a diverse target population is very complex and would require a large commitment of resources.

An important related question about developing cultural adaptations is, “how?” To date, there is not one generally accepted approach to developing cultural adaptations. The cultural adaptation of empirically supported treatments has been the most viable approach to date amidst the discussed complexities as evidenced by the studies included in this literature review. It is conceivable that deep structure adaptations could prove to be more meaningful than surface structure adaptations from the perspective of tribal communities. However, it is likely that the development of culturally adapting empirically supported treatments will vary in the degree to which culture is incorporated. It is important to explore how cultural adaptations are being conceptualized, developed, and implemented in order to move this work forward.

**Focus on efficacy and effectiveness of culturally sensitive interventions.** Much of the existing research to date has primarily focused on adherence to the methodological rigor of culturally sensitive interventions and the efficacy of these interventions (Gone & Alcantára, 2007; Jackson, 2009; Hodge, Jackson, & Vaughn, 2012). For various contextual reasons, such as difficulty recruiting large enough sample sizes, sampling for a single diagnosis, consistency in defining who is an Indian, and lack of assessments validated for this population (Gray, 2012), there is a lack of randomized controlled trials to establish convincing outcome results for AI/ANs. The emphasis on methodological rigor stems from a push towards finding and supporting empirically supported treatments. It has become increasingly apparent that to move forward in developing CSIs, establishing efficacy and effectiveness is required in order to gain

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support for implementation. Since it has been difficult to establish efficacy for CSIs among AI/AN populations, less has been done to evaluate efficacy of adaptations (Gray, 2012).

Despite the paucity of research overall, recent reviews have demonstrated evidence for CSIs being effective for some ethnic minority populations (Benish, Quintana, & Wampold, 2011; Barrera, Castro, Strycker, & Toobert, 2013; Gone & Alcantára, 2007; Griner & Smith, 2006; Jackson, 2009; Jackson & Hodge, 2010; Smith, Rodriquez & Bernal, 2011). Higher rigor has been linked to better outcomes (Jackson & Hodge, 2010). Thus, it appears there could be ways to resolve the conflict between fidelity and cultural fit.

**Conflict between valuing fidelity and cultural sensitivity.** Currently, there is an emphasis on developing culturally sensitive ESTs. As this movement evolves, mental health providers must learn how to implement these interventions with AI/AN populations. An important question in this work is one that Gordon Paul (1967) posed; "*What* treatment, by *whom*, is most effective for *this* individual, with *that* specific problem, and under *which* set of circumstances?" (p. 111). In January 2018, the Assistant Secretary for Mental Health and Substance Use released a public statement on the National Registry of Evidenced Based Programs and Practices (NREPP) and SAMHSA's new approach to implementation of evidence-based practices. In this statement, NREPP was regarded as "a biased, self-selected series of interventions further hampered by a poor search-term system" (SAMHSA, 2018). This statement, and the subsequent deletion of the NREPP database, illustrates how efforts to answer Gordon Paul's question continue to fall short.

Pomerville and Gone (2017) conducted a study comparing scores between urban American Indian health organization program directors to the national average on the Evidence Based Practice Attitudes Scale. The results revealed equivalent total scores and on most

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subscales, with the exception of the ‘requirements’ subscale. Program directors reported that they were more likely to require the use of empirically supported treatments if their supervisor or government entity required it. Contradictory to this finding is that at a statewide gathering of mental health providers serving AI/AN populations in Washington, several mental health providers reported not wanting to use ESTs, even when the state mandated it (Walker, Whitener, Trupin, & Magliarini, 2015). These mental health providers stressed the importance of cultural adaptation of ESTs, but noted that blanket cultural adaptation across multiple tribes was unhelpful. Further, they stated that many tribal behavioral health programs are not likely to agree to implement the same EST and would like to retain the freedom to choose. Consequently, rather than focusing on mass disseminating a particular EST, the group suggested a learning community (or collaborative) could be used to support all tribes culturally adapting and implementing several different ESTs at the same time. In particular, to tribal programs that provide substance abuse treatment, it was found that of 192 programs, at least 90% used an EST (Novins, Croy, Moore, & Rieckmann, 2016). This demonstrates that despite the contradictory opinions on using ESTs with AI/AN populations, even among program directors and mental health providers, they are still being implemented, potentially based on requirements, and not necessarily willingness.

A tip sheet developed by the Administration of Children and Families uses a graphic to illustrate cultural adaptation and how it influences fidelity, using a stop light analogy (ACF, n.d.). A green light adaptation is okay if it only makes surface structure adaptations. A yellow light adaptation means that cultural adapters should be cautious when making more than surface structure adaptations and beginning to lengthen sessions, adding activities, replacing videos or activities, or implementing with a different population or setting. A red light adaptation means

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that cultural adapters should refrain from making a lot of and/or in depth changes such as shortening a program, reducing or eliminating activities, or competing with or diluting the program's goals. In essence, making deep structure cultural adaptations is contraindicated. Although this tip sheet was developed for adapting evidence-based teen pregnancy prevention programming, it demonstrates how fidelity is prioritized even by government agencies.

Some empirically supported treatments have been culturally adapted, used with AI/AN populations, and have produced positive outcomes. Morsette and colleagues (2012) culturally adapted Cognitive Behavioral Intervention for Trauma in Schools for American Indian youth attending schools on reservations. As another example, Chaffin and colleagues (2012) conducted a study to explore American Indian parents involved in the child welfare system and their attitudes toward receiving SafeCare, an evidence-based home visiting treatment. Many American Indian parents reported perceiving SafeCare as better quality, culturally competent, and enhancing the relationship with their home visitor. This preliminary ability to develop culturally adapted ESTs that produce positive outcomes may be why this continues to be a viable effort.

Mental health providers often find themselves in the center of competing objectives. On one hand, practicing with fidelity to the intervention since it has an established evidence base and is encouraged by supervisors and/or funders (including insurance agencies) is one objective. On the other hand, practicing with cultural competency is a competing objective (Chu & Leino, 2017). Cultural adaptation of ESTs is an attempt to resolve the tension between these initiatives that are often in conflict with one another. When fidelity becomes highly prioritized, there is no room for infusing AI/AN culture in any depth. Many developers have become accustomed to asking mental health providers to sign agreements upon training and committing to following the treatment model as closely as possible. This one-size-fits-all approach is not congruent with the

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value of prioritizing cultural competency, which is embedded into many association standards (American Counseling Association, 2014; American Psychological Association, 2010; National Association of Social Workers, 2008; Bernal et al., 2009). It is therefore important to review current models of cultural adaptation.

### **Models of Cultural Adaptation**

A variety of theoretical models have been developed to explain the process of cultural adaptation. These include but are not limited to: Barrera and González-Castro's (2006) heuristic framework; Lau's (2006) data driven adaptation; Leong's (1996) cultural accommodation model; and Bigfoot and Schmidt's (2010) Honoring Children-Mending the Circle model. It has been argued by Chu and Leino (2017) that it does not make sense to continue to develop theoretical models that are not data driven or have not been tested with cultural adaptation science approaches. Chu and Leino (2017) highlight the work of Hwang (2009) and Nicholas, Arntz, Hirsch, and Schmiedigen (2009) in conducting preliminary efforts to move this work forward.

Chu and Leino (2017) conducted a thorough literature analysis of 45 articles using thematic synthesis of culturally adapted psychotherapy empirically supported treatments. Their work led to the development of the Cultural Treatment Adaptation Framework (CTAF; see Figure 2). Unlike other adaptation models and frameworks, this framework is data driven; using an inductive approach to conceptualization based on cultural adaptations that have been made to date and as such, reflects the most current status of cultural adaptations of ESTs. The framework is divided into peripheral and core treatment components. Core treatment components are components that are central to the intervention and account for symptom change. Peripheral treatment components enhance the cultural receptivity to the population of focus. Core treatment component modifications are categorized on a continuum of (a) no change, (b) no change but

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include additions, (c) change(s) or deletion, and (d) complete core modification or entirely different treatment. Peripheral treatment components are further subcategorized by engagement and treatment delivery. Engagement means the involvement of the population of focus in the treatment and includes enhancing treatment access/entry, retention/completion, and psychoeducation for recruitment. Treatment delivery includes changing and/or adding materials and semantics, cultural examples and themes, and restructuring the therapeutic framework. The latter category includes session structure (e.g., format, number, length of session, length of topic or component), provider-client relationship (interpersonal style), and person/place (other collaborators/stakeholders, group/individual, and setting treatment is delivered).

Using the CTAF for analysis, Chu and Leino (2017) found that of the 45 studies of cultural adaptations from the last twenty years, 66.67% modified core components, with the largest method being component addition, rather than modifying existing core components. All studies included peripheral component modification, with the largest method being engagement through retention (82.22%), followed by treatment entry (73.33%) and psychoeducation (17.78%). All studies included changes to treatment delivery. Within this category, all studies included cultural examples and themes, followed by changes to the therapeutic framework (93.33%) and materials and semantics (86.67%). Under the therapeutic framework category, the largest method was session structure (80.0%), followed by provider-client relationship orientation (64.44%) and person/place (64.44%). Five studies were classified as “delivery: other” and one study was labeled “unclassified.”

The development of the CTAF (Chu & Leino, 2017) is an important contribution in demonstrating how cultural adaptations have been made to date. It also helps to provide further support that cultural adaptation can include preservation of core treatment components (Chu &

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Leino, 2017; Smith, Domenech Rodríguez, & Bernal, 2011) and that the field is getting better at resolving the tension between fidelity and fit. Barrera and colleagues (2013) conducted a literature review to determine consensus points on the topic of cultural adaptation of evidence-based behavioral health interventions. “They determined that there is agreement that the process of cultural adaptation can be done in five stages: information gathering, preliminary design, preliminary testing, refinement, and final trial” (Barrera et al., 2013, p. 199). Although this area of research has been helpful to describe the current state of cultural adaptation, it has not yet resolved some of the complexities in appropriately developing cultural adaptations for AI/AN populations in particular.

**Cultural adaptation for ethnic minority populations.** Only within the last eleven years has guidance developed for when and how to develop cultural adaptations for ethnic minority populations (Chu & Leino, 2017). Despite this progress, a handful of articles about culturally sensitive interventions included in recent literature reviews are specific to AI/ANs (Gone & Alcantára, 2007; Jackson & Hodge, 2010), and only one focused on AI/AN youth (Jackson & Hodge, 2010). Gone and Alcantára (2007) identified only nine outcome studies that addressed work with AI/AN and just two of those studies used control group comparisons. Both of the control group studies were for prevention approaches rather than therapeutic interventions” (Gray, 2012, p. 206). Therefore, it is necessary to explore the broader areas of cultural adaptation beyond AI/AN populations.

One literature review conducted by Griner and Smith (2006) specifically focused on cultural adaptations for ethnic minority populations. These researchers conducted a meta-analysis of 76 studies with 5,225 adaptations and 43% of the studies providing five or more types of adaptations. Results suggested that interventions targeted to a specific cultural group were

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four times more effective than interventions provided to groups with different cultural backgrounds represented.

Perhaps the area obtaining the most focus right now is Cultural Adaptation Science (Chu & Leino, 2017), also referred to as Evidence-Based Cultural Adaptation. Cultural adaptation science refers to "adaptations that are well documented, systematic, and tested" (Bernal, et al., 2009, p. 362). Bernal, Jiménez-Chafey, and Rodríguez (2009) highlighted two examples (Hwang, 2009; Nicholas, Artntz, Hirsch, & Schmiedigen, 2009) of this rigorous approach to cultural adaptation. Cultural adaptation science tests the implementation of each cultural adaptation of a treatment at a time using various methods.

Documenting cultural adaptation is another area of emphasis. Cummins and colleagues (2003) developed a toolkit titled, *Assessing Program Fidelity and Adaptations*, to provide guidance on documenting adaptations. Stirman and colleagues (2013) developed a framework and coding system specifically for adapting ESTs (see Figure 1). More relevant to this study is a resource developed by Samuels and colleagues (2009) called, *Toolkit for modifying evidence-based practice to increase cultural competence*, which outlines a structured approach to selecting, modifying, and evaluating the successes of modifications. It is difficult to determine at this point how much these resources have been used, but their existence provides evidence of the effort toward the documentation of cultural adaptation approaches.

***Cultural adaptation of ESTs for AI/AN populations.*** Cultural adaptation in Indian Country has largely occurred by respectfully working with tribal leaders through a relational process. Community-based Participatory Research (CBPR) and Tribal Participatory Research, as conceptualized by Fisher and Ball (2003), are approaches to research in Indian Country that have been demonstrated in the literature as a means to engage tribes in research as collaborative



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partners. Fisher and Ball (2003) emphasized that interventions based on cultural values and practices may be the greatest avenue toward ensuring sustainability and fidelity. More recently, Tribally-Driven Participatory Research (TDPR; Mariella, Brown, Carter, & Verri, 2009) has encouraged research partnerships to take it a step further from collaboration to tribes acting as drivers of the research happening in their communities. Through this process, tribes have the authority to not only provide input into cultural adaptations, but vested authority to oversee and conduct the implementation of the culturally adapted, empirically supported treatment including evaluation. Furthermore, tribes develop an understanding of what success looks like and how it should be measured. AI/ANs then have the opportunity to become co-researchers. In this vein, cultural adaptation includes not just the cultural adaption of the intervention but also the modification towards thoroughly engaging tribal communities in research. To move this approach forward, Linda Tuhiwai Smith (1999) developed the Indigenous Research Agenda, which is a research model that exhibits a holistic approach in working toward self-determination in the areas of healing, decolonization, transformation, and mobilization. It is quite possible that the process of cultural adaptation could be considered healing in itself by supporting the self-determination of AI/AN communities to decide how healing happens in their communities.

A few ESTs have been culturally adapted for American Indians and Alaska Natives generally, and for specific tribes in particular. Some of these interventions include Trauma-Focused Cognitive Behavior Therapy, Parent Child Interaction Therapy, and a Cognitive Behavioral Therapy Depression Course for adolescents (Bigfoot & Funderbunk, 2011; Bigfoot & Schmidt, 2010; Listiq-Lunde, Vogeltanz-Holm, & Collins, 2013). As another example, Venner, Feldstein, and Tofoya (2006) adapted motivational interviewing for AI/AN counselors (Gray, 2012). Whitesell et al (2018) culturally adapted an Iowa Strengthening Families Program for

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Parents and Youth 10-14 (SFP 10-14) for a tribal community that utilized a CBPR method and resulted in deep structure cultural adaptations to the intervention. Unfortunately, these adaptations were not coupled with rigorous testing to determine which components were more or less linked to positive outcomes. It is not known how many deep structure and surface adaptations were made to these interventions or the degree to which adaptations were made. However, Goodkind and colleagues' (2010) acknowledgement of using surface structure adaptations when culturally adapting "Cognitive Behavioral Intervention for Trauma in Schools" for AI/AN youth is evidence of an interest to move this initiative forward. Overall, many articles did not include information to determine whether surface or deep structure adaptations were made; they also did not provide concrete detailed documentation for others to follow how cultural adaptations were made.

Five of the eleven outcome studies in the Jackson and Hodge's (2010) literature review on culturally sensitive interventions developed for AI/AN youth reported utilizing deep structure adaptations. However, many of these studies also did not give sufficient information about how these cultural adaptations were made or implemented. Acknowledging word limits as well as tribal determination of publishing specifications regarding cultural adaptation may have created limitations to providing thorough detail and discussion in peer-reviewed research. These limitations contribute to ambiguity in the process of cultural adaptation.

Much of the existing research about culturally sensitive interventions has focused on interventions that have been culturally adapted to the target population and on evidence based programs or practice rather than on ESTs in particular. Despite the number of existing culturally adapted mental health interventions for AI/AN populations, there are no current literature reviews examining specifically how these cultural adaptations are being made. Refining cultural

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adaptation processes is necessary to establish efficacy and effectiveness and will help give perspective and potential guidance for further development of culturally adapted mental health interventions. Currently, it appears that we are in a trial and error period of discovering what kinds of cultural adaptation processes are potentially more useful. Without a comprehensive review of these approaches, the cultural adaptation of interventions could continue to move forward in isolated or disjointed efforts.

### **Unexplored Topics Concerning Cultural Adaptation**

There are several remaining unexplored areas within the topic of cultural adaptation of ESTs with AI/AN populations. An unanswered question that arises is whether an adaptation can be classified as a deep structure adaptation when the target population includes AI/AN's from multiple tribes. It is questionable that a deep structure cultural adaptation can be made for a target population with diverse backgrounds and cultural differences unless the researchers and stakeholders specifically determined that the cultural adaptation was relevant for all the tribal backgrounds included in the target population. As mentioned at the gathering of mental health providers in Washington State, it was suggested that there be differing levels of cultural adaptation so that they can be made tribally specific when implemented at the local level (Walker, Whitener, Trupin, & Magliarini, 2015). However, this process has not been specified and documented to allow for replication.

An underlying assumption is that there is a positive relationship between deep structure adaptations and the application of a culturally adapted EST to a target population with tribal homogeneity. There is some evidence that suggests interventions targeted to specific cultural groups are four times more effective than interventions provided to groups with a mix of cultural backgrounds represented (Griner & Smith, 2006). An unanswered question is how to make

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cultural adaptations for individuals who are multi-tribal or multiracial. It is likely that there may be diverging viewpoints on this topic. As our world continues to grow in diversity this question will need to be an important part of this discourse.

Engaging the stakeholders involved in the cultural adaptation of empirically supported treatments is very important. As Fisher and Ball (2003) point out, if AI/AN are not involved in the cultural adaptation process, it could perpetuate a belief that AI/AN communities do not have the requisite ability to accomplish this independently. In addition, in the process of developing cultural adaptations of ESTs, there is the risk of ignoring historical and contextual factors when describing pathology of mental health difficulties. Therefore, stakeholders become crucial in this effort. In the literature reviewed, stakeholders are not specifically identified or described, so it is not known exactly who contributed to cultural adaptations for many of the interventions (Griner & Smith, 2006). Stakeholders were not mentioned in the CTAF framework most recently developed (Chu & Leino, 2017). It is logical to assume a relationship exists between the number of stakeholders participating and salience of cultural adaptations; there is likely also a relationship between type of stakeholders participating and salience of cultural adaptation. However, this has yet to be explored.

It is foreseeable that despite the existing definitions of deep and surface structure adaptations, there may be subjectivity of determining and differentiating between surface and deep structure adaptations. Although the CTAF (Chu & Leino, 2017) is very helpful in categorizing cultural adaptations, particularly distinguishing between peripheral and core treatment components, there was no mention of salience of cultural adaptation within each category and subcategories. This is another area in need of further research.

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It would be helpful to understand the purpose of cultural adaptation(s) (the “why”), to be more intentional in the use of cultural adaptations. This component was also not included in the CTAF framework (Chu & Leino, 2017) and although the fidelity toolkit developed by Cummins and colleagues (2003) is helpful for documenting the purpose of adaptations, this work is still in its infancy. Many journals have word limitations or reviewers may place value on outcomes therefore restricting the ability of researchers to provide more detailed information about cultural adaptations. Discovering the underlying reasons for cultural adaptation could help identify patterns and guide future cultural adaptation efforts.

Empirically supported treatments that are culturally adapted using Tribal Participatory Research (TPR) methods including Community-based Participatory Research methods, which emphasize collaboration, may be more likely to include richer cultural adaptation descriptions and be classified as deep structure adaptations as demonstrated by Whitesell et al (2018). These participatory approaches may influence how cultural adaptation is done and whether it aligns or not with how cultural adaptation has been accomplished so far.

### **Summary**

Given that the topic of cultural adaptation is still in its infancy, it is most appropriate to design a qualitative study to explore lived experiences at the provider level. In conducting this literature review a study, exploring mental health provider experiences in implementing ESTs was not found. Most studies to date have focused on attitudes towards EBTs generally, not ESTs particularly, and not the experience of implementation. Because Cultural Adaptation Science is a quantitative approach, it does not take into account mental health provider experiences. Conducting a phenomenological approach to capture these experiences is the necessary next step to add to the understanding of culturally adapting ESTs with AI/AN populations. It is important

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that this work move forward with this important perspective. Mental health providers are situated directly in the middle of how ESTs are implemented within tribal communities. It is not exactly known how mental health providers are implementing and culturally adapting ESTs for use with AI/AN populations after they receive training and consultation. Consequently, it is important to explore how mental health providers are perceiving and resolving the fidelity and fit of any given EST when using it with AI/AN populations. Therefore, interviewing them can provide information on how cultural adaptation is actually being put in practice.

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## CHAPTER 3.

### METHODOLOGY

Exploration of the implementation of empirically supported treatments (ESTs) in AI/AN populations is still in development. To better understand this phenomenon, it is appropriate to explore mental health providers' lived experience to improve our understanding of culturally adapting ESTs. This study took a phenomenological approach to gather data from multiple sources to investigate the lived experiences of mental health providers. The use of a demographic survey and semi-structured interview allowed participants to openly share their responses. The semi-structured interview explained that cultural adaptation has been defined in several ways and because it is a newer area of study, there was no "right way" to do this. Prior to asking questions it also instructed participants to take their time and gave them permission to reflect prior to answering if needed.

Skillfulness is required to reveal enough information to describe the process of cultural adaptation without disclosing sensitive information about tribal culture that tribal members may wish not to be shared. Researchers that align with best practice remain sensitive to what types of cultural information can or cannot be published in a public forum and seek consultation from the tribe. In light of the absence of information on cultural adaptation, this research describes the process of cultural adaptation as opposed to revealing specific information about tribal culture. I leaned toward removing information when it was less clear as a precautionary measure. I removed names of traditional ceremonies and practices. Names of communities and tribes were also removed to further protect tribal confidentiality.

This chapter presents the methodology used. First, the rationale for choosing a qualitative method and more specifically how a descriptive phenomenological psychological approach was

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chosen to explore the research question. Next, the researcher lens and accompanying bias relevant to this topic is presented. Subsequently, five chronological phases of survey development, interview protocol development, interviewing, and coding and data analysis will be discussed.

### **Qualitative Approach to the Research Question**

In order to strategically choose a research method for this study, it was important to understand the underlying philosophies of qualitative, quantitative and mixed method approaches that guide their use (Hathaway, 1995). Qualitative and quantitative research stem from very different underlying philosophies; and therefore serve different purposes and each has benefits and limitations.

Overall, the underlying ontological and epistemological philosophies of qualitative approaches is that due to individual differences, a subjective viewpoint needs to be taken to interpret the phenomenon being studied and the results are explained using inductive reasoning (Hathaway, 1995). The researcher is more involved in the research as a subjective individual with biases. These biases are stated prior to conducting the study. Because qualitative approaches use methods such as interviewing or observing phenomenon, more time is spent on data collection than in designing the study.

In contrast, quantitative research has arisen from positivism (Walker, 2005) or now often referred to as post positivism. Post positivists have challenged the earlier idea of being absolutely positive due to the nature of uncertainty when studying human beings/behavior (Creswell, 2009). This approach is based on the assumption that the researcher can observe phenomenon objectively and that as long as you can accurately define variables and tools of measurement, you can quantify data (Creswell, 2009; Walker, 2005). The researcher in this approach is able to be



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more objective and therefore is less susceptible to bias (Walker, 2005). More time is spent designing the study to consider possible confounding variables and threats to internal and external validity.

Creswell (2009) suggests that the selection of the research design rests on the research problem or question, personal experiences (including orientation and professional discipline, and the audience). The first reason a qualitative study was chosen is that it is a better method to answer the research question: What is the experience of mental health providers in culturally adapting empirically supported treatments for American Indian and Alaska Native populations? This research question's purpose is to understand the experience of individuals as opposed to defining the experience for individuals and quantifying the quality of these experiences. The second reason a qualitative study was chosen is that cultural adaptation is a phenomenon that is not easily quantifiable. Similarly, there is still various qualifications to be considered an empirically supported treatment. This is consistent with research in the counseling field as it is full of concepts that are not easily measured. For this reason, Hays and colleagues (2016) assert that qualitative research is more in line with counseling as opposed to quantitative methods. The third and final reason for choosing a qualitative approach is that there has been less emphasis on qualitative approaches to studying cultural adaptation of ESTs in general, and with AI/AN populations in particular. This study may be appealing to many stakeholders such as cultural adaptation researchers and upcoming researchers interested in this topic.

Several primary methodologies are employed in qualitative research. According to Hays and Wood (2011), out of the 15 or more approaches used in qualitative research, counseling researchers tend to use grounded theory, phenomenology, consensual qualitative research (CQR), ethnography, narratology, and participatory action research (PAR) more consistently

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than others. According to Creswell (2009), there are nine basic characteristics of qualitative research that are similar regardless of the particular approach used. These characteristics include: (1) interacting with participants in their natural setting, (2) the researcher is a key instrument to gather data whether or not an instrument is used, (3) multiple sources of data are collected so as not to only rely on one avenue, (4) uses inductive data analysis to build themes and more abstract concepts from the data, (5) focus on participants' meanings not the researchers or others who have written about the topic, (6) uses an emergent design, meaning that plans are flexible and phases of the process may change as the researcher begins to collect data to better answer the research question, (7) uses a theoretical lens, (8) is interpretive, meaning that because the researcher collects data it is up to the researcher to make sense of the information and make an interpretation of what they see, and (9) developing a visual holistic model to encompass the big picture view of the phenomenon (p. 175-176).

In choosing a specific qualitative methodology, it was helpful to review five questions developed by McCaslin and Scott (2003) for choosing a qualitative approach. Each of the five questions corresponds with one of the five major qualitative approaches (biography, phenomenology, ethnography, case study, and grounded theory) respectively. The five questions are: (1) biography-if I could discover the meaning of one person's lived experience, I would ask (individual) about (topic), (2) phenomenology-if I could discover the shared lived experiences of one quality or phenomenon in others, I would want to know about (topic), (3) ethnography- If I could experience a different culture by living/observing it, I would choose to experience (topic), (4) case study-if I could discover what actually occurred and was experienced in a single lived event, that event would be (event), and (5) grounded theory-if I could discover a theory for a single phenomenon of living shared by others, I would choose to discover the theory of (topic)

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(McCaslin & Scott, 2003, p. 450). After reviewing these questions, it was clear to see that phenomenology was the appropriate choice for answering the research question: What is the experience of mental health providers in culturally adapting empirically supported treatments for American Indian and Alaska Native populations? In conducting the literature review on the cultural adaptation of ESTs for AI/AN populations, not one article was found to use a phenomenological approach to study this topic.

**The descriptive phenomenological psychological method.** Edmund Husserl (1859-1938) is considered the father or founder of modern phenomenology (Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013). Phenomenology is the study of how a phenomenon (relationship between person and object) presents itself to our consciousness in order to develop a deeper understanding of it (Giorgi, 2012). There are two variants of phenomenology, descriptive or static phenomenology and transcendental or genetic phenomenology (Sousa, 2014). Static phenomenology describes Husserl's thinking during this earlier work, and is where a researcher perceives a phenomenon (relationship between person and object) as fixed or unchanging (Sousa, 2014) in order to understand its essence (Tuohy et al., 2013). Genetic phenomenology, was developed by Husserl later; he referred to it as a "living present," where the researcher takes into account the historical origins of a phenomenon (Sousa, 2014, p. 36.). This study uses a descriptive or static view of phenomenology.

Husserl believed that individuals perceive the world using a "natural attitude" (or sometimes called a "natural theoretical attitude"; Husserl, 1982, p. 5). This means that individuals understand and experience the world how it naturally appears to us, outside of our subjective perspective. In conducting research then, a "phenomenological attitude," is taken to suspend our "natural attitude" (a process known as epoché, a Greek term), to intentionally focus

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on the subjective experience of a given phenomenon (Giorgi, 2012). Said another way, the researcher's role is to not claim the experience exists the way that it presents but perceives it as a phenomenon (Giorgi, 2008). This process is referred to as taking a phenomenological reduction (Giorgi, 2012).

In preparing to conduct this study, I assumed a "natural attitude" about the experience of implementing cultural adapted ESTs. I observed it as it appears and assumed others writing about it assumed it in the same way to be able to conduct the literature review. In transitioning to a "phenomenological attitude," I was in a mode of discovery to explore what this experience means from the subjective view of mental health providers.

This study used a descriptive phenomenological approach (Giorgi, 2012), meaning the researcher has attended to the participants' descriptions of the phenomenon under study and rigorously examined the descriptions as they have been recorded. In contrast, interpretive phenomenology is when the researcher seeks to understand participants' experiences of the phenomenon, then transfers this knowledge into a coherent story or narrative. This does not mean that there isn't room for interpretation within the descriptive phenomenological psychological method, and in fact is used in the development of the mental model as outlined in the analysis section (Giorgi, 2012). Because the descriptive phenomenological approach discourages a lot of interpretation, it requires the use of "bracketing" which essentially means that the researcher attempted to explore the experiences of mental health providers while suppressing past experiences and knowledge in order to focus on participants' experiences as they were presented (Giorgi, 2008).

Because Husserl's original phenomenological method was philosophical, the researcher conducted this analysis using a second phenomenological reduction (Giorgi, 2008). Husserl

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(1931) later advanced his approach to additionally require the need to explore the eidōs or essence, which means exploring the features that make a phenomenon what it is. This process is also referred to as an eidetic reduction. To understand this process in context of this study, using an eidetic reduction, it is important to explore the question, “what makes cultural adaptation a cultural adaptation?” or “what is the essence of cultural adaptation?” More generally, the researcher asks what are the necessary and invariant features that make a phenomenon what it is and how participants perceive it collectively (Touhy et al., 2013). For example, considering if cultural adaptation is still cultural adaptation no matter who does it?

In carrying out the descriptive phenomenological psychological method, it was fairly clear to choose Giorgi’s (1975) method after reading an article by Lisa Whiting (2001) where she describes her exploration of other phenomenological methods in comparison to Giorgi’s (1975) method. Whiting (2001) cites five reasons for choosing this method: (1) he (Giorgi) focuses on descriptions and experiences and follows the Husserl tradition, (2) his method is understandable and applicable, (3) the method is not fixed or structured which allows for flexibility to study the specific topic at hand and analyze its associated data, (4) others have used it with success, and (5) he himself has analyzed and developed Husserl’s phenomenological approach and his method includes a data analysis process and is not specifically theoretical (Whiting, 2001, p. 62). These are strong reasons when compared to other more recently developed phenomenological research methods.

Although Giorgi’s (1975) method for analysis was chosen for this study, phenomenological methods are still debated (Finlay, 2009). Despite this debate, it seems that most developers of phenomenological research methods would collectively agree that analysis should include phenomenological reduction, description, and search for essences (Finlay, 2009).

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### **Researcher Lens**

Currently I serve as the Director for the National Native Children's Trauma Center (NNCTC) and have worked there in the past as a Behavioral Health Specialist. While working for the NNCTC, I have had the opportunity to participate in implementing ESTs with AI/AN populations. I am also currently participating in a workgroup to use AI/AN perspectives to modify Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2003) for AI/AN populations. I have observed that it has never been the case where training in an EST has occurred without the need for subsequent cultural adaptation. This important work has highlighted the nuances and differing opinions on the best approaches to the cultural adaptation of ESTs.

A few years ago, the NNCTC trained Indian Health Service, tribal behavioral health programs, and other mental health providers serving AI/AN populations in Child and Family Traumatic Stress Intervention (Berkowitz, Stover, & Marans, 2011); an intervention designed to prevent the onset of Posttraumatic Stress Disorder. During the subsequent Learning Collaborative, or guided approach, including a series of calls with the developer to facilitate implementation (Burroughs, Amaya-Jackson, Griffin, Ebert, & Guidi, National Child Traumatic Stress Network, 2013), it was found that many mental health providers could not identify children and families to use the intervention with due to clients being out of the peritraumatic window of time the intervention was designed for. Although this four-session intervention was promising, this is an example of an EST that did not fit the particular setting in which it was being implemented. Although guidebooks are currently being developed to provide topics of consideration for agencies in the selection of ESTs, situations such as these have biased my opinion that not all ESTs can be easily modified for implementation with AI/AN populations in

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all settings with all mental health providers. I recognize that it is possible for ESTs to eventually be implemented and helpful. However, it often takes much reflection and problem solving since it seems that most EST developers leave cultural adaptation to mental health providers responsible for implementing. I believe this results in a trial and error process that could be ethically questioned.

Having worked as a full-time Licensed Clinical Professional Counselor, I have found it difficult to allocate personal time and resources to sufficiently engage in formal cultural adaptation of treatment models. I sought out to be trained in culturally adapted mental health treatments but found there to be very few available and when they were available, they were costly. I found that often training and consultation in implementing the original treatment was needed prior and in addition to participating in a separate training and consultation process for the culturally adapted version. I also discovered that mental health agencies tended to choose specific treatment models for the agency and did not necessarily allocate funding for other training opportunities. As a counselor, I received training in multicultural counseling competencies, but not necessarily cultural adaptation of treatment models for specific minority populations.

As a tribal member, it is difficult to accept empirically supported treatments at face value without considering the cultural context in which implementation occurs. As a community member, I have heard of countless stories of poor cultural sensitivity when receiving services by mental health agencies, particularly those who are administered by federal and non-tribal entities. I recognize that these negative experiences are rooted in the historically rooted, conflicted relationship with the U.S. government and non-tribal organizations. Because of this reality, it is even more important to ensure treatments that are being implemented by mental health providers

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are both effective and culturally sensitive. Albeit the complexity and mixed opinions about how best to ensure treatments are effective and culturally sensitive, I believe there is a place for these concepts to converge.

Generally speaking, I view the implementation of empirically supported treatments as a mandate from institutions with power and resources to determine what is best for all individuals with mental health needs, including AI/AN populations. This approach does not adequately take into account AI/AN voice and choice, which is a trauma-informed principle according to the SAMHSA's Concept of Trauma and Guidance Toward a Trauma-Informed Approach (2014). I am not particularly opinionated as to how cultural adaptation happens or if it is used, but I am more concerned about the ability of AI/AN communities to decide how this should be done or if this is the approach clinicians should be using.

As a result of exploring my biases, I recognize that my perspective could influence my analysis; it could cause me to look for and highlight examples of poor EST fit with AI/AN populations. My perspective could also sway me to judge how collaborative clinicians are in culturally adapting and implementing ESTs with AI/AN populations. Similarly, I may have the tendency to discount positive stories of implementing culturally adapted ESTs. Due to these possibilities, it is important to describe how trustworthiness, accuracy, and verification of the data will be established to prevent these biases from influencing the interpretation of results. This will be described in Phase IV of the research methodology. The next sections will describe the phases of this approach.

### **Phase I: Development of the Guided Semi-structured Interview Protocol**

The guided semi-structured interview protocol was the first document to be developed. It includes an opening statement, consent to participate form, and interview questions (see Appendix A). The interview protocol was reviewed by four mental health providers and those



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with a mental health or counseling related background that identify as AI/AN. One expert informant, prior to reviewing the Guided Semi-structured Interview Protocol, participated in an interview as a mock participant in order to pilot the Guided Semi-structured Interview Protocol prior to Phase II. Expert informants reviewed the Guided Semi-structured Interview Protocol either before or after the mock interview. None of the expert informants reviewed it twice. Piloting the Guided Semi-structured Interview Protocol helped to ensure that interview questions were appropriately worded, the approximate length of the interview could be determined in order to inform participants in Phase II, and to ensure the Guided Semi-structured Interview Protocol's accuracy at capturing the essence of the phenomenon under study.

It was foreseen that participants might feel scrutinized about the way they have made cultural adaptations with AI/AN clients. Therefore, an explanation validating all potential experiences was included in the opening statements stating that any all experiences are accepted and that there are no right nor wrong answers. Piloting the Guided Semi-structured Interview Protocol tested whether the validation statement was sufficient to allow participants to feel comfortable sharing their experiences. It is acknowledged that this research cannot guarantee absolute truth from participants; however, in order to further create comfort, participants had a choice in how the interview was conducted. Depending on feasibility, the interview could take place in person, by video using Zoom, a videoconferencing software, or by just phone.

### **Phase II: Development and Distribution of a Qualtrics Survey and Other Preparation**

#### **Tasks**

I developed a Qualtrics survey (see Appendix B) to distribute online as a sampling strategy to help identify potential participants. The rationale for using a Qualtrics survey was that it would have been more difficult to identify potential participants due to the specificity of the

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participant inclusion criteria. The Qualtrics survey's cover page included necessary information about the study including the title, investigator and faculty supervisor contact information, inclusion and exclusion criteria, purpose of the study, procedures, potential risks and benefits, confidentiality, a voluntary participation/withdrawal statement and a statement of consent. The Qualtrics survey contained specific questions and helped the potential participant know whether they met the inclusion criteria to participate. If the potential participant did not meet the inclusion criteria, they were directed to a statement letting them know this status, thanking them for their interest and encouraging them to share the survey link with others who might meet the criteria and be interested in participating. If potential participants met the inclusion criteria, they were given two choices. They could both provide their contact information and allow permission for me to contact them or they could opt out of the study.

University of Montana Institutional Review Board approval was sought after the development of the Guided Semi-structured Interview Protocol and the Qualtrics survey. Appendix C includes the UM IRB approval letter with expedited review. As part of the IRB application, a research flyer was developed to conduct outreach (see Appendix D). After UM IRB approval was obtained emails with the approved flyer were disseminated.

Also, after developing the Qualtrics survey, I sought research assistants who could help transcribe and code interviews. One research assistant was an American Indian female, undergraduate, communications major who was in the last semester of her studies. She assisted in transcribing in order to fulfill an internship requirement. The other research assistant was a White female, who recently graduated with her Bachelor of Arts degree in Psychology and was applying to Graduate School programs. This research assistant was able to assist with transcribing but also coding and analysis. Both research assistants had limited exposure and

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experience in conducting qualitative research or had little background knowledge of cultural adaptations or empirically supported treatments. Both research assistants were provided with a verbal explanation of the study and also provided with the dissertation proposal, which included the introduction, literature review, and proposed methodology.

**Participant recruitments.** Distribution of the Qualtrics survey targeted licensed mental health providers. The criteria for licensed mental health providers to participate in this research included (1) implemented an empirically supported treatment on the list developed by the Society of Clinical Psychologists, (2) engaged in cultural adaptation of at least one of these treatments with American Indian and Alaska Native clients, (3) 18 years of age or older, and (4) resided in the United States. An attempt was made to obtain participants who self-identify as AI/AN and non-AI/AN, worked in a tribal community during implementation, as well as those who were working in an urban area during implementation. Consistent with the descriptive phenomenological psychological method, the selection of participants rested on not how many participants but reflecting on whether the participants had the experience related to the central research question (Englander, 2012). Exclusion criteria included: (1) mental health providers who are only using telemental health to provide counseling services, (2) license-eligible mental health providers, and (3) 17 years of age or younger.

**Sampling design.** Snowball, purposive sampling was also used to recruit participants. At the end of the interview, I asked participants if they could identify anyone else who might meet the inclusion criteria and would be interested in participating. As stated prior, the Qualtrics survey encouraged potential participants who did not meet the inclusion criteria to disseminate the research flyer and the Qualtrics link. This allowed additional participants to continue to be identified as the study progressed. When participants identified potential participants, the

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Qualtrics survey and the research flyer was distributed to them specifically or by the participant. When potential participants contacted me directly, inclusion and exclusion criteria were reviewed by phone. The Qualtrics survey kept individuals anonymous unless they met the criteria for participation and supplied their contact information. The Qualtrics survey was continuously distributed until data saturation was reached, which means until no new information was arising from interviews with participants (Kleiman, 2004). More information about how data saturation was determined is discussed later.

In order to identify participants, multiple sources were used. The Qualtrics Survey was distributed via email to mental health providers in my professional networks (e.g., colleagues, co-workers). The best method for recruiting participants was by individually emailing potential participants. This was achieved by searching Urban Indian Health Organizations mental health program and Tribal Behavioral Health Program publicly available contact information. This resulted in some individuals who contacted me by email to say that they did not meet the inclusion criteria but provided colleagues' names and contact information who might be of interest. I checked the Qualtrics survey report frequently and when someone supplied their contact information, I contacted them by email to discuss coordination in order to set up an interview. After this initial contact, I did not further email the participant until the potential participant responded to the email.

### **Phase III: In-depth Interviews with Mental Health Providers**

A description of each participant is provided without identifying information. It was necessary to remove tribal affiliation, and broaden the type of work setting and geographic areas where clinicians have practiced to prevent possible identification that could affect their current

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work. Due to the limited number of mental health professionals in tribal communities, providing specific demographic information could compromise their confidentiality.

**Description of participants.** Using initial study advertisement survey replies and then snowball sampling over fifteen individuals responded. Based on the study's inclusion criteria and point of saturation, eight participants were included. Five of the participants identified as female and three as male. Three participants were Licensed Clinical Psychologists, two were Licensed Clinical Social Workers, one was a Licensed Clinical Professional Counselor (also referred to as Licensed Professional Counselor), one was dually licensed as a Licensed Professional Counselor and a Licensed Marriage and Family Therapist, and one participant was a Licensed Addiction Counselor. Participants ranged in age from 38-57. Participants varied in the number of years they have worked with AI/AN populations (4-35 years). Four participants identified as Caucasian or White, three participants identified as American Indian and one participant identified as both American Indian and White. Each participant was assigned a number and pseudonym based on the order in which they were interviewed.

***Participant 1.*** Melissa is a female who identifies as American Indian and White. She has been providing counseling for seven years. She has worked in an Urban Indian Health Center and a mental health agency with several locations. She has worked with AI/AN clients in urban and in reservation communities. Melissa currently holds a supervisory role at her agency in the Midwest.

***Participant 2.*** Jane identifies as a White female. She has been working primarily with AI/AN populations her entire career in both urban and reservation communities for almost thirty five years. She has practiced in the Midwest and Southwest United States.

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***Participant 3.*** Robert identifies as an American Indian male practicing in the Midwest United States. He has been in the counseling field since 1991 and has experience counseling and directing programs in many types of settings both in reservation communities and in urban settings, but has always primarily worked with AI/AN populations.

***Participant 4.*** Jennae identifies as a White female. She has been practicing for about ten years as a counselor in an agency that serves AI/AN clients in a reservation community in the Midwest.

***Participant 5.*** Amber identifies as an American Indian female. She has provided services to AI/AN clients and families in both urban and reservation communities for four years, however, most of her experience is from working in her home reservation community.

***Participant 6.*** Lauren identifies as a White female. She has over 20 years experience providing counseling services. Lauren spent her earlier counseling years practicing in a school based reservation community setting and since then has been in private practice in an urban area primarily serving Caucasian clients.

***Participant 7.*** Charles identifies as a White male. He has been a counselor since 2002 and has worked in a variety of settings including schools, medical clinics, community mental health clinics, and in private practice. The majority of his experience in providing counseling with AI/AN populations has been in Alaska.

***Participant 8.*** Jalen identifies as an American Indian male. He has seven years of experience working specifically with AI/AN populations. He is the lead clinical supervisor at his agency. He has primarily provided services in the south and southwestern United States.

**Interview setting.** Participants were given the option of meeting in person if it was feasibly able to be arranged. Otherwise the interviews occurred via the Internet using Zoom, a

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videoconferencing software program. Participants chose between using the video chat function or whether to join by audio only. In two instances, the participants would have been open to video chat but due to technological difficulties, the interview was conducted by audio only.

**Procedure.** Participants who participated in Phase II and who met the eligibility requirements (i.e., inclusion and exclusion criteria) were provided the option to provide their contact information for me to reach out to them. Prior to the interview I engaged in either email exchanges, text messages, or phone calls with participants (at their preference) to provide an opportunity for them to ask questions about the study, inform them of the length of the interview, explain the technology used, the intention to audio record the interview, and to set up a meeting date and time.

At the time of the interview, participants were provided with directions to the meeting facility or instructions to meet via Zoom technology. Upon meeting participants for the interview, I explained the purpose of the study, research procedures (i.e., the use of technology used to record, plans for the deletion of recordings, data storage), any possible harm of participation, and answered any questions the participant may have had.

As outlined in the Guided Semi-structured Interview Protocol, the risks and benefits of participating in the study, how they were chosen for the study, confidentiality, and the identities of the research assistants and their roles were described. Prior to proceeding with the interview, I let participants know about my intention to use two handheld digital audio recorders, one for recording and the other for backup, in the case of malfunction. This was true even when using Zoom, as I did not want to record the video only audio. I then made sure the participant had no further questions before obtaining the participant's verbal consent to audio record the interview and to participate in the research interview.

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Interview questions were asked sequentially. Some questions were reworded to assist with the flow of the interview. Demographic information was sometimes asked prior to the interview questions or after depending on what felt appropriate. After the interview, the participants were thanked for their time and were provided with a beaded gift in person or by mail.

Upon completion of the interview, two research assistants (RAs) helped transcribe and code the data. Once an interview was completed, each interview was transcribed using Express Scribe. I organized and led a transcribing workshop for the RAs so they could get familiar with the computer software and technology used to transcribe the interviews. One research assistant transcribed two interviews, one research assistant transcribed three interviews, and I transcribed three of the interviews. Once six interviews were transcribed, I listened to all audio recordings while checking the accuracy of the transcriptions. The transcribed interview files were imported into Nvivo 12. A University of Montana Box folder was used to back up data in NVivo.

I continued to conduct interviews until saturation was reached, that is until there was no new data arising in subsequent interviews (Hunt, 2011). Inductive thematic saturation was used to determine saturation. Inductive thematic saturation is based on codes rather than the completeness of theoretical categories (Sanders et al, 2018). Although there is some debate about when saturation has been reached, recent perspectives have shifted the question from when has saturation been reached to a question of how much saturation has been reached (Saunders et al, 2018). A constant comparison approach was used to determine saturation because the procedure complements the coding procedure used in Phase IV: Coding and Data Analysis. Leech and Onwuegbuzie (2007) provide a detailed description of how to conduct a constant comparison analysis. First, I (and research assistants) read the transcribed interview in its entirety. Second, I



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dissected the whole into meaningful parts. Third, categories are developed from the codes. Data saturation is reached when no new codes or categories emerge from additional interviews. Leech and Onwuegbuzie (2011) outline a step-by-step approach to conduct constant comparison using NVivo (see Appendix E for the slightly adapted version for NVivo 12). This process involved developing nodes (codes) and tree nodes (categories). Coding stripes allowed me to see the frequency of nodes. Constant comparison of nodes was conducted after the sixth interview. After the sixth interview, the frequency of nodes were reviewed after the seventh and eighth interviews were transcribed and coded in NVivo. As coding took place, it was readily apparent that there were very few new nodes being added and more importantly, no new revelatory constituents being added to the existing data. The next phase describes the process of how coding and data analysis was conducted.

### **Phase IV: Coding and Data Analysis**

The results are situated within the subjective viewpoints to study experiences and phenomena, “while also allowing findings to emerge from the data rather than having preconceived or predetermined ideas/hypotheses about potential findings” (Hunt, 2011, p. 296). Essential to the analysis consistent with the descriptive phenomenological psychological method is to modify the transcripts into third person prior to data analysis (Englander, 2012). This allowed me to maintain an objective stance and engage in bracketing when analyzing and describing participants’ experiences into a coherent psychological structure (see Appendix F for codebook sample).

### **Description of the Analysis**

A process of phenomenological psychological analysis was used with clearly identified steps as Giorgi (1975; 2009; 2012) outlines. The first step is to assume a phenomenological

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attitude to explore the phenomenon while bracketing my preconceived notions. The second step is to read the entire written account for obtaining a sense of the whole. Although I read the entire written transcriptions for accuracy, in order to not multi-task checking for accuracy and obtaining a global sense of the interview, I read the entire written transcript at two times. Once this occurred after transcription and again after all information was chunked into meaning units. Delineating meaning units is the third step using this method. According to the descriptive phenomenological research method, meaning units are determined by looking for psychological shifts in the participant's narrative. These can be either internal (i.e., feelings) or external (i.e., topic). Unlike other qualitative methodologies that use line-by-line coding strategies, it is common for meaning units to be lengthier and often include multiple sentences. The fourth step is to transform these meaning units into a label describing these lived meanings into third person statements. Lastly, a general psychological structure was developed by determining what the constituents are of the experience. This is achieved by separating the whole from the sum of its parts. In other words, the constituents are the fundamental components of the participant's collective lived experience that cannot be removed without severely limiting our understanding of their experience (Schultz & Cobb-Stevens, 2004; Whiting, 2001). Once the constituents of the data were identified, direct quotes were pulled from the transcripts to substantiate or support each construct.

During data analysis, free imaginative variation was used to examine the information from all possible perspectives (Giorgi, 2008). In this process, evidence was explored that contradicted or supported my biases in order to consider whether they were influencing the data analysis. This involves perceiving the data from different lenses or perspectives to understand each phenomenon's essence. In this process, the goal is not to establish facts or bring in

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interpretive assumptions but rather understand the phenomenon from the participant's perspective and take it for what it is and how it has been explained.

Creswell (2009) points out that the method, the research questions, and the analysis should be interconnected. It has already been discussed why a phenomenological approach, and Giorgi's (1975) method of analysis in particular, was chosen; however, it is important to discuss how the research question and the three sub-questions were considered while developing the Guided Semi-structured Interview Protocol and in conducting the analysis. These sub-questions were developed to collect information related to the central research question. This is why the draft interview protocol included open-ended questions and a specific question asking participants if they would like to add additional information beyond what was asked. Although the Guided Semi-structured Interview Protocol questions can be organized under the central research question and organized into sub-categories (i.e., decision-making, methods of cultural adaptation, and implementation), it is important to acknowledge that bracketing also included suppressing these pre-supposed categories.

I attempted to intentionally engage in bracketing by exploring my biases (specifically by beliefs about ESTs and cultural adaptation), and my own prior experiences with ESTs and cultural adaptation. This was most important during the first and fourth step of Giorgi's method (1975; 2009; 2012). During the first step (adopting a phenomenological attitude), I attempted to forget what was in the literature review and explore the information from this new perspective. During the fourth step, I transformed the 404 meaning units into a label describing these lived meanings into third person statements. In instances where I agreed with the participant I found myself accepting this as truth and labeling it as truth. In instances where I disagreed with the participant, I found myself starting the label with "Participant thinks..." and then labeling. I

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reviewed all labels to change these statements to only state the label without this phrase so that I would appropriately code the resulting labels without remembering which ones I readily accepted as truth and which ones were different from my pre-existing assumptions. All resulting labels were included during the next phases of analysis. In order to remain in a phenomenological attitude, coding and analysis of the data was done without the sub questions in mind. This allowed me to analyze the data as it emerged from participants instead of psychologically organizing participant responses into presupposed categories.

The general psychological structure was developed from the constituents of the data by using a mental model. A mental model is a visual representation of the concepts and relationships between concepts from the data (Creswell, 2009). Content analysis, procedural mapping, task analysis, and cognitive mapping are all ways that have been used to develop mental models (Carley & Palmquist, 1992). The most relevant way to develop a mental model for this research is a type of content analysis called map analysis. Map analysis compares concepts and the relationships (including the strength, sign, direction, and meaning) between these concepts (Carley, 1993). Carley (1993) outlined several decision-making points that needed to be undertaken in map analysis but also discusses that there is no way to plan this out beforehand and that it is better decided after the researcher collects and completes coding. Specific to descriptive phenomenological psychology, Giorgi (2009) discussed that the resulting psychological structure should represent how the constituents are derived from the participants shared experiences.

**Trustworthiness of the data.** In order to establish trustworthiness of the data it was important to be able to establish accuracy (or credibility) and verification (or confirmability) of the research findings (Anney, 2014). This was achieved through peer debriefing. Peer debriefing

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included having others engage in the coding and analyzing the data and also included presenting my findings to obtain feedback to help get other perspectives of the data (Anney, 2014). Peer debriefing occurred after all data was transcribed and delineated into meaning units but before constituents were identified. During one peer debriefing session, one page of a transcript was provided to eight doctoral peers and a visiting professor. It is important to note that the visiting professor recently completed a dissertation using the descriptive phenomenological method and provided feedback based on this experience and knowledge. These peers engaged in step three of the method, which is to delineate the interview into meaning units. Although there were some differences, the resulting meaning units matched mine. Additionally, one research assistant engaged in delineating one full interview transcript into meaning units and transforming these meaning units into labels. This research assistant also reviewed coding in Nvivo, and the general psychological structure.

Note taking provided additional documentation during or subsequent to the interviews with research participants. The purpose of note taking was to document my thoughts, feelings, observations, and particular words or phrases that seemed important or needed to be clarified while conducting the interview.

**Accuracy.** To ensure accuracy of the data, clarifications were sought during the interview for content that had not been fully understood. There were instances where the participants used analogies or described a situation in the third person and I failed to seek clarification about these experiences. Also, because technological difficulties (i.e., internet speed) affected the audio recordings, this created some small misunderstandings due to words being unable to be transcribed. Overall, this happened rarely and was a minor limitation. To increase accuracy of the data, transcriptions of the audio recordings were checked for accuracy prior to being entered

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into NVivo. Without this additional step, the interview transcriptions would have been less accurate and could have led to inaccuracies in the quotes used to substantiate the constituents.

All notes and codes were stored in NVivo to ensure others could review it for accuracy if needed. As described earlier, utilizing the coding strips feature in Nvivo allowed me to check for saliency and representativeness across participants within each of the nodes that were developed. These quotes are also referred to sometimes as “thick description” or “rich thick description” that present and describe the essence of the constituents that emerged (Anney, 2014; Creswell, 2013; Hunt, 2011; Kleiman, 2004).

Additionally, prolonged interactions or engagement with participants was used to help gain insight into the context of the phenomenon (Anney, 2014; Creswell, 2013; Hunt, 2011; Kleiman, 2004). Although this was limited when conducting the interviews via Zoom technology, my time spent with mental health providers was helpful in understanding the phenomenon.

**Verification.** To analyze participants’ lived experiences, an in-depth analysis was done. The transcripts were reviewed in their entirety at least two times utilizing codes to explore the underlying meanings and exhaust all possible perspectives using free imaginative variation. I was immersed in the data by conducting each interview then reading through the transcripts during each phase of the coding process. In order to conduct triangulation, a process for corroborating evidence (Anney, 2014), a research assistant read the original transcripts and cross-referenced the constituents and their accompanying description. As referenced above, I also conducted a peer debriefing session with the research assistant to review the constituents that had been developed.

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Although the use of member checks, a process of verifying the data with participants, is a strategy that has been used in many qualitative studies, Giorgi (2008) outlines five reasons not to conduct member checks in qualitative research. The first reason is that participants describe their experiences while in the natural attitude, not from the phenomenological attitude. The second reason is that some expertise is required to understand the results with knowledge of descriptive phenomenological research and its philosophical underpinnings. The third reason is that when the data are presented back to participants we are asking them to confirm what was lived through a perspective causing them to use a phenomenological reduction. The fourth reason is the idea that participants can correct their experiences rendering the data fragile and paradoxically, more untrustworthy. Giorgi (2008) asks, “Why go through such a long procedure and possibly not get it right, when a simple word from the [participant] can presumably tell the researcher exactly what needs to be known? (p. 6). The fifth reason is the problems that arise from trying to sort out what to do to resolve the corrections. For example, Giorgi (2008) uses an example of a researcher who followed up with some participants and received corrections but could not locate all the others resulting in less than 100% feedback to ensure verification.

### **Summary**

The descriptive phenomenological psychology research approach was used to explore the lived experience of mental health providers who have implemented culturally adapted ESTs with AI/AN populations. Since qualitative research analysis, using Giorgi’s (1975) phenomenological method, is flexible in its application, it was helpful to revise and rethink about the methodology prior to and during each phase. The findings of this study are presented in Chapter Four. These include ten main themes to exemplify clinician’s lived experience.

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## CHAPTER 4.

### FINDINGS

Results from this phenomenological study of eight clinicians' lived experience in culturally adapting an empirically supported treatment for AI/AN's are presented in this chapter. Over the course of 60-90 minute one-time interviews, eight constituents emerged from synthesizing the initial revelatory constituents arising from 404 meaning units utilizing Giorgi's (1975; 2009; 2012) descriptive phenomenological psychological method. These constituents are: (a) developing an understanding of cultural adaptation, (b) focusing on building and maintaining therapeutic relationships, (c) immersion and engagement with community, (d) experiencing conflict between Western and Indigenous epistemology, (e) navigating the use of empirically supported treatments, (f) supporting traditional and culturally developed ways of healing, (g) clinicians' ability to embody cultural humility and increase cultural competency, and (h) coping with external factors (see Appendix G for the descriptive psychological structure).

This dissertation was positioned around a central research question that guided the chosen methodology for this study. The central research question was: "What is the experience of mental health providers in culturally adapting empirically supported treatments for American Indian and Alaska Native populations?" Due to the emphasis on exploring the lived experience of mental health providers from their perspective, a phenomenological approach was used. A descriptive phenomenological approach was used instead of an interpretive phenomenological approach in an effort to describe participants' experiences from their perspective as opposed to letting the researcher have leeway to interpret participants' experiences. Raw data were utilized in the analysis as much as possible and the full interviews were read by the researcher multiple times to ensure participants' experiences were captured in its essence as much as possible.



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The semi-structured interview protocol was reviewed by several Native and non-Native doctoral level individuals and the questions were set up to gain insight into the psychological experience of clinicians as they recreated instances of culturally adapting empirically supported treatments. Because participants had a much broader definition of cultural adaptation to include cultural responsiveness generally, participants both shared experiences of being culturally responsive as well as specific examples of culturally adapting empirically supported treatments. The analysis thus reflects this broader focus. A wealth of information was gathered and an analysis was able to produce constituents of the phenomenon as experienced across participants.

The descriptive phenomenological psychological method was used to guide the analysis. This method involves five sequential steps: (a) adopt a phenomenological attitude, (b) read each entire written transcript to get a sense of the whole, (c) delineate meaning units, (d) transform meaning units into labels (described in the third person), and (e) generate a psychological structure by determining the constituents of the participants' experience. These constituents are presented in this chapter and substantiated using "rich thick descriptions" using verbatim quotations from the eight participants.

### **Revisiting the Sub-Questions in Light of Participants' Experiences**

This study addressed the sub-questions that guided this study. The first sub-question was: What rationale and/or circumstances lead to choosing to culturally adapt an empirically supported treatment? All participants discussed how they realized cultural adaptation was necessary at some point in their practice. Some participants believed that although ESTs were able to produce positive outcomes, cultural adaptation had the potential to enhance the work and produce even greater positive outcomes. Participants realized that what they were doing was not working or fitting with the client, some discussed their knowledge and history of AI/AN

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populations and some recognized that systems of care have been developed by the White majority population.

Although not answered as central to the constituents that emerged, I was able to document the various strategies the participants have used in relation to answering the second sub-question: What methods have been used to culturally adapt empirically supported treatment for this population? A table of these strategies are presented later in chapter four in the *Additional Findings of Interest* section. This table of strategies also include participants' attempts to be culturally responsive.

The third and final sub-question is: What are mental health providers' experiences in implementing the culturally adapted treatment with this population? Although questions were included in the guided semi-structured interview protocol to address this, participants discussed not only how they culturally adapted empirically supported treatments but also their attempts to be culturally responsive generally. The results therefore reflect how these clinicians have engaged in both processes.

### **Constituents**

As a reminder, constituents are the psychological structure of participants shared lived experiences. Constituents are determined by separating pieces from the wholes (also referred to as constituents). Wholes or constituents are shared by several or all participants and are necessary to understand the shared lived experiences of participants. Pieces are shared by only few or one participant and are not necessary to understand the shared lived experiences of participants and can independently exist. Moments are interdependent on wholes and pieces. An analogy offered by Overenget (1996) to further explain wholes, pieces, and moments is: A house is a whole, windows or doors are the pieces, and the color of the house is a moment. Therefore,

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the constituents are interdependent and make up pieces and moments. As a result, the content has some overlap as constituents are described in this chapter.

### **Developing an Understanding of Cultural Adaptation**

Participants had varying definitions of what cultural adaptation is. The primary purpose of exploring how participants defined cultural adaptation was not to develop a shared definition or a theory, but to understand how they personally defined it as arising from their experiences. Participants described cultural adaptation as being difficult to put into words. Participants described it various ways including:

- Clinicians' understanding of self within the cultural landscape that's shared between them and the client
- Understanding and working within a frame of reference that resonates with the client
- Meeting the person where they're at
- Involves forethought of what might need to be changed and gauging how the client responds
- Identifying things that might be harmful or offensive to the culture or need a different perspective or explanation
- Recognizing that the client has a different worldview and to keep an open mind
- Involves knowing when to change something and seek help
- Involves education and trial and error
- Involves pre-work to explore potential changes
- Requires humility
- Involves empathy and dignity
- Focuses on the cultural needs of the client

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- Involves perspective taking and engaging in cultural humility, cultural empathy, and the belief that EST may need to be CA

Participants had other qualifiers for cultural adaptation. Jalen emphasized that cultural adaptation takes into account age and gender particularly when considering generational social norms. Melissa and Jane said that cultural adaptation includes subtle changes such as modifying the office environment by hanging up culturally relevant objects. Melissa further explained that for some individuals this will not matter but will matter for those who it is intended. Lauren emphasized that although the research literature has referred to these subtle changes as surface structure adaptations, these subtle changes have enhanced her credibility as a clinician and has reflected her attempts to modify her practice to fit the client's cultural needs. Cultural adaptation was also described as place based by Jennae as she considered she might culturally adapt her practice differently in another geographic area working with a different population or even with another AI/AN population than where she currently is. Although it is logical to assume that cultural adaptation is an intentional conscious act, Jane considered that cultural adaptation might happen on a subconscious level as she mirrors and matches the client.

Another attribute of cultural adaptation was the frequency in which participants engaged in cultural adaptation. Four participants discussed that cultural adaptation is continuously applied because every session something new is learned and applied by trial and error. Jalen explained he continually culturally adapts because the diversity of clients (religion, language, age, and acculturation) constantly evolve. Lauren stated that for her cultural adaptation has the potential to happen but does not always happen every session. Two participants described making changes "on the fly" or "in the moment." Although information on how clinicians have engaged in cultural adaptation over time as a clinician was limited to two participants, Charles described his

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cultural adaptation use as being “haphazard at first” and then became intentional over time. Jane echoed this as she described her growing confidence now as compared to when she was first beginning to provide therapeutic services. Two participants described feeling unsure at times, if they were engaging in cultural adaptation or just being culturally sensitive, or something else. These participant’s experiences would certainly affect their ability to recognize when to engage in cultural adaptation.

Developing an understanding of cultural adaptation includes the participants’ ability to recognize when to use it. This was a common initial step toward the intentional application of cultural adaptation. For these participants, “recognizing the need” came about in a variety of ways, including building knowledge about AI/AN culture, realizing that something needs to be modified to fit the cultural needs of clients they work with, or considering that they may not be accurately or fully conceptualizing what is happening. For example, Jane realized that what she was doing was not helpful and in order to make progress with her client, she needed to make changes that included the client’s culture. In one instance, she recognized that some clients did not understand the concepts of “catastrophizing” or “magnification.” It was not that it only took her spending more time to explain the concepts but she also had to use anecdotal stories from the client’s cultural context to help them fully understand what this meant. Jane described that she did not catch on to this right away and had learned this over time by asking clients if they understood.

The risk of not understanding the need to engage in cultural adaptation can have negative consequences. Jennae discussed that not recognizing the need to engage in cultural adaptation can lead to clinicians misperceiving their clients “for who they truly are.” Clients then are potentially not able to bring their authentic selves from their cultural context. Jennae said:

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We're the ones sitting on this side of the table, there is a power dynamic there...if we with the power do not shift the client may not be able to fully engage in the treatment.

Jennae acknowledged that she could not always rely on the client to explain everything to her that she needs to understand. This power dynamic between the clinician and client places the responsibility for cultural adaptation squarely on the clinician. This means that clinicians cannot always rely on clients to tell them when something needs to be changed.

AI/AN communities generally can also place responsibility for cultural adaptation on the clinician. Amber, who has provided services in her own community where she grew up, discussed the need for cultural adaptation as a requirement, so much so that it is expected. In this reservation community, Tribal members are the majority and White and other individuals from other ethnic groups or Tribes are the minority. Amber said, "Here we're always asking where's the culture?" She says this is because, "if you want people to really utilize it and make it their own" then this is necessary. Therefore, it would be advantageous for clinicians to recognize this expectation early on. When some participants were able to recognize the need for cultural adaptation, this meant not using some treatments if they have not been culturally adapted. Jane said,

You know like um, maybe even like Ellis's rational emotive therapy where you just dispute the thought...and I just look, even though I see its merits, and I understand that the concept of challenging, you don't just want to let these faulty thinking errors be flying around and not challenge them. But the method to practice that well, if it's not culturally adapted, I would stay away from it, personally...before, you might take a class that says Ellis is such a genius, and you know, dispute all irrational thoughts and here's how you do it and start now! And it's um, you know, it's like no, I'm not gonna (laughing). I'm going to stay away from that!

There are many elements to cultural adaptation as arising from participants' experiences. Two of the main elements appear to be determining what cultural adaptation means for participants as well as determining how and when to use it.

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### **Focusing on Building and Maintaining Therapeutic Relationships**

From the perspective of five of the participants, building rapport was the necessary conduit to carry out an empirically supported treatment. Participants put a lot of emphasis on building and maintaining relationships to develop and maintain rapport between clinician and client. Some participants believed the therapeutic relationship carried more weight than using an empirically supported treatment. Melissa said:

What you're really going to find is that they all work about the same but the crux of any of them being effective is that relational piece. And if you don't have relationship, you're not going to get anywhere.

Lauren had similar beliefs. She said:

It's been fairly easy um I guess my philosophy on therapy is I kind of trust in the process and my relationship with the client even more so than an intervention so it's not uncomfortable for me to not follow an intervention with fidelity if I feel like the process and relationship could benefit even more. The process and relationship is more important to me than fidelity of an intervention.

Participants believed that without a positive relationship providing treatment may become impossible or less effective.

As participants shared about developing therapeutic relationships with clients' they also emphasized: being genuine, developing trust, using a person-centered approach, being strengths based, and creating a safe place where the client can be authentic. Creating safety or comfort and altering recruitment and engagement strategies were ways to build relationship between not only the clinician and client but also the agency as a whole and clients or other community members. Specifically, many participants discussed the importance of culturally adapting recruitment and engagement as being central to establishing relationship and rapport with AI/AN clients.

Participants did this by changing intake procedures through various strategies such as:

lengthening the session time, conducting role induction, and modifying how or what questions

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are asked. Jalen talked about how cultural adaptation begins even before coming into contact with a client.

I think that you're doing it from even before you meet with a patient. So how are you advertising or how do they know about you. You know whether that is coming from word of mouth from family or whether you have advertisements in clinics or the places where people can see flyers. Even there you are having to decide how are we gonna be an open door for people and have people feel like it's going to fit them rather than okay this is a CBT thing and you are going to walk in here to get this or that. I think even before you see them you are thinking about how you are projecting yourself, or your company or your agency.

Jalen discussed that cultural adaptation not only includes what the clinician does but also how organizations as a whole are engaging with this population.

Participants likely value the therapeutic relationship with all clients, however, their experience is rooted in the need to develop trust. As they emphasize the need to develop relationship represents they do not have this trust and authenticity automatically but have to work intentionally to build and maintain it. This trust extends to trying to develop trust with clients' family members and the community at large.

### **Immersion and Engagement with Community**

Participants found it helpful to immerse themselves in the community by spending time in the community, attending cultural events, and sometimes even participating in ceremonies. As participants immersed themselves in community, they experienced an increase in engagement with clients but also their family and other community members. Five participants discussed that immersion resulted in them being vetted by community members. This community acceptance facilitated the ability to provide treatment, to culturally adapt treatments for their clients, and to assess the success of cultural adaptations strategies.

Many participants emphasized social engagement in the community as necessary. Robert discussed that social engagement for him really paved the way for the community to seek



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services from him after he played guitar with an elder community member and other community members saw them together. Robert further explained:

And my interpretation of that was that I needed some sort of approval from someone important, a legitimate person to come and spend time with. And I think that expanded my lens about what it means to culturally adapt in the sense that I need to integrate to some degree in this community and get to know folks in a personal way while at the same time recognizing that I'm not, that I'm a part of this community in a specific way. You know that I'm not from here and that makes me a little different but that I can also integrate and can be a part of the social realm and that I want to be that I want to be a part of it.

Aside from social engagement as a means toward clinician acceptance, another way clinicians have found community acceptance was through service provision. Jane recalled how typically, when providing services to AI/AN communities, additional family members would seek services after others have had positive experiences with her. Jane described a situation where this occurred:

Then they say you know I really like this and then there will be a whole another set of, 'I'm really not getting along with my partner and we don't really have good communication and I'm not sure what to do about that.' So then they might come in six or seven times with their partner and then the partner may say, 'You know I really have some issues around this that and the others,' then I would see the partner and then there would be like, 'Well, the grandma's really having a hard time.' So. So, it was I guess I never really thought of it before but there, it was more of a process of, of being invited into the family more, to the whole system. So it's ecosystemic or you know the layers became, it became its own process, and um that really did not happen with the non-Native's crowd.

Jane emphasized the difference of this in her experience of providing services in non-AI/AN communities.

Jalen recognized that community engagement is not just a means to recruit and maintain clients but to help treatment be successful for the client in the community.

Because if I'm not out in the community I'm not seeing people and how they are interacting with their world you know I'm just in this vacuum trying to create something in the session and that's not going to translate back into the community or outside my session.

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As Jalen articulated, spending time in the community allowed him to see how people interact with each other and prevented isolated thinking. He was able to learn much more and be more helpful as a clinician by immersing himself in the environment.

Community engagement also allowed participants to engage with the community to get their input on cultural adaptation. Amber described that in her reservation community, the community integrates culture everywhere and in everything. For her, obtaining verbal and written feedback from clients and community members was a way to seek their input. For Charles this meant asking clients directly in session. He tries to create a culture where he can check in with clients. For example, one of the questions he asks is, “Am I understanding this accurately from your personal perspective, your cultural perspective?” His hope is that he can create a context where they feel comfortable saying no.

Melissa saw not getting feedback from participants as harmful. She emphasized the concept of “nothing about us, without us” from the disabilities movement. These participants’ experiences emphasize how immersion and engagement with the community is a necessary component of cultural adaptation to be able to do it effectively. When participants immersed in the community it exposed them to the cultural context in which they were working in. It also allowed them exposure to Indigenous epistemologies in contrast to the Western epistemologies they have learned from.

### **Experiencing Conflict between Western and Indigenous Epistemology**

As participants developed and used cultural adaptations in their work, they found themselves in conflict between Indigenous and Western epistemologies. Participants reported attempting to navigate these two ways of knowing while providing services. The most exemplary clinician example of this was when Jane encountered a clinical supervisor who was not allowing

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her colleague to use a treatment developed for historical trauma. She was surprised by hearing this supervisor say things like, “It’s not scientifically proven. It’s not the Western way. It’s not the efficacious model. Historical trauma, why are you bothering with that?” Jane was immersed in the community, had learned about historical trauma affecting AI/AN populations, and even had been invited and participated in ceremonies. She understood the need to address historical trauma in working with this population. She described being surprised to face a supervisor who was not supportive of this and found it ironic that this was occurring in a reservation community “where the kids are growing up.” These Indigenous approaches to healing were viewed as in conflict with and less valued than Western approaches and the systemic norm.

Some participants described observing or experiencing systemic racism and spiritual harm as they or others attempted to engage in cultural adaptation. Participants described various scenarios including encountering group home staff reading about a ceremony and using it with American Indian youth with no guidance or being prohibited from supporting clients in smudging. In one instance, a principal assumed a student was using marijuana but was instead engaging in the practice of smudging. Jennae conceptualizes that this occurs because “clinicians are working in systems that have developed by the majority and do not always meet the needs of the client.” These kinds of events represent the clash between AI/AN populations and service systems. Jennae stated, “Obviously like systems and structural institutionalized um, bias, racism, and oppressive systems does not help.”

These events can pose a barrier for systems of care to serve AI/AN populations but also affect clinicians who are working in these settings. For Jane this meant she needed to get supervisor approval prior to implementing new strategies. Melissa observed Native colleagues became frustrated that they could not use Indigenous based treatment modalities and

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subsequently left the field altogether. These experiences would likely be a factor in shaping clinicians' perspective and approach to cultural adaptation.

Charles gave an example of how learning about ethics, and specifically boundaries, in a Western way prevented him from becoming a mental health resource in the community at first. He concluded that the strictness in which he followed the professional ethical code led to the rigid application of these concepts. Charles said:

And, not to say that I was just going around you know going out and you know going out to lunch with one of my clients or something like that. But interactions with clients or seeing them in community within Native communities where I worked was a common thing and so I think that helped me learn to adapt culturally from kind of an ethical standpoint of about these ethics codes that are supposed to guide my behavior and I am supposed to learn the cultural nuances of that a little bit better.

Charles sought supervision on these types of encounters and ultimately resolved this conflict by flexibly applying these ethical codes to his work. Facing these kinds of conflicts, clinicians ultimately had to find ways to resolve these conflicts or leaving their position or the field altogether.

### **Navigating the Use of Empirically Supported Treatments**

Despite being required to use empirically supported treatments in their practice, participants varied in their beliefs about empiricism and empirically supported treatments. Some participants viewed empirically supported treatments as helpful and others de-valued them. Jane said,

I would say that I'm pretty critical of the empirically supported treatment world in general because of the poor external validity. The fact that the way the studies are conducted are not the way that most clinicians practice. 'Cause fidelity tests are done in research studies but when clinicians go out and practice in the world the research indicates they are not following a manual, the vast majority, so I'm not a strong adherent of that from the get go.

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Other participants also questioned the external validity of the studies that have been done and also pointed out that many of these studies do not include AI/AN people. For Robert, EST was viewed as something that was developed outside of the community. He hypothesized that “if a non-Native went to the reservation with their treatment model, they would get a bashing one way or another.” Robert further discussed the difficulty resulting from being rigid and systematic. He observed clinicians losing their “humanness.” He emphasized that counseling in his mind, was human work. “We aren’t working with cattle,” he said. He saw EST’s as being too focused on outcomes and that humans were reduced to numbers. On the other hand, others like Lauren was able to see the positive outcomes as a result of measuring both quantitatively and qualitatively, the implementation of empirically supported treatments. Yet, Lauren believed EST’s have the potential to be even more helpful with specific cultural adaptations.

Although these two different ways of viewing empirically supported treatments are in contrast to one another, some participants balanced themselves between EST’s and being culturally responsive. Charles described feeling the need to use an EST when it had a lot of evidence for a particular disorder, however, also encountered times when he used an EST and the client said it was something else that was more helpful.

Balancing these two different viewpoints about empirically supported treatments can pose a challenge. Participants often found themselves in the cross hairs between having their agency, supervisor, or insurance agencies encouraging or mandating them to use empirically supported treatments and not being open to cultural adaptations. In these types of situations, participants found that when they aligned with the community members’ views about how service provision should occur, they also faced resistance by colleagues, supervisors and/or directors.

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Most participants found their own ways of balancing cultural responsiveness and EST application. For some participants, this meant that they still utilized EST's but de-valued fidelity because they viewed this rigid application as not being culturally responsive. Jalen described that it is necessary to remain balanced between the two when providing services. He has observed some clinicians who have not been able to balance this so well. He has seen some clinicians either too rigidly follow the manualized EST because it is a safety blanket for them. And he has also seen others that are so culturally focused that they let go of their training and knowledge they gained while preparing to become a clinician. He thinks it is up to the individual clinician to have this stance. He stated:

It's always, it's always that individual person's decision and work to be in the middle somewhere. And that's always what I've had to deal with is going a little bit over each line and yeah a little bit more empirical stuff and yeah a little bit more what this patient needs you know and just kind of back and forth between that versus getting extreme. And as soon as you get extreme I think that's when you run the risk of not helping your patient.

Some participants described changing their beliefs about empirically supported treatments and/or becoming more consciously aware of how they were using empirically supported treatments in their work. One approach that arose from being mandated to implement EST's involved clinicians examining and determining what they were already doing with clients and whether it fit within existing empirically supported treatment models. Charles described that over time he realized that in some cases what he was doing with clients was really Behavior Activation Therapy. He then translated and described that way in his documentation of treatment. Participants' beliefs about empiricism and empirically supported treatments, and the fact that such treatments are sometimes mandated or encouraged certainly affect how participants navigated their use.

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### **Supporting Traditional and Culturally Developed Ways of Healing**

Culturally developed healing interventions are created by community members who know specific tribal cultural practices as opposed to traditional healing which has been in existence for thousands of years. Although participants were either mandated or encouraged to utilize ESTs they still found ways to honor traditional or community developed ways of healing. Some clinicians used these traditional or culturally developed approaches in conjunction with what they were doing but more often by connecting clients with these resources outside of sessions. Some participants demonstrated a preference for what they called culturally based or culturally developed from the “ground up,” over cultural adaptation. Jennae stated:

But I also think is there’s like a real trend and change from culturally adapting to culturally based or culturally developed programming that can be instituted in our own, within our own structures. Um, I don’t know if it always works to adapt something to someone else’s culture.

Jennae is pointing out that cultural adaptation may not be the best approach. Some participants emphasized while talking about cultural adaptation that the ideal situation would be to develop treatments using Indigenous epistemology. Charles similarly stated:

You know there is the kind of philosophy of science standpoint on it that we should actually just build whole new theories from the ground up that come from within as opposed to adapting that something that started on the outside.

Melissa described that honoring of traditional healing and community developed ways of healing as breaking down barriers. She said:

You want the best care, I mean, that’s what’s going to break down barriers. Is seeing us in a position of authority and that incorporation of what we’ve always known to heal coming back full circle. Like we’ve known this for thousands of years. It works. It’s worked for thousands of years, minus the last couple hundred, thanks colonialization. But we’re bringing it back, and it’s still working.

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Participants therefore, recognize that these traditional healing practices have been around for generations and still have utility and also that community developed programming is just as important. Jennae said:

I think I would just try to access that for my clients and put value into that and also to know just as a non-native clinician this is may be a better way to handle this rather than me trying to culturally adapt programming to fit [the client's] needs.

Jennae described using dialogue with the client to determine whether the client would benefit from and want to experience these opportunities. By referring clients to these programs, Jennae is endorsing this as a viable way to provide and maximize healing to meet their needs.

A less common way to support these avenues is to use them in concurrence. For example, Charles collaborated with a traditional healer to treat trauma in conjunction with Eye Movement Desensitization and Reprocessing (EMDR). This meant for Charles not culturally adapting EMDR itself, but instead incorporating EMDR into what the traditional healer was offering. This represents a directional shift in which cultural adaptation occurs placing more emphasis on culturally adapting to the culture the clinician is working in as opposed to culturally adapting a Western approach to the client's culture. Charles described:

You know doing any sort of exposure treatment for trauma is emotionally overwhelming for clients, for counselors and to have him set that tone and mood through a ceremony was really powerful. And I think it helped legitimize in some ways both what I was doing and me as a person who could be helpful in that process...I think the context that this [traditional healer] set you know as a sort of a beginning of a session, this spiritual sacred context makes [the counseling session] more powerful for me...it feels more powerful because of that spiritual sacred context that was established by him quite intentionally. It seemed to make it work at least from my perspective. Um, hopefully more effective but certainly more profound would be the word I would use.

Charles's influential experience represents an acknowledgement and respect for traditional healing in this community. The collaboration with a traditional healer also seems to be a



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relatively uncommon arrangement as Charles also expressed that this was not typical practice in other communities that he worked in, which is the case for the other participants.

Participants spoke to how they have broadened their perspective of healing to become more holistic and how they realized the importance of incorporating and supporting spirituality regardless of whether their clients engaged in traditional or cultural activities. Participants have often experienced that direct and intentional discussions about spirituality and its role in the client's life is often missing in typical therapy and have encountered colleagues and supervisees who have been ill equipped to discuss this with the client in session. For example, Robert described that clinicians will need to address the client's "damaged spirit." Robert explained that clinicians are going to be spiritually challenged, meaning the clinician will need to navigate how to repair this as a clinician. Figuring out how to repair a damaged spirit may be challenging for clinicians to address by themselves. In order to serve AI/AN populations, participants recognized it is necessary to support and incorporate spirituality in the therapeutic process for clients. This often entailed asking what spirituality meant for the client.

### **Clinicians' Ability to Embody Cultural Humility and Increase Cultural Competency**

Engaging in a stance of cultural humility and increasing cultural competence certainly are important both when working with AI/AN clients but also to be able to cultural adapt EST's. In the process of working with AI/AN clients, participants found it helpful to utilize various multicultural strategies. Participants found it necessary to increase their knowledge about Tribes including: learning about historical traumatic events that have affected the tribe itself and AI/AN populations generally, learning about the diversity of culture between and within Tribal communities, and how AI/AN are not only ethnically different but have unique status with the government as they have the power to exercise Tribal sovereignty. Clinicians talked about how

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they received some training as they were preparing to be clinicians and some after but many expressed that their training didn't adequately prepare them for working with this population.

One multicultural counseling concept that was discussed several times is the concept of dynamic sizing. Dynamic sizing means clinicians have to decide when to generalize and when to individualize (Sue, 2006). In using this concept, most participants stated that they always attempted to culturally adapt to the specific individual person they were working with more often. Charles described the process of using the concept of dynamic sizing articulately in the scenario below:

You know I really like that idea of Stanley Sues concept of dynamic sizing that which is that fluid process of what we are talking about of determining on a case by case basis the degree to which a client identifies with what would be considered traditional beliefs from their cultural background or the degree to which they don't and try to adapt what we are doing to that individual person.

Jane described a similar dynamic process:

Every, the process is that it just deepens and deepens to every, every therapy sessions. You know something else is learned or something else that I've learned has been able to applied and so I say "ok good". So, working or I apply it and say "oops, not with this one" or "oh boy, that was close! Glad they didn't notice but."

As Jane revealed, this process can be improved upon session after session, but practicing dynamic sizing includes the possibility of error. Jennae echoed this:

I guess what I'm trying to say is, what I'm thinking is that (sigh) like it might be more insulting for that client to be, to feel like I'm adapting everything to fit a value system or an ethnic status that they don't identify with. So I feel like it's a real easy trap to fall into.

Participants all acknowledged that error occurs and sometimes there is also uncertainty about whether one is intentionally culturally adapting something or not.

Participants described that it was necessary to consider their own thought processes and consider what may be outside of their consciousness. Charles, Lauren Jane, and Jennae point out that clinicians must consider that there will be times when they are going to make mistakes while

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trying to be culturally responsive due to their own biases and blind spots. Jane considers that a clinician could engage in projection instead of reflecting on what they are doing that is disrespectful. She also told a story about a time when she focused on the wrong issue and found out later what the real issue was from the client's perspective that was culturally-based and how this resulted in the failure of EST implementation.

Charles described a story of a pivotal moment when he realized his limited scope of understanding when he first started working for a Native health clinic. He was just getting ready to fly out to a remote Alaska Native village when a colleague who had been working there for many years grabbed his arm and said, "Hey, [Clinician's Name] before you go out on this trip I just want to remind you that people in these communities have a long history of White people flying in who say they are coming to help." Charles describes his reaction as:

And it just sort of it just stopped me in my tracks and I think it uh, it that moment shifted, something shifted in side of me and it's not like I hadn't had exposure to concepts of multicultural counseling. I mean I had a graduate level class in it. I had worked with Native folks and people from other minority ethnic groups and felt like I knew something about it. But at that moment I realized how I had not taken into account to the degree that I should have, my own identity and my own lack of cultural humility. That moment just made me reflect on what it must be like to for someone on, in the other chair or in another community to have someone like me walk in as a, you know, a helper and it just, it steered me in this direction of way more of a stance of cultural humility and um, I think cultural empathy in a way.

For Charles, this pivotal moment activated within himself a responsibility to be more culturally empathic. This held true as he thought about implementing ESTs with this population. He said:

I can't just work with someone from a different cultural background and just try to shoe horn in an empirically supported treatment without thinking about how I need to adapt this to make it culturally responsive, how I need to adapt my own approach, adapt in a way that I can still be genuine and still be (myself) but so that it's still authentic but it also is um is appropriate and respectful in that cultural context.

Participants considered both times when they are aware but also the possibility that they have blind spots. Jennae described her experience with this:

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So one of the things that's central to that is the concept of cultural humility and recognizing that because of my own cultural identity I'm very likely to um, or not even very likely I know that I have blind spots and things that keep me from understanding the experience of clients from cultures that are different from my own and even similar cultures.

Jennae further explained:

Whether that's like, um, just trying to trying to come from an understanding perspective. Um, in terms of working with cultural differences or again just trying to examining my own lens of what I'm seeing of why and how. Um, because that is really where I can affect the most change in myself and so I think I can always continue to look internally as to like how I'm perceiving what's important about this person's culture. And what kinda comes forward as I bounce that forward and back.

Participants shared experiences of acknowledging that they wished they had more cultural competency earlier on. After Charles described his pivotal moment of recognizing his White positionality, he went on to say:

And it makes me wonder in what ways as I look back on it now I had such a tremendous lack of awareness. I had been a mental health professional for you know four years out of graduate school and it makes me wonder to what degree I am going to look back on myself now and think and recognize the gaps. So just that phenomena encourages me to be, try to be humble because at the time I didn't think I lacked awareness I thought I got this. And looking back I realize I didn't have it.

Engaging in cultural humility was viewed as a necessary part of engaging in cultural adaptation. Similarly, Jennae discussed that if we focus more on culturally adapting therapy as a whole that it would result in better being able to culturally adapt EST's and vice versa. She explained:

I mean like if we, and if vice versa, so the idea is that if generally we are looking at therapy as being more culturally informed and trying to actively adapt it to be more culturally appropriate for people that we are serving and meet the needs of our clients then that has to spill over to specific empirically developed therapeutic techniques. Like we have to look for ways to adapt these certain little things we say or do. Um, and then I think those techniques and therapeutic methods, and theory bases and modalities like would impact our understanding in general of therapy and like what is important and how we do it and why. Um, as like an agency culture or something I don't know on a national level. At least for ourselves and like our clinical practice. Like if we can adapt these smaller pieces from a theory base then we can acknowledge that within the models, then we can bring it back to the larger overall agency-based understanding of cultural adaptation and the need for culture in therapeutic services.

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Jennae brings up the idea that engaging in cultural adaptation can reverberate to national system wide incorporation of culture in service provision. This indirectly points out that cultural adaptation and culture generally in service provision is not currently happening on a nation system wide level.

Another reason for the possibility of error is the clinician needs to understand the client's cultural context considering the diversity that exists within and between AI/AN populations. Some participants thought that assessing for acculturation helped determine whether to engage in cultural adaptation or not. These participants found that if a client was more traditional they needed to make more attempts to engage in cultural adaptation strategies. Participants assessed for acculturation informally by asking questions if clients engage in cultural practices. Others found it helpful to not ask right away and see if the client brings forth this information on their own. Jane has found that over time she has been able to assess this by the client's appearance and demeanor. She says she can recognize sometimes in the way client's carry themselves. Most participants either stressed that they mostly culturally adapt to the individual client that is in front of them or that they hold the person in context of their cultural background, tribal affiliation, and as an AI/AN person generally all at once. Participants described feeling that sitting with clients was often complex, especially when clients had multiple co-occurring issues or events happening in their lives. Jane described feeling the need to consider many more possibilities of how culture is influencing how she is conceptualizing what is happening at the same time while she is in the room with the client. She joked about this as she shared how difficult it can be for clinicians to make this look natural during the session as she holds all of this in the back of her mind.

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### **Coping with External Factors**

Participants described experiencing external factors that were both supportive of cultural adaptation or were barriers to cultural adaptation. These include their own life experiences and identities, work setting and supervisor factors, and work load.

Participants considered that their own life experiences and identities could facilitate or hinder their ability to engage in cultural adaptation. It also influenced how they approached healing, for instance, one participant shared how their upbringing affected how exposed and open they were to learning about other religions and cultures. Participants also considered how their own identities influenced their own worldview and how clients then saw them. For example, Melissa considered how others may perceive her personality and recognized that this may not mesh with everyone. Some White participants described how this identity left them feeling limited in their ability to further culturally adapt and how it could even be inappropriate and harmful. Lauren described:

...there's a little bit of hesitancy to adapt something because I'm not entirely sure how to go about it and so therefore, I think it's so much more important even for non-Native clinicians to utilize some resources and to check out with the consulting group maybe to not do it in isolation for sure.

Jennae also describes feeling limited due to being White. She said,

I think my cultural adaptation nowadays looks like um, within the context of therapeutic services, so I really don't offer more of medicine wheel teachings or spiritual based interventions because I'm not Native so I don't really work hard to do that kind of stuff 'cause it's just not my place. But if I needed to link someone to services or to help them find someone to come in or. So mine would more look like um, offering understanding around them engaging in their own practice on their own time. Kind of you know or encouraging it. But not like being the one to facilitate it myself.

Participants described that work setting and leadership or supervisors could either enhance or inhibit their ability to culturally adapt EST's but also to be culturally responsive generally. Jane described her experience dealing with external factors and considering leaving her position.

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Yeah, um, to adapt to the outside pressures that have nothing even to do with therapy and I'm doing inside the room either but, you know? Whatever doesn't kill you makes you stronger. I've just been determined you know? If I throw up my hands and give up and say this is impossible then there is one less person with all this experience trying to culturally adapt and be there with the person then there was before, so I really need to pursue this you know?

For Jane, she foresaw that her absence as a clinician engaging in cultural adaptation would have been detrimental to future clients.

Another barrier identified by several participants was clinician workload and how that prevented them from being able to meaningfully engage in cultural adaptation of empirically supported treatments. Amber explained, "... 'cause sometimes that that's one of the biggest challenge is it the capacity on the ground to actually do some of the things that need to be done." Participants also described how workload could also affect other things such as the ability to participate in clinician-client studies. Jalen said:

We've never done a full on like big you know big CBT adaptation for a group or tribe that I've worked with. We are limited by our workload and some of the things that our agency has kind of put up a red tape.

These certainly do not represent all of the external factors that support or prevent the participants from engaging in cultural adaptation; however, were some common experiences among the participants who were interviewed.

### **Additional Findings of Interest**

This study focused on the lived experiences of clinicians as they engage in cultural adaptation of empirically supported treatments. The third subquestion of this study aimed to determine how clinicians have implemented cultural adaptation. Therefore, this section attempts to document cultural adaptation strategies used by participants as they shared. However, because participants perceived cultural adaptation to be much broader to include culturally adapting therapy as a whole it was difficult to determine when they were talking about culturally adapting

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ESTs specifically or broadly describing how they modified their practice. Therefore both are presented.

Due to the limited literature on cultural adaptation strategies specifically used for AI/AN populations, it becomes necessary to highlight how these participants have engaged in cultural adaption. The following table represents strategies brought up by clinicians during interviews. Table 1 does not represent all of the ways participants have engaged in cultural adaptation, however, it provides valuable insight on where cultural adaptation has occurred. These strategies and modifications are presented in three columns to demonstrate where cultural adaptation has occurred, in either engagement, treatment delivery, or specific to the clinician.

Table 1. Cultural Adaptation Strategies and Modifications Used By Participants		
Engagement	Treatment Delivery	Clinician Efforts
Changing Program Mission	Collaborative Treatment Planning	Increasing knowledge of Tribes (including history, diversity between Tribes, Tribal sovereignty) and multicultural concepts
Physical Office Space	Focus on Place Based	Increasing knowledge of cultural adaptation
Obtaining Feedback from Clients and Community	Speech and language used and following up to make sure clients understand	Increasing emotional pain tolerance
Native clinician and Native client match	Pacing (slower)	Being in the present moment
Longer intake session or sessions	Trial and Error	Humor
Modifying recruitment, engagement and initial meeting	Incorporating spirituality	Dynamic sizing
Incorporation of family and community even if it's just the client coming in	Incorporating cultural activities and other immersive community experiences such as doing arts and crafts with a giveaway	Clinician dress



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Creating Safety and Comfort	Documentation	Body language and demeanor
Having ethnic minorities on Board of Directors	Cooking and Meals	Increasing awareness
Revising intake questions and process	Modifying anecdotes, examples, workbooks, worksheets, relaxation scenarios, videos and other materials	Seeking help from cultural expert, supervisor, and peers
Modifying advertising	Not asking too many questions; Modifying inquiry	Finding out what other clinicians are doing
Role induction	Welcoming dialogue about spirituality and worldview	Keeping an open mind
Prep client for intake session	Acknowledging intergenerational resilience and being strengths-based	Moving aside preconceived notions
Open discussion about documentation	Having clients discuss how they experience symptoms from their worldview	Examine own lens and perspective continually
Learn clients story	Fit existing work into EST	Recognizing different patterns and issues that are in different communities
	Asking clients about tribal affiliation and cultural practices they engage in	Considering that some English words may not have existed in traditional language and what this means for the client
	Storytelling in psychoeducation	Engaging in cultural adaptation workgroups to adapt ESTs
	Changing visualizations	Used community advisory board to culturally adapt a family program
	Using examples that are embedded in culture such as micro-aggressions, prejudice, bullying, and situations involving current popular figures	Responding neutrally to clients out of the norm responses
	When providing psychoeducation changing something that might be linear to be circular or wave (or other)	Decreasing eye contact
	Having a dialogue about boundaries, limits, raising	

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	children to get a sense of how to approach issues	
	Consider how clients take in information	
	Bringing in discussions on topics such as trauma (including historical trauma), genocide, oppression, assimilation	
	Reflecting on how behavior change might happen differently (what they do in and out of session)	
	Link to cultural resources by referring to culturally developed programming (such as Gathering of Native Americans (GONA) youth camps or Fatherhood is Sacred, which is a parenting program)	
	Bringing in elders	

In the field, clinicians have supported the recruitment of AI/AN to the field such as engaging graduate schools to recruit practicum students, asking ethnic minorities about systemic racism, and talking to administrators about supporting AI/AN clinicians. The participants did not often talk about what not to do but some did have some advice in this area. These include: (a) staying away from generic application of medicine wheel teachings, (b) not culturally adapting in isolation, (c) avoiding negative internal dialogue, and (d) refraining from having clients share sacred things in session but focusing more on cultural norms. These strategies certainly represent a variety of viable approaches to engaging in cultural adaptation with AI/AN clients that include some of the central constituents emerging from analyzing the interviews with participants.

### **Chapter Summary**

The findings from this chapter reveal the definition of cultural adaptation, main constituents, and cultural adaptation strategies arising from interviewing eight clinicians about their lived experience in culturally adapting empirically supported treatments. Although the findings tend to be more applicable for how clinicians have engaged in cultural adaptation generally, as opposed to about EST's specifically, they still reveal how clinicians have navigated cultural adaptation. Now that the findings of this study have been presented, it is necessary to discuss how this information can be used in the future. Chapter Five provides a summative conclusion including limitations, recommendations for future research, implications of the study for various stakeholders, and conclusions.

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## CHAPTER 5.

### SYNTHESIS AND DISCUSSION

Constituents of the experience of clinicians who have engaged in cultural adaptation of empirically supported treatments (ESTs) were identified by conducting a descriptive phenomenological data analysis. The constituents include: (a) developing an understanding of cultural adaptation, (b) focusing on building and maintaining therapeutic relationships, (c) immersion and engagement with community, (d) experiencing conflict between Western and Indigenous epistemology, (e) navigating the use of empirically supported treatments, (f) supporting traditional and culturally developed ways of healing, (g) clinicians' ability to embody cultural humility and increase cultural competency, and (h) coping with external factors. The findings of this study need to be considered in light of its shortcomings, therefore, this chapter includes limitations. It also presents implications of the results for various stakeholders. Additionally, recommendations for practitioners, treatment developers, academic programs, funders, future clients, counselor education and supervision programs and the counseling field are presented. Then, future research directions are considered such as documenting cultural adaptations strategies, studying evidence-based relationship factors, characteristics of evidence-based therapists, and utilizing Indigenous research methods. Finally, this chapter ends with concluding statements.

The primary purpose of this study was to capture clinicians' lived experience with culturally adapting empirically supported treatments. Most research on this topic focuses on outcomes as opposed to how cultural adaptations have been made. This study fills a gap between outcome studies concerning culturally adapted ESTs and what actually happens in practice. Utilizing a qualitative research design allowed rich detail to be gathered from clinicians to

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understand the complexity of navigating both the implementation of ESTs and being culturally responsive. It helps shed light on how clinicians are navigating fidelity to treatment models and cultural responsiveness to meet the needs of AI/AN clients.

Cultural adaptation was left to the participants to define. This allowed the exploration of what participants thought about this concept and what it meant to them. Participants found it difficult to define and explained it in various ways. Although the scope of this study was not to explore culturally adapted therapy as a whole, participants brought this into the study as they discussed that they defined cultural adaptation more broadly.

The findings of this study suggest that clinicians realize the need for cultural adapting ESTs when working with AI/AN clients, however, also emphasize that using ESTs may not be the ideal or only approach when working with this population. Other approaches consist of broadening the application of cultural adaptation to making modifications to therapy to improve engagement and retention of this specific population in treatment. Some participants also stressed the need to incorporate traditional healers and practices as much as possible, and to support culturally developed ways of healing to demonstrate value for Indigenous epistemology, as it is often perceived as inferior to Western theories. Participants ultimately had to navigate conflict between Indigenous and Western epistemology. Participants also emphasized the need to culturally adapt themselves as clinicians. They did this by engaging in introspection and self-reflection, increasing knowledge about AI/AN populations, and immersing and engaging personally and professionally in AI/AN communities. This effort not only facilitated the clinician to be culturally responsive but also assisted the clinician to intentionally develop and utilize cultural adaptation strategies. All participants valued the therapeutic relationship between clinician and client, emphasizing that any errors resulting from trial and error dynamic sizing

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would be able to overcome these ruptures and repairs in applying cultural adaptations strategies. Furthermore, it has already been demonstrated that CSIs have been demonstrated to improve rapport building and client engagement (Jackson-Gilfort, Liddle, Tejada, & Dakof, 2001; Jackson & Hodge, 2010).

Not surprisingly, the therapeutic relationship was perceived as a foundational conduit to engaging in cultural responsiveness and culturally adapting ESTs. Laska, Gruman, and Wampold (2014) point out that the therapeutic alliance between clinician and client is the most verified factor in outcomes across treatment studies. This is consistent with Norcross and Lambert's (2011) assertion that "treatment methods are relational acts" (p. 5). It is also consistent with the common factors theory and evidence that aside from extra-therapeutic factors, common factors such as the therapeutic relationship account for 30% of change (Lambert, 1992). Common factors theory also suggest that only 15% of change is attributed to the specific therapies and treatments used. These findings are perhaps why there has been a recent shift to not just focus on EST's but to think about what evidence-based relationship practice would look like (Sommers-Flanagan, 2015). And further beyond, exploring the idea of evidence-based therapists (Blow & Karam, 2017; Hadjipavlou, Kealy, & Ogrodniczuk, 2017). Charles brought up this notion towards the end of his interview. He said:

A lot of research is coming out nowadays about empirically supported therapists. You know some therapists tend to have better results regardless of what approach they are using. And so I think in my view I'm trying to apply some of that and some of the frameworks of culturally adaptation to that domain like in terms of making a shift from how am I adapting this particular treatment as opposed to how am I trying to adapt myself as a person as a counselor who is trying to engage in a helping relationship with people.

It is likely that although there are newer developments focused on thinking about evidence based relational factors or therapists, that there will remain an emphasis to use

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empirically supported treatments (Blow & Karam, 2017; Hadjipavlou, Kealy, & Ogrodniczuk, 2017; Sommers-Flanagan, 2015). This study then sheds light on clinicians' perspectives and experiences of utilizing ESTs with AI/AN populations. Although not representative of all clinicians, this study's findings give a glimpse into how clinicians are navigating this complex process. It also reveals their struggles with external factors. Previous research has not considered supervisor support and agency setting in either facilitating or inhibiting clinicians' ability to be culturally responsive and more specifically culturally adapt ESTs.

### **Limitations**

There are four primary limitations of this study: (a) reliance on participants' self-report, more specifically, their recall ability, (b) the absence of an Indigenous Research Methodology to explore this topic, (c) limitations of researcher bracketing and (d) differences in clinical training and experience of participants.

**Recall.** Participants had difficulty recalling specific instances and moments of cultural adaptation of empirically supported treatments and talked about their experience of being culturally responsive more generally. For some participants it had been several months since they had engaged in cultural adaptation of empirically supported treatments with an AI/AN client, causing difficulty in the ability to recall and recreate these experiences. It is also quite possible that even though there was a disclaimer included in the guided semi-structured interview protocol to ease participants' concerns of being judged about how they have engaged in cultural adaptation, they could have still been uneasy to fully share their experiences in depth. Participants could have been intentionally engaging in impression management. This resulted in difficulty in analyzing which meaning units could be attributed to cultural adaptation specifically, unless specifically stated. Strategies therefore include both strategies to culturally

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adapt ESTs specifically and participant efforts to engage in cultural humility and increase their cultural competency in their practice more generally.

**Absence of Indigenous research methodology.** Indigenous Research Methodologies are those that represent a shift from an “Indigenous perspective in research” to “researching from an Indigenous paradigm” (Wilson, 2001, p. 175). This shift is also present when considering participants’ need to resolve the conflict between Indigenous and Western epistemologies. On the one hand, systems of care are set up to utilize Western theories and treatments and at the same time need to consider that traditional healing and culturally developed interventions are grounded in Indigenous epistemology and is not only a viable approach to healing but potentially may produce greater positive outcomes. It makes logical sense that this approach could better explore this topic, especially when interviewing AI/AN clinicians. It is important to acknowledge the direction in which cultural adaptation occurs as it represents the power dynamic between Indigenous and Western approaches. Are we culturally adapting Western approaches to AI/AN clients or are we culturally adapting traditional and culturally developed healing practices to be used in Western developed systems of care? Or, are there other alternatives?

**Limitations of bracketing.** Although bracketing was used to suppress my biases and preconceived notions, bracketing is not fail safe. My biases may have still influenced data collection and analysis. Both research assistants had little exposure and experience with qualitative research or my topic. This could have helped with verification, however, I also provided both research assistants with my proposal, which included the first, second, and third chapters of this dissertation. Consequently, they were exposed to my writings about my research lens, which may have influenced the perspectives of the research assistants. Additionally, the



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research assistant that helped with coding and analysis did not go through a process of reflecting on and bracketing their own biases.

**Differences in clinical training and experiences of participants.** Participants possessed a wide range of clinical training and experiences. Licensure of participants varied widely from licensed addiction counselors, which can take a minimum of two years to complete, to licensed clinical professional counselors, which can take a minimum of six years of education and supervision to complete. Multicultural competency training of participants is likely highly variable and may or may not have directly discussed application to AI/AN populations specifically. Also, participants probably had different experiences in working with AI/AN populations depending on where they practiced and the types of settings they have practiced in. Participants' diverse training and experiences are only superficially known and therefore it is difficult to determine how this has influenced and contributed to their lived experiences.

### **Implications**

This study has several implications for various stakeholders. Implications are presented for: practitioners, treatment developers, funders, academic programs, clients, and the counseling profession.

**Practitioners.** Recognizing the need to engage in cultural adaptation rests on a continuum. Clinicians must have the ability to perceive the need prior or after beginning to provide services to AI/AN clients; they also must have the ability to meet the need for cultural adaptation after it arises. The implication for practitioners is to continually consider the need for cultural adaptation when implementing empirically supported treatments specifically but also in practice more generally. Perhaps there will be situations where cultural adaptation of empirically supported treatments may not be necessary, however, it is important to consider whether it is

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applicable rather than assuming it is not applicable. Practitioners who are serving AI/AN populations must realize the importance of supporting traditional and community developed strategies as they continue to provide therapy. The underlying premise is that supporting these avenues of healing becomes a corrective and indigenously-affirming experience by allowing opportunities for community members to guide how healing happens in the community.

Participants described the need to engage in cultural adaptation because of the unique individual cultural needs of the client. This implies that practitioners can utilize cultural adaptation for all clients with whom they work. Cultural adaptation can be conceptualized as not just applicable to the interventions and treatments that have been developed, but to therapeutic practice as a whole. This shift requires clinicians to self-reflect on the underlying purpose of cultural adaptation, that is, to modify approaches to meet the needs of AI/AN clients, as opposed to having AI/AN clients modify themselves to fit various mental health systems of care produced by the dominant culture. This study also reveals that increasing immersion and engagement with AI/AN communities may facilitate cultural adaptation for some or many practitioners. In light of the literature review, it seems that clinician immersion in the community and increased engagement with community members is a growing recommendation in relation to the cultural adaptation of ESTs with AI/AN populations (Barden, Mobley, & Shannonhouse, 2014). This finding supports the hypothesis that deeper engagement with community and utilizing Tribally-Driven Participatory Research could yield deep structure cultural adaptations (Mariella, Brown, Carter, & Verri, 2009).

This study's findings support all four ways of developing CSIs are being viable approaches to implementation; they are: (a) implementing existing traditional healing practices, (b) co-developing and studying interventions that have combined both traditional healing and

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EST's, (c) testing cultural adaptations of ESTs, or (d) developing Indigenous or culturally developed interventions (Goodkind, Lanoue, and Milford, 2010; Gone & Calf Looking, 2015). Although evaluation still poses to be challenging, all of these approaches have been viably used by the participants in this study. Either they implemented these approaches themselves or clinicians have referred clients to these approaches.

**Treatment developers.** When treatment developers are creating treatments and researching them, it would be helpful for them to consider that cultural adaptation may be necessary. Currently, treatment developers leave it to those implementing treatments to make cultural adaptations to fit their service area needs. Treatment developers can aid this decision making by exercising forethought about when cultural adaptation might be necessary. Forethought and explication of specific core components of the treatment model are absolutely necessary for positive outcomes and is recommended. Although, this process may prove to be difficult, it would be a positive direction to pursue for cultural adaptation.

Treatment developers must recognize factors, external to the treatment itself, can either enhance or inhibit the implementation of treatments in systems of care serving AI/AN populations. Bernal, Jiménez-Chafey, and Rodríguez (2009) have pointed out the existence of several emerging models to aid in the cultural adaptation of ESTs. This study's findings reveal that many of the constituents identified are not explicit in existing cultural adaptation frameworks.

**Funders.** The status quo is to support treatments that have been developed outside of the community for other populations and fund efforts to introduce them and try to make it sustainable. This approach is often seen as just another way institutions of power decide what is best for AI/AN communities. Funding community efforts to develop or support the revitalization

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of traditional healing practices is logically sustainable and could certainly have long-term positive effects on AI/AN mental health (Goodkind, Lanoue, & Milford, 2010). Given the landscape of focusing on establishing empirically supported treatments, sponsors of future funding could consider that cultural adaptation may need to be explored prior to and while implementing an empirically supported treatment or support Indigenous research methodologies as an avenue for providing evidence of traditional healing's effectiveness.

**Counselor education and supervision.** As counselor education and supervision programs prepare future mental health providers, it is necessary to consider how and where programs can introduce topics such as the cultural adaptation of empirically supported treatments and Indigenous approaches to healing into their curricula. Counselor education and supervision programs can provide opportunities for future counseling students to learn about other approaches to treating mental health from other cultures. Helping students understand the importance of considering whether these approaches are used by clients, and exploring ways other clinicians have partnered with community members and immersed themselves into the community to address or refer clients to accessing traditional healing is a worthwhile effort (Barden, S. M., Mobley, K., & Shannonhouse, L., 2014).

Participants in this study pointed out the need for better preparation in cultural competency generally but also in the ACA ethical codes specifically. Although multicultural competency is required of CACREP program accreditation, perhaps a shift needs to occur in how program evaluation occurs concerning multicultural competency standards in counseling programs. Depending on the counseling program, multicultural counseling may be a standalone course or infused into all counseling courses. It is recommended that the latter approach may better provide instruction on how content areas such as ethics apply in the context of

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multicultural education. Increasing recruitment and retention of diverse students into mental health programs is also recommended.

**Counseling field.** This study's findings further emphasizes the need to culturally adapt to the individual. This is consistent with the finding at the statewide Washington convening of mental health providers where they shared that blanket cultural adaptation to AI/AN populations as a whole was unhelpful (Walker, Whitener, Trupin, & Magliarini, 2015). These mental health providers also thought it would be better to develop learning collaboratives to consult with peers about the implementation of EST's and cultural adaptations as they are being made.

This study's findings demonstrate that clinicians didn't want to engage in cultural adaptation in isolation and sought out cultural experts, peers, and supervisors. Considering that participants found it helpful to seek out supervisors and peers for consultation concerning cultural adaptations, it makes sense for the counseling professionals to intentionally create space for these conversations to occur. Although clinician workload and capacity was cited as a barrier to cultural adaptation, clinicians also discussed that client retention was a barrier to being able to implement culturally adapted EST's or any treatment at that. Since CSIs have been linked to client retention and treatment outcomes it makes sense to focus on developing and implementing CSIs to improve client engagement in treatment (Gone & Alcantára, 2007; Hodge, Jackson, & Vaughn, 2012; Jackson, 2009; Jackson & Hodge, 2010; Miranda et al., 2003).

Quality improvement is a necessary component to service provision. Therefore having conversations about cultural adaptations and being culturally sensitive more generally would help not only the specific professionals in that setting but build agency knowledge regarding culturally responsive service delivery for AI/AN populations. This increase in dialogue may help

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to gather more specific knowledge, skills and abilities related to cultural competency guidance to teach counselors-in-training to better serve this diverse population.

### **Recommendations for Future Research**

There are several opportunities for future research to explore beyond this study such as documenting cultural adaptations strategies, studying evidence-based relationship factors, characteristics of evidence-based therapists, and utilizing Indigenous research methods. Recommendations for future research are presented in the following order: research directions developed directly from participant interviews, those that derived from limitations of this study, those based on delimitations, and those that are related to the central research question.

**Research directions developed directly from the data.** Some participants directly stated their recommendations for future directions during the interview and it is important to acknowledge their voices in contributing to recommendations for future research. In his final concluding comments, Jalen brought up the need for clinicians who understand the importance of documenting strategies for cultural adaptation and have avenues of sharing these with each other. Jalen said,

I think you know obviously what helps is when people can do research and they can kind of put it out there that's accessible to me and I can look at it, I can read it, I can take, I can think about it critically and I can pull pieces that I think are going to be helpful... I love empirical research that is being generated, and it helps me pull pieces and integrate things.

Documenting cultural adaptation strategies as done by Griner and Smith (2006) in quantifying the number of cultural adaptations made. Further, qualifying cultural adaptations as deep structure or surface structure adaptations (Goodkind, LaNoue, & Milford, 2010), and documenting the purpose and description of cultural adaptations can further contribute to the replication and further development of cultural adaptation strategies. Utilizing recent toolkits that

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have been developed for this purpose, for example, the *Toolkit for Modifying Evidence-Based Practice to Improve Cultural Competence* (Samuels, Schudrich, & Altschul, 2009), can further aid in this effort.

Jalen also stressed the importance of clinician involvement in documentation. He said:

But I see a real need for people that have the ability to write the empirical side and the individual side be in the actual field you know on the front line and that's become more apparent to me and is a lacking piece of the communities that I've been in anyway.

Jalen seems to be supporting an integrative approach to recognizing the strengths of empirically supported treatments but also clinicians' experience in engaging in cultural adaptation. In this way, Jalen is highlighting the important point that it is difficult for clinicians to rely solely on non-practitioners to come up with strategies for cultural adaptation. This means that future directions should also include practicing clinicians to provide their expertise in conversations about culturally adapting empirically supported treatments, developing cultural adaptation frameworks, and when conducting future research on this topic.

Charles brought up another approach to cultural adaptation: to think about “empirically supported therapists” and what internal shifts happen when culturally adapting themselves in therapy. This supports the idea that we cannot conduct studies that isolate treatments irrespective of considering who is providing the treatment and the importance of the therapeutic relationship as the vehicle to delivering EST's but also cultural adaptation strategies. Cultural adaptation, in light of this study's findings, seems difficult to isolate and measure. Although Cultural Adaptation Science (Chu & Leino, 2017), has been recommended as a novel method to measuring cultural adaptations, it may be yet another methodology that would prove difficult to set up in AI/AN treatment settings. However, it still would be worthwhile to continue to contribute to the inductive approach to developing the Cultural Treatment Adaptation

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Framework (Chu & Lieno, 2015). This study's findings support the modification of the peripheral treatment components (those concerning engagement and treatment delivery) of the CTAF and less so modifications to core treatment components (those accounting for symptom change).

Considering the ideas of evidence-based relationship factors or evidence-based therapists seems like a worthwhile effort to continue to explore (Blow & Karam, 2017; Hadjipavlou, Kealy, & Ogrodniczuk, 2017; Sommers-Flanagan, 2015). Relevant to this particular study, researchers can ponder: What are evidence-based relationship factors considering the setting and population the therapist and client are in, and what do evidence-based therapists look like in relation to who they are serving?

**Derived from limitations of the study.** It was difficult for clinicians to recall and psychologically recreate their experience of culturally adapting empirically supported treatments specifically. Future research could involve observation of clinicians as they work with AI/AN clients in various conditions. For example, as they implement EST's with fidelity to the model or EST's with the incorporation of cultural adaptation strategies. This may even involve, corroborating these findings with interviews with AI/AN clients with whom the clinicians were providing services to. More importantly than these specific suggestions, introducing qualitative approaches in addition to study of outcomes of ESTs would produce fruitful information as opposed to only focusing on outcomes. Future research could also include specific quantitative evaluation of the eight constituents identified.

There is still a great need to explore how to measure the outcomes of traditional healing practices that are culturally appropriate. Indigenous research methodologies may be a viable way to study not only cultural adaptation but also traditional healing practices that may be less



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controversial then using Western research methods. This avenue would require support of future funders to recognize Indigenous research methodologies as valid. Utilizing Indigenous research methodologies could hold some promise for being able to substantiate and support their use.

**Based on delimitations.** The first interviewee suggested that this study is missing an important perspective relating to this topic by not including license-eligible clinicians. The argument was that many AI/AN license-eligible clinicians have a reduced likelihood of passing the licensing examination and therefore, do not become licensed clinicians. After talking with my committee chair, a professor in the University of Montana's School of Social Work, searching for articles in the University of Montana's library databases, perusing the licensing examination websites as well as the Montana Board of Behavioral Health website, no information was found that could be cited. Exploring if there is a disproportion of AI/AN licensed-eligible candidates who have difficulty passing their licensing examinations may help determine whether this is a barrier for future AI/AN students to being able to become a licensed mental health professional and remain in the field.

**Relevant to the research problem.** At this point in time, there is not a systematic practical way to obtain information regarding what interventions of all types are being used with AI/AN populations, what kind of evidence was gathered, and how outcomes are being measured. It is a logical step to encourage the development of a shared space to collect both academic literature and anecdotal data related to the implementation of ESTs in AI/AN communities. While federal agencies and organizations continue to develop lists for empirically supported treatments, a list could be generated by and for AI/AN communities on "best practices" as defined by AI/AN people.

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It is important to note that while this dissertation was being completed the conversation around evidence based treatments and empirically supported treatments has continued to evolve. For instance, the SAMHSA's NREPP was taken down to reconsider the definition of "evidence" and for whom, for what problem, in what settings this holds true for existing treatment models. It is also important to note that dialogue also continues to occur on how to demonstrate "evidence" of existing traditional healing practices that have been used for generations. In perusing recent grant solicitations, funding agencies are still requiring the use of "evidence-based practices." Upon further inquiry of a particular funding agency, the funding agency interpreted this phrase broadly to include the inclusion of research studies or even local data to support the proposed practice as having evidence. This suggests that again, the definition of evidence is broad to include ESTs but also any practice that can be presented as evidence.

### **Conclusion**

This study has provided the opportunity to obtain clinicians' experiences in culturally adapting ESTs for AI/AN populations. Although a limitation of this study is that participants have had a variety of clinical training and experiences in culturally adapting and implementing ESTs, this means that this study's findings probably has moderate transferability to other mental health providers serving AI/AN populations. Participants have had some unique challenges associated with working with AI/AN populations specifically both in urban areas and in reservation communities. The findings from this study illuminate the need to consider all factors associated with implementing EST's with this population including those that involve the therapist, the setting, the population, the community, supervision and leadership, peers, the treatment itself, and the approach used to implement. Clinicians are in a unique position to navigate the selection of EST's and implementing them with AI/AN clients. However, due to

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their workload and other demanding tasks, knowledge about cultural adaptation (and culturally responsive strategies generally) will continue to be stagnate if other stakeholders are not involved in future development, planning, evaluation and implementation.

Emphasis of using EST and the growing diversity within the U.S. population, and within AI/AN populations is changing the landscape of mental health services (UIHI, 2012). As this shift occurs, it is necessary for cultural adaptation to remain a necessary part of research on and the implementation of ESTs with AI/AN populations specifically and minority populations generally. More importantly, supporting traditional healing practices is also a path that has not yet been fully explored as a method for treating multiple mental health issues that has the propensity to affect community wide healing. It remains likely that mental health systems will remain rooted in Western approaches to treatment, however because of the increasing diversity in the US and specifically among and within AI/AN populations, it is necessary to understand that a one size fits all mentality is not likely to address the growing health and mental health disparities among this population.

Appendix A

Guided Semi-Structured Interview Protocol

<p><b>Prior to the Interview:</b></p> <p>Ensure you have the following materials:</p> <ul style="list-style-type: none"><li>• Computer</li><li>• Internet (plugged directly into port if possible)</li><li>• Pencil</li><li>• Paper</li><li>• Brief description of the study and contact information for the participant to keep</li><li>• Traditional gift (if meeting in person)</li><li>• An audio recorder and a backup recorder (in the case of Zoom malfunction)</li></ul> <p>Ensure the following tasks have been completed:</p> <ul style="list-style-type: none"><li>• Zoom meeting has been scheduled and/or room has been arranged</li><li>• Confirm meeting place and time</li><li>• Send instructions to the participant to schedule at least an hour and half for the interview<ul style="list-style-type: none"><li>○ (If conducted via Zoom technology) Ensure instructions include instructions to reduce distractions and create a space for increased confidentiality</li><li>○ (If conducted via Zoom technology) Ensure instructions include an orientation and resources for using Zoom technology</li></ul></li></ul>
<p><b>Opening statement</b></p> <p><i>Hello. Thank you for coming today and making time to meet with me. Before we launch into the interview itself it would be good to get to know each other better.</i></p>
<p><b>Introductions</b></p> <p>May nor may not introduce myself first depending on customs and traditions of introductions</p> <p>May or may not disclose more depending on what the other person shares</p>
<p><i>To honor any traditional ways of doing introductions is there a way you would like to start with introductions?</i></p> <p><i>Would you like for me to go first?</i></p> <p><i>My name is Maegan Rides At The Door and I am a doctoral student in the Counselor Education and Supervision Department at the University of Montana. I am also member of the Fort Peck Sioux Assiniboine Tribes in Montana and a descendent of the Absentee Shawnee Tribe of Oklahoma but largely grew up in Northeast Montana on the Fort Peck Reservation. I carry a Blackfeet last name by marriage so sometimes people confuse me with being Blackfeet. My professional background includes working as a mental health counselor and grant work at the University of Montana.</i></p>

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<b>Ice Breaker (purpose is to get the person sharing more and building rapport)</b>
<i>Thank you for introducing yourself. I'm curious, what made you interested in participating in this study?</i>
<b>Explain Research Study</b>
Explain (who, what, when, where, why)
<i>It is great to hear why you are interested. I am appreciative of your willingness to share. Before I start asking you the questions I have prepared for our interview today, I would also like to tell you a bit more about the research I am conducting, talk with you about the technology we will be using, and answer any questions you might have. Our meeting will probably take about an hour and a half, but might take a little longer depending on various factors. Do you have any time constraints that we need to be mindful of?</i>
<i>I will do my best to complete this efficiently so I don't take up too much of your time. The purpose of this research is to explore mental health provider experiences in culturally adapting empirically supported treatments for American Indian and Alaska Native populations. You were chosen as a participant because of the way that you answered questions on the electronic survey you completed.</i>
<i>People, like you, were chosen because you stated that you have engaged in cultural adaptation. This term is used broadly on purpose to include any kinds of changes to mental health treatments that are made to address cultural factors. There is no right way of doing this, so any approaches you share will be adding to our knowledge.</i>
<i>Another reason you were chosen is because you said that you implemented an empirically supported treatment on the list developed by the Society of Clinical Psychology. This study focuses on these specific treatments and not on any experiences you've had culturally adapting other treatments.</i>
<i>Finally you were also chosen because of your experience in implementing these treatments with American Indian and Alaska Native populations.</i>
<i>Do you have any questions about any of this? My purpose of explaining this is so that when we get into the interview questions soon, that you can reflect upon these specific experiences.</i>
<i>(If not mentioned during introductions or permitted to be shared from the Qualtrics Survey, gather the following demographic information):</i>
<ul style="list-style-type: none"><li>• <i>Race and ethnic background</i></li><li>• <i>Gender</i></li><li>• <i>Age</i></li><li>• <i>Experience working with American Indian and/or Alaska Native populations as a licensed mental health provider (Setting; Years of experience)</i></li></ul>

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- *What empirically supported treatments have you culturally adapted and implemented with American Indian and/or Alaska Native clients?*

### **Inform Participant about Potential Risks and Benefits, Recording and Obtain Verbal Consent**

*(Risks): The risks to participants is minimal. The questions you will be asked today concern your role as a clinician. Today I will ask you questions about your experiences involving cultural adaptation of empirically supported treatments and the implementation of these treatments with American Indian and Alaska Native clients.*

*(Benefits): There is minimal benefit of participating in this interview. Those who participate and complete this interview in its entirety will be gifted with a traditional gift. Participating may develop a feeling of altruism as they contribute to the general knowledge regarding cultural adaptation of empirically supported treatments for American Indian and Alaska Native populations.*

*I'd like to remind you that you can withdraw from participating at any time.*

*I would like to record our interview today I will be using two audio recorders, one for recording, and one for backup just in case the main recorder doesn't work. After our interview two research assistants and I will work on transferring the audio recording to a text version using a software called NVivo. The transcript will not have your name on it. A pseudonym will be used instead. Any demographic information disclosed at the end of this interview will be kept with the assigned pseudonym separate from the interview data. The recording will be deleted after the transcribed data has been coded and analyzed.*

***(Mandatory Question) Do you have any further questions about the recording today?***

***(Mandatory Question) Is it okay to audio record this interview today?***

***(Mandatory Question) Do you consent to participate in this research?***

*Thank you for providing your consent to participate in the interview today. Before we begin: Do you have any further questions for me?*

***\*\*\*If participant provides consent: START RECORDING NOW\*\*\****

### **Q&A**

*Okay I am going to turn on the recorders now.*

### **Introductory Interview Statement**

*Today I am hoping to learn about your unique experience as a clinician by asking you questions about your application of empirically supported treatments. Please provide as much detail as possible. There is no rush to respond immediately to the questions. Please take the time you need before answering.*

### **Interview Question # 1**

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<i>How do you define cultural adaptation?</i>	
<i>(or said another way, what comes to mind when thinking about cultural adaptation?)</i>	
Interviewer Comments:	Reflective Notes:
<b>Interview Question #2</b>	
<i>How have you engaged in cultural adaptation of an empirically supported treatment?</i>	
<i>Potential Follow Up Question: (If needed: What specifically have you had to adapt?) How frequently have you engaged in cultural adaptation and has this changed over time?</i>	
Interviewer Comments:	Reflective Notes:
<b>Interview Question #3</b>	
<i>What does the process or processes of cultural adaptation look like from beginning to end?</i>	
Interviewer Comments:	Reflective Notes:
<b>Interview Question #4</b>	
<i>While engaging in cultural adaptation, how were you modifying the treatment for a specific tribe, multiple tribes, or an individual person?</i>	
<i>(In other words, who was the target population?)</i>	
Interviewer Comments:	Reflective Notes:
<b>Interview Question #5</b>	
<i>How did you realize that cultural adaptation was necessary?</i>	
<i>(Said another way: What factors influenced the decision to culturally adapt an empirically supported treatment?)</i>	
Interviewer Comments:	Reflective Notes:
<b>Interview Question #6</b>	
<i>What influenced your ability to culturally adapt a specific treatment?</i>	
Interviewer Comments:	Reflective Notes:

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<b>Interview Question #7</b>	
<i>What has been your experience in using these culturally adapted treatments with American Indian or Alaska Native clients?</i>	
<i>Potential follow up questions: What has been helpful? What has been unhelpful?</i>	
Interviewer Comments:	Reflective Notes:
<b>Interview Question #8</b>	
<i>What has been your experience using empirically supported treatments that have not been culturally adapted with this population?</i>	
Interviewer Comments:	Reflective Notes:
<b>Interview Question #9</b>	
<i>What has it been like for you to be balancing the priorities or needs of treatment developers and American Indian and Alaska Native clients?</i>	
Interviewer Comments:	Reflective Notes:
<b>Interview Question #10</b>	
<i>Do you have anything else you would like to share that I did not ask about relating to this topic?</i>	
Interviewer Comments:	Reflective Notes:
<b>Wrap Up Discussion, Gather Demographic Information and Thank You</b>	
<i>These are all the questions that I have for you today. I am going to turn off the audio recording devices now.</i>	
<i>(Turn off audio recorders)</i>	
<i>Thank you for sharing your time and experience with me today. I do have a traditional gift of appreciation.</i>	
<i>(If via Zoom technology ask: What is the best way to get this to you?)</i>	
<i>I will be sure to share the results of this study with you upon completion. If you have any further questions, do not hesitate to contact me.</i>	
<i>(Provide contact information, if needed)</i>	



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## Appendix B

### Qualtrics Survey

Title of Study: “THE EXPLORATION OF CLINICIANS’ LIVED EXPERIENCES IN CULTURALLY ADAPTING EMPIRICALLY SUPPORTED TREATMENTS FOR AMERICAN INDIAN AND ALASKA NATIVE POPULATIONS”

Investigator:

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406-243-4263

Inclusion [and Exclusion] Criteria:

Inclusion criteria include licensed mental health providers who have implemented an empirically supported treatment (the list developed by the Society of Clinical Psychologists is used in this survey to help determine this criteria), and have engaged in cultural adaptation of at least one of these treatments with American Indian and Alaska Native clients.

Exclusion criteria include licensed mental health providers who are only using telemental health to provide counseling services, license-eligible mental health providers, and 17 years of age or younger.

Purpose:

The purpose of this survey is to identify potential participants who meet the inclusion criteria to participate in this research study. Your responses will be recorded but your identity will remain anonymous to the investigator unless you choose to share the information with the investigator or contact the investigator. Because the inclusion criteria is very specific this Qualtrics survey helps the investigator identify potential participants more efficiently.

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### Procedures:

You will be asked a series of questions to determine your eligibility to participate in this research. At the end of this survey you will be informed of your status to participate in this research. If you meet the inclusion criteria to participate in this research you will have two options at the end of this survey. You can give permission for the investigator to see your responses given in this Qualtrics survey and provide your name and contact information to speak with the investigator to set up an interview. Or you can decline to further participate. If you choose this option, the investigator will not know your identity but will still be able to see your responses.

### Risks/Discomforts:

There is no anticipated discomfort for those who answer the questions to this survey, so the risk to participants is minimal. Participants can stop the survey at any time without negative consequences.

### Benefits:

There is no benefit to participating in this survey. Participants who meet the inclusion criteria and participate in an interview with the investigator will receive a traditional gift. Those who participate in this study may develop a sense of altruism as they contribute to the general knowledge regarding cultural adaptation of empirically supported treatments for American Indian and Alaska Native populations.

### Confidentiality:

Your identity will be kept anonymous unless it is determined that you meet the inclusion criteria to participate in this study, you give permission and provide your contact information for the investigator to contact you to participate. The investigator will inform you of the confidentiality procedures applicable to the remaining portion of the research study if you choose to participate in the research interview.

### Voluntary Participation/Withdrawal:

Your decision to take part in this research study is entirely voluntary. You may refuse to take part in or you may withdraw from the study at any time without penalty or loss of benefits to which you are normally entitled. You may leave the study for any reason.

### Questions:

If you have any questions about the research now or during the study, please contact:

Maegan Rides At The Door

University of Montana

Missoula, MT 59812

406-880-0222

Maegan.RidesAtTheDoor@umontana.edu

### Statement of Your Consent:

I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I

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have been assured that any future questions I may have will also be answered by the investigator. I voluntarily agree to take part in this survey by clicking the arrow > button below.

I am currently a:

- Licensed Professional Counselor (or Licensed Clinical Professional Counselor)
- Licensed Clinical Psychologist
- Licensed Clinical Social Worker (including Licensed Independent Social Workers and Academy of Certified Social Workers)
- Licensed Addiction Counselor (or Licensed Clinical Alcohol & Drug Abuse Counselor)
- Licensed Marriage and Family Therapist
- × None of these

Please review the following list of empirically supported treatments (determined by the Society of Clinical Psychology) and click the radio button next to the ones you have implemented with American Indian and/or Alaska Native clients.

- Acceptance and Commitment Therapy (for Obsessive-Compulsive Disorder, Chronic Pain, Depression, Mixed Anxiety Disorders, Psychosis)
- Applied Relaxation for Panic Disorder
- Assertive Community Treatment (ACT) for Schizophrenia
- Behavioral Activation for Depression
- Behavioral and Cognitive Behavioral Therapy for Chronic Low Back Pain
- Behavioral Couples Therapy for Alcohol Use Disorders
- Behavioral Treatment for Obesity
- Biofeedback-Based Treatments for Insomnia
- Cognitive Adaptation Training (CAT) for Schizophrenia
- Cognitive and Behavioral Therapies for Generalized Anxiety Disorder
- Cognitive Behavioral Analysis System of Psychotherapy for Depression

## CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

- Cognitive Behavioral Therapy (CBT) (for Schizophrenia, adult ADHD, Anorexia Nervosa, Binge Eating Disorder, Bulimia Nervosa, Chronic Headache, Insomnia, Obsessive Compulsive Disorder, Panic Disorder, Social Anxiety Disorder, Post-Traumatic Stress Disorder)
- Cognitive Remediation for Schizophrenia
- Cognitive Therapy (CT) (for Bipolar Disorder, Depression)
- Dialectical Behavior Therapy for Borderline Personality Disorder
- Emotion Focused Therapy for Depression
- Exposure and Response Prevention for Obsessive-Compulsive Disorder
- Exposure Therapies for Specific Phobias
- Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder
- Family Focused Therapy (FFT) for Bipolar Disorder
- Family Psychoeducation for Schizophrenia
- Family-Based Treatment (for Anorexia Nervosa, Bulimia Nervosa)
- Friends Care for Mixed Substance Abuse/Dependence
- Guided Self-Change for Mixed Substance Abuse/Dependence
- Healthy-Weight Program for Bulimia Nervosa
- Illness Management and Recovery (IMR) for Schizophrenia
- Interpersonal and Social Rhythm Therapy (IPSRT) for Bipolar Disorder
- Interpersonal Psychotherapy (for Binge Eating Disorder, Bulimia Nervosa, Depression)
- Mentalization-Based Treatment for Borderline Personality Disorder
- Moderate Drinking for Alcohol Use Disorders
- Motivational Interviewing, Motivational Enhancement Therapy (MET) and MET plus CBT for Mixed Substance Abuse/Dependence
- Multi-Component Cognitive Behavioral Therapy (for Fibromyalgia, Rheumatologic Pain)
- Paradoxical Intention for Insomnia

## CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

- Present-Centered Therapy for Post-Traumatic Stress Disorder
- Prize-Based Contingency Management (for Alcohol Use Disorders, Cocaine Dependence, Mixed Substance Abuse/Dependence)
- Problem-Solving Therapy for Depression
- Prolonged Exposure Therapy for Post-Traumatic Stress Disorder
- Psychoanalytic Treatment for Panic Disorder
- Psychoeducation for Bipolar Disorder
- Psychological Debriefing for Post-Traumatic Stress Disorder
- Rational Emotive Behavioral Therapy for Depression
- Relaxation Training for Insomnia
- Reminiscence/Life Review Therapy for Depression
- Schema-Focused Therapy for Borderline Personality Disorder
- Seeking Safety (for Mixed Substance Abuse/Dependence, PTSD with Substance Use Disorder)
- Self-Management/Self-Control Therapy for Depression
- Self-System Therapy for Depression
- Short-Term Psychodynamic Therapy for Depression
- Sleep Restriction Therapy for Insomnia
- Smoking Cessation with Weight Gain Prevention
- Social Learning/Token Economy Programs for Schizophrenia
- Social Skills Training (SST) for Schizophrenia
- Stimulus Control Therapy for Insomnia
- Stress Inoculation Training for Post-Traumatic Stress Disorder
- Supported Employment for Schizophrenia

## CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

- Systematic Care for Bipolar Disorder
- Systematic Treatment Selection for General Outpatient Populations
- Transference-Focused Therapy for Borderline Personality Disorder
- None of these

Have you culturally adapted one of the listed empirically supported treatments for American Indian and/or Alaska Natives?

- Yes
- No

Are you 18 years of age or older?

- Yes
- No

When implementing culturally adapted empirically supported treatments with American Indian and/or Alaska Natives, was this in person or online using telemental health technology?

- In person
- Online using telemental health technology

When implementing culturally adapted empirically supported treatments with American Indian and/or Alaska Natives, were you licensed or licensed eligible?

- Licensed
- Licensed-eligible (non-licensed)

# CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

## Appendix C


### Institutional Review Board Approval



**INSTITUTIONAL REVIEW BOARD**  
*for the Protection of Human Subjects in Research*  
FWA 00000078  
Research & Creative Scholarship  
Interdisciplinary Science Building 104  
University of Montana  
Missoula, MT 59812  
Phone 406-243-6672

**Date:** October 25, 2018

**To:** Maegan Rides At The Door, Counselor Education  
Dr. Lindsey Nichols, International Development Studies  
Dr. John Sommers-Flanagan, Counselor Education

**From:** Paula A. Baker, IRB Chair and Manager 

**RE:** IRB #205-18: "The Exploration of Clinicians' Lived Experiences in Culturally Adapting Empirically Supported Treatments for American Indian and Alaska Native Populations"

Your IRB proposal cited above has been **APPROVED** under **expedited review** by the Institutional Review Board in accordance with the Code of Federal Regulations, Part 46, section 110. Expedited approval refers to research activities that (1) present no more than minimal risk to human subjects, and (2) fit within the following category for expedited review as authorized by 45 CFR 46.110 and 21 CFR 56.110:

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

A waiver for the obtainment of written informed consent is granted for this project, as verbal consent will be obtained, and the following conditions apply:

1. Participation involves no more than minimal risk to the subjects; and
2. No procedures are involved for which written consent is normally required outside of the research context.

**Amendments:** Any changes to the originally-approved protocol must be reviewed and approved by the IRB **before** being made (unless extremely minor). Requests must be submitted using [Form RA-110](#).

**Unanticipated or Adverse Events:** You are required to timely notify the IRB if any unanticipated or adverse events occur during the study, if you experience an increased risk to the participants, or if you have participants withdraw from the study or register complaints about the study. Use [Form RA-111](#).

**Continuation:** Federal and University of Montana IRB policy requires you to file an annual Continuation Report ([Form RA-109](#)) for expedited studies. You must file the report within 30 days prior to the expiration date, which is **October 24, 2019**. *Tip: Put a reminder on your calendar now.* A study that has expired is no longer in compliance with federal or University IRB policy, and all project work must cease immediately.

**Study Completion or Closure:** Finally, you are also required to file a Closure Report ([Form RA-109](#)) when the study is completed or if the study is abandoned. See the directions on the form.

Please contact the IRB office with any questions at (406) 243-6672 or email [irb@umontana.edu](mailto:irb@umontana.edu).

Appendix D

Flyer

## Looking for Research Participants to Interview

**Research Topic:**  
**“THE EXPLORATION OF CLINICIANS’ LIVED EXPERIENCES IN CULTURALLY ADAPTING EMPIRICALLY SUPPORTED TREATMENTS FOR AMERICAN INDIAN AND ALASKA NATIVE POPULATIONS”**

Complete the Qualtrics Survey to see if you qualify!

Qualtrics Survey Link:

[https://umt.co1.qualtrics.com/jfe/form/SV\\_4IWDwAyxL5Hh7jT](https://umt.co1.qualtrics.com/jfe/form/SV_4IWDwAyxL5Hh7jT)

### Criteria for Participation:

- \*Licensed Mental Health Provider
- \*Culturally adapted at least one empirically supported treatment
- \*Implemented a culturally adapted empirically supported treatment with American Indian and/or Alaska Native clients
- \*18 years of age or older
- \*Reside in the United States

### Institutional Review Board Approval

The University of Montana IRB  
Expiration Date 10/24/2019  
Date Approved 10/25/2018  
Chair/Admin [Signature]

Principal Investigator: Maegan Rides At the Door, MA, LCPC, Doctoral Candidate, Counselor Education and Supervision Department, University of Montana  
e-mail: [Maegan.RidesAtTheDoor@umontana.edu](mailto:Maegan.RidesAtTheDoor@umontana.edu)





Appendix E

Using NVivo 12 To Conduct Constant Comparison Analysis

If a node exists that you would like to reuse:

Highlight selected text.

Right click to open a list of choices.

Select *Code Selection*.

Select *At Existing Nodes*. The *Select Project Items* window will appear.

Check the box next to the node you would like to reuse.

Click on *OK*. Your selected text is now coded.

If there is not an existing node to reuse:

Highlight selected text.

Right click to open a list of choices.

Select *Code Selection*.

Select *At New Node*. The *New Node* window will appear.

Type the name of the new node in the box next to *Name*. You can also include a description of the node under *Description*.

Click on *OK*. Your selected text is now coded.

Once your text is coded, you can create Tree Nodes. These are groupings of your Free Nodes.

First, click on *Nodes* (located in the bottom left hand corner). Your Free Nodes will be displayed.

Look through your free nodes and identify nodes that are similar. If you are unsure, you can double click on the node to bring up the data that have been coded with the node.

Highlight and drag your free nodes that are similar over to *Tree Node* (located in the upper left hand corner).

Once you have moved all the similar free nodes, click on *Tree Nodes*. The Tree Nodes will now be displayed.

Right click and select *New Tree Node*. Type in the name of your new Tree Node. Then, click on the nodes that are included in this Tree Node and drag them into the new category.

Once your Tree Nodes are organized:

## CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

Each Tree Node can then be written as a theme (perform this step outside of the NVivo program). To see the frequency of used codes in one source:

Click on the Tree Node you would like to search

Click on *Open*

Click on *Coding Stripes*

From the drop down menu, select the type of strips you would like to view (*Recent Coding, Selected Items, All Coding, Most Coding, Least Coding, Coding Density Only*). The coding stripes will appear to the right of the data window.

CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

Appendix F

Codebook Sample

Natural Meaning Unit	3 <sup>rd</sup> Person Shift	Revelatory Constituents (What does this tell me about cultural adaptation?)	Constituent
Interview 1-Melissa			
And so when I started working with (tribe) (tribe) and I'm a (tribe) and so (tribe) and (tribe) are vastly different than other plains tribes so I really don't have a clear understanding of their ceremony and the way they see things. And then (tribe) and (tribe) are vastly different from one another.	Melissa knows there is diversity among Tribes and does not have a clear understanding of some ceremonies and worldviews	Acknowledge diversity between Tribes and how this can limit clinician understanding	Developing an understanding of cultural adaptation
And so that's the piece I always train, to establish your relationship, establish your rapport, value their perspectives and the way they see the world because I don't live their lives. Their goals are not my goals. My job is to help them meet their goals as defined in their treatment plan	Melissa stresses establishing relationship, rapport, and valuing client perspectives to meet client goals	Establish relationship, rapport and value client perspectives to meet client goals	Focusing on building and maintaining relationships
I try to create an office environment that's open to communication so I've got like some sweet grass hanging. Not only is that important to me personally, or I've got a buffalo robe, just something that lets people know like I want this to be a safe place to talk about things.	Melissa tries to create an office environment with cultural items to create a safe place	create an office environment with cultural items to create a safe place	Focusing on building and maintaining relationships
Interview 2-Jane			
Yeah, umm to adapt to the outside pressures that have nothing even to do with therapy and I'm doing inside the room either and so um but, you know? Whatever doesn't	Jane has had to adapt to outside pressures outside of therapy	Clinician has had to adapt to outside pressures outside of therapy	Coping with external factors

CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

<p>kill you makes you stronger. I mean you know? I just been determined you know?</p>			
<p>For example in on (Tribal Reservation) there (Tribe) and (Tribe) and when and then there's inter marriages of course so there people who but almost in my experience almost everyone would more identify with one. They would say I'm (Tribe) and (Tribe) but you know my grandmother taught me (Tribe) or I know (Tribe) so I talk, they you know they will like let you know that how they identify if I don't ask question "Who do you identify with most?" It's just a dumb question but it's interesting to me to know the answer to that.</p>	<p>Jane notices that clients who are from different tribes will identify with one more and that it's important to ask if they don't share</p>	<p>Clients who are from different tribes may identify with one more than other(s) and that it's important to ask if they don't share</p>	<p>Clinicians ability to embody cultural humility and cultural competency</p>
<p>Cause you have to do um, relaxation that is done or if you use a visualization, I would mostly likely not use the beach you know uhhh. Then you're at the ocean and it's glittering and you put your hands in the warm sand and I would use (Tribe) lake or if I'm talking about you know I would make a visualization about something that would be more immediate to their surroundings, their place will be a lake or be a river, it wouldn't be a ocean. If that makes any sense? So I use that. So it would be doesn't mean I couldn't use the ocean or it wouldn't be successful, but it would be much harder for that person trying to connect to relax when they have never seen the ocean.</p>	<p>Jane says when she does relaxation she changes the visualizations to be more relevant for the client</p>	<p>Changing visualizations to be more relevant for the client</p>	<p>Clinicians ability to embody cultural humility and cultural competency</p>

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Interview 3-Robert			
Well, the number one thing is establish that relationship you know. It's cause I mean there a lot of lack of trust that goes in there	Robert thinks the number one thing is to establish relationship	Establish relationship	Focusing on building and maintaining relationships
It's a step in a relationship because I know whenever they say well you're going to have a two hour intake. Me I'm probably sit there about maybe half a day talking to somebody and it's like you know and you know I'll go through you know the intake fill out the paper work but you know having to understand where that individual is at. You know? Instead you know sticking to the text saying ok well you know I've got this you know we're going to put you in this treatment planning we are going to put you in that treatment plan and everything else but you know I kinda break it down more. You know it's like their feelings of treatment.	Robert tries to prolong intake sessions to really understand the client and their feelings about treatment	Clinician tries to prolong intake sessions to understand the client and their feelings about treatment	Focusing on building and maintaining relationships
Well I mean you know whenever you say you learn from mistakes. I learned not only from my mistakes but many of others mistakes (laughing) saying well you know, I'm not going to do that! (laughing)	Robert has learned from his mistakes and others	Learn from own mistakes and others	Clinicians ability to embody cultural humility and cultural competency
Interview 4-Jennae			
I mean if I was in Arizona would I know how to culturally adapt to a client? Maybe not. I would have to	Jennae thinks CA is place based; locally based	CA is place based	Developing an understanding

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learn so I think that's why I think it's maybe place based and like locally based.			of cultural adaptation
If we don't modify or adjust or shift or adapt ourselves in our practice. I mean we are the ones with the power. We're the ones sitting on this side of the table, there's a power dynamic there. You know and so to if we with the power do not shift we, the client may not be able to fully engage in the treatment.	Jennae points out that clinicians are the ones with the power	Clinicians are the ones with the power	Developing an understanding of cultural adaptation
But if I needed to link someone to services or to help them find someone to come in or. So mine would more look like um, offering understanding around them engaging in their own practice on their own time. Kind of you know or encouraging it. But not like being the one to facilitate it myself.	Jennae can link people to cultural resources	Link people to cultural resources	Supporting traditional and culturally developed ways of healing
Interview 5-Amber			
I'm trying to clarify it more and figure out how do it and so um that things can be more relevant and, and um used in communities since a lot of our empirically supported treatments and interventions are not necessary tested first um when they become empirical uh in our in minority communities so that how I see adaptation. It just um creating something more relevant and something that people can relate to better and can see um how how it actually relates to them and themselves in that intervention and how they can do it.	Amber is trying to use it to make EST more relevant because ESTs aren't tested in our minority communities	Trying to make EST relevant because EST are not tested among minority communities	Navigating the use of ESTs

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<p>People will call stuff out like if we use traditional (name) program videos people would be like uhh you know we don't have granite countertops here we they were all there was no native people in those videos and you know they were kinda outdated to and they just you know I don't know if they would be as engaging or um or as you know relevant or also just like you know how if you watch something that's old you kinda just don't pay attention or you pay attention to the pieces aren't important like the granite countertops and the um the outdated clothing or whatever you know what I mean?</p>	<p>Amber has experienced that community members will comment on cultural irrelevancies</p>	<p>Community members will comment on cultural irrelevancies</p>	<p>Immersion and engagement in the community</p>
<p>Having capacity on the ground to actually do it um cause sometimes that that's one of the biggest challenge is it the capacity on the ground to actually do some of the things that need to be done.</p>	<p>Amber says one challenge is to have capacity</p>	<p>Capacity is a challenge</p>	<p>Coping with external factors</p>
<p>Interview 6-Lauren</p>			
<p>So it would be um like on the fly in the moment it would be checking in with the client um but maybe noticing...verbally letting them know that um it doesn't seem like this is fitting well. Is that correct? So checking in with them. Seeking clarification I guess from the client to put it in a summative form.</p>	<p>Lauren says CA is checking in with the client in the moment</p>	<p>CA is checking in with the client in the moment</p>	<p>Developing and understanding of cultural adaptation</p>

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<p>I've also had the benefit of in multiple settings of consulting with someone so it might not be that I'm consulting with another clinician but I'm consulting with someone who um is recognized by others as being of an expert on the culture um and who feels comfortable sharing with me um information knowing that I'll use it in a therapeutic setting.</p>	<p>Lauren has consulted with other experts on the culture knowing it will be used in a therapeutic setting</p>	<p>CA involves consulting cultural experts</p>	<p>Clinicians ability to embody cultural humility and cultural competency</p>
<p>Um like I think I would have the awareness that something needs to be adapted but it might be a lack of know how like how exactly do I adapt this so that it works better um because I have a limited knowledge of that tribe so I might know that oh this isn't going well but not know exactly what to do on my own.</p>	<p>Lauren considers that she may know that something needs to be changed but may not know exactly what to do on her own</p>	<p>CA involves knowing when to change something and how to seek help</p>	<p>Clinicians ability to embody cultural humility and cultural competency</p>
<p>Yeah that um either you can see empirical um positive changes whether that be pre-post tests or um qualitative feedback from the child's teachers or parents or from the child himself so um the evidence based practices that I have used I feel like they have been helpful for Native American students but I feel like they could be even more helpful if changes were made. If more changes were made I should say.</p>	<p>Lauren can see empirically supported changes quantitatively or qualitatively but feels more changes would make them even more helpful</p>	<p>Clinician can see can see empirically supported changes quantitatively or qualitatively but feels more changes would make them even more helpful</p>	<p>Developing an understanding of cultural adaptation</p>
<p>Interview #7-Charles</p>			



CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

<p>And I suppose the way it was culturally adapted was you know my understanding of behavioral activation is its very rigid. So what's your plan? How many times a week are you going to do this activity? All written out. Identifying the problem. The behavior that they could engage in that would help them reduce depression or individual symptoms that they may be experiencing. For me it was far more fluid, it seemed a little incongruent or not culturally responsive to go about that in this rigid way. And this was based on my own subjective experience but also on readings that influenced my viewpoint as well.</p>	<p>Charles found it not culturally responsive to carry out EST rigidly</p>	<p>Not culturally responsive to carry out EST rigidly</p>	<p>Navigating the use of empirically supported treatments</p>
<p>So I think, this is something that goes through my head when working with a client, whether or not I embody that in a way that resonates I guess we have to ask the client.</p>	<p>Charles thinks we cant really know if what we are doing resonates with the client we have to ask</p>	<p>Need to ask the client if what the clinician is doing resonates with them</p>	<p>Clinicians ability to embody cultural humility and cultural competency</p>
<p>I don't know that empirically supported treatment is necessary. So having said that I think um, uh, I think cultural adaptation of who I am and how I personally approach a client or who the counselor is, is necessary I don't know that empirically supported treatments in the typical sense in which we think about them is necessary. So I would say cultural adaptation or cultural responsiveness in regard to the interpersonal qualities and</p>	<p>Charles thinks how CA of clinician is necessary but not necessarily EST are necessary</p>	<p>CA of clinician is necessary but EST are not necessary</p>	<p>Navigating the use of ESTs</p>

CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

<p>dynamics that the counselor brings to the table is important and I'm not sure that empirically supported treatments is necessarily needed or required.</p>			
<p>Interview 8-Jalen</p>			
<p>Yes I think that you're doing it from even before you meet with a patient. So how are you advertising or how do they know about you. You know whether that is coming from word of mouth from family or whether you have advertisements in clinics or the places where people can see flyers. Even there you are having to decide how are we gonna be an open door for people and have people feel like it's going to fit them rather than okay this is a CBT thing and you are going to walk in here to get this or that. I think even before you see them you are thinking about how you are projecting yourself, or your company or your agency. So that's before they walk in the door.</p>	<p>Jalen thinks even before meeting with a client CA includes how you are engaging them to come in (i.e. advertising, flyers) ("how you are presenting yourself/agency")</p>	<p>CA includes engagement/recruitment prior to client coming in</p>	<p>Focusing on building and maintaining the relationship</p>
<p>That kind of stuff ends up happening with CBT or DBT um manuals or workbooks that we end up having that we like to use we end up having to develop those ourselves and retype them or try to incorporate some of the values that people are telling us about. We and in other more smaller clinics like tribal that I've worked in, when we have had tribal people or we had connections to tribal people</p>	<p>Jalen retypes or incorporates cultural values in manuals and workbooks</p>	<p>CA involves retyping or incorporating cultural values in manuals/workbooks</p>	<p>Clinicians ability to embody cultural humility and cultural competency</p>

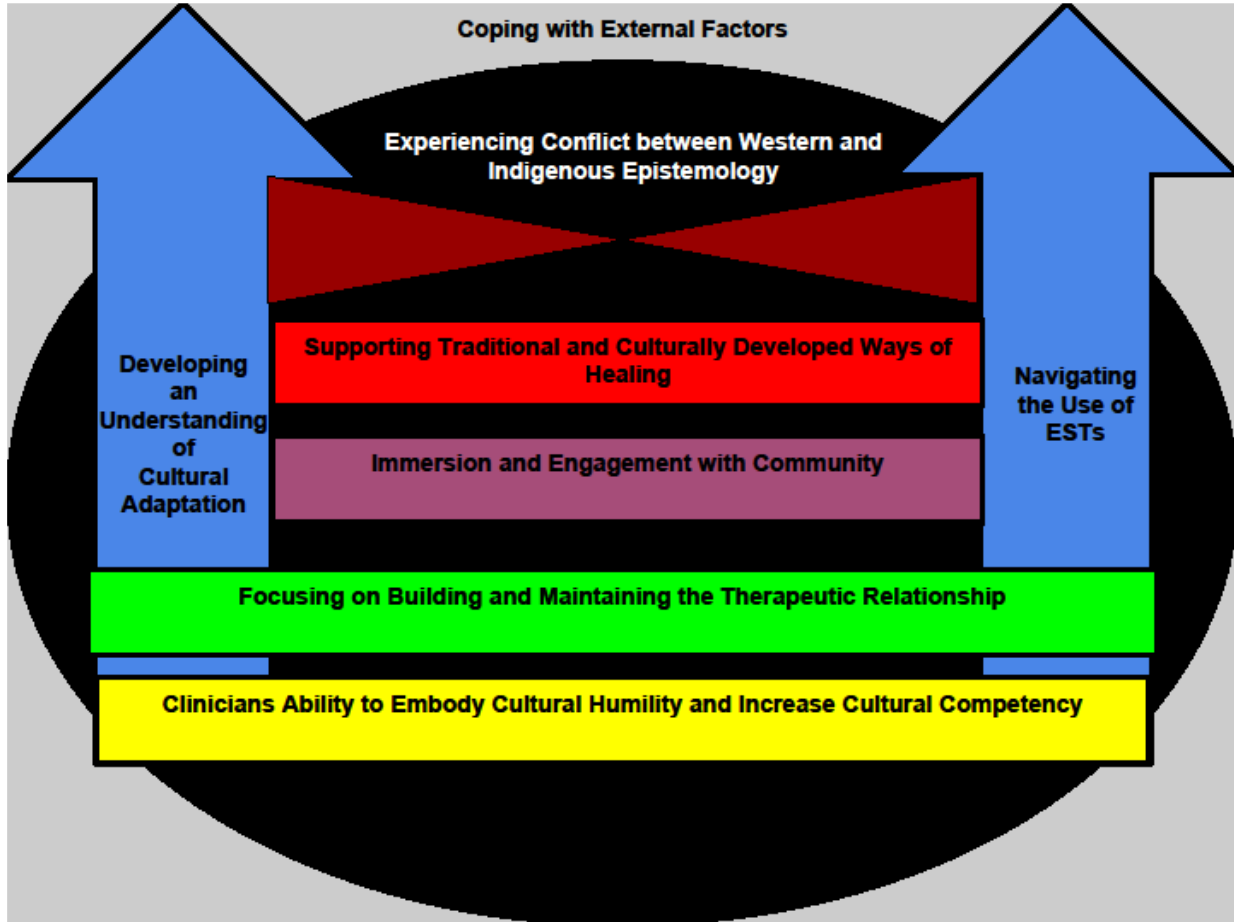
CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

<p>who were like um in ceremonial type of situations that could give us feedback we would try to incorporate what they were saying into what we were doing.</p>			
<p>And so um translation so we understand things a certain way from the empirically supported therapies that we know about and then so if we are in classroom situation with a group or we have a something we have for an individual we are teaching psychoeducation wise in those areas we are drawing it and writing it in a lot different language. Even the shapes of things are going to be different. So something that looks linear like cognitions, emotions and behaviors on a regular CBT worksheet is not going to look so linear in our session. You know it might look more circular or it might look more like a wave you know and I think that ends up having a bigger impact on our patients than this, this happens that's very rare that it's kind of how they view the world but um so I think those are the biggest ones.</p>	<p>Jalen says he has changed the way he explains things when doing psycho education (i.e. linear to circle or wave)</p>	<p>Changing psychoeducational explanation (i.e. linear to circular or wave)</p>	<p>Clinicians ability to embody cultural humility and cultural competency</p>

CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

Appendix G

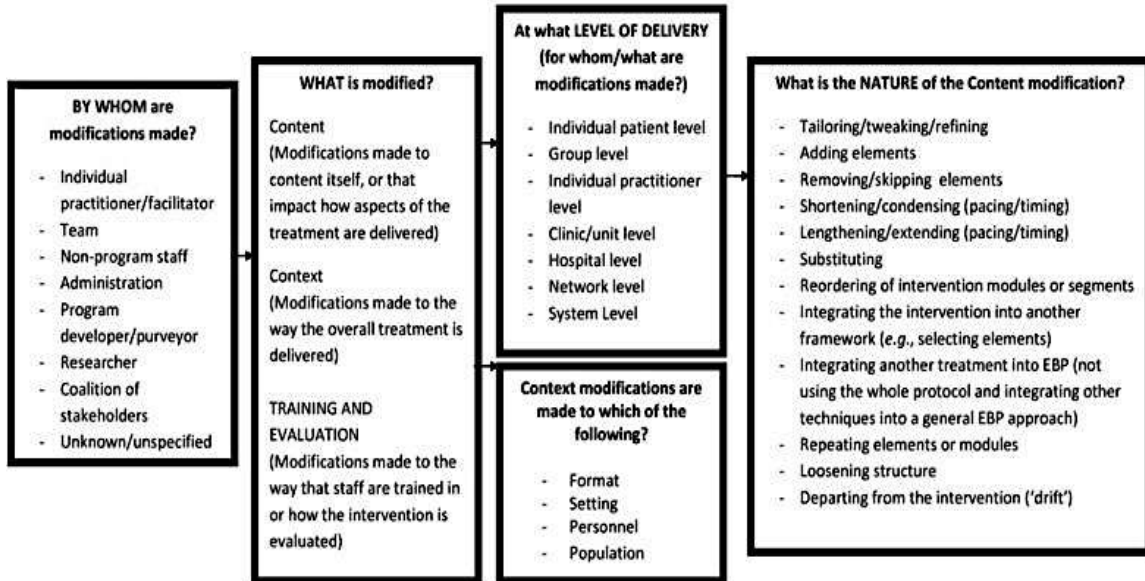
Descriptive Psychological Structure



# CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

Figure 1

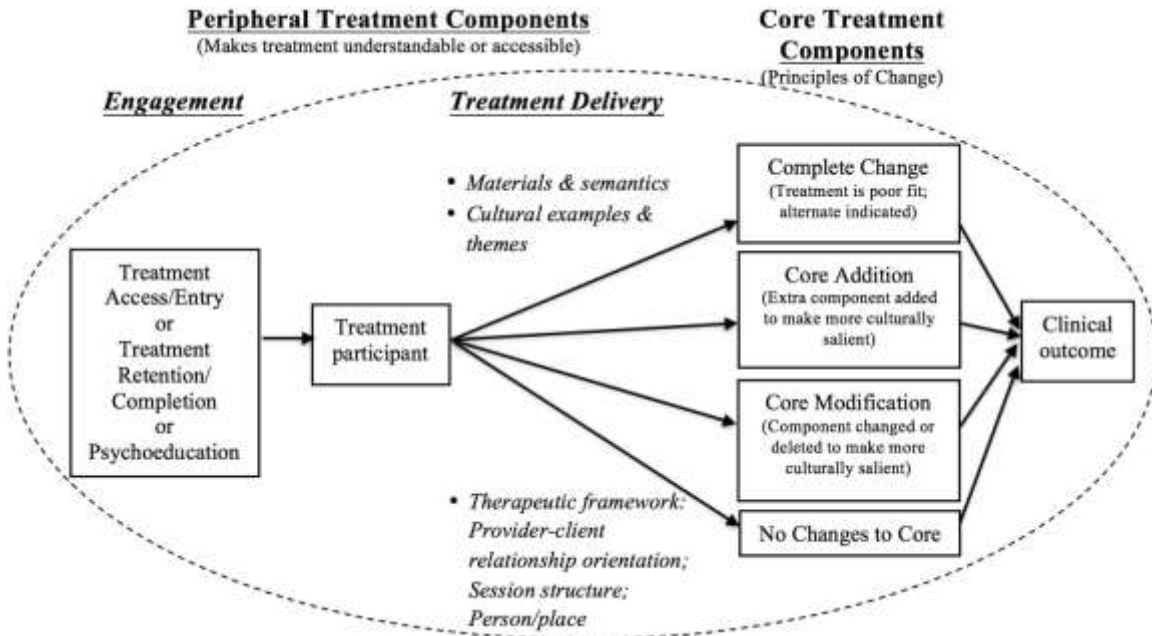
Framework for Culturally Adapting EST's (Stirman, et al, 2013)



# CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

Figure 2

Cultural Treatment Adaptation Framework (Chu & Leino, 2017)



# CULTURAL ADAPTATION OF EMPIRICALLY SUPPORTED TREATMENTS

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