Integrating Cultural Values Into Mental Health Treatment

Barry Carlton, Deborah A. Goebert, Cathy Kaheauilani Bell, Michelle Horton, ʻIwalani R. N. Else, Marsha Marcinowski, and Lynn Yamada

The authors review existing literature on the mental health needs of adolescents, resilience factors, and cultural competency. A cultural integration program for adolescents (ages 12 to 18) is presented, and case examples are illustrated to provide preliminary evidence that integrating culture into treatment contributes to greater engagement, meaningfulness, resilience, and wellness for Native Hawaiian youth with severe mental illness. In addition, integrating culture assists clinicians in assessing treatment response and can potentially improve outcomes. Youth programs should consider integrating cultural values into treatment for mental health problems.

CORRESPONDENCE MAY BE SENT TO:
Deborah A. Goebert, Department of Psychiatry, John A. Burns School of Medicine
University of Hawai'i–Mānoa, 1356 Lusitana Street 4th Floor, Honolulu, Hawai'i 96813
Email: goebertd@dop.hawaii.edu

Hūlili: Multidisciplinary Research on Hawaiian Well-Being Vol.7 (2011)

He pūkoʻa kani ʻāina.
A coral reef that grows into an island.

—ʻŌlelo Noʻeau (Pukui, 1983, no. 932)

Metaphorically, this proverb suggests that a person begins in a small way and gains steadily until she or he becomes firmly established. In their past travels around the Pacific, the Hawaiians would pass by many coral heads that the navigators would mark in their memories and pass on to their apprentices. Eventually, they noticed these small coral heads would grow into full islands, and so comes the insightful wisdom that we cannot expect to be fully mature and successful right away. The coral heads must also weather storms and turbulent oceans. Therefore, we all start small, we encounter turmoil, and over time, like a coral head, we will mature and reach our potential.

Adolescence has been described as a phase of life beginning in biology and ending in society (Petersen, 1988). It is a period of rapid physical transitions in body proportions and hormonal changes. These biological changes influence and are influenced by psychological, social, cultural, and historical contexts (Gottlieb, 1992; Lerner, 1998). For example, early pubertal maturation was linked to delinquency in adolescent girls who attended mixed-sex schools (Caspi, Lynam, Moffitt, & Silva, 1993) or have older friends (Stattin & Magnusson, 1990). During this phase, there is continual change and transition between individuals and their contexts (Lerner & Galambos, 1998). These changing relations constitute the basic process of development in adolescence. They underlie both positive and negative outcomes that occur during this period. For youth with mental illness, it can be a protracted period of "storm and stress." In this article, we describe a cultural integration program devised to engage youth in their learning and treatment, gain insight into their lives, increase their resilience and well-being, and, ultimately, help them to attain their potential.

Youth in Need

Mental health is often considered the most important component of adolescent health because so many youth experience mental health problems that interfere with their development and daily life activities (Prince et al., 2007). The National Institute of Mental Health estimates that one in five children and adolescents in America may have a mental health disorder (Merikangas et al., 2010). Andrade et al. (2006) reported the first prevalence study of mental disorders among indigenous and nonindigenous youth in Hawai'i. Overall, indigenous Hawaiian youth had higher rates of mental illness than non-Hawaiian youth (32.7% vs. 23.7%, respectively) when controlling for gender, and girls had higher rates than boys (30.8% vs. 21.1%, respectively) when controlling for ethnicity. These findings were primarily the result of the significant differences in rates regarding anxiety disorders. However, boys had significantly higher rates of substance abuse than girls, with indigenous Hawaiian boys having the highest rate and non-Hawaiian girls having the lowest rate. Furthermore, meta-analyses comparing indigenous Hawaiian rates with other groups demonstrated that indigenous Hawaiians follow similar diagnostic trends as Native American and other high-risk youth.

In the general population, major mental illness affects approximately 1 in 10 youth, with 2 per 1,000 children and adolescents under 17 years of age being admitted to a hospital for mental health treatment (Case, Olfson, Marcus, & Siegel, 2007; Muroff, Edelsohn, Joe, & Ford, 2008). This type of information is not available for indigenous youth. Given the developmental implications of this phase of life, during which psychological, socioemotional, cognitive, and vocational pathways are being set, it is not surprising that mental disorders can seriously limit potential (McGorry, Purcell, Hickie, & Jorm, 2007). Associated with mental disorders among youth are high rates of school failure, impaired or unstable employment, and poor family and social functioning, leading to dysfunction and disadvantage throughout their life span. Given the high rates of mental illness among indigenous Hawaiian youth, it is not surprising that they have higher rates of delinquency, incarceration, interpersonal violence, suicide attempts, substance use, teenage pregnancy, and high school dropouts (Alu Like, 1985; Chesney-Lind et al., 1992, 1995; Else, Andrade, & Nahulu, 2007; Gao & Perrone, 2004; Goebert & Birnie, 1998; Hishinuma et al., 2001, 2005; Kana'iaupuni, Malone, & Ishibashi, 2005a, 2005b; Office of Hawaiian Affairs, 1998; Spoehr et al., 1998; Yuen, Nahulu, Hishinuma, & Miyamoto, 2000).

Treatment Engagement

For health practitioners to facilitate engagement of youth in treatment, they must not only be competent in treatment modalities but also be culturally competent. Competence refers to the application of knowledge and the interpersonal and decision-making skills expected for the practice role (National Council of State Boards of Nursing, 1996). Cultural competence refers to accepting and respecting differences and reinforcing the strengths of the patient, family, community, or population in the process of engagement (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). To be culturally competent means to continually assess oneself regarding culture, to have a regard for and attention to the dynamics of difference, and to engage in ongoing development of cultural knowledge, resources, and flexibility within service models to work toward better meeting the needs of minority populations (Substance Abuse and Mental Health Services Administration [SAMSHA], 2000). In 2000, SAMSHA released its "Cultural Competence Standards in Managed Care Mental Health Services." The principle of cultural competence indicates attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care to diverse populations, that is, to work within a person's values and reality conditions. Recovery, rehabilitation, and personal well-being are more likely to occur when managed care systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of children and families from the four underserved, underrepresented racial/ethnic groups and their communities. The four core groups are Hispanics, American Indians/Alaska Natives, African Americans, and Asian/Pacific Islanders. Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs, emotions, and values in determining an individual's mental wellness/illness, as well as incorporating those variables into assessment and treatment.

Continuing education is essential to ensure cultural competence among clinical staff and to promote effective response to the mental health needs of patients. Core areas include the following: understanding consumer populations' backgrounds, clinical issues, how to provide appropriate treatment, and agency/provider role; communicating effectively across cultures; providing quality assessments; formulating and implementing quality treatment plans; providing quality treatment by using one's self and knowledge in the treatment process; and having nonjudgmental attitudes. Cultural competency is not just a form of social justice; it is

also social action. If practitioners embody cultural competency at all times, their relationship with the people they serve will reflect respect and affirm the gifts, strengths, and aspirations of individuals, families, and communities.

Building Resilience

Resilience typically refers to the positive capacity to cope with adversity, the ability to bounce back after a disruption, or an adaptive system that uses exposure to adversity to increase capacity for dealing with future negative events (Carlton et al., 2006; Masten, 2007). Although there are increasing empirical studies of adolescent resilience, few studies focus on interventions, and these rarely include cultural factors (Brady, 1993; Frison, Wallander, & Browne 1998; Werner, 1995). Werner pioneered work in the field of resilience, examining multiple protective factors and their impact on adolescents on Kaua'i (Werner, 1971; Werner & Johnson, 1999; Werner & Smith, 1982, 1992). However, culture was not a focus. There is increasing support for a strong connection between well-being and identification with culture among indigenous youth. Several studies underscored the role of culture facilitating resilience for indigenous people facing adversity (Adelson, 2000; Montgomery, Miville, Winterowd, Jeffries, & Baysden, 2000; Roberts & Holmes, 1999; Wexler, DiFluvio, & Burke, 2009; Whitbeck, Hoyt, Stubben, & LaFromboise, 2001). Additionally, a strong sense of ethnocultural identity has been correlated with higher levels of psychological health for indigenous youth, including feelings of self-worth, self-efficacy, connectedness, and purpose (McCabe, 2007; Minore, Boone, Katt, & Kinch, 1991; Whitbeck, Chen, Hoyt, & Adams, 2004; White, 2000).

Resilience research has been shifting from an emphasis on building protective factors among individuals toward focusing on protective processes and studying how different factors are involved (Luthar, Cicchetti, & Becker, 2000). The association between well-being and culture among indigenous peoples may result from the process of cultural maintenance, which creates collective meaning, a perception of community through mythology, history, and symbolic representation (Nagel, 1994; Wexler et al., 2009). Specifically, creating meaning out of shared experience can provide a sense of coherence and group purpose (Damon, Menon, & Bronk, 2003; Erikson, 1968; Hernandez, 2002; Hunter & Csikszentmihalyi, 2003).

Discussion of their shared experience may provide for a deeper understanding of how these individuals negotiate hardship as well as promote positive youth development. A synergistic relationship between self and collective meaning and interests can help establish pathways for understanding illness and effective treatment, and thereby promote resilience (Wexler et al., 2009). Thus, resilience can be viewed as a dynamic process based on interpretations and social affiliations.

Integrating Cultural Values Into Treatment

Considering the risks and outcomes faced by youth affected by serious mental illness and the value of promoting resilience, it seems critical to integrate cultural values into treatment interventions. Culture is the learned, shared, and transmitted values, beliefs, norms, and life ways of a particular group that guides thinking, decisions, and actions in patterned ways, often intergenerationally (Leininger & McFarland, 2006). Cultures vary with respect to the meaning they impart about mental illness (Kleinman, 1988), reflecting their way of making sense of the subjective experience of illness and distress. The meaning of a mental illness refers to deep-rooted attitudes and beliefs a culture holds about mental illness. This can include whether the condition is "real" or "imagined"; whether it is of the body, the mind, or the spirit (or all); whether it warrants sympathy or exclusion; how much stigma surrounds it; what might cause it; and what type of person might succumb to it.

Culture is important to mental health treatment because it frames what all people bring to the clinical setting, including, but not limited to, deciding whether to seek help, the types of help they seek (mental health specialist, primary care provider, clergy, and/or traditional healer), the coping styles and social supports they have, the amount of stigma they attach to mental illness, and treatment engagement (U.S. Department of Health and Human Services, 2001). Thus, interventions must be culturally compatible for treatment and recovery of the child or adolescent to be successful. Interventions must focus on the whole child or adolescent, as a cultural being. They must target resilience, family relationships, social and interpersonal stressors, and cohesion and functioning around youth and family needs (Beardslee & Knitzer, 2003). Youth programs often invoke culture as a major part of their program content as a vague construct (Grande, 2004; Meyer, 2001).

However, treatment that builds on cultural strengths, such as resilience in the face of multiple challenges, and adaptive ways of coping (connecting with extended family and increasing kinship ties, spirituality, creating positive meaning) can reduce symptoms. Programs that integrate cultural processes and encourage youth participation can lead to improved mental health and wellness for youth (Trinidad, 2009).

Local practitioners recognize the importance of culture in mental health. The Native Hawaiian Partnership (a community collaboration formed in 2005 by the Co-Occurring State Incentive Grant) shared a vision to ensure that Native Hawaiians, their families, and communities have access to substance abuse and mental health services that honor culturally responsive treatment (Papa Ola Lōkahi & ʻImi Ke Ola Mau, 2007). In June 2007, Papa Ola Lōkahi, on behalf of the Native Hawaiian Partnership, submitted an application to SAMHSA requesting Hawaiʻi's participation in the Policy Academy on Substance Use and Mental Health Disorders for Native Groups. Before attending the academy meeting, Hulu Kupuna (esteemed elder) Aunty Malia Craver named the partnership ʻImi Ke Ola Mau, which translates as "To perpetuate a life of health and healing." ʻImi Ke Ola Mau expresses a process of health and healing as a lifelong journey from kamaliʻi (child) to kupuna (elder). ʻImi Ke Ola Mau invokes the fluid nature of health and well-being. In order for indigenous Hawaiians to heal,

> [They] need a sense of self, retrieved from our past through ancestors, present through purpose, and future through descendants. [They] need our language, traditions, and ceremonies which provide ways to reconnect to our spirituality and to our concept of our Source. [They] need the resiliency and protection our culture provides, in order to prevent relapse and redefine ourselves away from pathological diagnoses. (Papa Ola Lōkahi & ʻImi Ke Ola Mau, 2007)

We can also learn from educational contributions. For inpatient mental health treatment, there are direct applications, given education must be provided to school-age youth. Additionally, mental health treatment can be informed by their content, context/environment, and approaches. The Hawaiian Cultural Influences in

Education (HCIE) study examined relationships among culture-based educational strategies, socioemotional development, and educational outcomes of students. HCIE is a collaborative study by Kamehameha Schools, the Hawai'i Department of Education, and Nā Lei Na'auao, the alliance of Hawaiian-focused charter schools (www.ksbe.edu/SPI/CBE_home.php; Ledward & Takayama, 2009a, 2009b; Takayama & Ledward, 2009). The study states that

> Culture-based education is the grounding of instruction and student learning in the values, norms, knowledge, beliefs, practices, and language that are the foundation of a(n indigenous) culture.
>
> Hawaiian culture-based education grounds teaching and learning in culturally relevant content, contexts, and assessments, which draw heavily on 'ohana (family), kaiāulu (community), and 'ōlelo (Hawaiian language).
>
> At the state, national, and international levels, culture-based educational strategies are increasingly being seen as a promising means of addressing educational disparities between indigenous students and their peers.
>
> HCIE is a community-based, participatory research study aimed at understanding the impact of culture-based educational strategies on middle and high school students.

HCIE found that culturally based educational approaches (a) have a significant impact on students' Hawaiian language ability, internalization of Hawaiian values, and participation in cultural activities; (b) have a positive impact on students' emotional and cognitive engagement; (c) have a significant impact on community connectedness (sense of place, community involvement, and engagement with cultural issues); and (d) contribute to positive self-concept by cultivating students' ethnic identity development. All of these four approaches are also important for treatment. It is not enough to simply be able to identify Hawaiian values. In order for these values to lead to reduction in symptoms, youth must internalize these

values and integrate them into their identity, be given the ability to master cultural activities, and link with community. The educational setting and treatment milieu can provide opportunities for safe exploration of values and their meaningfulness.

The Na Haʻawina Hoʻopono website (www.healthhi.hawaii.edu) describes the Native Hawaiian Education Council's guidelines for culturally healthy and responsive learning environments as well as a culturally responsive high school health curriculum. For example, the first of 13 guidelines states that "the learning environment needs to incorporate cultural traditions, language, history and values in meaningful holistic processes to nourish the emotional, physical, mental/intellectual, social, and spiritual well being of the learning community that promote healthy *mauli* [life] and *mana* [spiritual power]." The health curriculum integrates the guidelines, providing lesson plans for 11 units, such as getting acquainted, lōkahi (harmony), communication, wellness, mental health, and substance use. It demonstrates ways to reinforce key Hawaiian principles while meeting state-required standards, benchmarks, and performance indicators through a semester-long course curriculum. This curriculum provides a starting place for building a Hawaiian values-based program, compatible with Hawaiʻi Department of Education requirements. It can also provide ideas for the educational component that are responsive to treatment priorities for youth at the Family Treatment Center.

The Family Treatment Center

The Queen's Medical Center's Family Treatment Center is committed to promoting the health and well-being of Hawaiʻi's adolescents and their families (Bell et al., 2010; The Queen's Medical Center, n.d.). The Family Treatment Center's multidisciplinary team provides short- and longer term inpatient mental health services for youth who are generally between the ages of 12 and 18 (though younger children have been admitted) with a wide variety of emotional and behavioral disorders. This variety reflects the illnesses and disorders commonly seen in the community, such as mood, anxiety, disruptive behavior, developmental, psychotic, eating, and substance use disorders. The multidisciplinary team consists of child and adolescent psychiatrists, clinical nurse specialists, nurses, social workers, a psychologist, occupational and recreational therapists, a special education teacher, and a

pharmacist. Services provided include psychiatric assessments; treatment modalities including individual, family, and group therapy; skill building in the areas of social skills, problem solving, and emotional regulation; crisis intervention services; educational support; and care coordination services to effectively transition youth back to their communities. Treatment is individualized to meet the needs of each patient and family in a safe and supportive environment.

Core strategies utilized at the Family Treatment Center include using cognitive-behavioral approaches (e.g., educational competence; healthy, constructive thinking; age-appropriate behavior; and appropriate judgment in social situations); developing emotional competence (e.g., developing coping skills to deal with intense feelings, building a capacity for empathy, developing positive regard for self and others); family strengthening (e.g., improving family communication and problem solving, creating healthy and supportive relationships within the family); promoting physical health and well-being (e.g., positive care of self); and developing a sense of community (e.g., enriched and balanced life experiences; cultural, spiritual, and social awareness; Hawaiian concepts of community and relationships to people and the environment; group discussion on spiritual issues).

In the following section, we describe the program at the Family Treatment Center and provide examples from synthesized cases. These cases are based on a compilation of patients treated at the center in the last 3 years. They are constructed from therapist notes, classroom assignments and journals, and collective staff memory. Any resemblance to individuals is purely coincidental.

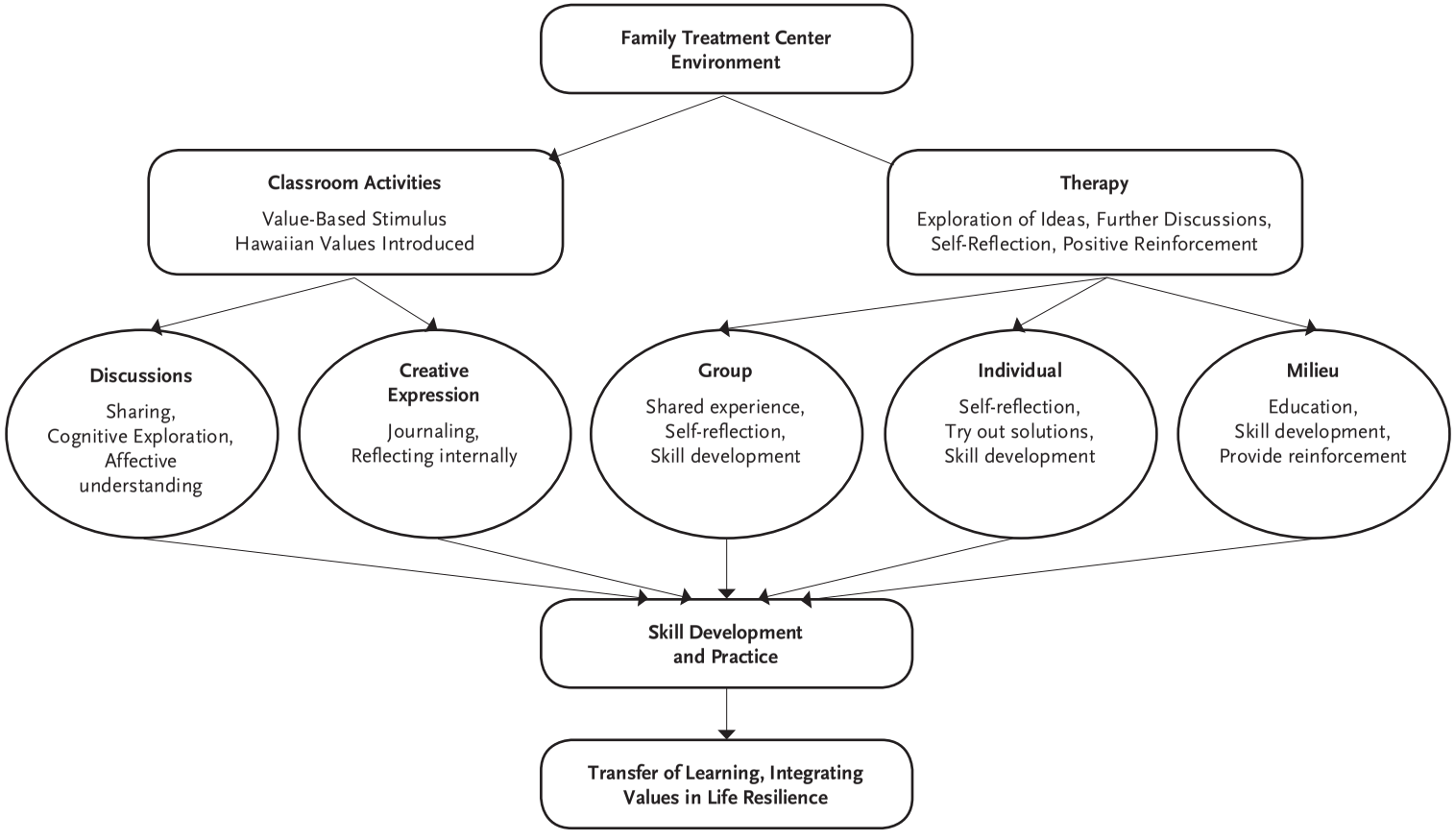
The Family Treatment Center's Cultural Integration Program

The cultural integration program is based on the premise that values are a central component of well-being. Developing prosocial values can provide adolescents with a foundational guide for beliefs, social behavior, and attitudes and lead to decisions that are honest, respectful, socially acceptable, and responsible (Rohan, 2000; Spreacker, 2001). According to Living Values Educational Program (www.livingvalueseducation.org; Tillman, 2002), teaching values helps individuals to think about practical ways of expressing values in relation to themselves, others,

the community, and the world. It also deepens their understanding, motivation, and responsibility in making social and personal choices in life. Lastly, teaching values provides the principles and tools of developing the whole person physically, mentally, emotionally, and spirituality. The core values chosen for use at the Family Treatment Center are considered universal in nature and meet the Hawai'i Department of Education's standards. Using values in therapy can be very useful and can allow the therapist to have awareness and understanding about the youth's thoughts, views, and perspectives; emotional and cognitive capacities; interpersonal relatedness; and morality that they may not have otherwise.

The goals of the cultural integration program are to have the values reinforced in class, in individual and family therapy, and throughout the treatment milieu. The program is open to adolescents in high school that are admitted to the Family Treatment Center. Although the program is currently restricted to the classroom and group therapy, staff want to help reinforce the values so that the students practice and live them so they become internalized and promote confidence, resilience, and well-being. This could be accomplished by supervision with students in all disciplines (e.g., nursing, medical, social work, and psychology), including discussion of individual youth progress in applying the values in team meetings, discussions and application in the classroom and all group therapies, visual reminders throughout the milieu, and incentives for the application of the values for each youth (e.g., credit for application of the value within the point level system; rewarding points for application during family, group, and individual treatments). Social learning and values education theories posit that the more the values and resultant prosocial behaviors are reinforced and practiced in therapy, school, and the family setting, the more the youth will be able to live them (Bandura, 1977; Narvaez, 2005; Rotter, 1945; Shweder, 1993). It is believed that by living the values, the youth will become more resilient and able to cope better with adversity in the future. Figure 1 outlines the cultural integration program at the Family Treatment Center. Values are introduced and discussed during classroom activities. Youth spend time during therapy exploring the meaning of the values. They can practice and receive reinforcements throughout the therapeutic milieu.

FIGURE 1 Conceptual model of integrating culture in inpatient psychiatric treatment at the Queen's Medical Center's Family Treatment Center



Given the relatively brief time students spent at the Family Treatment Center, the psychiatrist wanted to have the students read a Hawaiian myth in group and then extract values and meaning from the myth and relate it to themselves. It was thought the myths would allow greater explanation and more ready understanding of its application in life. However, given the complexity of the Hawaiian myths and often multiple meanings, it would be too difficult for most of the adolescents. With the use of a Hawaiian dictionary (Pukui & Elbert, 1986), 24 values were identified that were thought to be helpful in therapy. Flash cards were created with each value, including the English word written at the top and the Hawaiian word under it. There is a one- or two-word description of the meaning of the value and then an example of how that value would be portrayed. For example,

> Hope
> Hilinaʻi
> To have belief; Assurance
> A conviction in oneself or an idea

The following includes an outline for the cultural integration program, administered through education and therapy. The program generally lasts 4 weeks. Each week, a Hawaiian value is introduced to the students in the classroom setting by the teacher every Monday morning. The teacher randomly chooses a youth to pick the value for the week from flash cards. Some of the values that are often chosen by the students include hope (hilinaʻi), harmony (lōkahi), acceptance (ʻāpono, hoʻāpono), change (loli, hoʻololi), responsibility (kuleana), positive attitude (ʻoluʻolu), patience (ahonui), faith (manaʻoʻiʻo), forgiveness (kala, hoʻokala), and respect (hōʻihi). The teacher writes the value on the board, discusses the Hawaiian word and meaning, and elicits responses from the students on how this value relates to their mind, body, and spirit (lōkahi). Responses are written on the board. Students are then asked to write about the value in their journals/notebooks and how it applies to their lives or experiences. This process is repeated over the remaining weeks. The rationale for a 4-week program, as opposed to a longer duration, was based on the average length of stay for adolescents in the Family Treatment Center. This is similar to other adolescent psychiatric inpatient settings. The length of time for each value or the program overall may be adjusted based on time constraints, opportunities, and group dynamics. Furthermore, the intervention is repetitive, which should enhance understanding of the values, thereby increasing the adolescent's ability to develop prosocial attitudes and behaviors (Bandura, 1977).

The value is also covered in group therapy on Monday mornings and Thursday afternoons. The psychiatrist routinely covers certain themes in the group sessions. The group session starts with patients succinctly explaining (10 words or less) the reason(s) that they have been admitted into the Family Treatment Center, the number of times they have been to the center or a place like it, and whether or not they live with any family member or are a ward of the state. The psychiatrist asks the group about their families, because a majority of the patients believe that most of their problems would be solved if they did not have to live with their family. The intent is to establish a basis for shared experiences, building on the commonality among the patients in their reason for admission (family problems, suicide, drugs, victim of rape or violence, etc.). It does not matter whether the patient is acutely or chronically ill; they all have something in common. The psychiatrist explains to the group that no one who leaves the Family Treatment Center wants to come back, yet around 60% will return. Furthermore, patients who live with any family member tend to do better than those placed in any state agency. Patients who do not return are able to make positive changes in their lives, and it is this positive change that needs to occur.

Once a shared experience is established, the psychiatrist asks the group members to discuss how they can apply the value to themselves and their treatment. Youth who are capable of managing the concept and cognitively participating in the discussion are included. During the discussion, youth reflect on the value, and the value is made relevant to their lives. This can take from 3 to 10 minutes per individual during each session. Members of the group provide feedback to the individual on their perceptions and whether they feel the person is being honest with the group and him- or herself. In this process, the group as a whole shapes its own understanding of cultural values and creates a meaningful context on which it can evolve. On an individual level, the process of linking these values to emotional experiences allows youth to build cognitive and emotional tools. Through these discussions, youth are able to contrast the effects of values on actions and thereby deal more effectively with the external forces that shape the consequences of their actions. Some discussions are followed by self-reflection and brought up during individual therapy. The psychiatrist guides feedback and reinforces the importance of these values in the patients' behaviors and attitudes.

The ways in which these values are integrated into the patients' lives and treatment can be seen in their classroom notebooks. For example, when the Hawaiian value *lōkahi* was covered in the classroom, the patients were asked to write about how it related to them. One student writes, "Lōkahi means living in peace, harmony and in total nirvana." This patient has inadvertently applied the value to herself and her treatment. She had run away from her adoptive home and lived with her birth father for many months, abusing drugs and alcohol. During group, she had promised to go into a drug treatment program to help her stop abusing drugs and alcohol. However, her statements seem to lack conviction. Her writing indicates her intentions, because for her, "nirvana" is her substance use. However, there is another student who has considerable substance use but shows promise in her treatment when she writes that lōkahi means "Taking care of your mind, body and spirit through a higher power." This demonstrates that she has internalized some of the 12-step program in her attitude about drugs. These examples show that the values do aid the youth and the psychiatrist in other aspects of the therapy. Values integration can also be seen during exchanges that occur in group therapy, such as the two following examples provided of acceptance (ʻāpono, hoʻāpono) and love (aloha).

Acceptance (ʻĀpono, Hoʻāpono)

During group therapy, an insightful patient spoke about his situation of not being accepted by his family and not being able to return home by saying, "My parents have rejected me because of my lifestyle so I will have to make it here on my own."

Another patient stated, "I have a severe illness where my moods make me crazy and I hear voices and I was sick for a month, therefore I need to accept that I need to take medicine, even though I don't like the side effects, otherwise I can't live." However, not everyone in group is able to embrace each value, such as the patient who said, "I can't accept the fact that my family has rejected me, so I can't move on. I'm stuck wanting to get back to the family that never cared about me."

Love (Aloha)

Many of the patients at the Family Treatment Center feel that they have been rejected by their family either because their parents are in prison or their parental rights have been terminated. These patients often have difficulty dealing with the concept of love in any meaningful way. During group, this was expressed by statements such as "All I can care about is myself and no one else. I just want to feel good right now and that's all that matters" and "People expect me to care about them, but the people in my life are always changing, no one is stable." However, patients with family can conceptualize the value, "I know my parents care about me, but what I have done has made them so angry, it's hard for me to see their love."

Two Case Illustrations

Two cases are provided to illustrate the way that the cultural integration program stimulated engagement in treatment. They also highlight the overall benefits of the program.

The Case of Ryan

Ryan is a 16-year-old part-Hawaiian in 10th grade at a local public high school. His father is part-Hawaiian and his mother is Filipino. He was admitted to the Family Treatment Center after striking out against his mother and siblings. He abused methamphetamine and marijuana. His biological parents continue to be married; however, there is a lot of family turmoil. Although the parents could not get along, they both declined divorce. There is also considerable conflict with Ryan's father's family, who identifies strongly with Hawaiian values. On admission, Ryan identified himself as Hawaiian; however, he knew very little about his family of origin or genealogy and expressed an interest in learning more about his culture.

Through the cultural integration program, Ryan was exposed to Hawaiian values in his learning environment as well as in his individual and group therapy sessions and began to reflect on their meaning. He actively participated when values were discussed, indicating interest in his culture and background, and he eventually became interested in lua (ancient Hawaiian martial art of self-defense). He then

asked for books about lua and began studying it. The more he learned about his culture and adopted Hawaiian values, the more he wanted to improve his life and chart a new course for himself. Ryan made steady progress in treatment and was able to move from aggression toward authority and an all-for-me attitude to being a part of a greater whole.

With regular urine monitoring for his substance use, participation in individual and family therapy as an outpatient, and continued exploration of his Hawaiian culture and values, Ryan was able to graduate from high school and attend a university. Although therapy ended a few years ago, his parents maintained contact with the therapist to provide updates on Ryan's progress. Ryan continues to do well. While Ryan was at the university, he contacted the therapist and was interested in learning about methamphetamine and what it had done to his brain. He described his continued interest in lua and other aspects of Hawaiian culture and was hopeful that he would be able to transmit what he had learned to his cousin who was abusing drugs as he had. He described the knowledge of his background and culture as a way of organizing his life. It provided him with values and a sense of purpose that he would not have had otherwise.

The Case of Keoki

Keoki is Hawaiian on both sides of his family, although the parental rights for both his mother and father have been terminated. He lives with extended family. Keoki was frequently and seriously bullied while growing up. He was admitted to the Family Treatment Center when he was 15 years old after he seriously injured another student at school. On admission, he reported experiencing no guilt or remorse. He abuses marijuana. He recalled that when he was younger, he was clearly being cared for and had a strong identification with his Hawaiian family. As he entered primary grades and junior high school, he became a victim of bullying. He accepted being bullied and never fought back. He felt that this was how he was supposed to live.

Coming into the program, Keoki thought he had to accept his circumstances. He felt his only remaining option was to fight back. During the early groups, Keoki presented himself as a victim and drew attention to his shortcomings. The group felt he was not representing himself fairly. They pointed out his strengths. His self-reflections began to include his skills and abilities, and he gradually presented a more balanced view. Keoki selected the value hope (hilina'i), and he described

and talked about how he had hope. He discovered that he had musical talents, he became physically fit, and he had considerable pride in his body. These strengths (his music and athletic abilities) gave him hope. With this insight, Keoki realized he could influence his situation. Keoki felt that he could manage his aggression, and he realized that he could create a future for himself that did not involve violence. During the remainder of his stay, he worked hard to learn techniques to help reduce his anger and respond in less aggressive ways. He felt that when he accomplished this, he would make his family proud of him, and he would be proud of himself.

Conclusion

Structured values education interventions have been shown to enhance both understanding and practice of prosocial values among adolescents with mental illness (Lerner & Galambos, 1998). Through its cultural integration program, the Family Treatment Center has expanded on the work of values education programs by not only providing a values curriculum in the classroom but also including ongoing discussion of cultural values during group and individual therapy. We provide preliminary evidence that integrating culture into treatment contributes to greater engagement and increased meaningfulness of group process, at least for some Native Hawaiian youth. Further integration into all aspects of the treatment milieu, such as individual therapy, family therapy, recreation, and unstructured time, could have a more widespread impact during hospitalization. It may also better prepare adolescents for their transition to community settings. Although research has been inconsistent of the role of cultural factors in treatment, several studies have shown that integrating culture can lead to improved program success among indigenous Hawaiian and minority youth (Hurawai, Sellman, Sullivan, & Potiki, 2000; Williams, Nasir, Smither, & Troon, 2006; Withy, Lee, & Renger, 2007). Disparate findings may be due in part to the ways in which programs are evaluated and limits of existing measurement tools. For effectiveness in such a setting, appropriate program evaluation should include measures of knowledge, attitude, behavior, and skills change to determine effectiveness in a culturally relative manner (Withy et al., 2007). Our approach shows promise for improving mental health of youth in Hawai‘i. We will continue to evaluate and enhance our program to meet our patients’ needs.

Our experience also has implications for promoting understanding of cultural values and cultural competency among mental health providers. Rapport building is a critical component of competency development. Understanding how youth interpret and express cultural values facilitates the development of trust and enhances the individual's investment and continued participation in treatment. It is also incumbent on mental health providers to continuously conduct self-assessments regarding culture and their own values. Furthermore, practitioners need to create opportunities for ongoing development of cultural knowledge, as well as the resources and flexibility within service models to meet the needs of minority populations (Saldaña, 2001). As stated in the final report of the President's New Freedom Commission on Mental Health (2003),

> The mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups.

We believe that by combining cultural competency with interventions such as the Family Treatment Center's cultural integration program, we can improve mental health services for Native Hawaiian youth.

References

Adelson, N. (2000). Re-imagining aboriginality: An indigenous peoples' response to social suffering. *Transcultural Psychiatry, 37*, 11–34.

Alu Like. (1985). *E ola mau: Native Hawaiian Health Needs Study*. Honolulu, HI: Author.

Andrade, N. N., Hishinuma, E. S., McDermott, J. F., Jr., Johnson, R. C., Makini, G. K., Jr., Nahulu, L. B.,...Yates, A. (2006). Prevalence of mental disorders in Native Hawaiian adolescents using the NIMH Diagnostic Interview Schedule for Children (DISC). *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 26–36.

Bandura, A. (1977). *Social learning theory*. New York, NY: General Learning Press.

Beardslee, W. R., & Knitzer, J. (2003). Strengths-based family mental health services: A family systems approach. In K. Maton, C. Schellenbach, B. Leadbeater, & A. Solarz (Eds.), *Investing in children, youth, families and communities: Strengths-based research and policy* (pp. 157–171). Washington, DC: American Psychological Association.

Bell, C. K., Guerrero, A., Matsu, C., Takeshita, J., Haning, W., & Schultz, K. (2010). Curricular adaptations in inpatient child psychiatry for the 21st century: The Flexner model revisited. *Academic Psychiatry, 34*, 195–202.

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.

Brady, M. A. (1993) Health issues for aboriginal youth: Social and cultural factors associated with resilience. *Journal of Pediatrics and Child Health, 29*(Suppl. 1), S56–S59.

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

Case, B. G., Olfson, M., Marcus, S. C., & Siegel, C. (2007). Trends in the inpatient mental health treatment of children and adolescents in US community hospitals between 1990 and 2000. *Archives of General Psychiatry, 64*, 89–96.

Caspi, A., Lynam, D., Moffitt, T. E., & Silva, P. A. (1993). Unraveling girls' delinquency: Biological, dispositional, and contextual contributions to adolescent misbehavior. *Developmental Psychology, 29*, 19–30.

Chesney-Lind, M., Leisen, M. B., Allen, J., Browne, M., Rockhill, A., Marker, N.,...Joe, K. (1995). *Crime, delinquency and gangs in Hawaii: Evaluation of Hawaii's gang response system, Part 1*. Honolulu, HI: University of Hawai'i–Mānoa, Social Science Research Institute, Center for Youth Research.

Chesney-Lind, M., Marker, N., Rodriquez-Stern, I., Yap, A., Song, V., Reyes, H., Reyes, Y.,...Taira, J. (1992). *Gangs and delinquency in Hawaii*. Honolulu, HI: University of Hawai'i–Mānoa, Social Science Research Institute, Center for Youth Research.

Damon, W., Menon, J., & Bronk, K. C. (2003). The development of purpose during adolescence. *Applied Developmental Science, 7*, 119–128.

Else, I. R. N., Andrade, N. N., & Nahulu, L. B. (2007). Suicide and suicidal-related behaviors among indigenous Pacific Islanders in the United States. *Death Studies, 31*, 479–501.

Erikson, E. (1968). *Identity: Youth and crisis*. New York, NY: Norton.

Frison, S. L., Wallander, J. L., & Browne, D. (1998). Cultural factors enhancing resilience and protecting against maladjustment in African American adolescents with mild mental retardation. *American Journal on Mental Retardation, 102*, 613–626.

Gao, G., & Perrone, P. (2004). *Crime in Hawai'i 2003: A review of uniform crime reports*. Honolulu, HI: Hawai'i State Department of the Attorney General, Crime Prevention and Justice Assistance Division.

Goebert, D., & Birnie, K. K. (1998). *Injury and disability among Native Hawaiians. Pacific Health Dialog, 5*, 253–259.

Gottlieb, G. (1992). *Individual development and evolution: The genesis of novel behavior*. New York, NY: Oxford University Press.

Grande, S. M. A. (2004). *Red pedagogy: Native American social and political thought*. Lanham, MD: Rowman & Littlefield.

Hernandez, P. (2002). Resilience in families and communities: Latin American contributions from the psychology of liberation. *Family Journal: Counseling and Therapy for Couples and Families, 10*, 334–343.

Hishinuma, E. S., Foster, J. E., Miyamoto, R. H., Nishimura, S. T., Andrade, N. N., Nahulu, L. B.,...Carlton, B. S. (2001). Association between measures of academic performance and psychosocial adjustment for Asian/Pacific Islander adolescents. *School Psychology International, 22*, 303–319.

Hishinuma, E. S., Johnson, R. C., Kim, S. P., Nishimura, S. T., Makini, G. K., Jr., Andrade, N. N., & Revilla, L. A. (2005). Prevalence and correlates of misconduct among ethnically diverse adolescents of Native Hawaiian/part-Hawaiian and non-Hawaiian ancestry. *International Journal of Social Psychiatry, 51*, 242–258.

Hunter, J. P., & Csikszentmihalyi, M. (2003). The positive psychology of interested adolescents. *Journal of Youth and Adolescence, 32*, 27–35.

Hurawai, T., Sellman, J. D., Sullivan, P., & Potiki, T. L. (2000). Optimal treatment for Maori with alcohol and drug-use-related problems: An investigation of cultural factors in treatment. *Substance Use and Misuse, 35*, 281–300.

Kana'iaupuni, S. M., Malone, N. J., & Ishibashi, K. (2005a). *Income and poverty among Native Hawaiians*. Honolulu, HI: Kamehameha Schools, Policy Analysis & System Evaluation.

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

Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. New York, NY: Free Press.

Ledward, B., & Takayama, B. (2009a). *Hawaiian Cultural Influences in Education (HCIE): Community attachment and giveback among Hawaiian students* (Culture-Based Education Brief Series). Honolulu, HI: Kamehameha Schools, Research & Evaluation. Retrieved from www.ksbe.edu/spi/CBE_prod.php

Ledward, B., & Takayama, B. (2009b). *Hawaiian Cultural Influences in Education (HCIE): Cultural knowledge and practice among Hawaiian students* (Culture-Based Education Brief Series). Honolulu, HI: Kamehameha Schools, Research & Evaluation. Retrieved from www.ksbe.edu/spi/CBE_prod.php

Leininger, M. M., & McFarland, M. R. (2006). *Culture care diversity and universality: A worldwide nursing theory* (2nd ed.). Boston, MA: Jones & Bartlett.

Lerner, R. M. (1998). Theories of human development: Contemporary perspectives. In W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology: Vol 1. Theoretical models of human development* (pp. 1–24). New York, NY: Wiley.

Lerner, R. M., & Galambos, N. L. (1998). Adolescent development: Challenges and opportunities for research, programs, and policies. *Annual Review of Psychology, 49*, 413–446.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*, 543–562.

Masten, A. S. (2007). Resilience in developing systems: Progress and promise as the fourth wave rises. *Development and Psychopathology, 19*, 921–930.

McCabe, G. H. (2007). The healing path: A culture and community-derived indigenous therapy model. *Psychotherapy: Theory, Research, Practice, Training, 44*, 148–160.

McGorry, P. D., Purcell, R., Hickie, I. B., & Jorm, A. F. (2007). Investing in youth mental health is a best buy. *Medical Journal of Australia, 187*(Suppl. 7), S5–S7.

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 49*, 980–989.

Meyer, M. A. (2001). Our own liberation: Reflections on Hawaiian epistemology. *Contemporary Pacific, 13*, 124–148.

Minore, B., Boone, M., Katt, M., & Kinch, P. (1991). Looking in, looking out: Coping with adolescent suicide in the Cree and Ojibway communities of Northern Ontario. *Canadian Journal of Native Studies, 11*, 1–24.

Montgomery, D., Miville, M. L., Winterowd, C., Jeffries, B., & Baysden, M. F. (2000). American Indian college students: An exploration into resiliency factors revealed through personal stories. *Cultural Diversity and Ethnic Minority Psychology, 6*, 387–398.

Muroff, J., Edelsohn, G. A., Joe, S., & Ford, B. C. (2008). The role of race in diagnostic and disposition decision-making in a pediatric psychiatric emergency service (PES). *General Hospital Psychiatry, 30*, 269–276.

Nagel, J. (1994). Constructing ethnicity: Creating and recreating ethnic identity and culture. *Social Problems, 41*, 152–176.

Narvaez, D. (2005). Integrative ethical education. In M. Killen & J. Smetana (Eds.), *Handbook of moral development* (pp. 703–733). Mahwah, NJ: Erlbaum.

National Council of State Boards of Nursing. (1996). *Definition of competence and standards for competence*. Chicago, IL: Author.

Office of Hawaiian Affairs. (1998). *Native Hawaiian data book*. Honolulu, HI: Office of Hawaiian Affairs, Planning and Research Office.

Papa Ola Lōkahi & ʻImi Ke Ola Mau. (2007). *A strategic plan for improvement of substance abuse and mental health outcomes for Native Hawaiians, their families and communities*. Retrieved from http://www.amhd.org/Cooccurring/reports/2007%20Policy%20Academy%20Strategic%20Plan.pdf

Petersen, A. C. (1988). Adolescent development. *Annual Review of Psychology, 39*, 583–607.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, Final report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: Author.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *Lancet, 370*, 859–877.

Pukui, M. K. (1983). *ʻŌlelo noʻeau: Hawaiian proverbs and poetical sayings*. Honolulu, HI: Bishop Museum Press.

Pukui, M. K., & Elbert, S. H. (1986). *Hawaiian dictionary: Hawaiian-English, English-Hawaiian* (Rev. and enl. ed.). Honolulu, HI: University of Hawaiʻi Press.

The Queen's Medical Center, Family Treatment Center (n.d.). Retrieved from http://www.queensmedicalcenter.net/index.php?option=com_content&view=article&id=119%3Afamily-treatment-center&catid=29%3Aservices-info&Itemid=54

Roberts, G., & Holmes, J. (1999). *Healing stories: Narrative in psychiatry and psychotherapy*. Oxford, UK: Oxford University Press.

Rohan, M. J. (2000). A rose by any name? The values construct. *Personality and Social Psychology Review, 4*, 255–277

Rotter, J. B. (1945). *Social learning and clinical psychology*. New York, NY: Prentice-Hall.

Saldaña, D. (2001). *Cultural competency: A practical guide for mental health providers*. Austin, TX: Hogg Foundation for Mental Health.

Shweder, R. (1993). *Thinking through cultures*. Cambridge, MA: Harvard University Press.

Spoehr, H., Akau, M., Akutagawa, W., Birnie, K., Chang, M.-L., Kinney, E.,...Soares, D. (1998). Ke ala ola pono: The Native Hawaiian community's effort to heal itself. *Pacific Health Dialog, 5*, 232–238.

Spreacker, A. (2001). Educating for moral development. *Gifted Education International*, 15, 188–193.

Stattin, H., & Magnusson, D. (1990). *Pubertal maturation in female development*. Hillsdale, NJ: Erlbaum.

Substance Abuse and Mental Health Services Administration. (2000). *Cultural competence standards in managed care mental health services: Four underserved/underrepresented racial/ethnic groups* (Publication No. SMA00-3457). Washington, DC: Author.

Takayama, B., & Ledward, B. (2009). *Hawaiian Cultural Influences in Education (HCIE): Positive self-concept among Hawaiian students* (Culture-Based Education Brief Series). Honolulu, HI: Kamehameha Schools, Research & Evaluation. Retrieved from www.ksbe.edu/spi/CBE_prod.php

Tillman, D. (2002). *Theoretical background and support for living values: An educational program*. Haines Falls, NY: Living Values Education Program. Retrieved from http://www.livingvalueseducation.org/Articles.htm

Trinidad, A. M. O. (2009). Toward *kuleana* (responsibility): A case study of a contextually grounded intervention for Native Hawaiian youth and young adults. *Aggression and Violent Behavior, 14*, 488–498.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Werner, E. E. (1971). *The children of Kauai: A longitudinal study from the prenatal period to age ten*. Honolulu, HI: University of Hawai'i Press.

Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Science, 4*, 81–85.

Werner, E. E., & Johnson, J. L. (1999). Can we apply resilience? In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations* (pp. 259–268). New York, NY: Kluwer Academic/Plenum.

Werner, E. E., & Smith, R. S. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth*. New York, NY: McGraw-Hill.

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. Ithaca, NY: Cornell University Press.

Wexler, L. M., DiFluvio, G., & Burke, T. K. (2009). Resilience and marginalized youth: Making a case for personal and collective meaning-making as part of resilience research in public health. *Social Science & Medicine, 69*, 565–570.

Whitbeck, L. B., Chen, X., Hoyt, D. R., & Adams, G. W. (2004). Discrimination, historical loss and enculturation: Culturally specific risk and resiliency factors for alcohol abuse among American Indians. *Journal of Studies on Alcohol, 65*, 409–418.

Whitbeck, L. B., Hoyt, D., Stubben, J., & LaFromboise, T. (2001). Traditional culture and academic success among American Indian children in the Upper Midwest. *Journal of American Indian Education, 40*(2), 48–60.

White, W. L. (2000). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcohol Treatment Quarterly, 18*(1), 1–23.

Williams, N., Nasir, R., Smither, G., & Troon, S. (2006). Providing opioid substitution treatment to indigenous heroin users with a community health service setting in Adelaide. *Drug and Alcohol Review, 25*, 227–232.

Withy K. M., Lee, W., & Renger, R. F. (2007). A practical framework for evaluating a culturally tailored adolescent substance abuse treatment programme in Molokai, Hawaii. *Ethnicity & Health, 12*, 483–496.

Yuen, N. Y. C., Nahulu, L. B., Hishinuma, E. S., & Miyamoto, R. H. (2000). Cultural identification and attempted suicide in Native Hawaiian adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 360–367.

Acknowledgments

Work on this publication was funded, in part, by a grant from The Queen's Medical Center, Honolulu, Hawai'i.

About the Authors

Barry Carlton, MD, Deborah A. Goebert, DrPH, Cathy Kaheauilani Bell, MD, Michelle Horton, and ʻIwalani R. N. Else, PhD, are affiliated with the Department of Psychiatry at the John A. Burns School of Medicine, University of Hawaiʻi–Mānoa (UHM). All are faculty or staff members of the Department of Psychiatry and members of the National Center for Indigenous Hawaiian Behavioral Health. Dr. Carlton is the medical director at the Family Treatment Center, The Queen's Medical Center in Honolulu, Hawaiʻi. Dr. Goebert is a senior scientist at The Queen's Medical Center. Dr. Bell is a psychiatrist at Kaiser Permanente and, at the time this was written, was at the Family Treatment Center. Dr. Else is the director of institutional research and assessment at The College of St. Scholastica and, at the time this was written, was an associate professor with the Department of Psychiatry at UHM. Marsha Marcinowski is a special education teacher. Lynn Yamada is a licensed clinical social worker who worked at the Family Treatment Center and is now at Kaiser Permanente.