Behavioral Health Service Delivery with Pacific Islanders

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Please note the authors are aware that some historical facts that can be found in the literature may be inaccurate. They also acknowledge the many different perspectives from historical events. They have made attempts to find the most accurate information and exclude all biases, but humbly ask for forgiveness of anything that is unintentionally misrepresented.

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E lauhoe mai nā wa‘a; i ke kā, i ka hoe; i ka hoe, i ke kā; pae aku i ka ‘āina

Translation: Everybody paddle the canoes together; bail and paddle, paddle and bail; and the shore will be reached.

Figurative Translation: If everybody pitches in, the work is quickly done.

When paddling the canoe, everyone has a special role to fulfill and is vital to the success

L. T. Benuto et al. (eds.), *Handbook of Cultural Factors in Behavioral Health*,
https://doi.org/10.1007/978-3-030-32229-8_11

of the voyage. The "stroker" occupies the first seat and seats 1 and 2 have the role of ensuring the rhythm and pace of the paddle strokes. Seats 2 and 3 call the changes when the paddlers change sides of the canoe. Seats 3 and 4 are often called the power seats and are for the strongest paddlers. Seat 4 has the additional responsibility of bailing out the water when necessary. Seat 5 is responsible for having the knowledge of steering to assist the steersperson when necessary. They must also keep the ama (outer float). Seat 6 is the steersperson, or the captain of the canoe. They are responsible for motivating the crew and setting up the canoe for the best course and catching the swells. If everybody works together the work will be done quickly. Embodied within this metaphor/story are the traditional cultural values of Pacific Islanders that continue to guide their way of living. Metaphors like this one are commonly infused in treatment to remind people of the importance of their individual role within the success of the group.

Part I Background History

Pacific Islanders are well known for their knowledge and history of voyaging. To begin this chapter and discussion of how to effectively work with Pacific Islanders, we must first discuss who the term "Pacific Islanders" refers to. Figure 11.1 above shows the map of Oceania. The islands within the narrower definition of the Pacific Islanders include those within Polynesia, Micronesia, and Melanesia. The broader definition of the Pacific Islanders includes those within Polynesia, Micronesia, and Melanesia, as well as adjacent countries in this map (Philippines and China) and other Asian cultures that have also had major migrations to the Pacific Islands (Japanese, Korean, and Filipino). The broadly defined Asian American and Native Hawaiian/Pacific Islander community is one of the fastest growing racial/ethnic groups (Hoeffel, Rastogi, Kim, & Shahid, 2012). In the State of Hawaii, more than 2/3 of the population consider themselves as non-white according to US Census Bureau (2012).

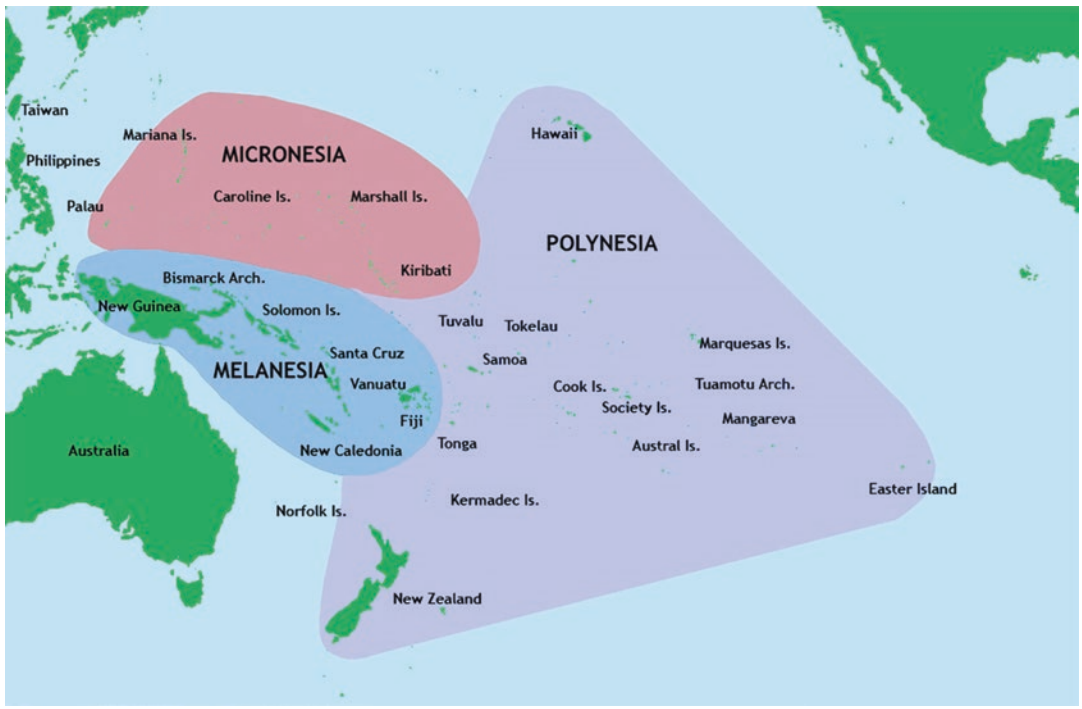


Fig. 11.1 Map of Oceania

Within the narrower definition of Pacific Islanders, many of the island cultures share similar beliefs, values, and customs. The Pacific Islands also share many characteristics as they are small and remote. The islands were previously self-sufficient but presently depend on outside resources. The largest group of Pacific Islanders are the indigenous people in the islands of Hawai‘i, the Native Hawaiians, “kanaka maoli,” meaning real or true person (Blaisdell, 1989; Mau et al., 2010). The Hawaiian Islands are within the Polynesia group of Oceania. Early Polynesians were voyagers and used stars, ocean current, wind, and birds as navigational tools. The decision to navigate to find new lands was believed to be due to increasing populations. All Polynesian societies were similar in that they had three main classes of people, this includes the royal class (ali‘i), priests (kahuna), and the commoners (maka‘āinana). Above all people were their akua, or Gods and spirits, which they believe are present in all natural things. There were many ceremonies and rituals to please the Gods. With the societal classes in Polynesia, genealogy was of great importance in knowing where one stood within a society. The importance of family and extended family is important throughout Polynesia and most often traced through the paternal side.

The Hawaiian Islands were no different from its Polynesian counterparts. Figure 11.2 shows a more detailed version of the traditional Hawaiian society. This triangle shows the top as being most sacred or kapu and working its way downwards. The Mō‘ī was the high chief who worked closely with Ali‘i Nui (Political Council) and Kahuna Nui (religious advisors). The Ali‘i Nui and Kahuna Nui had people below them who would then work with the maka‘āinana (commoners). Hawaiian history and genealogy shows that the Hawaiian Islands themselves are direct descendants of the Gods and came long before humans. The legends tell the story of the islands being born from Wākea, our sky-father, and Papahānaumoku, our earth-mother. They then had their first human offspring, Ho‘ohōkūkalani, who later had children with Wākea. The first of their children together

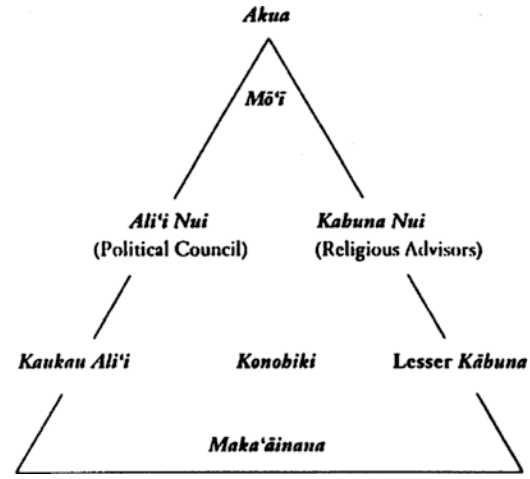


Fig. 11.2 Traditional Hawaiian Society (Kameeleihiwa, 1992)

was Hāloa-naka, who was still-born and buried. It was from his burial site that Hawai‘i’s main staple plant came about, the kalo or taro. Their second child was Hāloa, who became the first Ali‘i Nui of Hawai‘i (Kameeleihiwa, 1992). It is from this genealogical story that Hawaiians had high value and respect for land as it is their ancestor and older sibling who showed that the land will care for its people if the people care for the land. With this, villages or clans were strategically set up so all people had access to all resources from mountain to ocean. Family played an important role for the Hawaiian people who could trace their lineage through the paternal or maternal line. Kinship rather than race were early defining factors that helped to develop the multi-racial climate of Hawai‘i today (McDermott & Andrade, 2011). Hawaiians like many other Pacific Islanders believed that all things have mana or power. There was mana in knowledge, living things, items, and so on. Knowing one’s genealogy held a great amount of mana and shaped the Traditional Hawaiian society. Some of the most common populations currently represented in the islands of Hawai‘i are Samoan, Fijians, Tongans, Chuukese, and New Zealanders.

Within this narrower definition of Pacific Islanders, not only do its members share similar values, cultures, and customs, but they also face many of the same challenges. This may be related

to microgenetics or exposure to European culture. Rates of heart disease and diabetes are much higher among groups of Pacific Islanders than of those endorsing Asian descent (Juarez, Davis, Brady, & Chung, 2012). Similarly, Pacific Islanders have higher rates of poverty, substance abuse, and over-representation in jails and prisons compared to Asian Americans. Native Hawaiians have the highest incidence of morbidity and mortality, the highest age-adjusted mortality, and the highest rate of health disparities of any ethnic group in Hawai‘i (Anderson et al., 2006; Braun, Look, & Tsark, 1995). Native Hawaiians may also have even higher rates of substance abuse, arrests, and incarceration of all ethnic groups in Hawai‘i (Kana‘iaupuni, Malone, & Ishibashi, 2005). Consequently, the risks of combining the many ethnicities that identify as Pacific Islander/Asian American may result in a loss of significant findings and identification of meaningful differences.

Historical Culture of Hawai‘i

Archaeological evidence suggests that the inhabitants of Hawai‘i began between 200 and 600 A.D. (Graves & Addison, 1995). There were likely two waves of migration from other areas of Polynesia. Early settlers may have been forced back into deeper valleys. The chiefs (ali’i), changed frequently, typically through negotiation or battles and it was their duty to make sure their people’s needs were met. See Handy and Pukui (1972) for a more comprehensive written account of Ancient Hawaiian culture. As previously explained, Hawaiians did not own the land but rather worked with the land as if it were a living family member (Kameeleihiwa, 1992). The Hawaiians believed in many different gods and goddesses and built heiau to worship them. Ancient Hawaiians had four major gods, Kāne, Kanaloa, Kū, and Lono, although there is some disagreement over their descriptions. The gods and goddesses took on many physical forms (kinolau) like plants and animals that became sacred (kapu) (Kameeleihiwa, 1992). The Hawaiians also had many words to describe prosocial behavior and those things that could destroy social and spiritual relationships as can be shown in Table 11.1 (McCubbin & Marsella, 2009). Negative actions could allow spiritual forces to enter in their lives, so ritualistic behaviors, such as those in Table 11.2, are required with Native Hawaiian traditional healing arts (McCubbin & Marsella, 2009). Traditional Hawaiian medicinal practices, or Lā‘au Lapa‘au, are practiced by Hawaiian practitioners. The traditional practices are handed down in families or to other people who show promise. This tradition of passing on knowledge is something that many Pacific Island cultures have in common.

Table 11.1 Prosocial vs. antisocial behavior (adapted from McCubbin & Marsella, 2009)

Prosocial behavior	Antisocial behavior
• Humility and modesty (ha‘aha‘a)	• Hate (inaina)
• Politeness and kindness (‘olu‘olu)	• Jealousy (lili)
• Helpfulness (kōkua)	• Rudeness (ho‘okano)
• Acceptance, hospitality, and love (aloha)	• Being nosy (nīele)
• Respect (hō‘ihi)	• Bearing a grudge (ho‘omauhala)
• Caring (mālama)	• Bragging (ha‘anui)
	• Showing off (ho‘oi‘o)
	• Breaking promises (hua ‘ōlelo)
	• Speaking bitter thoughts (waha ‘awa)
	• Stealing (‘aihue)
	• Fighting (hakakā)
	• Anger (huhū)

Table 11.2 Native Hawaiian traditional healing (adapted from McCubbin & Marsella, 2009)

Native Hawaiian traditional healing
• Spiritual healing (lā‘au kāhea)
• Medicinal healing (lā‘au lapa‘au)
• Massage (lomilomi)
• Conflict resolution (ho‘oponopono)
• Apology (mihi)
• Dream interpretation (moe ‘uhane)
• Clairvoyance (hihi‘o)
• Prayer (pule ho‘onoa)
• Cleanse with sprinkling salt water (pī kai)
• Purification sea bath (kapu kai)

Colonization

After European's first contact with the Hawaiian Islands in 1778 with Captain Cook and 1820 with European missionaries, the population of Native Hawaiians changed from approximately 700,000 (although estimates vary widely) to 40,000 in 1893 (McCubbin & Marsella, 2009). Colonizers brought with them livestock, clothing, plants, metal weaponry, and diseases. Reasons underlying the dramatic decrease in the population were the introduction of illness and new weaponry. Indigenous species populations also decreased as they could not survive the new invasive species. Early accounts of Europeans and missionaries described Native Hawaiians as "savages" and "inferior" to Europeans (McCubbin & Marsella, 2009). Many other Pacific Islanders have dealt with similar if not worse effects of colonization and the early negative beliefs of Europeans.

The Overthrow of Hawai'i

There are some additional influences that have dramatically impacted culture in Hawai'i. At the time when Hawai'i, under the reign of Queen Lili'uokalani, was illegally overthrown by the USA in 1893, the locals had no claims to the land and many were against annexation. Queen Lili'uokalani was overthrown in a time where she wanted to do justice for her people and change the constitution, known as the Bayonet Constitution, that her brother and ruler before her, King Kalākaua, was forced to sign. The Bayonet Constitution, written by Lorrin Thurston, gave white foreigners power over the Hawaiian legislature and cabinet (Kameeleihiwa, 1995). A group of Americans, who became known as the Provisional Government of Hawai'i, undermined the queen to gain Hawai'i as a territory of the USA. President Cleveland later considered the overthrow of Hawai'i "an act of war" and felt that "a substantial wrong has been done" that they "should endeavor to repair" (Lander & Puhipau, 1993) with the provisional government not asking the people of Hawaii a formal vote for annexation. A formal apology was later made with the "Apology Bill" (US Public Law 103–150) of 1993 by President Clinton (Cummings, 2002). This acknowledged the illegal overthrow of the Kingdom of Hawai'i and apologized to Native Hawaiians on behalf of the people of the USA (Lander & Puhipau, 1993).

Annexation resulted in a changing economy with an influx of services both good and bad. The locals, who were self-sufficient people and worked to maintain their community with no income or titles to lands, were forced into a new economic system that they were not prepared for. Foreigners began to buy lands and take ownership of places that were free for all people to use and the natives suffered greatly. As an example of how westernization has affected the lifestyle of many Native Hawaiians, consider how the traditional diet, which was low in fat and high in complex carbohydrates, has changed to a typically western diet, high in fat and low in complex carbohydrates (Blaisdell, 1993, 1996). Studies in Hawai'i and other islands have suggested that a return to traditional diets, focused on staples, such as taro, breadfruit, and sweet potato, could help lower serum cholesterol, blood sugar levels, and other obesity related conditions. Other Pacific Islands have also suffered from colonialism by Westerners. Many of the surrounding islands were used to test nuclear bombs, which caused a loss of natural resources and made for unhealthy living conditions. Micronesia is one example, where nuclear testing occurred. The USA has tried to help by providing canned meat and fish and access to medical care; however, the Micronesian people face similar health and social disparities as Hawaiians and their lands will likely never be the same.

With annexation many of the traditional Hawaiian language and practices were banned. In the 1970s, when Hawaiian practices were no longer illegal, there was a resurgence in Hawaiian culture termed the Hawaiian Renaissance, involving a movement towards improving spirit and health by utilizing cultural practices. Some examples of this resurgence included development of a Hawaiian immersion educational program in 1984–1985, as a way for the Hawaiian language and culture to remain alive. The

Hawaiian Cultural Influences in Education evaluated culture-based education strategies and educational outcomes of students linked with positive impact on emotional and cognitive engagement, community connectedness, positive self-concept, and participation in cultural activities (Carlton et al., 2011). Several other types of programs and partnerships have been formed since this Hawaiian Renaissance to incorporate cultural values within all aspects of life including health care with positive outcomes. The Native Hawaiian partnership formed in 2005 was designed to provide culturally responsive substance abuse and mental health treatment. In the health care aspect of Hawai'i, the University of Hawai'i John A Burns School of Medicine has partnered with multiple community sites to implement delivery of cutting-edge services to rural and hard to reach populations. Since the Hawaiian Renaissance, there have been continual efforts of Native Hawaiians to further help the growth of the Hawaiian culture. The story of the overthrow of the Hawaiian islands is one that is well known throughout the world, but the experiences they faced is one that many Pacific Islanders can relate to. Many Pacific Island subgroups have also experienced cultural disintegration and trauma (Crabbe, 1998).

Cultural Immigrations

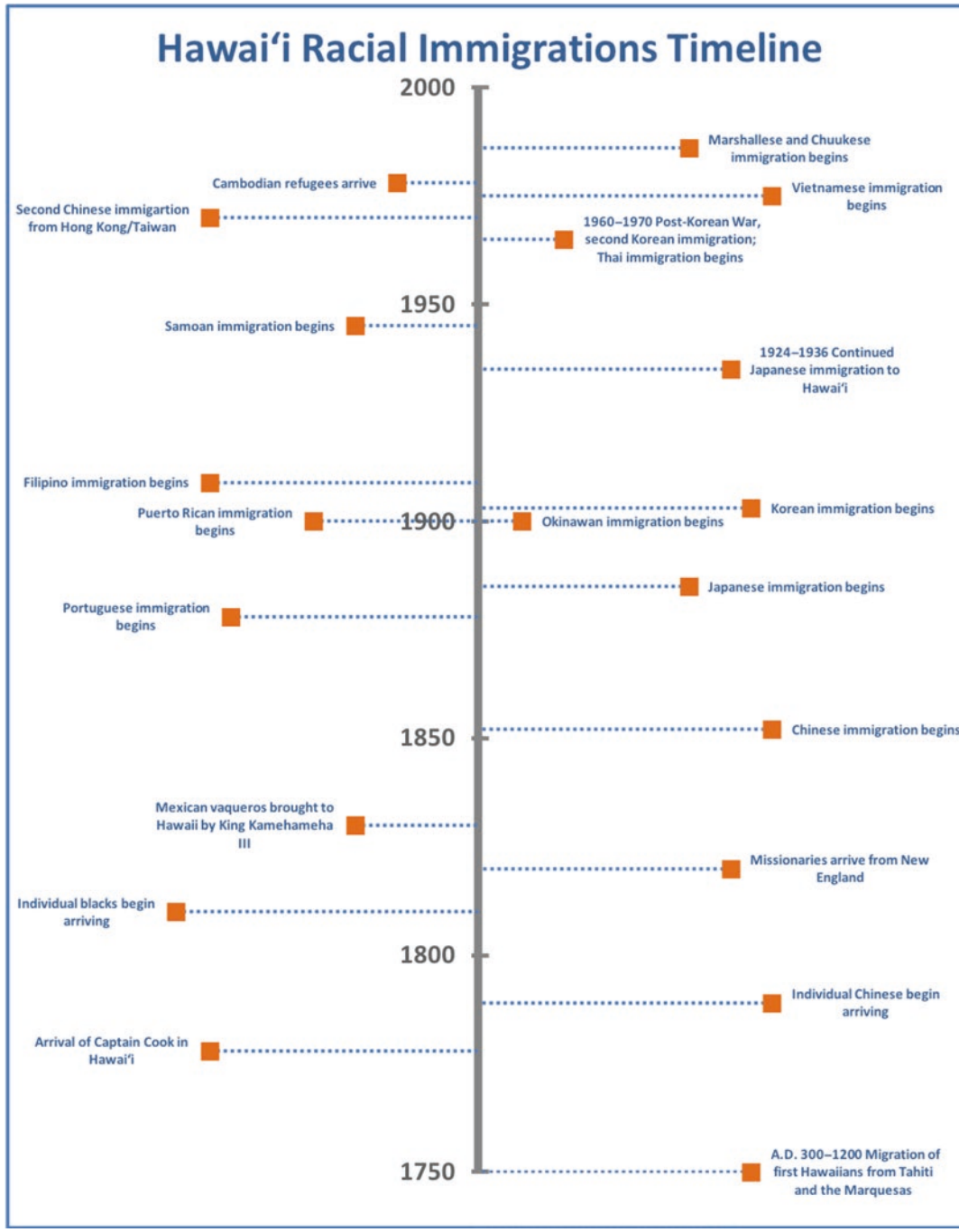
Here is a brief review of cultural immigrations after Europeans first contact (Table 11.3).

The rich ethnic diversity of Hawai'i provides a wealth of cultural influence and the Native Hawaiian people have historically embraced the introduction of new cultures. Native Hawaiians have a long history of accepting and identifying others as being part of their "hānai" or adopted family and having no prejudice around interracial marriage. The residents of Hawai'i embraced the cultural influences of others and did not carry a historical dislike of other ethnicities. Consequently, the development of a "hapa" or mixed race began early in the history of Native Hawaiians. It is culture rich with embracing and engaging in multiple cultural practices and identities. In the USA, the term "melting pot" is often used to describe the theory that each cultural identity would "assimilate" to shed their previous identities and to become American. In Hawai'i and most other Pacific Islands, they are thought of as a "stew" when it comes to cultural interactions where each culture is not expected to give up their ethnic identities to forge into one, but rather, there is a horizontal and vertical appreciation of the cultural and racial identities of others (McDermott & Andrade, 2011); however, some may reject both terms. Pacific Islanders are often more accepting of other cultures being that they were victims of colonialism and understand how that can negatively affect a person's culture and identity. For example, many of the cultural traditions, holidays, and foods from other countries are still represented among many people residing in Hawai'i. Holidays such as New Years, Chinese New Year, Boys Day and Girls Day, Prince Kūhiō Day, and King Kamehameha Day are among the many that are celebrated in Hawai'i. Foods from many different ethnic backgrounds can be easily found within the islands as well. You can find specific Native Hawaiian foods like kalua pig, pork laulau, and poi alongside foods from other ethnic backgrounds like malasadas (Portugal), poke (Japan), and pork adobo (Filipino).

Native Hawaiian Culture

Culture describes the rituals, traditions, system of beliefs, spirituality, religion, language, behavioral norms, ways of communication, and learning knowledge. Culture can serve as a bridge between multiple dimensions of life, as well as supporting the development of a greater understand of oneself and others. Native Hawaiians tend to view themselves collectively, consider multiple perspectives, and interpret themselves through ecological, historical, and cultural contexts. They tend to see group goals as more important than individual goals (Oliveira et al., 2006). As previously mentioned, the Hawaiians as well as other Pacific Islanders had a sense of harmony or lōkahi from nature ('āina), humankind (kanaka), and spirits (akua). This can be shown below in Fig. 11.3. The ultimate goal was

Table 11.3 Hawai‘i racial immigrations timeline (adapted from McDermott & Andrade, 2011)



to elevate one's earthly presence to a place where health and prosperity was gotten for all (Cook, Withy, & Tarallo-Jensen, 2003). Within these terms, the complex interaction between physical, psychological, and spiritual can be seen. The term ‘āina includes one's ancestral home as well as substances required to nourish the body. A psychological ‘āina refers to positive and nega-

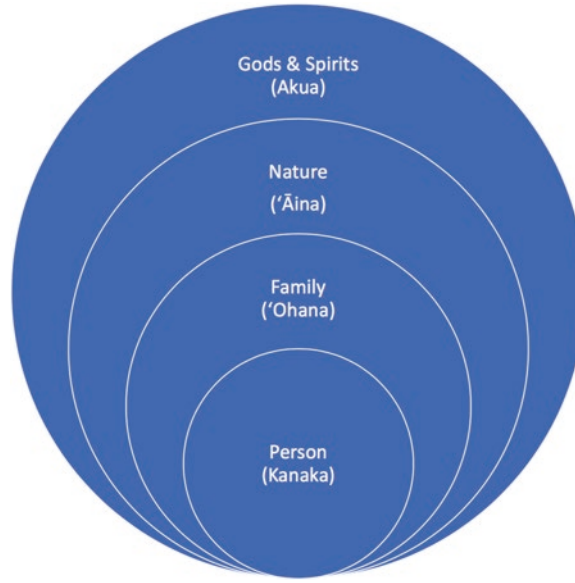


Fig. 11.3 Depiction of the view of Hawaiians

tive thinking that constitutes mental health. Spiritual ʻāina refers to relationships with the spiritual world. A well-known Hawaiian proverb is "Aloha aku, aloha mai" or "give love, get love," which shows the belief that if one gives love freely, it will come back to that person. There is also the belief of mālama, which means to care for, and can be applied to all things. There is a belief in acting pono, or righteous, which works to achieve balance or harmony. In this case, one must act pono to achieve lōkahi with the body, mind, and spirit. Understanding specific terms within a culture can elucidate important values.

Part II Working with Pacific Islanders

Is Culturally Adapted Therapy Necessary?

Both the growing diversity in the USA and the critical call of addressing health disparities in minority populations have resulted in a dramatic change in the number of studies including ethnic minorities, with Pacific Islanders as one of the more recent populations (Huey, Tilley, Jones, & Smith, 2014). Initial studies documented high levels of medical and mental health disparities among ethnic minorities. Many studies have been devoted to understanding the reasons for these disparities and how to better address them. Some of the major hypotheses were access to care, lack of buy-in when care was available, premature drop-out, and finally that ethnic minorities were not included in original samples determining efficacy of interventions and that treatment effectiveness may differ in different populations. Matching cultural beliefs may underlie many of these variables (Oliveira et al., 2006). For example, problematic behaviors in Western culture is viewed as a problem with the individual or their culture, whereas within Pacific Islander cultures problematic behaviors are often viewed as being caused by an imbalance between relationships and emotional bonds (Marsella, Oliveira, Plummer, & Crabbe, 1995). Additionally, if the proposed treatment does not fit within the cultural beliefs of the individual they may not be interested in pursuing treatment or may drop out prematurely. Focus groups are often used to gain information on diverse populations. Native Hawaiians were asked about their priorities and concerns in terms of their health care in a series of focus groups (Kamaka, Paloma, & Maskarinec, 2011). They identified (1) an importance of customer service with complaints of long wait times and short visits, as

well as long wait times for results (2) wanting to feel respected, and cared for (3) providers who were good communicators and good teachers (4) thoroughness of care, which would include understanding reservations or fears (5) costs. In traditional Pacific Islander views, healing for the physical body cannot occur without setting right any problems within the mental or spiritual realm (Fig. 11.3). Utilizing the cultural approach could help to motivate behavior change through a willingness to try new behavior. Even within the medical community, culturally specific interventions have found success. In treating diabetes, the PILI Ohana Pilot Project (Mau et al., 2010) for Chuukese, Filipino and Samoans utilized a community based participatory research (CBPR) design. Members of the communities to be targeted devised important themes in controlling diabetes. They identified food related issues (e.g., cost and cultural eating expectations), physical activity related issues (e.g., group exercise), social support issues (e.g., changes are made by whole family and time management), and community assets within the three domains of social/community, family, and individual. These domains were then utilized to derive a conceptual model of weight loss specific for these populations with their specific needs, barriers, and strengths in mind.

There have been numerous studies evaluating cultural adaptations of mental health services for non-Western populations with mixed results likely related to methodological heterogeneity and range of adaptations utilized. A review of meta-analyses determined overall effect sizes of cultural adaptations range from 0.23 to 0.75 (Rathod et al., 2018). The meta-analysis by Griner and Smith (2006) indicated effect sizes of 0.46. Huey and Polo's meta-analysis in 2008, which evaluated behavioral health treatments for ethnic minority youth, had a small effect size and inconsistent quality (Rathod et al., 2018). A meta-analysis conducted by Benish, Quintana, and Wampold (2011) included both published and unpublished studies and found an effect size of 0.32. This is lower than subsequent meta-analyses and may be related to including too many studies that lacked scientific rigor.

A study by Benish et al. (2011) not only compared culturally adapted treatments to both a control group and the evidence-based treatment, they also determined if adaptation to a person's cultural explanation of how illness occurs was the sole moderator of better results. Other factors that have been evaluated as moderators include where the interventions are provided, individual versus group, diagnosis, age, language match, and ethnic match of the provider (Degnan et al., 2018; Hodge, 2010; Huey & Polo, 2008; Rojas-Garcia et al., 2015). One study found that of all the ethnic groups, Asian Americans benefitted the most from culturally adapted interventions (Rojas-Garcia et al., 2015). Overall, the majority of adaptations address areas of language, communication, context, family, content, delivery, therapeutic alliance, and treatment goals (Degnan et al., 2018). In addition to treatment effectiveness, variables like increased participation and therapy retention are important in reducing health disparities and may be improved with cultural adaptations. Estimates of increased family engagement for culturally adapted interventions are 40% (Kumpfer, Magalhaes, & Xie, 2017). Cultural adaptations may be more cost-effective than cultural interventions designed from the ground up (Kumpfer et al., 2017), although interventions from the ground up utilize the community from initiation of the idea throughout the intervention and are fully vetted within the community likely leading to even higher levels of community participation.

Other Cultural Considerations

Despite the use of cultural adaptation, caution should still be used to be mindful of subgroups like sexuality or poverty. Many ethnic minorities are also often dealing with chronic stressors related to low socio-economic status (SES). In fact, because these two factors are so inextricably woven within the USA, it is hard to determine the influence of one without the other. There have been numerous articles discussing the increased rate of chronic adverse events that those in a

lower SES are exposed to (Schieman & Koltai, 2017). Low SES is also highly disproportionate in chronic health disparities and is consistently associated with poorer mental health, poorer academic achievement and employability (Blustein et al., 2002; Goodman & Huang, 2001).

Cultural Competency

Culturally adapted interventions may be an important step in decreasing health disparities, but the other crucial component is cultural competence within the health professional (Dinos, 2015). Cultural competency includes understanding the role of culture in understanding health beliefs, attitudes, and behaviors to be able to establish rapport and trust to promote proactive health behaviors (Kamaka et al., 2011). Competence can also be seen as "accepting and respecting differences and reinforcing the strength of the patient, family, community, or population in the process of engagement (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003)." Cultural competence also involves being flexible and continually examine one's own belief system and how it interacts with the population of interest. Native Hawaiian patients have described the importance of having culturally competent providers (Kamaka et al., 2011). By understanding culture, we may understand how people view the health care system, seek help, or are reluctant to seek help because of shame. The cultural competence described in this chapter is distinct from the term "cultural competency" when used to refer to traditional healers who provide specific traditional healing practices by those who are "island-born" and are taught by elders or kupuna. Table 11.4 below shows elements proposed to enhance cultural competency in working with diverse populations (Kaholokula, 2013).

Table 11.4 Elements to ensure cultural competency (Kaholokula, 2013)

Elements to ensure cultural competency
• Knowledge and understanding of cultural norms
• Understanding client's conceptualization of mental illness and variables influencing it
• Culturally appropriate assessment strategies
• Culturally relevant treatment when applicable and incorporate native practices and values
• Development of evidence-based treatment
• Ongoing re-evaluation of self and the patient to assess current practices and effectiveness
• Appropriate discharge planning that is reflective of services available in the community

Therapy with Pacific Islanders

Working within this Pacific Islander community requires a genuineness and ability to connect with others. Pacific Islanders tend to be more perceptive to non-verbal cues. Haole the term typically used to describe Caucasians refers to lack of breath and symbolically referred to the distance that the European visitors had when they said hello. Traditionally, Hawaiians would exchange breaths (hā) with one another in close proximity with the forehead and nose of the people involved touching the other persons. When foreigners arrived to Hawai'i and did not exchange breaths, Hawaiians described them as haole, 'ole meaning none and hā as in breath. This sharing of breath is a sacred tradition that can be found within other Pacific Islands as well. In working with this population, I believe that this is the most critical piece and has also been identified in best practices (Kalibatseva & Leong, 2014). People can quickly determine if their service provider has poor intentions or is not willing to do what it takes to get to know the "patient" and their circumstances or if they "are working from their heart." This is one reason for preference of working face to face with providers so they can judge intent, sincerity, and trustworthiness (Kaholokula, Ing, Look, Delafield, & Sinclair, 2018). Commonly, Pacific Islanders try to identify commonalities with one another. They may ask questions like where your family is from, where you went to high school, and do you know so and so. This could partially be due to Pacific Islander's beliefs about having a spiritual connection to ancestral place, with an openness to the flow and use of energy, brings

intention and understanding, and relates to the past, present, and future (Oneha, 2001). This is also because it is culturally appropriate to develop common interests before getting to the specific needs of the provider, which is consistent with cultural values of "talk story." Questions during the intake should also include family, extended family, community, and the patients' role in all of these (Whealin, Seibert-Hatalsky, Howell, & Tsai, 2015). Elements like prayers to open and close sessions and group therapy can also be used. In general, experiential activities like walking on trails or going in the garden can help people to feel more natural and give them the desire to open up in a different environment. The experience can also incorporate Pacific Islander values like talking about plants and protocols that guide human behavior that can be generalized to their current situations of school or job or family. For example, knowing how to pick certain plants, asking permission before taking the plant, and thanking the plant for the sustenance. This can be generalized to a child engaging in respectful behavior in the classroom and not taking things from other children without permission or to the recovering addict for not stealing. In the past, the Pacific Islanders were well known for being sustainable and taking only what they need. Take fishing, for example, Pacific Islanders will take only what is needed for their community rather than overfishing. They would also take the bigger fish and return small fish to the ocean so they are able to grow. These examples illustrate the connection between the individual, others, and their environment.

Wellness and Strength Based Models

Wellness or strength based models tend to be preferred to illness models because wellness is believed to be curable, whereas illness is not (Agnew et al., 2004). Furthermore, the relationship between patient and provider may become more distant if the "illness" takes precedence in the relationship. The wellness model also tends to be very holistic and may be unique in incorporating more work with extended family, which is very important with Pacific Islanders. Treatment of the whole person becomes particularly salient in considering the high comorbidity of medical illness and mental health (Sokal et al., 2004). Protective factors against depression and suicide in Asian American and Native Hawaiian/Pacific Islanders adolescents included individual and ethnic self-esteem, bicultural language competence, spirituality, and good social support (Wyatt, Ung, Park, Kwon, & Trinh-Shevrin, 2015). Family culture may also be seen as a protective factor for insulating Asian Americans/Pacific Islanders (Xu et al., 2011). Native Hawaiian youth report receiving informal support from multiple community (Medeiros & Tibbetts, 2008). As a combined group Asian Americans/Pacific Islanders tend to have lower rates of psychiatric disturbance and substance abuse (Sentell et al., 2014) than others. When examining the Pacific Islander/Asian American groups separately, Native Hawaiians had higher rates of hospitalization for depression, bipolar disorder, and anxiety disorder than other Asian American/Pacific Islander groups, although they had shorter lengths of hospitalizations (Sentell et al., 2014). Understanding these statistics and understanding history and cultural practices is a first step towards becoming culturally competent (Table 11.5).

Table 11.5 Parallel strengths (Kaholokula, 2013)

Western healing practices	Hawaiian healing practices
Focus on physical/psychological signs, symptoms and causes within the individual	Focus on interpersonal or spiritual causes
Organic or psychological problem	Problem results from imbalance in relationships/life roles
Treatment involves medicine, cognitive restructuring, and lifestyle changes	Treatment involves prayers, herbs, and repairing imbalance

Other Therapy Considerations

Equally important as gaining trust in this population is understanding where our patients reside and current stressors they face. Sometimes these factors underlie behavior choices that may appear as non-compliant to their providers. Considering these multiple levels of factors also directly ties into the systems perspective that is inherent in working with Pacific Islanders. Wyatt et al. (2015) have postulated an "ecological framework" in translating social determinant of health to behavior. They describe the three systems as microsystem (interpersonal relationship and environment encountered on the day to day), mesosystem (kinship networks and standards of practice), and macrosystems (institutional, political, social, and economical aspects creating social norms and expectations). In rural communities, those that often have higher levels of poverty also display resiliency factors like the community coming together to address common concerns (Berkes & Ross, 2013).

Understanding these factors for our patients may assist in reducing stigma associated with seeking help, improve compliance with recommendations of providers, and improve health.

One factor we have found as important in reducing the stigma of seeking behavioral health services is providing integrated care within all of the separate clinics in our large Community Health Center. In this model, we demonstrate to the patient that we believe in holistic care, with the understanding that behavioral health needs are vital to address with typical medical care, which is in line with Native Hawaiian/Pacific Islander values of treating the whole person (Crabbe, 1998). A second point in the importance of considering other factors commonly experienced in the Pacific Islander population served by the Community Health Center is understanding and devising alternative solutions to barriers in treatment. Mental health issues may become even more important in treating chronic pain and substance use, although we also believe that keeping individuals mentally healthy at various stages in their lives also leads to children and families who are more healthy. A couple of other factors that have reduced the stigma associated with receiving mental health services is the almost universal healthcare in Hawai'i and our welfare system requiring mental health treatment for those claiming mental health issues as the reason for unemployment.

Although great improvements have been made, there is much more that can be done once there is an understanding of environmental factors a patient is facing. These socioeconomics can interplay with race/ethnicity and gender to affect health inequity (Cooper, 2002). Factors, such as poverty, homelessness, drug use, domestic violence, and multiple families in one living space, involvement with Child Protective Services (CPS) plays an important role in the physical and mental health of a population. For example, a patient with repeat visits for urinary tract infections may be related to having to hold their urine for long periods of time because of limited access to restrooms. Having this understanding quickly opens up a dialogue between the client and provider to explore other options. Nutrition programs have been created to both support proper nutrition for our patients and our farmers with doubling food stamps making access to healthy foods affordable. Socioeconomic status has a strong relationship with mental health (Goodman, Slap, & Huang, 2003). In our population, these economic and social stressors may have been present for generations. It is not uncommon to work with an adult who is currently involved in a domestic violence situation, their partner uses drugs, they live with 4 other adults and 7 children, they feel unable to work because of depression and irritability, have two children at home, and the patient has diabetes. They may not have graduated from high school and do not have any family members who are currently employed or are in a "healthy relationship." Chronic exposures to these stressors in addition to cultural factors of discrimination, prejudice, intergenerational trauma have been associated with higher levels of aggression, incarceration, and mental health issues (Baker, Hishinuma, Chang, & Nixon, 2010). Chronic stress may also impair brain development in executive function and regulation of impulses

(Romeo, 2013). Developing this knowledge can enhance understanding of the patient, be able to cater treatment based on the needs of the patient meaning more sessions may include problem solving for getting basic needs met, and conceptions of positive outcomes. Practical considerations like providing shorter sessions, availability of childcare or being able to bring children to the session (Dinos, 2015) make it much more likely for patients to seek and continue care.

Specific Culturally Adapted Treatments

Are there evidence-based culturally adapted interventions for Pacific Islanders? Many evidence-based practices have been implemented with efficacy and include cognitive behavioral therapy, emotional competence, family strengthening, and improving physical health and well-being (Carlton et al., 2006). Intervention studies generally pertain to specific symptoms or behaviors. Only a few of the many adaptations that are regularly employed with Pacific Islanders have been published. These will be reviewed in the following section and some of the other notable interventions utilized with this community.

Depression and Suicide

There are several studies that have investigated depressive symptoms and suicidal ideation. In Asian American/Pacific Islander youth depressed symptoms worsened in later adolescence, and were more prevalent in females and those who used alcohol and tobacco (Wyatt et al., 2015). For suicide, Hawaiian adolescent females were at higher risk than other Asian American ethnicities (Nishimura, Goebert, Ramisetty-Mikler, & Caetano, 2005). Sexual minorities were at higher risk of suicide in Guam than other Asian American and Pacific Islander adolescents (Bostwick et al., 2014; Pinhey & Millman, 2004). Specific factors related to ethnic minorities such as acculturation, marginalization, discrimination, generational status, and language proficiency have all been shown to be correlated with depression and suicide in Asian American and Native Hawaiian/Pacific Islander adolescents (Wyatt et al., 2015). Many family variables, particularly family conflict and bullying in school were identified as risk factors, which means intervention programs focused on decreasing bullying and family violence can be impactful for suicide prevention. In fact, there have been multiple wide scale suicide prevention programs that were collaborations between UH JABSOM and community sites. The first of these, Hawaii's Caring Community Initiative, a community based participatory approach (CBPR) brought training to community agencies and schools to help individuals, adolescents and providers recognize suicide risk factors and empower adolescents and adults to get additional help (Chung-Do et al., 2015). The first step was enhancing the community networks to appropriately respond to suicide and the second arm of the program was empowering our youth as leaders to help other youth and as partners in the project based on the BRAVEHEART (Building Resistance Against Violent Environments thru Honorable, Empowered And Resilient Teens) curriculum that has been validated in other minority communities (Chung-Do et al., 2015; Sugimoto-Matsuda & Rehuher, 2014; Wilcox et al., 2011).

Post-Traumatic Stress Disorder and Trauma

The Koa program was developed to treat PTSD in veterans for veterans living in rural Hawaii (Whealin et al., 2017). The program is an 8-session psychoeducational program utilizing Pacific Islander values, beliefs and healing with empirically validated cognitive behavioral therapy (CBT) treatment. The program was delivered to remote locations through telemedicine and included veteran's family members. The intervention workbook was modified to match linguistic, educational, and cultural needs on both surface and deep structure.

The Children's Association of Mental Health Division of the State of Hawaii has also developed a culturally based program for treating trauma in girls. The Kealahou Services program collaborates with Hawaii's child-serving agencies, communities and families to help girls build and nurture healthy relationships that will allow them to reconnect with their families, communities and themselves.

Severe Mental Illness

A meta-analysis regarding culturally adapted interventions for schizophrenia across different cultures and categorized the types of interventions. In regards to communication, reparative action and balancing needs of mutual respect and avoidance of confrontation for Chinese cultures was effective (Degnan et al., 2018). Other studies included incorporation of spiritual or traditional practices. There was a significant relationship between the number of adaptation and better total symptoms (Degnan et al., 2018). There is another chapter on cultural adaptations for treating severe mental illnesses including bipolar disorder. Rathod, Kingdon, Pinninti, Turkington, and Phiri (2015) also authored a chapter on cultural adaptations that can be applied for use with Pacific Islanders including how to use cultural influences to improve medication compliance and identify triggers for mood changes or psychosis. They suggest using regular family or cultural activities to support treatment plan, to improve medication adherence, help reduce stress and for discovering other strengths of the individual.

Substance Abuse Treatment

One of the most efficacious substance abuse treatments on Oahu is Hoʻomau Ke Ola. They utilize a combination of Western curriculum ((CBT), dialectical behavioral therapy (DBT), trauma-informed care, social skills training, 12-step familiarization classes) and culturally specific curriculum (kūkulu kumuhana (statement of purpose), moʻokuaauhau (geneology), ʻoli (chanting), ka huakaʻi (migration), moʻolelo (storytelling), ʻike hana lima (craftmanship), paʻani kahiko (ancient games), hoe ka waʻa (canoe paddling), hula basics to teach precision, self-discipline, perseverance, and spiritual connection, ohana day, mālama ʻāina in the loi, and Native Hawaiian crafting). They also include other important skills for their patients to learn with smoking cessation classes, health and nutrition classes, physical recreation opportunities, gender specific process groups, cinema therapy, financial literacy and several other living skills classes.

Incarcerated Youth

An evidence-based treatment regarding mindfulness, the Mind Body Awareness Project (Himelstein, 2011) was culturally adapted for work with Native American Youth (Le & Goebert, 2015) and further adapted for use with Pacific Island Incarcerated Youth (Le & Proulx, 2015). Mindfulness was tied to the literal meaning of aloha and breath. Patients were advised to connect their breath to their connections of themselves and their culture.

Other Pacific Islander Models

Samoan Models

Faafaletui Model, alternatively called the Wellington model and was produced by the Wellington Family Centre (Tamasese, Peteru, & Waldergrave, 1997). It loosely refers to holding an investigation on a particular matter. There is similarly a traditional Samoan healing treatment, which included traditional elements of the traditional massage (fofo) and of the healers who carried out the traditional fofo practices (i.e., to the taulasea or tohunga). There are also special herbs, oils and liquids used in traditional Samoan practices. Similar to other Pacific Island cultures, their traditional practices are handed down in families or to other people who show promise.

New Zealand

The Fonofale (MoH, 1997; Pulotu-Endemann, cited in MoH, 1995) model was described as one of the key holistic models to address New Zealand health needs. Another model was termed woven strands or Pandanus model which means the different strands in a case cannot be all woven together in the same way. "Responding to the needs of a Pacific consumer and his/her family therefore requires recognition of the heterogeneity of Pacific problems. Weaving together the strands of the Pandanus mat was raised as a metaphor for how the different strands of a (mental health) case are woven together. The point being that the strands interlock to form a whole and that the mat's durability depends on how well the strands are woven together. The suggestion is that like a good Pandanus mat, a good health and wellbeing model requires that all the key strands of a person's life needs to be well thatched to be able to withstand the test of time and different elements." The canoe theme mentioned at the beginning of this chapter was described as the Te Vaka model.

Filipino's

Filipino's have different values from other East Asian American cultures since they were colonized by the Spanish (Javier et al., 2014). Cultural values that may correspond to lower levels of service utilization include a belief in fatalism (bhala na), shame (hiya), cultural mistrust and collectivism (Javier et al., 2014). In their community engagement study where they utilized a combination of focus groups and quantitative analyses, they identified four ways to more effectively engage Filipino adolescents in mental health services. They discussed strengthening parent-child relationships with improving communication and spending quality time. They also suggested providing parenting programs to address this need. Specific suggestions were that the parenting style used in the Philippines may not be effective in the USA, which included "put-downs" and "verbal shaming." Because of the importance of religion, inclusion of cultural leaders or messages through church can be helpful in necessary components and in ensuring that parent mental health needs are being addressed. Another author used the *Incredible Years* curriculum to strengthen parenting and reduce mental health issues, which was used effectively with Chinese Americans and Korean Americans (Kim, Cain, & Webster-Stratton, 2008; Lau, Fung, & Yung, 2010). Flores et al. (2015) implemented the program through catechism classes. Participants reported that it improved positive reinforcement and taught new techniques like setting rules, teaching responsibility, and improving quality time. Other benefits were increase of social support for parents and children.

Training Future Practitioners

Hawaii has 14 Federally Qualified Health Centers on six islands that provided care for 150,000 patients in 2016. The FQHCs serve the rural and low-income residents on all six islands who would otherwise lack access to primary care services. The FQHCs are the largest provider network for Medicaid and second-largest provider source of direct primary medical services in the state. There are American Psychological Association (APA) psychology internship training sites at several of these community health centers. This section will describe the psychology training program for one of these Federally Qualified Community Health Centers on the island of Oahu.

Beginning with interviews, each applicant to our large community health center serving primarily Pacific Islanders is taken on a tour of the campus, which describes the many buildings and services provided, as well as the history of the Health Center and culture of our community and patients. Many other features of the campus are highlighted such as patient gardens with traditional and medicinal plants, walking trails, and fitness center. When students come to the health center for training, they are immediately exposed to Native Hawaiian culture. There is a welcome ceremony, beginning with a traditional Hawaiian protocol, involving chanting. The chant introduces the students and asks for permission to enter. There is a welcoming chant that describes

the attributes of the Health Center in terms of spirituality, the site, and the patients we serve. The student group will also bring symbolic offerings to health center directors and be greeted with leis. The students are then welcomed by current support staff and providers, and each person shares something about themselves and serving our population. Students are reminded that the most important virtue is a willingness to serve and a caring heart, which is directly related to the perceptions of our patients. This formal ceremony is followed by a typical orientation day of obtaining badges; review of training handbooks, policies, and procedures; documentation; and HIPAA and Electronic Medical Records training. In the beginning of the year, there are focused full-day experiential cultural trainings within the communities where our patients reside. Students are taken to heiau (religious sites), homeless encampments to see the culture of our patient communities and possible barriers to care, and through local communities to gain a further understanding of and enhanced connection to the culture of our patient population. The other component of this full-day training is beginning to share with students the stories of the Native Hawaiian's (mo'olelo), discussing values and increasing readiness (ho'omākaukau) to provide services by clearing one's own mind, body, and feelings.

The students continue to receive training throughout the year on culturally mindful care in individual and group supervision, through direct clinical experience with patients, and weekly didactics on relevant topics that include cultural considerations or relevance to our population. Many of our trainees from Hawai'i are familiar with different aspects of local culture, but we also train students from other areas of the USA, who may be unfamiliar with the culture or working with Native Hawaiian or Pacific Islanders. Interns perform three case conceptualizations throughout the year, where cultural considerations are an important aspect.

As part of the learning process, students often need to become knowledgeable of commonly used Hawaiian or Pidgin terms if they are not from Hawaii. Rapport building may differ with some of our patients, and a slight increase in self-disclosure may help to facilitate connection with some patients. Psychology services may include more case management and holistic care. Our health center prides itself on integrated care so behavioral health providers are part of a multidisciplinary team in various clinics. Therapists must also consider Maslow's hierarchy of needs when treating patients and ensuring that basic needs (e.g., food and shelter) are met prior to addressing more higher-order challenges. This also needs to be considered when assigning homework or with other aspects of therapy. As a result, depending on the patient or presenting problem, therapy may be more solution focused. They are also taught to consider our patients' perspective of more collective goals and harmony among others. Patients can be specifically asked in goal setting which area of the lokahi triangle they need to work on.

Our trainees also gain experiences in research with vulnerable populations. They are exposed to the safeguards in place for ensuring that research is done for the benefit of the community, and to different levels of community based research. They also gain first-hand experience of recruitment in hard to reach populations.

Acknowledgments Additional heartfelt mahalo to the interns of Community Health Center 2017–2018 training year, Kasha Kim, Ciara Hansen, Leila Mitsunaga, Micah Keaney, and Kellen Imada as well as our training director Kristy Sakai-Costigan, Psy.D. for their critiques and revisions of this chapter, as well as their excellence in all aspects of our patients care.

References

Agnew, F., Pulotu-Endemann, F. K., Robinson, G., Suaalii-Sauni, T., Warren, H., Wheeler, A., … Schmidt-Sopoaga, H. (2004). *Pacific models of mental health service delivery in New Zealand ("PMMHSD") project*. Auckland, NZ: Health Research Council of New Zealand.

Anderson, I., Crengle, S., Kamaka, M. L., Chen, T. H., Palafox, N., & Jackson-Pulver, L. (2006). Indigenous health in Australia, New Zealand, and the Pacific. *Lancet, 367*(9524), 1775–1785.

Baker, C. K., Hishinuma, E. S., Chang, J. Y., & Nixon, D. C. (2010). The relationship among exposure to

stressful life events, drug use, and violence perpetration in a sample of native Hawaiian, Samoan, and Filipino adolescents. *Journal of Interpersonal Violence, 25*, 379–399.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58*(3), 279–289.

Berkes, F., & Ross, H. (2013). Community resilience: Toward an integrated approach. *Society & Natural Resources, 26*(1), 5–20.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health. *Public Health Reports, 118*, 292–302.

Blaisdell, K. (1989). 'Hawaiian' vs. 'kanaka maoli' as metaphors. *Hawai'i Review, 13*, 77–79.

Blaisdell, R. K. (1993). The health status of Kanaka Maoli (indigenous Hawaiians). *Asian American and Pacific Islander Journal of Health, 1*(2), 116–160.

Blaisdell, R. K. (1996). 1995 update on kanaka maoli (indigenous Hawaiian) health. *Asian American and Pacific Islander Journal of Health, 4*(1–3), 160–165.

Blustein, D. L., Chaves, A. P., Diemer, M. A., Gallagher, L. A., Marshall, K. G., Sirin, S., & Bhati, K. S. (2002). Voices of the forgotten half: The role of social class in the school-to-work transition. *Journal of Counseling Psychology, 49*, 311–323. https://doi.org/10.1037/0022-0167.49.3.311

Bostwick, W. B., Meyer, I., Aranda, F., Russell, S., Hughes, T., Birkett, M., & Mustanski, B. (2014). Mental health and suicidality among racially/ethnically diverse sexual minority youths. *American Journal of Public Health, 104*(6), 1129–1136.

Braun, K. L., Look, M. A., & Tsark, J. A. (1995). High mortality rates in native Hawaiians. *Hawai'i Medical Journal, 54*, 723–729.

Carlton, B. S., Goebert, D. A., Miyamoto, R. H., Andrade, N. N., Hishinuma, E. S., Makini, G. K., … Nishimura, S. T. (2006). Resilience, family adversity and well-being among Hawaiian and non-Hawaiian adolescents. *International Journal of Social Psychiatry, 52*(4), 291–308.

Carlton, B., Gobert, D. A., Kaheauilani Bell, C., Horton, M. Else, I. R. N., Marcinowski, M., & Yamada, L. (2011). Integrating cultural values into mental health treatment Hülili: Multidisciplinary research on Hawaiian well-being, Vol.7 (2011).

Chung-Do, J. J., Goebert, D. A., Bifulco, K., Tydingco, T., Alvarez, A., Rehuher, D., … Wilcox, P. (2015). Hawai'i's caring communities initiative: Mobilizing rural and ethnic minority communities for youth suicide prevention. *Journal of Health Disparities Research and Practice, 8*(4), 108–123.

Cook, B. P., Withy, K., & Tarallo-Jensen, L. (2003). Cultural trauma, Hawaiian spirituality, and contemporary health status. *Californian Journal of Health Promotion, 1*(SI), 10–24.

Cooper, H. (2002). Investigating socio-economic explanations for gender and ethnic inequalities in health. *Social Science and Medicine, 54*(5), 693–706.

Crabbe, K. M. (1998). Etiology of depression among Native Hawaiians. *Pacific Health Dialogue, 5*, 341–345.

Cummings, T. K. (2002). *A political review of the situation in Hawai'i: 2002* (unpublished manuscript).

Degnan, A., Baker, S., Edge, D., Nottidge, W., Noke, M., Press, C. J., … Drake, R. J. (2018). The nature and efficacy of culturally-adapted psychosocial interventions for schizophrenia: A systematic review and meta-analysis. *Psychological Medicine, 48*, 714–727.

Dinos, S. (2015). Culturally adapted mental healthcare: Evidence, problems and recommendations. *BJPsych Bulletin, 39*(4), 153–155.

Flores, N., Supan, J., Kreutzer, C. B., Samson, A., Coffey, D. M., & Javier, J. R. (2015). Prevention of Filipino youth behavioral health disparities: Identifying barriers and facilitators to participating in "Incredible Years," an evidence-based parenting intervention, Los Angeles, California, 2012. *Preventing Chronic Disease, 12*, E178.

Goodman, E., & Huang, B. (2001). Socioeconomic status, depression, and health service utilization among adolescent women. *Women's Health Issues, 11*, 416–426. https://doi.org/10.1016/S1049-3867(01)00077-9

Goodman, E., Slap, G. B., & Huang, B. (2003). The public health impact of socioeconomic status on adolescent depression and obesity. *American Journal of Public Health, 93*, 1844–1850.

Graves, M. W., & Addison, D. J. (1995). The Polynesian settlement of the Hawaiian archipelago: Integrating models and methods in archaeological interpretation. *World Archaeology, 26*(3), 380–399.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531–548.

Handy, E. S. C., & Pukui, M. K. (1972). *The Polynesian family system in Ka'u, Hawai'i*. Clarendon, VT: Tuttle Publishing.

Himelstein, S. (2011). Mindfulness-based substance abuse treatment for incarcerated youth: A mixed method pilot study. *International Journal of Transpersonal Studies, 30*, 1–10.

Hodge, D. R. (2010). Social justice as a unifying theme in social work education: Principles to realize the promise of a new pedagogical model. *Journal of Comparative Social Welfare, 26*(2–3), 201–213.

Hoeffel, E., Rastogi, S., Kim, M. O., & Shahid, H. (2012). *The Asian population: 2010*. Washington, DC: United States Census Bureau.

Huey, S. J., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 262–301.

Huey, S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to

evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology, 10*(1), 305–338.

Javier, J. R., Supan, J., Lansang, A., Beyer, W., Kubicek, K., & Palinkas, L. A. (2014). Preventing Filipino mental health disparities: Perspectives from adolescents, caregivers, providers and advocates. *Asian American Journal of Psychology, 5*(4), 316–324.

Juarez, D. T., Davis, J. W., Brady, S. K., & Chung, R. S. (2012). Prevalence of heart disease and its risk factors related to age in Asians, Pacific Islanders, and White in Hawai'i. *Journal of Health Care for the Poor and Underserved, 23*(3), 1000–1010.

Kaholokula, J. K. (2013). Community-based participatory research (CBPR) with native and pacific populations: Addressing cultural competency issues. *Hawaii Journal of Medicine & Public Health, 72*(8 Suppl 3), 6.

Kaholokula, J. K., Ing, C. T., Look, M. A., Delafield, R., & Sinclair, K. (2018). Culturally responsive approaches to health promotion for native Hawaiians and pacific islanders. *Annals of Human Biology, 45*(3), 249. https://doi.org/10.1080/03014460.2018.1465593

Kalibatseva, Z., & Leong, F. T. L. (2014). A critical review of culturally sensitive treatments for depression: Recommendations for intervention and research. *Psychological Services, 11*, 433–450.

Kamaka, M. L., Paloma, D. S., & Maskarinec, G. G. (2011). Recommendations for medical training: A native Hawaiian patient perspective. *Hawaii Medical Journal, 70*(11 Suppl 2), 20–24.

Kameeleihiwa, L. (1992). Traditional Hawaiian metaphors. In *Native land and foreign desires* (pp. 19–49). Honolulu, HI: Bishop Museum Press.

Kameeleihiwa, L. (1995). *A synopsis of traditional Hawaiian culture, the events leading to the 1887 bayonet constitution and the overthrow of the Hawaiian government (0 AD-1898)* (unpublished manuscript).

Kana'iaupuni, S. K., Malone, N., & Ishibashi, K. (2005). *Ka huaka'i: 2005 native Hawaiian educational assessment*. Honolulu, HI: Kamehameha Schools, Pauahi Publication.

Kim, E., Cain, K. C., & Webster-Stratton, C. (2008). The preliminary effect of a parenting program for Korean American mothers: A randomized controlled experimental study. *International Journal of Nursing Studies, 45*(9), 1261–1273.

Kumpfer, K., Magalhaes, C., & Xie, J. (2017). Cultural adaptation and implementation of family evidence-based interventions with diverse populations. *Prevention Science, 18*, 649–659.

Lander, J., & Puhipau. (Directors). (1993). In Nā Maka o ka 'Āina. (Producer), *Act of War*. Video retrieved from https://oiwi.tv/oiwitv/act-war/

Lau, A. S., Fung, J. J., & Yung, V. (2010). Group parent training with immigrant Chinese families: Enhancing engagement and augmenting skills training. *Journal of Clinical Psychology, 66*(8), 880–894.

Le, T. N., & Goebert, J. (2015). Translating and implementing a mindfulness-based youth suicide prevention intervention in a Native American community. *Journal of Child and Family Studies, 24*, 12–23.

Le, T. N., & Proulx, J. (2015). Feasibility of mindfulness-based intervention for incarcerated mixed-ethnic native Hawaiian/Pacific Islander youth. *Asian American Journal of Psychology, 6*(2), 181–189.

Marsella, A. J., Oliveira, J. M., Plummer, C. M., & Crabbe, K. M. (1995). Native Hawaiian culture, mind, and well-being. In H. I. McCubbin, E. A. Thompson, A. I. Thompson, & J. E. Fromer (Eds.), *Resiliency in ethnic minority families: Native and immigrant American families* (pp. 93–113). Madison, WI: University of Wisconsin-Madison.

Mau, M. K., Kaholokula, J. K., West, M., Efird, J. T., Leake, A., Rose, C., … Palakiko, D. (2010). Translating diabetes prevention research into native Hawaiian and Pacific Islander communities: The PILI 'Ohana Pilot project. *Progress in Community Health Partnerships: Research, Education, and Action, 4*(1), 7–16.

McCubbin, L. D., & Marsella, A. (2009). Native Hawaiians and psychology: The cultural and historical context of indigenous ways of knowing. *Cultural Diversity and Ethnic Minority Psychology, 15*(4), 374–387.

McDermott, J. F., & Andrade, N. (2011). *People and cultures of Hawai'i: The evolution of culture and ethnicity*. Honolulu, HI: University of Hawai'i Press.

Medeiros, S. M. & Tibbetts, K. A. (2008). Ho'omau i nā 'Ōpio: Findings from the 2008 Pilot Test of the Nā 'Ōpio: Youth Development and Assets Survey. Honolulu: Kamehameha Schools Research & Evaluation.

MoH. (1997). *Making a difference: Strategic initiatives for the health of Pacific people – A consultative document*. Wellington, New Zealand: NZ Ministry of Health.

Nishimura, S. T., Goebert, D. A., Ramisetty-Mikler, S., & Caetano, R. (2005). Adolescent alcohol use and suicide indicators among adolescents in Hawaii. *Cultural Diversity & Ethnic Minority Psychology, 11*(4), 309–320.

Oliveira, J. M., Austin, A. A., Miyamoto, R. E. S., Kaholokula, J. K., Yano, K. B., & Lunasco, T. (2006). The rural Hawai'i behavioral health program: Increasing access to primary care behavioral health for Native Hawaiians in rural settings. *Professional Psychology: Research and Practice, 37*, 174–182.

Oneha, M. F. (2001). Ka mauli o ka 'oina a he mauli kanaka: An ethnographic study from an Hawaiian sense of place. *Pacific Health Dialog: A Publication of the Pacific Basin Officers Training Program and the Fiji School of Medicine, 8*(2), 299–311.

Pinhey, T. K., & Millman, S. R. (2004). Asian/Pacific Islander adolescent sexual orientation and suicide risk in Guam. *American Journal of Public Health, 94*(7), 1204–1206.

Pulotu-Endemann (in MoH 1995, MoH 1997) MoH. (1995). *Guidelines for cultural assessment in mental health services*. Wellington, New Zealand: NZ Ministry of Health.

Rathod, S., Gega, L., Degnan, A., Pikard, J., Khan, T., Husain, N., … Naeem, F. (2018). The current

status of culturally adapted mental health interventions: A practice-focused review of meta-analyses. *Neuropsychiatric Disease and Treatment, 2018*(14), 165–178.

Rathod, S., Kingdon, D., Pinninti, N., Turkington, D., & Phiri, P. (2015). *Cultural adaptation of CBT for serious mental illness: A guide for training and practice*. Chichester, UK: Wiley.

Rojas-Garcia, A., Ruiz-Perez, I., Rodriguez-Barranco, M., Goncalves Bradley, D. C., Pastor-Moreno, G., & Ricci-Cabello, I. (2015). Healthcare interventions for depression in low socioeconomic status populations: A systematic review and meta-analysis. *Clinical Psychology Review, 38*, 65–78.

Romeo, R. D. (2013). The teenage brain: The stress response and the adolescent brain. *Current Directions in Psychological Science, 22*, 140–145.

Schieman, S., & Koltai, J. (2017). Discovering pockets of complexity: Socioeconomic status, stress exposure, and the nuances of the health gradient. *Social Science Research, 63*, 1–18. https://doi.org/10.1016/j.ssresearch.2016.09.023

Sentell, T., Unick, G. J., Ahn, H. J., Braun, K. L., Miyamura, J., & Shumway, M. (2014). Illness severity and psychiatric hospitalization rates among Asian Americans and Pacific Islanders. *Psychiatric Services, 64*(11), 1095–1102.

Sokal, J., Messias, E., Dicerson, F. B., Kreyenbuhl, J., Brown, C. H., Goldbert, R. W., & Dixon, L. B. (2004). Comorbidity of medical illnesses among adults with serious mental illness who are receiving community psychiatric services. *Journal of Nervous and Mental Disorders, 192*, 421–427.

Sugimoto-Matsuda J., & Rehuher, D. (2014). Suicide prevention in diverse populations: A systems and readiness approach for emergency settings. *Psychiatric Times*. Retrieved August 23, 2014, from http://www.psychiatrictimes.com/cultural-psychiatry/suicideprevention-diverse-populations-systems-and-readiness-approach-emergency-settings

Tamasese, K. C., Peteru, K., & Waldergrave, C. (1997). *Ole Taeao Afua, the new morning: A qualitative investigation into Samoan perspectives on mental health and culturally appropriate services*. Wellington, New Zealand: Health Research Council of New Zealand. Research Project of The Family Centre.

US Census Bureau. (2012). *State and county quick facts*. Retrieved August 23, 2014, from http://quickfacts.census.gov/qfd/states/15000.html

Whealin, J. M., Seibert-Hatalsky, L. A., Howell, J., & Tsai, J. (2015). Telehealth preferences in ethnoracially diverse veterans and national guard members. *Journal of Rehabilitation Research and Development, 52*, 725–738.

Whealin, J. M., Yoneda, A. C., Nelson, D., Hilmes, T. S., Kawasaki, M. M., & Yan, O. H. (2017). A culturally adapted family intervention for rural Pacific Island veterans with PTSD. *Psychological Services, 14*(3), 295–306.

Wilcox, S., Gonda, D., Chung-Do, J., Miao, T. A., Goebert, D., & BRAVEHEART Leaders. (2011). *Hawai'i find your voice youth summit 2010*. Waimānalo, HI: Ke Ola Hou.

Wyatt, L. C., Ung, T., Park, R., Kwon, S. C., & Trinh-Shevrin, C. (2015). Risk factors of suicide and depression among Asian American, Native Hawaiian, and Pacific Islander youth: A systematic literature review. *Journal of Health Care for the Poor and Underserved, 26*(20), 191–237.

Xu, Y., Okuda, M., Hser, Y., Hasin, D., Liu, S., Grant, B. F., & Blanco, C. (2011). Twelve-month prevalence of psychiatric disorders and treatment-seeking among Asian Americans/Pacific Islanders in the United States: Results from the national epidemiological survey on alcohol and related conditions. *Journal of Psychiatric Research, 45*, 910–918.