



Michael Aakhus. *Tulum*. Mixed media on panel, 36" × 48".
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Ho`oponopono, a relational process that integrates spiritual beliefs and support, may be a promising means for reducing the negative impact of breast cancer among Native Hawaiians.

Training Community Practitioners in a Research Intervention: Practice Examples at the Intersection of Cancer, Western Science, and Native Hawaiian Healing

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This practice paper describes the preintervention training component of a feasibility study exploring the use of ho`oponopono, an indigenous Hawaiian healing practice, for enhancing psychosocial adaptation to breast cancer among Native Hawaiian women. Practitioners' adherence to research protocols and competence in intervention delivery are both regarded as essential to obtaining valid results in tests of intervention feasibility and efficacy; thus, training in this study dually focused on fortification of adherence and enhancing competence among those recruited to deliver the ho`oponopono intervention.

A manual-based training, using adult pedagogical strategies infused with Native Hawaiian cultural practices, was delivered to community practitioners. Effects of the training on practitioners' knowledge and skills were evaluated through multiple methods. Knowledge significantly increased between pre- and post-intervention assessment. However, knowledge application for some practitioners was hindered by skill deficits, stylistic differences, and cultural conflict.

Ongoing attention to competence and adherence is indicated. In-service training may bolster competence; however, practitioners may have difficulty in adhering to protocols for different reasons, and individualized clinical supervision and cultural consultation may be helpful in some situations.

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Overview

Development of culturally informed, evidence-based care is acknowledged as important in improving the quality of life experienced by cancer patients in the multiculturally diverse landscape of the 21st century and may be especially crucial in culturally distinct, native and ethnic minority communities that persistently bear the burden of this disease.^{1,3} Cancer, particularly breast cancer, is a significant health issue in the Native Hawaiian community^{3,8} and *Na Lei Pulama* (NLP), which means “cherish our beloved ones,” is a study that explores the feasibility of using *ho`oponopono*, a traditional Hawaiian healing practice to enhance adjustment and adaptation among Native Hawaiian women diagnosed with breast cancer and their families (National Cancer Institute, Special Populations Network, U01 CA86105, L.S. Ka`opua, Principal Investigator [PI]). Conceptually informed by McCubbin et al⁹ in *Resiliency in Ethnic Minority Families: Native and Immigrant American Families*, NLP proceeds from the premise that families in stressful conditions, such as those that may ensue after a cancer diagnosis, can benefit from new or enhanced relational processes incorporating customary or familiar beliefs and practices. Prior research on Native Hawaiian cancer survivorship suggests that coping is enhanced by practices involving spiritual beliefs and support from the family collective.^{6,7} By definition, *ho`oponopono*, a relational process, integrates both of these elements^{10,14} and may be a promising means for reducing the negative impact of breast cancer among Native Hawaiians.

This paper focuses on the training of a small group of experienced community practitioners recruited to deliver a psycho-educational intervention that uses and teaches *ho`oponopono* to breast cancer patients and families. Practitioners' adherence to research protocols and competence in intervention delivery are both regarded as essential to obtaining valid results in tests of intervention feasibility and efficacy^{15,17}; thus, training in this study dually focused on fortifying adherence and enhancing competence among those recruited to deliver the *ho`oponopono* intervention. As defined in prior intervention research, practitioners' adherence refers to the capacity to deliver the intervention, as specified in the research protocols and to the exclusion of other non-specified therapeutic procedures or methods; competence refers to skill in delivering the intervention and includes relevant knowledge.^{15,16} Although the competence and adherence by practitioners are optimally evaluated through different means, these constructs are conceptually related and for the most part may be fortified through similar training activities.¹⁷ Attention to competence and adherence is important

throughout the implementation phase of a study and optimally is institutionalized from the study's onset, beginning with preintervention training.^{15,17} NLP's preintervention training objectives, strategies, and activities included attention to both.

This study's definition of competence also included cultural competence, or the capacity to initiate and sustain productive therapeutic relationships through the use of interventions tailored to be congruent with family and group values and practices.^{10,11,18} Learning strategies and activities that reflected integrity and respect for both Western science and traditional Native Hawaiian culture and healing were identified and used. Subsequent sections highlight relevant literature and describe the methods used to design and deliver training. Illustrations from *Na Lei Pulama*'s training and relevant evaluation findings are presented. Practice specific to preintervention training with and for Native Hawaiians is discussed. Although this paper is specific to training in a traditional Native Hawaiian practice, issues raised may provide considerations for training community practitioners in research at the intersection of cancer, Western science, and indigenous practices.

Background and Significance

Native Hawaiians and Breast Cancer

Breast cancer takes a disproportionate toll on Native Hawaiian women. In Hawai'i, this group has the second highest incidence of breast cancer and the highest rate of incidence to mortality, even after controlling for stage of diagnosis, geographic residence, and marital, menopausal, and socioeconomic statuses.^{4,5,8} Once treated, Native Hawaiians have the lowest 5-year survival rates of any other ethnic group in the state.^{4,5} Disease burden in this population is associated with patterns of low utilization of health services and is understood by some Native Hawaiian health researchers to be at least partially the result of cultural conflict experienced in accessing conventional Western health care.^{4,6,8} The Cancer Awareness Strategic Plan for Native Hawaiian Communities underscores the urgent need for empirically tested interventions aimed at enhancing quality of life in ways that incorporate the group's cultural strengths, including coping through reliance on spirituality and the family collective.⁶

Traditional Culture, Historical Denigration, Ho`oponopono

Contemporary Native Hawaiians, including full and part Hawaiians, are descendants of the Polynesian

voyagers who settled the Hawaiian archipelago and established a thriving social system that was guided by a paradigm of holistic health known as *ola pono*.^{14,19,21} From within this paradigm, health is a function of harmony in the three interrelated domains: the physical world, social relations, and spiritual life. This triad of relations is reflected in native healing practices. *Ho`oponopono* was traditionally practiced as part of an integrated system that viewed illness (*ma`i*) of an individual as an imbalance in or more of the key realms; healing involved making relationships right, or *ho`oponopono*.¹⁹ Traditionally used as a complement to herbal treatments, the process of *ho`oponopono* was a means to identify and resolve spiritual or interpersonal conflicts and concerns that might interfere with treatment of a patient's physical ailments and it was also believed to facilitate assurance that herbal treatments go straight to the mark (*i kaukahi ka la`au*).²¹

The health status of indigenous Hawaiians rapidly deteriorated upon contact with the West in 1778 due to foreign diseases, profound socioeconomic upheaval, and the imposition of colonial laws that denigrated and forbade use of native healing.^{11,19,20} Native healing, including *ho`oponopono*, was a target of derision, and all practices were sharply limited in the clash between the traditional ways of Native Hawaiians and Western colonizers.^{11,20} Fundamental differences in the Western biomedical paradigm, which was grounded in scientific materialism with its inherent disavowal of the metaphysical and the individual-oriented practice of Western allopathic medicine, collided with the traditional Hawaiian viewpoint (*emic*) of holistic health, which was grounded in spirituality and the more collectivist orientation of native healing.^{11,19,20} In the 19th century, pervasive discrediting of native medicine and colonial sanctions against its practice contributed to the development of "underground" networks of indigenous healers who perpetuated the ancient ways in remote, rural areas.^{11,19,22} Native Hawaiians who preferred a more holistic approach to healing continued to seek assistance from native healers, albeit discreetly. The necessarily secret practice of native medicine in the culturally intolerant atmosphere of the 19th and early 20th centuries has resulted in contemporary Hawaiians' subsequent lack of familiarity and even misunderstanding of what *ho`oponopono* involves.^{11,19,20} To some extent, practitioners recruited and trained to deliver the NLP intervention exemplified this phenomenon and varied considerably in their understanding and experience with *ho`oponopono*. This complicated the challenge of achieving adherence and competence in the research intervention and necessitated clear specification and consistent reinforcement of protocols, as well as system-

atic attention to the development of relevant knowledge and skills.

Kupuna Pukui's Style of Ho`oponopono

The type of *ho`oponopono* used in NLP originated from a remote, culturally intact enclave of the island of Hawai`i and was promoted by Mary Kawena Pukui, a native of the area and a prominent Hawaiian scholar.^{14,21} In the 1970s, the onset of the Hawaiian cultural renaissance, *Kupuna* (elder) Pukui taught *ho`oponopono* to personnel of a Hawaiian family services agency as part of an effort to identify interventions that incorporated the strengths of native culture.¹¹⁻¹⁴ This style of *ho`oponopono* was tested for feasibility with contemporary Hawaiian families¹³ and subsequently promoted by that agency as a means of assisting Native Hawaiians to adapt positively to stressful situations.¹²⁻¹⁴ Although there are a number of variations of *ho`oponopono*, *Kupuna Pukui's* "style" is the most clearly specified and thus was chosen as the basis of NLP's intervention.

In the modern idiom, *ho`oponopono* has been compared with Western modalities of family problem solving and conflict resolution.^{11,12,14} However, *ho`oponopono*, as taught by Pukui and her students, reflects the Hawaiian paradigm of holistic health (*ola pono*) and thus, unlike most types of conventional Western family therapy, is inherently spiritual.¹² Prayer (*pule*) is offered at the beginning (*pule wehe*) and ending (*pule ho`opau, pule pani*) of the process, as well as at times of impasse or particular challenge. Another fundamental difference relates to the role of the leader (*haku ho`oponopono*) who is responsible for directing all discussion (ie, family members speak only to the leader and interact with each other only at the leader's direction) and for maintaining a spiritual atmosphere (ie, the leader's capacity to invoke a spiritual presence is understood to facilitate the family's ability to use their own spiritual resources as difficulties arise).¹¹⁻¹⁴

The overall process includes four distinct phases, each with a set of procedures.¹²⁻¹⁴ The first phase is aimed at foundation building (*kukulu kumumana*) and includes procedures for discussing sensitive subjects, establishing an alliance with the family, assisting members to pool their collective spiritual strengths, and identifying issues of concern. The second phase is aimed at understanding the meaning of an event to an individual and to the family collective. This phase is characterized by "peeling back the layers" (*mahi-ki*) of a problem, conflict, or concern. In this phase, discussion focuses on one concern (layer) at a time and progresses toward obtaining deep and detailed meaning. Through leader-directed discussion, mem-

bers share their hurt (*hala*) and resentments (*ho`omauhala*), and the web of emotions and actions surrounding their hurt (*hihia*) are disentangled. Time out (*ho`omalū*) is intermittently used for introspection and meditation. The third phase focuses on resolution of concerns and involves taking responsibility for one's part in a problem, seeking forgiveness and making amends (*mihī*), releasing hurt, resentment, and other negative emotions (*kala*), and finally, severing from the hurt of the past with the concomitant agreement to move forward (*oki*). The fourth phase involves closure of discussion (*panina*) and includes prayers of completion and closure (*pule ho`opau*, *pule pani*, respectively) and celebration (*pa`ina*) of family unity through sharing a meal and possibly music. As traditionally conducted, the *ho`oponopono* permitted family members to disclose and discuss the personal impact of an illness or other event on everyday life, to clarify needs for support, and to resolve problems within the collective. Notably, when conducted on a regular basis, the *ho`oponopono* was believed to avert family crisis and thus was a means for problem prevention and promotion of family well being.^{12,14}

Training Theories

Ho`oponopono, as taught by *Kupuna* Pukui and her followers, involves several phases, each with a set of sequential procedures. The PI anticipated that community practitioners unfamiliar with this type of *ho`oponopono* might be daunted by its seeming complexity. Furthermore, since few of the practitioners had prior experience in delivery of a research intervention, it was expected that some might find it challenging to adhere to the intervention, as specified in the protocols. Proceeding from these premises, three pedagogical or training theories were identified to guide NLP's preintervention training: self-efficacy,²³ diffusion,²⁴ and adult learning.²⁵

Self-efficacy theory assumes that confidence, or perception of a task as doable, is the most important precondition for performing a desired behavior or for changing an ingrained one. Self-efficacy is associated with the perception that a behavior (ie, conducting *ho`oponopono*, elucidating its procedures to families) can be facilitated by training that partitions complex behavior or processes into smaller units, allows for practice of each unit, and reinforces successive approximation through constructive feedback.

Diffusion theory focuses on the differential ways in which new ideas are communicated or diffused and then adopted by a group or community. It presumes that individual members of a group accept and adopt new behaviors at different times and through different means. Early adopters tend to

make decisions based on rational thinking and are likely responsive to training messages that logically present the rationale, benefits, and evidence for adopting a new behavior. In turn, early adopters serve as role models, and through social interaction they influence the acceptance of a new behavior or process by other group members.

Adult learning theory posits that adults integrate new information into the base of their life experiences and are motivated to learn when information is portable, action oriented, and perceived to be relevant to real-life situations. Thus, adult learners are responsive to training that includes case-based situations. The lecture is used parsimoniously to transmit essential knowledge, and more experiential exercises (eg, role playing, demonstration, discussion) are emphasized. Learning is viewed as a transactional process, and opportunities for continuous feedback are built into the training and dynamically inform *in vivo* training.

Methods

Recruitment and Training of Community Practitioners

Initial recruitment efforts proceeded through a network of practitioners previously trained by NLP's project elder, *Kupuna* Malia Craver, a former student of the late *Kupuna* Pukui and a prominent cultural authority. Although the PI intended to recruit practitioners exclusively from the network of those trained by *Kupuna* Craver, this was not possible. The situation was corrected by asking practitioners from this network to identify others who were familiar with *ho`oponopono* through either their own family experience or academic study. All interested practitioners were interviewed and given information about the study by the PI, a licensed social worker with training in *ho`oponopono*. Practitioners were selected to participate in the preintervention training based on five criteria: (1) experience in working with Native Hawaiian families, (2) knowledge, training, and/or experience in *ho`oponopono*, (3) comfort with delivery of a spiritually grounded method that uses prayer, (4) openness to participation in a research intervention, and (5) availability to attend a 16-hour preintervention training. Eleven individuals, eight of whom were of Hawaiian ancestry, attended the first of a two-part training. Only one individual did not complete the full training. This individual, a Native Hawaiian, explained that family elders declined to give their approval to participate on the grounds that she was not designated within her family system to assume the status of leader (*haku*). The

final group of 10 practitioners was composed primarily of women (n = 9). They tended to be highly educated, with more than half holding masters or doctoral degrees in a health/mental health profession (n = 6). Practitioners ranged in age from 30-61 years, with a mean age of 50 years. All 10 practitioners completing the preintervention training had directly worked in a healing/helping capacity with Native Hawaiian families. Other relevant experience included the following: 3 were members of a family that practices *ho`oponopono*, 3 had completed prior training in Kupuna Pukui's style of *ho`oponopono*, 3 noted that their family prays together.

Training Procedures

Manual of Intervention Procedures: The essential components of Kupuna Pukui's *ho`oponopono* were identified through a review of *ho`oponopono* relevant documents and a consensus-building process that included NLP staff (PI, project coordinator, graduate student interns), the NLP project elder (*kupuna*), experienced *ho`oponopono* leaders (*haku*), two elders associated with the Native Hawaiian Health Care System, and selected members of the culture, scientific, and community advisory councils of *Imi Hale*, the Native Hawaiian Cancer Awareness, Research, and Training Project. (The identified components are presented in the section titled *Kupuna Pukui's Style of Ho`oponopono*.) The components of *ho`oponopono* were explicated in a special section of the manual developed by expert *ho`oponopono* leader Stephanie Bell, MSW, DCSW,²⁶ and were included in a manual of intervention procedures intended for use by instructional faculty in the preintervention training, as well as by those who would later deliver and supervise the intervention. Contents of the manual also included an overview of the research intervention, procedures and checklists for maintaining and monitoring fidelity or adherence to the intervention, procedures and materials for conducting and teaching *ho`oponopono* to Native Hawaiian families, emergency protocols for handling unexpected and/or adverse situations, relevant cultural information, selected journal articles on the psychosocial/spiritual impact of cancer on families, and national and local cancer-related resources. The manual was organized by topic, indexed, and ordered to conform to the training agenda. Additionally, NLP staff tailored the peripheral elements (fonts, graphics, colors) of the manual to reflect Native Hawaiian culture and the *ho`oponopono*.²⁷ For example, the cover of the manual included an opening prayer (*pule wehe*), such as might be used in the *ho`oponopono*. This prayer was encircled by a

flower garland (*lei*) and intended not only to communicate welcome, but also to reflect the name of the project, *Na Lei Pulama*.

Preintervention Training: Prior to the delivery of training, the PI met with Kupuna Craver, the project elder, as well as other cultural consultants, and two expert *ho`oponopono* leaders (*haku*) who agreed to provide preintervention training. This group reviewed and approved the training goals, objectives, substantive content, and learning activities. The project elder approved the fitness of individual members of the training team to deliver the preintervention training. The team included the PI and two expert *ho`oponopono* leaders, all of whom agreed to the following overall goals and broad learning objectives. Goal 1 was to increase the competence of the practitioners in intervention delivery by (a) presenting information on the overall process of *ho`oponopono* as well as its specific phases, (b) providing activities related to increasing skill in carrying out *ho`oponopono* procedures, and (c) presenting opportunities for consultation and group networking. Goal 2 was to fortify practitioners' intent to adhere to the treatment protocols by (a) presenting information on NLP as a research intervention and information and tools for use in practitioners' adherence, (b) offering activities that increase practitioners' awareness of when nonspecified therapeutic procedures are used, (c) providing guidelines and scenarios for increasing knowledge and skill in tailoring the intervention within the parameters of the intervention, and (d) providing knowledge and activities that familiarize use of emergency protocols. Goal 3 was to increase competence in delivery of the intervention to Native Hawaiian families in the context of breast cancer diagnosis and treatment by (a) providing knowledge of breast cancer, treatment, and psychosocial and spiritual issues and (b) providing knowledge and activities that enhance use of culturally appropriate entry etiquette and other social practices for use in forming productive alliances with Hawaiian families. Trainers also agreed to follow a format that included didactic presentation (eg, lecture, PowerPoint presentation, interactive discussion), modeling, and case application with practice, feedback, and discussion. Although the project elder was unable to attend the preintervention training, she maintained regular contact (ie, face-to-face meeting, electronic and telephone communication) with the PI throughout the duration of the training. This ensured that the training delivered was appropriate, accurate, and reflective of the integrity of the traditional process.

Training logistics were coordinated by NLP staff. A 16-hour training was delivered in two Saturday sessions held during October 2002 and conducted in a

large conference room at the CRCH-UH. To create a welcoming and culturally appropriate environment, staff decorated the training room with Hawaiian artifacts and plants, played Hawaiian music prior to training, and arranged chairs and tables to encourage group interaction.

Both training sessions opened and concluded with group prayer (*pule*) and familiar Hawaiian spiritual songs (*himeni*). On the first training day, practitioners were invited to participate in an “icebreaker” based on the traditional practice of naming (ie, to name is to invoke intent and often reveals significant information about an individual in the context of their family). The substantive emphasis of training was on developing knowledge and skill in *ho`oponopono* and on conducting the intervention, as specified. The importance of practitioner adherence, or fidelity, was highlighted in the project overview delivered by the PI. Other members of the training team reinforced the need for practitioner adherence in subsequent training units and thus functioned as early adopters of the research intervention. The *ho`oponopono* process was presented in a brief lecture and followed by sequential units that detailed specific procedures within each of the major phases of the *ho`oponopono*: foundation building (*kukulu kumuhanā*), discussion of concerns (*mahiki*), resolution of concerns (*mihi/kala*), and closure of discussion (*panina*). Prayer (*pule*), a central element of the *ho`oponopono* used across all phases, constituted a specific training unit. On the second day, training focused on breast cancer, treatment, relevant psychosocial/ spiritual issues, use of community resources, and continued practice application. Professional staff of the Cancer Information Services, CRCH-UH, provided not only an overview of the disease and its treatment, but also practice in using the National Cancer Institute’s information telephone service. Another notable offering included personal testimony by a Native Hawaiian breast cancer survivor. To enhance camaraderie and project team building, all speakers, trainers, and practitioners shared a potluck lunch on both days of training and joined together to make music (*ho`okani pila*) through singing and playing of stringed instruments (*ukulele*).

Evaluation: Pre- and post-test evaluations were administered at the beginning of the first day of training and at the end of the fourth day. Ten knowledge-related items were included: three about *ho`oponopono*, four about intervention protocols, and three about practitioner adherence. Capacity to conduct *ho`oponopono* procedures as specified and the perceived comfort in delivering the intervention were assessed through process discussion that was summarized in NLP’s project log. All results from

written evaluations, process discussions, and direct observation of practice simulations were reviewed to improve subsequent training and implementation of the intervention.

Training Example: Hawaiian Spirituality and Prayer

In this unit, trainer Earl Kawa`a, MSW, provided an overview in a short lecture, followed by more-detailed information presented through an interactive discussion patterned on the “talk story” (conversation-like) practice familiar to longtime residents of Hawai`i.²⁸ Through lecture and talk story discussion, Hawaiian spirituality and prayer (*pule*) were explicated and demonstrated. It was explained that prayer is used extensively by the leader (*haku ho`oponopono*) throughout all phases of the process and is purposefully said aloud in the family to create an atmosphere of sincere communication, to enable family members to focus on resolving concerns, and to call on the Higher Power(s) to assist the family in consolidating their spiritual, emotional, and mental resources.¹²⁻¹⁴ According to Kawa`a, prayer in the *ho`oponopono* reflects the more general use of prayer in the Hawaiian culture and, as elucidated in *Lau Kukui, a Hawaiian Primer/Reader*,²⁹ has four parts: a formal opening and acknowledgment (*kahea`ana*) of Higher Power(s) (*Akua*), glorification or praise and acknowledgment (*ho`omaika`i ana*), statement of purpose and request (*kumumana`o, ho`opomaika`i ana*), and closing (*panina*) with an affirmation of spiritual beliefs.

The trainer acknowledged that prayer is generally a private and personal practice and that the family or group prayer used in *ho`oponopono* may be less familiar. However, it was emphasized that personal prayer may serve as a building block for prayer in the *ho`oponopono*. Practitioners in the training were asked who prayed prior to coming to training, and those who responded in the affirmative were asked what they said in opening their prayer. Responses were summarized and examples offered from the trainer’s own experience said in both the English and Hawaiian languages. Practitioners noted the poetic nature of the Hawaiian language, cultural references to elders, the multigenerational family composed of those both living and deceased, and sense of place imbued with spirituality. Each of the three other parts of the Hawaiian prayer was similarly discussed. A capstone activity was orchestrated that included four practitioners, each of whom was asked to say one of the four parts of the Hawaiian prayer. Practical applications were discussed. Practitioners were given the homework of writing a prayer suitable for sharing in the second training ses-

sion, and they were encouraged to compose several prayers that might be used as templates in the various *ho`oponopono* phases.

Evaluation Results

Results of the paired-samples *t* test (two-tailed) analysis indicated that knowledge increased significantly between preintervention baseline and posttraining evaluation, $t(9) = 17.897, P < .001$. Individual scores increased by an average of 5½ points. At posttraining, all 10 practitioners in the final training group were able to correctly define adherence and could name the essential components of the *ho`oponopono* intervention, as specified. Despite knowledge gains, 80% of practitioners reported that they experienced some kind of difficulty in application ($n = 8$). Process discussion revealed difficulties in specific procedures of the problem resolution phase ($n = 3$), in seeing themselves as credible leaders, or *haku* ($n = 3$) because of either age (“too young”), lack of cultural knowledge, or non-Hawaiian ethnicity, and in reconciling stylistic differences related to prior mental health professional training ($n = 2$). Practitioners and trainers stated that identified difficulties could be addressed through additional practice and supervision.

Discussion and Practice Implications

There are several limitations in using results of the evaluation to direct practice with other groups. First, the small number of practitioners who participated in NLP’s training were primarily identified through a specific *ho`oponopono* network, and social desirability may have influenced their participation as well as the nature and extent of information disclosed. The training group was largely composed of university-educated individuals, and this likely biased participation in favor of those more open to testing a traditional healing practice using methods of Western scientific empiricism. Nonetheless, practitioners in the training group faced several challenges that bear exploration for their potential value to guide NLP’s future training, supervision, and monitoring of intervention competence and adherence.

Approximately one third of practitioners identified difficulty in applying specific procedures from the intervention’s problem resolution phase, even though their knowledge of the procedures was adequately demonstrated in the evaluation. Although this training unit was formatted in the usual way, included practice, and was designated the same amount of training time as other units, it is possible that some

phases like this one are simply more complicated than others and thus require longer training units. For these practitioners, additional case-based practice is indicated to ensure competence prior to intervention. This might include skill building in phase-specific procedures, followed by practice that integrates this phase with the whole process. Monitoring competence once practitioners begin to see families is also indicated, and clinical supervision as well as consultation may help to ensure competence, as suggested in other family intervention research.¹⁵⁻¹⁷

Another one third of the training group was concerned that families might not accept them as credible *ho`oponopono* leaders. Practitioner credibility is a legitimate concern in the delivery of an intervention using a traditional practice like *ho`oponopono*. It is unclear how families will respond to a leader who is either non-Native Hawaiian or youthful in appearance (ie, older age is generally accorded with authority in traditional Hawaiian culture). These are important issues to explore in the pilot intervention. Through clinical supervision and consultation with the project elder and other cultural experts, these practitioners may be able to identify culturally appropriate means for exploring these issues during the foundation building phase of the *ho`oponopono*.

Lack of cultural knowledge was also identified as a source of discomfort. At a practical level this may be addressed through additional study; however, deeper exploration of this concern is indicated. It is possible that this practitioner needed to secure the “blessing” of family and cultural authorities (ie, project elder, expert *ho`oponopono* leaders) in order to transition to the role of *ho`oponopono* leader. As previously noted, the project elder was unable to participate in the delivery of preintervention training and this may have impeded practitioners’ sense of credibility and readiness to assume *ho`oponopono* leadership status. Stylistic differences were a source of difficulty for two practitioners, both of whom shared a common grounding in conventional, Western mental health modalities. These practitioners had difficulty with the degree to which the *ho`oponopono* leader (*haku*) directs discussion, and they favored more “facilitative” (vis a vis directive and authoritative) leadership and approaches believed to allow more dynamic family interaction. In other studies, adherence is potentially threatened by practitioner’s clinical belief systems that are dissonant with those of the intervention research, and it is suggested that these be directly addressed.¹⁶ While challenged by stylistic differences, process discussion ascertained that these practitioners were motivated to conduct the intervention as specified. Practitioners with more defined styles of work and clear ideas about how to handle complex family sit-

uations may need time to selectively alter customary responses and replace them with new ones.

As the feasibility of *ho`oponopono* is tested for use with cancer patients and their families, critical next steps to fortifying adherence and competence will necessarily involve monitoring not only the issues raised by practitioners in the posttraining evaluation, but also other issues that emerge during the implementation phase. Clinical supervision and cultural consultation will proceed from a review of progress notes entered into participants' charts, from project checklists identifying practitioners' use of specified *ho`oponopono* procedures, and from elicitation of feedback on the ways in which patients and families respond to the intervention and ultimately adjust and adapt to cancer diagnosis and treatment. Difficulties, challenges, and successes in applying procedures to specific case situations will be discussed in a supportive climate that optimally allows practitioners to honestly explore and satisfactorily resolve challenges that arise in the course of the intervention.

This training was part of a pilot study that tests the feasibility of an indigenous healing method to enhance psychosocial adaptation to breast cancer among native women and their families. Training provided an opportunity to lay a foundation for practitioners' competence and adherence in delivery of the research intervention. Attention to adherence and competence in subsequent implementation of the research intervention is strongly recommended. While group training may be an efficient means to address practitioners' skills in delivering the research intervention, practitioners may be differentially challenged to adhere to protocols, indicating that individualized clinical supervision and cultural consultation may be helpful. Research intervention at the intersection of cancer, Western science, and native healing requires incorporation of both traditional values and contemporary Western mores. The training for practitioners and implementation of the intervention also need to incorporate such values.

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