Native Hawaiian Traditional Healing: Culturally Based Interventions for Social Work Practice

Donna E. Hurdle

Developing cultural competence is a key requirement for social workers in the multicultural environment of the 21st century. However, the development of social work interventions that are syntonic with specific cultural groups is a great challenge. Interventions that are based on the traditional healing practices of a particular culture ensure cultural relevance and consistency with its values and worldview. This article discusses the importance of culturally based interventions within a cultural competence framework and offers examples of such interventions used with Native Hawaiians. Two interventions are discussed, targeted to the micro (direct practice) level and macro (community practice) level of practice. Culturally based social work interventions may be most appropriate for client systems within a particular culture; however, some methods, such as ho'oponopono, have been successfully used with clients from other cultures as well.

Key words: *cultural competence; culturally based intervention; Native Hawaiians; traditional healing*

Cultural competence is an emerging focus of social work practice that is encouraged by both major social work professional organizations, NASW and the Council on Social Work Education, and reflects the reality of America's multicultural society. As described by Lum (1999), social work practice with people of color and various ethnic groups has evolved over the past two decades from ethnic-sensitive approaches, to cultural awareness, to cultural diversity, and finally to cultural competence. Each of these approaches has a different focus, ranging from the development of enhanced awareness in practitioners to greater knowledge of specific cultural groups and finally to the more integrated concept of cultural competence. Cultural competence is a practice method also used by other helping professions to refer to the development of adequate professional skills to provide services to ethnic, racial, and cultural groups. With the development of common terminology and scholarship, training and content in cultural competence can now be compared across the helping disciplines. At the present time, counseling psychology seems to have the most clearly articulated set of competences, ethics, and training requirements (Lum, 1999; Sue et al., 1998).

Although cultural competence is a relatively new concept for the social work profession, it developed from a long tradition of providing services to people from a variety of ethnic and racial backgrounds. This article describes the elements of cultural competence as conceptualized by the current leading theorists in different disciplines. The use of culturally grounded social work interventions is identified as a core skill in culturally competent practice. As this concept is best understood through the use of examples, the article describes two interventions with Native Hawaiians. Culturally grounded interventions based on traditional healing practices may have the most chance for success in working with ethnic groups, because

they reflect the culture and tradition of a particular group. A culturally based approach to social work practice could be developed from the healing traditions of many ethnic groups, and is a new area for development of cross-cultural practice skills.

Cultural Competence in the Helping Professions

Perhaps the first identification of cultural competence was provided by the Child and Adolescent Services Technical Assistance Program (CASSP) at Georgetown University, Washington, DC (Cross, Bazron, Dennis, & Isaacs, 1989). This conceptualization identified the elements of cultural competence for individual practitioners, agencies, and systems of care. *Cultural competence* was defined as a set of behaviors, attitudes, and policies that enable systems, agencies, or professionals to work effectively in cross-cultural situations (Cross et al.). The focus of the CASSP model was on defining effective services for children from ethnic minority groups who have severe emotional disturbances. The strength of this model was its inclusion of both self-awareness and behaviors of practitioners, as well as its recognition of the need for incorporating particular elements in agency systems. This framework continues to be a foundation of the theory and descriptions of cultural competence in social work and other helping professions (Lum, 1999; Pierce & Pierce, 1996).

Cultural competence was defined as a set of behaviors, attitudes, and policies that enable systems, agencies, or professionals to work effectively in cross-cultural situations.

In the 1990s the Association for Multicultural Counseling and Development developed a framework of cultural competences for professional counselors in the field of counseling psychology. This model served as an inspiration for the social work cultural competence framework developed by Lum (1999). It includes three dimensions: (1) counselor awareness of personal values and biases, (2) understanding the worldview of culturally different clients, and (3) developing appropriate intervention strategies and techniques. Each of these areas further includes competence in attitudes and beliefs, knowledge, and skills (Sue et al., 1998). Characteristics of culturally competent organizations also are identified in this framework. It is believed that the combination of personal awareness, knowledge of different cultures of clients, as well as the development of appropriate skills allows mental health professionals to ably provide services to clients that are culturally different from themselves. This is seen as a necessity in the multicultural world of the United States in the 21st century. Multicultural counseling and therapy, originally called "cross-cultural counseling/therapy" recognizes that both Western and non-Western approaches to helping may be necessary, as well as culturally appropriate awareness, knowledge, and skills (Sue et al.).

Significant work in cultural competence also has occurred in the field of family therapy. McGoldrick (1998) noted that all families are embedded in and bounded by socioeconomic status, culture, gender, and race; how a society defines and values these relationships is critical to understanding how family processes are structured. The "culture" of families is seen as a multidimensional construct consisting of levels of identification with various identities—ethnicity, race, gender, socioeconomic status, and sexual orientation (Laird, 1998).

Other factors in understanding the cultural nature of a family include migration and acculturation, ecological context (including interaction with the community, work, and social institutions), stage of family life cycle, and family organization (Falicov, 1995). Each of these dimensions varies by country, culture, religion, socioeconomic status, and acculturation among other variables. Assessment tools have been developed to articulate the role of culture in particular families, such as the cultural genogram (Hardy & Laszloffy, 1995), culturagram (Congress, 1994), and the multidimensional comparative framework (Falicov).

Another crucial factor is the stance of the therapist working with culturally different families. Whereas awareness of his or her cultural background, biases, prejudices, and stereotyping is important, the attitude with which a practitioner approaches a family is equally influential to the outcome of therapy. Adopting an ethnographic

perspective with a sense of curiosity and naiveté enables practitioners to collaborate with clients to learn about their culture and how it influences their behavior (Dyche & Zayas, 1995). This has also been termed "cultural humility" (Tervalon & Murray-Garcia, 1998). Therapists can best understand the multidimensional nature of family culture by using a narrative approach that enables a family to tell its story, including aspects that are "problem saturated" as well as those reflecting family strengths and values (Laird, 1994, 1998). This approach moves practitioners away from a predetermined assessment framework to examining the unique aspects of the culture of each family.

Cultural competence also has been a focus in the field of nursing, evolving from transcultural nursing practice. This tradition focused on understanding the health care practices of people from different cultures, their varying ways of defining health and illness, and how caring is conceptualized in their cultures (Leininger, 1985). In an analysis of the concept of cultural competence from a nursing perspective, Smith (1998) identified the components of the model, as well as their antecedents and consequences. The antecedents or prerequisites for cultural competence are practitioner self-assessment of assumptions, biases, and values; an open attitude; and development of new knowledge. The components of cultural competence in this framework parallel those discussed earlier (that is, cultural awareness, cultural knowledge, and cultural skill). To these are added cultural sensitivity, participation in cultural encounters, and liaison and linkage for health care resources and services.

After increasing their knowledge and awareness in these areas, culturally competent nurses are able to empower clients, decrease their anxiety or fear of the health care system, engage clients more effectively in treatment, and improve their health status and satisfaction with services. This conceptualization further enriches the literature on cultural competence and adds important additional elements.

Cultural Competence in Social Work

Several models of cultural competence have been developed in the profession of social work (Green, 1999; Lum, 1999; McPhatter, 1997). *Cultural competence in social work* can be defined as the ability to understand the dimensions of culture and cultural practice and to apply them to clients and their cultural–social environment (Lum, 1999). This model has evolved from earlier social work literature on the dual-perspective (Norton, 1993) ethnic-sensitive practice (Devore & Schlesinger, 1987; Granger & Portner, 1985), and social work with ethnic minority groups (Chau, 1989; Lum, 1982, 1996). It also has been influenced by the literature on cultural competence in other helping disciplines.

Lum (1999) identified four areas of cultural competence in social work: (1) personal and professional awareness of ethnicity by the practitioner, (2) knowledge of culturally diverse practice, (3) skill development in work with culturally diverse clients, and (4) inductive learning; he further identified the levels of these competences for both general and advanced practice. Some of these aspects paralleled other models of cultural competence, such as personal awareness, knowledge of cultural groups, and development of skills.

Regarding personal awareness, Lum developed a useful self-assessment that helped social workers identify their experiences with people of color and different cultures. In the knowledge component of his model, Lum went beyond a focus on racism, prejudice, and discrimination to discuss cultural values and practice theories, such as social construction, that led to new models of practice, such as narrative approaches to treatment. The last component of the model, inductive learning, referred to the development of critical thinking and lifelong learning about culturally diverse practice. This component is essential to the development of culturally competent social workers, as the process of continuing to develop new knowledge and enhanced perspective, questioning the accuracy and relevance of one's existing knowledge base, and using clients as "cultural informants" to further develop specialized information must be ongoing. Cultural competence is not a static process of acquiring ability but rather an ongoing process of attuning oneself to the ever-changing cultures of various client groups.

McPhatter's (1997) concern was cultural competence in child welfare, where there is an overrepresentation of children from ethnic minority groups in state care. Her cultural competence attainment model consisted of three overlapping spheres of information: (1) grounded knowledge base, (2) enlightened consciousness, and (3) cumulative skill proficiency. There are

similarities between this model and others described earlier; enlightened consciousness refers to the restructuring of the worldview of the social worker as one moves from a monocultural to a multicultural position embracing both the positive and negative aspects of their own culture and that of clients. A grounded knowledge base includes knowledge of the history, culture, traditions and customs, language, values, spirituality, art forms, and healing beliefs of clients; it also includes critiquing psychological theories that have traditionally guided social work practice but reflect the dominant culture. Feminist psychologists have criticized the psychodynamic theories of Freud and the developmental theories of Erikson and Kohlberg for their lack of applicability to the experiences of girls and women (Gilligan, 1982). The knowledge base further includes social problems, dynamics of oppression and racism, diverse family structures, and neighborhood and community profiles. McPhatter's final component of cultural competence was cumulative skill proficiency, which referred to appropriate assessment and intervention skills for clients of color, with an emphasis on cross-cultural communication skills.

Green (1999) defined a culturally competent services provider as one who delivers services in "a way that is congruent with behavior and expectations normative for a given community and that are adapted to suit the specific needs of individuals and families"(p. 87). He approached cultural competence from an anthropological perspective and emphasized ethnographic interviewing, familiarity with cultural descriptions, participant observation, and use of cultural guides. Green also was concerned with the help-seeking behaviors and traditions of healing for different cultures; these influence when and how a client system interacts with a helping system, of which social workers are a part. Culture influences how problems are defined, as well as the nature of problem resolution. Without recognition of these variables, social workers cannot know what type of assistance clients may be seeking that would be compatible with their cultural views of problem resolution.

Many of these models of cultural competence imply that after social workers acquire specific skills, enhance their knowledge and awareness, and learn new intervention techniques, they will become "culturally competent." However, this formula-driven approach does not take into account the fact that cultures continually change over time, as do individual, family, and community expressions of culture. Cultural competence is an evolutionary process that needs continual attention from the helping professionals. Social workers must continually focus on issues of culture in their clients and in themselves, knowing that their knowledge and skills must grow and develop over time.

To apply this discussion of cultural competence to social work practice, it is useful to examine examples of culturally competent interventions with particular cultural groups. By looking at specific culturally based interventions, it is possible to identify the knowledge and skill components that are necessary, as well as the values and cultural worldview of a unique client group. Because cultural worldviews are so diverse, social workers must have knowledge of particular groups and their cultures to provide therapeutic interventions that are relevant and appropriate. This article discusses culturally specific interventions that have been found to be useful with one indigenous Native American group—Native Hawaiians: a direct practice intervention used with Native Hawaiian families, and a community-based intervention used with a Native Hawaiian community.

Culturally Based Interventions

The models of cultural competence reviewed all encourage social workers to use culturally diverse intervention skills that are appropriate for different practice levels—micro, meso, and macro (Lum, 1999). According to Lum, the results of these strategies are empowerment, parity, and maintenance of culture and should be based in the unique experience of cultures. Indigenous interventions, such as those described in this article, are ways of helping based on the history and culture of a particular ethnic group. As stated by Shook (1985), practitioners should "cloak therapy in the garments of the client's cultural milieu" (p. 30). Sue and Zane (1987) suggested that using culturally compatible helping strategies builds credibility with culturally different clients, which is a key variable in successful interventions.

Some literature has developed in social work and other disciplines concerning the use of traditional healing practices and folk healing with specific ethnic groups. *Folk healing* can be defined as "health beliefs and practices derived from ethnic

and historical traditions that have as their goal the amelioration or cure of psychological, spiritual, and physical problems" (Applewhite, 1995, p. 247). The advantage of indigenous therapies is that the values and philosophical basis of the interventions are compatible with client values because they are based in the client's own cultural tradition. As the majority of these interventions occur in a family or group setting, these natural support systems also are activated to assist the client. Cultural approaches to healing are consistent with a strengths perspective on social work practice (Saleebey, 1996). A traditional healing approach requires an ethnographic orientation to specific cultures, as these interventions may need to be learned from indigenous practitioners or elders within a particular culture, and then adapted for use by helping professionals. Some scholars suggest that particular helping skills are needed for work with members of a particular culture. Weaver (1999) found that Native American social workers and students suggest that practitioners use containment skills with Native American clients, which involve patience, the ability to tolerate silence, listening, and limited verbalizations.

A variety of indigenous healing approaches have been used therapeutically with different cultural groups. Folktales communicate culture-specific values, customs, and wisdom as well as problem-solving methods and coping skills; they can be used in counseling with both children and adults (Alexander & Sussman, 1995). One example of this is the use of "dichos," or Latino folk sayings, as metaphors in therapeutic work with Latino clients (Zuniga, 1992). Other approaches have been developed by mental health providers in other countries and brought to the United States for use with clients from those countries, such as Morita therapy, a Japanese treatment for anxiety disorders (Smith, 1981). In many non-Western and indigenous cultures, healing is performed by a medicine man or woman or shaman through the use of ceremonies, herbs and medicinal cures, trances, and other mechanisms. Many of these traditions are active today in indigenous cultures in the United States and other countries (Lee & Armstrong, 1995; Voss, Douville, Little Soldier, & Twiss, 1999). Often family-centered methods of intervention are suggested with clients from ethnic minority cultures, as most of these cultures have a strong emphasis on extended family (Pedersen, 1997).

Culturally Based Interventions with Native Hawaiians

Native Hawaiians are the indigenous peoples of the former monarchy of Hawaii, which was colonized by the United States in the mid-1800s; they originally migrated to the Hawaiian Islands from Tahiti about 750 A.D. After generations of intermarriage with other Asian and Pacific Islander groups (Chinese, Japanese, Filipino, Samoans, Tongans), as well as Europeans and Americans, the population of Hawaii is now primarily of mixed ethnic heritage. Current estimates of the Native Hawaiian population range from 12.5 percent of the population of the state of Hawaii (138,742) by the 1990 U.S. Census to 21.5 percent (240,000) by the 1993 State of Hawaii Health Department, with several hundred others living on the mainland (University of Hawaii, 1994). In recent years, there has been a resurgence of cultural identity among Native Hawaiians, which has included using the Hawaiian language, reclaiming traditional land, and developing Hawaiian music and dance (hula) forms, traditional healing practices, and culturally based programming in health care and social services.

Native Hawaiians have significant social, health, and mental health problems that indicate an urgent need for social work intervention (Mokuau, 1990; Mokuau & Matsuoka, 1995). Native Hawaiians have a 34 percent higher death rate than other ethnic groups in the United States, which reflects higher incidence rates of heart disease, cancer, and cerebrovascular disease (Mokuau, 1990). They also have a shorter life expectancy and higher rates of suicide, child abuse and neglect, substance abuse, and criminal conviction than other ethnic groups in the state of Hawaii (Mokuau, 1990). Additional indicators of dysfunction include low incomes, infrequent use of prenatal care resulting in high incidences of low birth rate and premature infants, and limited use of health care (University of Hawaii, 1994).

There are a number of efforts underway by health and human services organizations to address these problem areas. Congress passed the Native Hawaiian Health Care Improvement Act in 1988 (P.L. 100-579) that funded programs on most of the islands to provide culturally based health care and health education and promotion. These services incorporate traditional Hawaiian values and healing practices into their program design and delivery; congruence is therefore

achieved between the Hawaiian worldview and the assessment, intervention, and evaluation stages of services delivery (Mokuau, 1990). Social services agencies have incorporated traditional healing practices into their human services interventions with families, in prisons, in schools, and in residential treatment centers (Nishihara, 1978; Shook, 1985). The adaptation of cultural traditions into health and human services is a unique emphasis that has resulted in increased participation by Native Hawaiians in health and human services programs.

Culturally based interventions in Hawaii provide an example of how human services interventions can be grounded in the culture of an ethnic group so that they reflect the worldview, values, and traditions of the culture. This approach can be adapted to other cultural groups to develop intervention approaches suited to their unique characteristics.

Ho'oponopono—*A Family Conflict Resolution Process*

Ho'oponopono, or setting to rights, is a family-based conflict resolution process that was originally performed in ancient Hawaii by *kahuna* (traditional healers) to maintain harmony in the community. It fell out of use with the colonization of Hawaii and the introduction of the Christian religion (Pukui, Haertig, & Lee, 1972). However, in the early 1970s a therapeutic children's center in Honolulu, Hawaii, became aware that Native Hawaiian children were not progressing in treatment or changing their dysfunctional behaviors with the Western psychotherapeutic approaches that were used at that time. To address this issue, the mental health staff began meeting with Hawaiian elders and kahuna to develop more culturally syntonic ways of treating the children. Over time, the group began to revitalize the use of ho'oponopono, an ancient Hawaiian conflict resolution process, in the center and with the families of the residents (Shook, 1985). Social workers from the School of Social Work at the University of Hawaii later became involved in this effort, and a training film was eventually made. This method also has been adapted for use in residential treatment centers for youths (Shook), in schools (Nishihara, 1978), and in Hawaiian churches (Ito, 1985).

The ho'oponopono process was originally used by extended Native Hawaiian families to discuss and settle arguments, assuage hurt feelings, mediate angry words, and deal with other types of interpersonal problems (Pukui et al., 1972). This conflict resolution model is embedded in the traditional Hawaiian values of extended family, need for harmonious relationships, and restoration of good will, or *aloha.* It has several specific stages that must be followed in a particular order, with a protocol as to how family members must conduct themselves during the ritual. Traditionally it was led by a kahuna within the extended family; however, this role is now taken by an elder family member or a therapist when used in a professional setting. An explanation of the stages of the process is necessary to fully understand this family conflict resolution process.

To begin the ho'oponopono, the leader calls the family members together, with the understanding that they will participate in the process until it is complete, which may take a number of hours or even several sessions on multiple days (Shook, 1985). All family members involved in the conflict must attend; these typically include the nuclear family and some members of the extended family system. The rules of the process include the control of all communication by the leader and a prohibition on expression of emotional excess; this prevents individuals from directly confronting each other and eliminates the risk of further escalation of the problem or the creation of additional misunderstandings. The goal of the ho'oponopono is the restoration of harmony within the family and the development of a solution to the problem.

The ho'oponopono is opened with a prayer, which is followed by the identification of the problem, both in a general and a specific manner (Shook, 1985). This includes a description of the *hala,* or transgression, and the negative entanglement, or *hihia,* thus created. Each participant who has been affected by the problem, either directly or indirectly, is asked to share his or her feelings (*mana'o*). An emphasis is placed on self-scrutiny, honest and open communication, and avoidance of blame. If participants become emotional during the process, the leader may declare a cooling-off period of silence (*ho'omalu*). After the discussion phase, the resolution phase begins with the *mihi*; this is a confession of wrongdoing and the seeking of forgiveness, which is expected to be forthcoming. To establish mutuality, the wronged party also asks forgiveness for his or her reactions

to the offense. This is a unique part of the process because all parties to the conflict ask forgiveness of each other, which establishes equal status among them. Restitution for the offense may be appropriate, and if so a plan for this may be determined. The *kala* concludes this phase, whereby the conflict and hurt are released, and the negative entanglement is broken. The closing phase, *pani,* includes a summary of the process, a reaffirmation of the family's strengths and enduring bonds, and a final prayer. The problem that has been worked out is then declared closed and should not be brought up again. If subsequent sessions are needed to work out other layers of the problem, the final pani is delayed until that time. After the completion of the ho'oponopono, a meal is often shared by all participants.

An example of this process as described by Shook (1985) concerns problems within a family following a child's refusal to complete her chores. In this example, the father conducted the ho'oponopono with members of a nuclear family group. The process opened with a prayer and a request for honest discussion about the problematic family interrelationships. The father asked each family member to recount his or her view of the presenting problem; as the process unfolded, it became apparent that the teenager's failure to complete the chore resulted from anger over past interactions with her mother and brother. After all family members individually discussed their participation in the present and past events, the father directed the teenager to ask forgiveness of other family members and then asked the other family members to ask forgiveness for their roles in past events and the tension and anger they had experienced. After this, the father summarized the discussion, praised family members for their honesty and openness, and closed the process with a prayer.

This Hawaiian conflict resolution process includes many aspects of therapeutic interventions used by social workers—identification of the problem with all involved parties, discussion of the effect on the family system, identification of possible solutions to the problem, and then implementation of the selected solution. It is implemented in an extended family system, which is similar to some methods of family therapy that use a network approach (Attneave, 1985). However, it is also very different from these interventions in that the process is based on a shared cultural tradition with understood roles for participants; there is a spiritual focus and an impetus for resolution to restore harmony. The formal nature of the ritual lends an aura of solemnity and importance to the process, which is crucial to many forms of traditional healing.

The model of ho'oponopono described above was developed by Shook (1985) after surveying Native Hawaiian social workers who had extensive experience providing this intervention. In this research, she identified the common elements of the process as described by a number of practitioners and formulated a composite model that could be taught to students in schools of social work. The ho'oponopono technique can be used by social workers from different cultural heritages and is applicable to work with all types of families and their problems as well as to interventions with groups of nonrelated people, such as in residential care settings (Shook). This is an excellent example of traditional healing that has been adapted for modern use by helping professionals.

The ho'oponopono method of conflict resolution can be used by mental health professionals of various cultural backgrounds after they learn the process; it has been used in residential treatments and in schools with children of various cultural backgrounds with much success (Ito, 1985; Mokuau, 1990; Shook, 1985). Although no studies have yet identified the precise nature of the effectiveness of the ho'oponopono technique, one can speculate that its basis in the culture and values of Native Hawaiians may enable families to engage in the process in a comfortable manner. In addition, the spiritual component of this process is reflective of the integration of spirituality with healing in many indigenous cultures.

Culture-Centered Community-Based Practice

Community development activities that recognize and build community strengths, understand the culture and values of ethnic communities, and work as partners with them have the best chance of success (Gutierrez, Alvarez, Nemon, & Lewis, 1996). To be an effective and culturally competent community organizer requires many of the cultural competence skills discussed earlier, such as understanding one's own cultural heritage and gaining knowledge of the ethnic group with which one is working, including its history, traditions, and values. Recognition of the strengths of communities of color is a key factor, particularly the

family and community support networks and collectivist worldview (Gutierrez et al.). Often there is a need for interpreters or cultural mediators to ensure that communication is fully understandable to the community; these roles should not be held by community organizers because they are an excellent vehicle for developing indigenous community leadership (Heskin & Heffner, 1987).

Ho'opono Ahupua'a—*A Native Hawaiian Community Development Project*

In the mid-1990s, a Hawaiian foundation, the Queen Emma Foundation, targeted several rural communities on the island of Oahu for assistance, because they had high concentrations of Native Hawaiians and had significant health and education problems. To facilitate the involvement of the indigenous community, the foundation developed a culturally competent community development strategy with the goal of enabling the communities to identify their own problems and help create needed programs and services. In 1995 the foundation adopted the Ahupua'a Access and Support Model, a plan for development of healthy Native Hawaiian communities based on ancient Hawaiian values (Janoff & Weisbord, 1997). This model outlines a framework for support of communities based on levels of access; all levels are interdependent and holistic and rest on the foundation of *lokahi* (unity). The primary support system is the family, both nuclear and extended, with the community (*malama'ohana*) being of secondary support. The community level is envisioned to support a *pu'uhonua* (place of refuge); historically, this was a particular location that provided refuge and protection to people in need. The pu'uhonua is now being reframed as a community center that provides services such as outpatient medical care, counseling services, or respite care (Janoff & Weisbord).

To initiate the community development project, the rural communities participated in a future visioning process in which they developed their "ideal" community (Janoff & Weisbord, 1997). The several-day conference, with participation from representatives of all areas of the community, resulted in a master community plan for the development of a variety of programs and services. Task groups were formed to plan and initiate programming in various topical areas. The project was so successful that at follow-up a year later, the community had created a child care center, a farmer's market, and a health promotion program; also they had developed a healthy lifestyle program that included nutritional instruction based on a Native Hawaiian diet. In addition, they had integrated Native Hawaiian healers into local medical clinics (Janoff & Weisbord). Foundation funding was used for several of these projects. It was apparent that the community development process was responsible for the tremendous progress that these previously marginally functioning communities had made in self-determination and mobilization of resources.

This example of culturally based community development used many of the principles of multicultural community organizing. The project was based on the values and worldview of the Native Hawaiian communities it served, and it built on community strengths by integrating cultural practices into program delivery, such as the use of Native Hawaiian healers and dietary instruction based on the Native Hawaiian diet. Community members became leaders of task groups to plan and initiate the development of needed community services. The funding foundation worked as a partner with the community rather than sending in staff to develop programs for the community. The articulation of Native Hawaiian values into the guiding principals of the foundation was a key aspect of the success of this project (Janoff & Weisbord, 1997).

Conclusion

Cultural competence requires the use of intervention skills that are a good fit with the cultural worldview and values of specific ethnic groups. Developing cultural competence requires social workers to engage in an ongoing cultural knowledge development process, as well as learning about traditional healing practices that can be applied to work with ethnic clients. A primary focus needs to be on empowering the client systems to determine the problems to be addressed and the solutions they envision. The intervention process then uses culturally based interventions to achieve these goals. This process requires a trusting relationship to be developed with clients, which is facilitated by the use of culturally based social work practice.

The two different types of interventions, based on traditional Hawaiian values and practices, discussed in this article provide assistance to families and to the community and reflect the importance

of cultural values and spirituality in the intervention process. They are also examples of how traditional indigenous healing practices can be applied to contemporary social work practice. For client systems in the Hawaiian Islands, both Native Hawaiians and members of other cultures, use of these intervention methods is very appropriate. These methods also may be useful with other cultural groups on the mainland, as the ho'oponopono process has been found to be effective with members of various cultural groups (Shook, 1985). These two Hawaiian methods also may serve as examples of different ways in which indigenous cultural healing concepts and practices can be integrated into direct social work practice with families and communities. Because the literature on these types of culturally based interventions is very limited, this is an area in which further research and development is needed. ■

References

Alexander, C. M., & Sussman, L. (1995). Creative approaches to multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Susuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 375–384). Thousand Oaks, CA: Sage Publications.

Applewhite, S. L. (1995). *Curanderismo*: Demystifying the health beliefs and practices of elderly Mexican Americans. *Health & Social Work, 20,* 247–253.

Attneave, C. L. (1985). Practical counseling with American Indian and Alaska Native clients. In P. Pedersen (Ed.), *Handbook of cross-cultural counseling and therapy* (pp. 135–140). Westport, CT: Greenwood Press.

Chau, K. L. (1989). Sociocultural dissonance among ethnic minority populations. *Social Casework, 70,* 224–230.

Congress, E. P. (1994). The use of culturagrams to assess and empower culturally diverse families. *Families in Society, 75,* 531–539.

Cross, T., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: Volume I. A monograph on effective services for minority children who are severely emotionally disturbed.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Devore, W., & Schlesinger, E. G. (1987). *Ethnic sensitive social work practice* (2nd ed.). Columbus, OH: Merrill.

Dyche, L., & Zayas, L. H. (1995). The value of curiosity and naivete for the cross-cultural psychotherapist. *Family Process, 34,* 389–399.

Falicov, C. (1995). Training to think culturally: A multidimensional comparative framework. *Family Process, 34,* 373–388.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Granger, J. M., & Portner, D. L. (1985). Ethnic- and gender-sensitive social work practice. *Journal of Social Work Education, 21,* 38–47.

Green, J. W. (1999). *Cultural awareness in the human services: A multi-ethnic approach* (3rd ed.). Needham Heights, MA: Allyn & Bacon.

Gutierrez, L., Alvarez, A. R., Nemon, H., & Lewis, E. A. (1996). Multicultural community organizing: A strategy for change. *Social Work, 41,* 501–508.

Hardy, K. V., & Laszloffy, T. A. (1995). The cultural genogram: Key to training culturally competent family therapists. *Journal of Marital and Family Therapy, 21,* 227–237.

Heskin, A. D., & Heffner, R. A. (1987). Learning about bilingual, multicultural organizing. *Journal of Applied Behavioral Science, 23,* 525–541.

Ito, K. L. (1985). Ho'oponopono, "to make right": Hawaiian conflict resolution and metaphor in the construction of a family therapy. *Culture, Medicine and Psychiatry, 9,* 201–217.

Janoff, S., & Weisbord, M. R. (1997). Speaking with the ancients. *Healthcare Forum Journal, 40,* 26–34.

Laird, J. (1994). "Thick description" revisited: Family therapist as anthropologist–constructivist. In E. Sherman & W. J. Reid (Eds.), *Qualitative research in social work* (pp. 175–188). New York: Columbia University Press.

Laird, J. (1998). Theorizing culture: Narrative ideas and practice principles. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 20–36). New York: Guilford Press.

Lee, C. C., & Armstrong, K. L. (1995). Indigenous models of mental health intervention: Lessons from traditional healers. In J. G. Ponterotto, J. M. Casas, L. A. Susuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 441–456). Thousand Oaks, CA: Sage Publications.

Leininger, M. M. (1985). Transcultural caring: A different way to help people. In P. Pedersen (Ed.), *Handbook of cross-cultural counseling & therapy* (pp. 107–115). Westport, CT: Greenwood Press.

Lum, D. (1982). Toward a framework for social work practice with minorities. *Social Work, 27,* 244–249.

Lum, D. (1996). *Social work practice with people of color: A process-stage approach* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Lum, D. (1999). *Culturally competent practice: A framework for growth and action.* Pacific Grove, CA: Brooks/Cole.

McGoldrick, M. (1998). Introduction: Re-visioning family therapy through a cultural lens. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 3–19). New York: Guilford Press.
McPhatter, A. R. (1997). Cultural competence in child welfare: What is it? How do we achieve it? What happens without it? *Child Welfare, 76,* 255–278.
Mokuau, N. (1990). The impoverishment of Native Hawaiians and the social work challenge. *Health & Social Work, 15,* 235–242.
Mokuau, N., & Matsuoka, J. (1995). Turbulance among a native people: Social work practice with Hawaiians. *Social Work, 40,* 465–472.
Native Hawaiian Health Care Improvement Act of 1988, P.L. 100-579, 102 Stat. 2916.
Nishihara, D. P. (1978). Culture, counseling, and Ho'oponopono: An ancient model in a modern context. *Personnel and Guidance Journal, 56,* 562–566.
Norton, D. G. (1993). Diversity, early socialization, and temporal development: The dual perspective revisited. *Social Work, 38,* 82–90.
Pedersen, P. B. (1997). *Culture-centered counseling interventions: Striving for accuracy.* Thousand Oaks, CA: Sage Publications.
Pierce, R. L., & Pierce, L. H. (1996). Moving toward cultural competence in the child welfare system. *Children and Youth Review, 18,* 713–731.
Pukui, M. K., Haertig, E. W., & Lee, C. A. (1972). *Nana I Ke Kumu (Look to the source)* (Vol. 1). Honolulu: Hui Hanai.
Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work, 41,* 296–305.
Shook, E. V. (1985). *Ho'oponopono: Contemporary uses of a Hawaiian problem-solving process.* Honolulu: University of Hawaii Press.
Smith, K. (1981). Observations on Morita therapy and culture-specific interpretations. *Journal of Transpersonal Psychology, 13,* 59–69.
Smith, L. S. (1998). Concept analysis: Cultural competence. *Journal of Cultural Diversity, 5*(1), 4–10.
Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., LaFromboise, T., Manese, J. E., Ponterotto, J. G., & Vazquez-Nutall, E. (Eds.).(1998). *Multicultural counseling compentencies: Individual and organizational development.* Thousand Oaks, CA: Sage Publications.
Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42,* 37–45.
Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9,* 117–125.
University of Hawaii, John A. Burns School of Medicine. (1994, June 18). *Native Hawaiian health briefing paper.* Honolulu: Author.
Voss, R. W., Douville, V., Little Soldier, A., & Twiss, G. (1999). Tribal and shamanic-based social work practice: A Lakota perspective. *Social Work, 44,* 228–241.
Weaver, H. N. (1999). Indigenous people and the social work profession: Defining culturally competent services. *Social Work, 44,* 217–225.
Zuniga, M. E. (1992). Using metaphors in therapy: Dichos and Latino clients. *Social Work, 37,* 55–60.

Donna E. Hurdle, PhD, ACSW, *is assistant professor, School of Social Work, Arizona State University, P.O. Box 871802, Tempe, AZ 85287-1802; e-mail: donna.hurdle@asu.edu.*

Original manuscript received September 18, 1998
Final revision received November 29, 1999
Accepted December 10, 1999