The Roles of Family Obligation and Parenting Practices in Explaining the Well-Being of Native Hawaiian Adolescents Living in Poverty

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This study examines parenting practices and adolescents' sense of family obligation in promoting resilience in 155 Native Hawaiian youths living in poverty. Two aspects of adolescent well-being, behavioral adjustment and physical health, were studied. Four variables—supportive parenting, punishment, youth respect, and youth support—predicted the likelihood of youths' engagement in internalizing/externalizing problem behaviors and youths' general health status after family demographics, family history of psychosocial risk, and chronic medical conditions were controlled. Results suggest that parenting practices and youths' values of family obligation were significant correlates of youths' behavioral adjustment and well-being. Greater attention should therefore be paid to the protective function of Native Hawaiian families and development of positive family value systems in Native Hawaiian youths.

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Many Native Hawaiian (NH)[1] youths face challenges and obstacles on the path to successful adulthood. As children, they perform more poorly in school than do non-Hawaiians, as evidenced by lower standardized test scores and over-representation in special education programs (Kana'iaupuni & Ishibashi, 2003). As teens, NH youths are more likely to engage in risk behaviors such as antisocial activities, drug use, and early sexual intercourse, and are less likely to graduate from high school (Kana'iaupuni & Ishibashi, 2003; Lai & Saka, 2000; Pearson, 2004). Later in life, NH adults are overrepresented among those who are arrested or incarcerated (Gao & Perrone, 2004; Marsella, Oliveira, Plummer, & Crabbe, 1995; Yuen, Hu, & Engel, 2005). Native Hawaiians face health disparities as well. They display the highest rates of certain chronic health conditions such as obesity, diabetes, asthma, and high blood pressure, and have the shortest life expectancy of all ethnic groups in the state of Hawai'i (Hawai'i Department of Health, 2004; Marsella et al., 1995). All of the negative outcomes mentioned above are also associated with poverty (Center on Budget and Policy Priorities, 2000; Duncan & Brooks-Gunn, 2000; Moore & Redd, 2002). By whatever indicator is used—income, homelessness, welfare assistance, or children receiving free or reduced school lunches—Native Hawaiians are disproportionately found among the poor (Aloha United Way, 2005; Harris & Jones, 2005; Stern, Yuen, & Hartsock, 2004).

To date, much of the research on the NH population has been descriptive, with a focus on documenting negative health and social conditions. There is a need for additional research that documents positive outcomes as well as vulnerabilities. Both policymakers and the general public need to remember that there is considerable variation in well-being across different members of the NH community, with most individuals and families showing healthy outcomes. Most important, there is a need to better understand the factors and processes that contribute to strength and resiliency among the more vulnerable Native Hawaiians.

Some researchers point to the family as the starting point for understanding the developmental trajectories of Native Hawaiians (Kana'iaupuni, 2004; Stern et al., 2004). The cultural value of commitment to the *'ohana* (family) continues to be held among contemporary Hawaiians and is an essential component of NH identity (Kana'iaupuni, 2004). Native Hawaiians tend to exhibit greater family-centered characteristics than do non-Hawaiians. For example, Native Hawaiians are more likely to live in multigenerational households, NH children have more contact with grandparents and other kin, and extended family members play a larger role in child rearing as compared with other ethnic groups in Hawai'i (Goebert et al., 2000; Stern et al., 2004). NH adolescents report higher levels of

emotional support and closer relationships with family members (Goebert et al., 2000), and NH families are more likely to regularly engage in cultural practices (Stern et al., 2004). In this article, we examine the family as a source of strength for NH adolescents living under the risk condition of poverty. Two aspects of the family context are considered: parenting practices and the adolescent's sense of obligation to his or her 'ohana.

Poverty and Parenting

Poverty is consistently associated with problems in child health, socioemotional adjustment, and school achievement, including problems such as low birth weight, disability, chronic asthma, internalizing and externalizing problem behaviors, grade retention, and school dropout (Duncan & Brooks-Gunn, 2000; Moore & Redd, 2002). Although the deleterious effects of poverty are certainly multicausal in nature, one contributing mechanism operates via the family environment. The *family stress model* posits that chronic financial pressure can disrupt the positive family processes that promote children's healthy psychosocial development (Conger & Elder, 1994; Duncan & Brooks-Gunn, 2000; McLoyd, 1990). The anxiety and distress experienced by financially stressed parents can make them become less affectionate, less supportive, and less involved with their children and more likely to use inconsistent, harsh, or explosive discipline. However, financially stressed parents who are able to maintain a stable, loving, and stimulating home environment may help their children overcome at least some of the environmental disadvantages associated with chronic economic hardship.

The family stress model has been applied across several populations (e.g., displaced workers, small farm families, urban and rural poor), certain ethnic groups (Caucasian, African American, Mexican American), and even historical periods (e.g., contemporary, the depression era; see Brody et al., 1994; Conger & Elder, 1994; Elder, 1974; Liem & Liem, 1988; McLoyd, 1990; McLoyd, Jayratne, Ceballo, & Borquez, 1994; Mistry, Vandewater, Huston, & McLoyd, 2002; Parke et al., 2004). However, it has not been applied to Native Hawaiians, a population that is neglected in studies of family poverty.

Parenting Practices and Healthy Youth Development

There is a large literature that highlights the importance of parent–child relations and the effects of child-rearing practices on children's psychosocial adjustment (Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Maccoby & Martin, 1983; Parker & Benson, 2004; Patterson, Reid, & Dishion, 1992; Steinberg, Mounts, Lamborn, & Dornbusch, 1991). Within this literature, much attention has been paid to the construct of authoritative parenting. This parenting style is characterized by high warmth and involvement with the child, coupled with firm but reasonable control, as seen in clear rules and standards for behavior and the use of reason-oriented discipline. Authoritative parenting is widely found to enhance a variety of positive child outcomes, such as self-esteem, avoidance of risk behavior, social skills, and academic achievement.

To our knowledge, the construct of authoritative parenting has not been studied in NH families. Ethnographic work suggests that NH parents are affectionate and indulgent with infants but less demonstrative toward older children (Howard, 1974). Compared with parents from other ethnic backgrounds (particularly Caucasian parents), NH parents may engage in less explicit teaching and instead use more indirect methods of shaping their children's behavior. NH parents may be reluctant to use praise or material rewards for fear of establishing in their children a dependence on external incentives (Howard, 1974). In addition, because social sensitivity is highly valued, NH adults may expect children to read social cues and attend to the needs of others without prompting or acknowledgment (Shook, 1985, cited in Yee, Huang, & Lew, 1998). There is also a lack of information about discipline practices in NH families. Although cultural historians suggest that severe punishment was not part of traditional Pacific child rearing (Korbin, 1990; Morton, 1996), NH children are overrepresented among the ranks of confirmed child abuse cases in Hawai'i (Marsella et al., 1995).

Even less is known about the ways in which parenting in NH families influences children's development. One study (Goebert et al., 2000) found that NH adolescents who reported high levels of support from their families showed reduced risk for internalizing symptoms such as depressed mood. Another study using a

mixed sample of Asian Americans/Native Hawaiians found positive associations between authoritative parenting and youth behavioral adjustment (DeBaryshe, Yuen, & Stern, 2001). Clearly, there is a need for research that demonstrates the mechanisms through which NH families contribute to their children's healthy development.

Family Obligation

Family obligation is a construct that includes both behaviors and attitudes that indicate an adolescent has a strong sense of emotional bonding, duty, and mutual responsibility with his or her extended family. Indicators of family obligation include putting the good of the family first, showing respect for and seeking the advice of older family members, spending time in family activities, providing instrumental assistance to other family members, and maintaining emotional ties with parents across the life span (Chao & Tseng, 2002; Fuligni, Tseng, & Lam, 1999; Phinney, Ong, & Madden, 2000). Family obligation has been studied most extensively in immigrant families. However, the construct is relevant to NH families, for whom personal identity is embedded in the matrix of extended family relationships (Blaisdell & Mokuau, 1991; Mokuau & Chang, 1991).

Research on Asian and Latino immigrants suggests that family obligation is positively associated with feelings of closeness with one's parents in adolescence and with psychological well-being in early adulthood (Fuligni et al., 1999; Fuligni, Yip, & Tseng, 2002). It also appears to play a central role in motivating young people, especially lower achieving youths, to pursue a college education (Fuligni, 2001). It has been suggested that youths who value family obligation will avoid engaging in risk behaviors (DeBaryshe et al., 2001).

The Present Study

The purpose of this study is to determine whether parenting practices and youths' sense of family obligation contribute to the well-being of at-risk NH youths. In this case, the at-risk condition was economic deprivation. We looked at two aspects of adolescent well-being, namely, behavioral adjustment and physical health. These outcomes are important as NH youths show high rates of risk behavior and face an elevated likelihood of chronic health problems in adulthood. Unlike many other studies of NH youths, we collected information on family processes and youth well-being from the perspective of multiple family members, thus avoiding the potential reporting bias associated with the use of only youths' self-reports.

Method

Participants

Participants were 155 low-income Native Hawaiian families living on the island of O'ahu. All families received needs-based financial assistance, that is, Temporary Assistance to Needy Families (TANF), Temporary Assistance to Other Needy Families (TAONF), and/or food stamps. Selection criteria included the receipt of public assistance, the presence in the home of an adolescent child age 10–17, and the presence in the home of at least one of the child's biological parents. Of our sample, 87 households were headed by a single mother; in the remaining 68 homes the mother was married or cohabiting with a male partner. Throughout this report, we refer to the male householder as the father, even though some men were not the participating youth's biological parent. Demographic information on the families is shown in Table 1.

TABLE 1 Demographic characteristics of NH families in this study

Variable	*Mean*	*Standard deviation*	Range
Mother's age (in years)	36.77	5.51	28–54
Father's age (in years)	39.31	6.51	26–56
Youth's age (in years)	12.92	1.95	10–17
Per capita income ($)	5,258.00	2,164.61	1,512–13,500
	% of families		
Single parent	56.1		
Two parent	43.9		
Welfare recipient	48.4		
Food stamps recipient	51.6		
At least one employed adult	78.7		
Parent education	% of parents		
	Mother	Father	
< High school	9.7	29.4	
GED/high school diploma	59.4	58.8	
Some college/associate's degree	25.1	11.8	
Bachelor's degree or higher	5.1	0.0	
Missing	0.6	0.0	

Note: For fathers, $n = 68$; for mothers, youths, $n = 155$.

Procedure

Participants in this report are a subset of families from the Financial Strain and Family Resiliency study (Center on the Family, 2003). In the larger study, participants were a stratified random sample of all current benefit recipients who met our inclusion criteria (stratification variables were benefit type and family composition). In this report, we include data from all the Native Hawaiian families in the original Financial Strain and Family Resiliency sample.

Participating families received a $100 gift certificate for their time and effort. Data collection occurred in the families' homes. Each family member was interviewed individually, in a session lasting approximately 2 hours. The interviews were highly structured and consisted primarily of orally administered versions of survey instruments with known psychometric properties. The interview staff consisted of employees from a local research firm. Interviewers were selected on the basis of their interpersonal skills and ability to communicate respect and authenticity with families. Several members of the interview team were themselves former welfare recipients. Interviewers were trained by the Center on the Family research staff who are authors of this article and were required to pass a mock interview prior to working in the field.

Measures

CONTROL VARIABLES. Six control variables were measured. Each control variable represents an aspect of the youths' ongoing family or personal circumstances that could reasonably be expected to correlate with current health and psychosocial adjustment. *Youth age, youth gender,* and *single-parent* versus two-parent household status were all individual questions included in the parent and youth interviews. Using information on household size and a wide variety of earned and unearned sources of income (TANF and food stamp benefits, alimony, wages, rental income, etc.), we also computed household *per capita income*.

Youth risk history was a 6-item self-report scale measuring past problems with family violence, substance abuse, mental illness, and criminal activity in the child's family of origin ($\alpha = .55$). Each item was scored using a yes/no response scale. Sample items include "Have you ever worried that someone in your family might seriously hurt another family member (for example, punch them or threaten them with a knife or gun)?" and "Have you ever been arrested, put in juvenile detention or probation, or been in jail?" High scores on the risk history variable indicate a higher level of psychosocial risk.

Chronic health conditions was a composite variable formed by taking the mean of parent and youth reports on whether the youth suffered from five chronic medical conditions: asthma, allergies, sinus/ear infections, speech/vision/hearing problems, and any other major health problem. All items were answered using a yes/no response scale with a higher total score indicating more health problems. These items were adapted from the yearly Hawai'i Health Survey (Hawai'i Department of Health, 2004) and represent the most frequently reported medical conditions affecting children in the state.

PARENTING PRACTICES. Five different aspects of parenting practices were measured: use of monitoring, positive reinforcement, strict consequences, harsh discipline, and problem solving. Later, these five aspects of parenting were reduced to two composite scores using factor analysis. The parenting measures used in this study were also used in the Center on the Family's (1997) study of family adjustment to recent unemployment and are adaptations of instruments used in two longitudinal studies of parenting and adolescent development (Conger & Elder, 1994; Patterson et al., 1992). Each scale was administered both to children and parents. Adults reported on their own behavior vis-à-vis the child, while the child reported on each parent separately. All items were answered on a 5-point scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Most items were parallel across parent and youth reports, although for some scales the youth report version contained more items.[2]

Monitoring was a 4-item scale measuring adult knowledge of the focal child's activities, companions, and whereabouts (e.g., "You know where *child* is and who he/she is with even if you aren't there"; $\alpha = .70$ for mothers, .72 for fathers, .62 for youth reports on mothers, and .59 for youth reports on fathers). The positive reinforcement scale contained three items for adults and five items for youths

(α = .79, .68, .82, and .86); it measured parents' use of physical and verbal reinforcement and tangible rewards (e.g., "When *child* does something you like, you give him/her a smile or some other small sign that you like what he/she did" and "Your mom does nothing when you do something good because she doesn't want you to be too proud of yourself" [reflected]). Strict consequences was a 3-item scale (α = .66, .60, .63, and .69) measuring parents' consistent administration of strictly enforced but nonabusive consequences (e.g., "When you do something wrong, your dad gives you chores or extra work to do"). The harsh discipline scale contained four items for parents and six items for youths (α = .52, .45, .69, and .73). This scale measured the use of more severe discipline techniques such as corporal punishment or locking the child out of the house (e.g., "You use physical punishment when your child does something wrong" and "Your dad tries to make you feel a sense of shame when you do something wrong"). Problem solving was an 8-item scale (α = .58 to .80) measuring the quality of family problem solving (e.g., "When the two of you have a problem to solve, how often does your mother seriously think about your ideas on how to solve the problem?").

We first computed scale scores for each respondent and then a family-level score by taking the mean for all respondents, yielding five family-level scores. Because the five parenting scores were highly correlated, we reduced the data using factor analysis. The monitoring, positive reinforcement, problem-solving, strict consequences, and harsh discipline family-level scores were entered in a factor analysis using maximum likelihood extraction and orthogonal factor rotation. A 2-factor solution provided a good fit to the data, $\chi^2(1, N = 155) = 1.35$, $p < .25$, and accounted for 55% of the item variance. The first factor, labeled *supportive parenting*, had high loadings for positive reinforcement (λ = .80), monitoring (λ = .65), and problem solving (λ = .59). The second factor, labeled *punishment*, had high loadings for harsh discipline (λ = .84) and strict consequences (λ = .55) and a high, negative loading for problem solving (λ = –.48). We computed factor scores for each family, and the two factor scores, supportive parenting and punishment, served as the two measures of parenting practices used for data analysis.

FAMILY OBLIGATION. The Family Obligation Scale (Fuligni et al., 1999) was administered to each adolescent. Two scores were derived from this instrument. *Youth respect* was a 7-item scale (α = .70) addressing the youth's beliefs about the importance of showing respect and deference to older family members. Items include "How important is it to you to do well for the sake of your family?" and "How important is it to you to treat your parents with great respect?" *Youth support*

was a 6-item scale ($\alpha = .70$) measuring the extent to which the youth values maintaining ties of emotion, propinquity, and mutual assistance with family members across the life span. Examples include "How important is it for you to help your parents financially in the future?" and "How important is it to you to live or go to college near your parents?" Youth respect and youth support served as our two measures of family obligation. In each case, a high score indicates a higher level of family obligation.

PROBLEM BEHAVIOR. *Youth problem behavior* was a composite variable formed by combining youth, mother, and father reports on an 11-item internalizing scale and an 11-item externalizing scale ($\alpha = .72$ to .89) adapted from the Child Behavior Checklist (Child Trends, 1999). High scores indicated the presence of more problem behaviors.

GENERAL HEALTH. *Youth general health* was a composite variable formed by combining parent and youth reports on two items regarding the adolescent's overall physical health. The first item, "How would you rate your/your child's overall physical health?" was answered using a 5-point response scale ranging from 1 = *poor* to 5 = *excellent*. For the second item, "How would you compare your/your child's overall physical health with other children of your/his/her age?" the 5-point response scale ranged from 1 = *much worse* to 5 = *much better*. The items were scored so that a high score indicates better current overall health.

Analysis

We conducted data analyses using hierarchical, multiple linear regression. Hierarchical regression is commonly used with cross-sectional data as a way of making quasi-causal inferences. Our aim was to explain variance in each of the two youth outcome measures (problem behavior and general health). In hierarchical regression, predictor variables are entered in groups or steps. Variables entered in the first step of the analysis are those that theoretically are more distal causes or predictors of the outcome or dependent variable. Variables entered in succeeding steps are seen as more proximal causes.

In our analyses, the control variables were entered in Step 1. Control variables included the demographic measures of age, gender, single-parent household status, and per capita income. An additional control variable differed according to which dependent measure was being predicted. In the equation predicting youth problem behavior, we included family risk history as a control measure, as this measure should be strongly associated with the likelihood of youth problem behavior. In the equation predicting youth general health, we included as a control the number of chronic medical conditions, which is a very stringent control for preexisting health status. By entering these control variables into the analysis first, their influence is already taken into account when the next set of predictors is added to the regression equation.

In Step 2 of the regression analyses, we entered the four measures of parenting practices and family obligation. This allowed us to determine the extent to which this set of predictors explains variance in the outcome measures above and beyond the prediction already achieved by the control measures. A significant increment in prediction in Step 2 is consistent with, but does not conclusively demonstrate, a possible causal role of the Step 2 variables.

Results

Descriptive statistics on the 12 variables used in the regression analyses are shown in Table 2. Distribution plots and skewness and kurtosis statistics were examined for each variable. Only one measure, per capita income, was significantly nonnormal. To correct for this, we trimmed outlying scores (those more than 3 standard deviation from the mean) by replacing the outlying scores with values that were $1,000 higher than the highest score in the sample that was not an outlier (Tabachnick & Fidell, 2001). Results of the regression analyses are shown in Table 3. We conducted two hierarchical multiple regression procedures using the SPSS 14 statistical package. Ordinary least-squares computation procedures were used.

TABLE 2 Descriptive statistics on analysis variables

Variable	*Mean*	*Standard deviation*
Youth age (in years)	12.92	1.95
Youth gender[a]	1.55	0.50
Single parent[b]	0.56	0.50
Per capita income ($)	5,258.00	2,164.61
Youth risk history[c]	0.30	0.24
Chronic health conditions[c]	0.82	0.84
Supportive parenting[d]	0.00	0.88
Punishment[d]	–0.01	0.86
Youth respect[e]	4.38	0.54
Youth support[e]	4.02	0.66
Youth problem behavior[f]	0.52	0.29
Youth general health[e]	3.70	0.62

[a] 1= male, 2= female. [b] 0 = two parent, 1= single parent. [c] 0–1 response scale with items summed for a maximum score of 5. [d] Measure is a factor score, so means are zero. [e] 1–5 response scale. [f] 0–2 response scale.

TABLE 3 Beta coefficients, R^2, and F statistics for the regression of control variables, parenting practices, and youth family obligation on youth problem behavior and general health

Variable	Youth problem behavior	Youth general health
Youth age	–.14*	–.09
Youth gender	.10	–.08
Single parent	–.02	–.09
Per capita income	.06	–.02
Youth risk history	.31****	
Chronic health conditions		–.25***
Supportive parenting	–.21**	.31***
Punishment	.36****	–.11
Youth respect	–.15+	.09
Youth support	.16*	–.07
Step 1		
ΔR^2	.21****	.11**
F(5, 149)	8.13	3.73
Step 2		
ΔR^2	.18****	.13****
F(4, 145)	10.69	5.97
Total		
R^2	.39****	.24****
F(9, 145)	10.45	5.01

Note: Beta coefficients shown at the top of the table are for the full model. Variables entered at Step 1 are age, gender, single parent, per capita income, and either risk history or chronic health conditions. Variables entered at Step 2 are supportive parenting, punishment, youth respect, and youth support.

+ $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$. **** $p < .0005$.

Predicting Youth Problem Behavior

Results for the equation predicting youth problem behavior are shown in Table 3. The five control variables collectively accounted for 21% of the variance in youth problem behavior ($\Delta R^2 = .21$, $p < .005$). When supportive parenting, punishment, youth respect, and youth support were added in Step 2, these four variables explained an additional 18% of the variance in problem behavior ($\Delta R^2 = .18$, $p < .005$). The standardized regression coefficients for the final, full model are also shown in Table 3. Each coefficient represents the unique association of that particular variable with youth problem behavior, above and beyond the variance shared with all the other predictors in the equation. Inspection of Table 3 shows that five variables had significant, unique shared variance with the outcome measure, and one variable had a marginally significant unique association. Specifically, when all other predictor measures were controlled, more frequent problem behavior was associated with higher levels of family risk history ($\beta = .31$, $p < .0005$), more frequent punishment ($\beta = .36$, $p < .0005$), and higher levels of youth support ($\beta = .16$, $p < .05$). Lower levels of problem behavior were associated with being an older teen ($\beta = -.14$, $p < .04$), with having parents who engage in high levels of supportive parenting ($\beta = -.21$, $p < .01$), and, marginally, with higher levels of youth respect ($\beta = -.15$, $p < .09$).

Predicting Youth General Health

Results for the regression equation predicting youth general health are shown in Table 3. For health outcomes, the five control measures entered in Step 1 explained 11% of the variance in youth general health ($\Delta R^2 = .11$, $p < .003$). When supportive parenting, punishment, youth respect, and youth support were added in Step 2, these variables explained an additional 13% of the variance in youth health ($\Delta R^2 = .13$, $p < .0005$). Inspection of the standardized regression coefficients in Table 3 indicates that only two predictor variables had unique associations with the dependent measures. Specifically, when all other predictors were controlled, general health was worse for youths with a higher number of chronic health conditions ($\beta = -.25$, $p < .001$) and better for youths whose parents engaged in high levels of supportive parenting ($\beta = .31$, $p < .001$).

Discussion

In her review of identity processes in contemporary Native Hawaiians, Kana'iaupuni (2004) stated that "today's Hawaiian families have been overlooked in much of the research on family diversity and strengths" (p. 54). The present study begins to rectify this gap by providing evidence that the family is an important source of resiliency for at-risk NH youths. In this sample of NH adolescents living in poverty, both parenting practices and youths' values relating to family obligation were significant correlates of their behavioral adjustment and physical well-being. For both problem behavior and general health status, parenting practices and youth family obligation explained a significant proportion of the variance above and beyond the effects of family demographic characteristics, history of family psychosocial risk, and chronic health conditions.

In terms of relative influence on problem behavior, parenting practices were most strongly associated with youth problem behavior, with youth family obligation playing a lesser role. Specifically, harsh punishment was a risk factor associated with poor behavioral adjustment, whereas supportive parenting was a resource that predicted low rates of problem behavior. Adolescents' own belief in the importance of respecting family members was also a protective factor associated with low levels of problem behavior. It is interesting to note, in the context of all other predictors, that the second aspect of youth family obligation—the belief in the importance of providing instrumental support for family members—was associated with higher rates of problem behavior. In terms of youth general health status, supportive parenting was the strongest unique protective factor of all the measures included in this study.

The two parenting variables measured in this study—supportive parenting and punishment—together represent the construct of authoritative parenting. Parents high on supportive parenting and low on punishment would be described as showing a prototypical authoritative parenting style. Consistent with predictions from the literature, supportive parenting was a resiliency factor associated with positive youth well-being, and punishment was a risk factor associated with negative adjustment. Thus, this study demonstrates empirically that an authoritative parenting style, which has been widely shown to facilitate positive youth development in other ethnic groups, functions in a similar way among Native Hawaiians.

This study also empirically validates the hypothesis that family-centered values and the importance of ‘ohana (as measured on the family obligation scale) are strengths that can buffer NH youths from the deleterious effects of poverty.

It is also interesting that one aspect of family obligation was associated with an increased likelihood of youth problem behaviors. In the context of all other independent variables, youths high on youth support—that is, those who placed a greater importance on providing instrumental assistance and support to family members now and in the future—had higher levels of behavior problems. This is an unexpected finding and suggests that expectations for ongoing financial and practical obligations to one’s family can be a source of stress. Expectations for future support may be problematic for adolescents who perceive a conflict between providing for their families and desiring personal independence, or if youths feel poorly equipped to obtain lucrative employment that will help support family members financially in a locale known for its high cost of living.

The present results suggest that prevention or intervention efforts for at-risk NH youths should have a dual focus on changing both parents and their children. In other words, families, not individuals, should be seen as the recipient of programs or services. Because we did not collect data relating to grandparents, older siblings, or other kin, we cannot say with confidence that extending the focus of intervention beyond the parent–child partnership to include the larger ‘ohana would have additional benefits. However, given that NH youths report that the extended family network provides important child-rearing and caretaking functions (Goebert et al., 2000), we suggest that future research should explicitly compare the effectiveness of interventions that include parents and children only with those that address the larger family system.

With regard to prevention or intervention efforts that focus on parenting practices, attention should be paid to the following: replacing punitive, reactive punishment with more productive discipline techniques; encouraging open expressions of affection and approval; promoting proactive monitoring and supervision of children’s activities and companions; and increasing rational, inductive, and collaborative parent–child problem solving. The focus for youths should be on recognizing and appreciating the concern and efforts that parents extend on their behalf, and

giving real consideration to the wisdom of the advice and directions that parents and elder kin provide. It is likely that these two aspects of family life—parenting practices and youths' valuing of family obligation—are dynamically related. As parents become more involved with their children and allow greater communication and collaborative decision making, children's respect for and bonding with their parents should increase, making them more willing to follow parents' advice and share their parents' goals and reasoning.

What is the likelihood that prevention or intervention efforts that focus on authoritative parenting and on promoting family-related values would be well received in the NH community? We propose that these topics are consistent with NH cultural values; thus, we expect a good chance of uptake by program participants. Recent statewide surveys present a mixed picture of NH family life as compared with other ethnic groups in the state (Goebert et al., 2000; Pearson, 2004). On one hand, NH adolescents report high levels of family risk factors, particularly in the areas of exposure to and lack of sanctions against violence, antisocial behavior, and alcohol and other substance use. On the other hand, NH youths report higher levels of protective family factors, including more parental supervision, greater enjoyment of shared family time, and greater self-disclosure with their parents. This suggests that many NH families, including at-risk families, already engage to some degree in interaction patterns similar to those we propose as the focus of possible intervention. For many families, then, rather than replacing or changing family interaction patterns, prevention/intervention efforts would raise self-awareness of the strengths that families already possess and increase the frequency and intentionality of healthful family interactions.

A notable finding in the present study is the identification of psychosocial correlates of physical health. Most of the health disparities suffered by Native Hawaiians emerge in middle age (Hawai'i Department of Health, 2004). It would be worthwhile to ascertain whether the link between family interaction practices and better health that we found for adolescents is also present in NH adults. Our findings also raise interesting questions about possible health prevention efforts. If positive parenting experienced by adolescents is associated with better physical health, could parenting programs have the unexpected positive side effect of preventing later health issues by promoting good health among children earlier in life?

In summary, we have shown that parenting practices and family obligation beliefs are nontrivial predictors of the behavioral and physical well-being of NH adolescents living in poverty. One important limitation of the present study is that our data are cross-sectional. To address this limitation, we controlled in our analyses for demographic characteristics, long-term family risk factors, and chronic medical conditions, thus looking at the effects of parenting and belief systems above and beyond the influence of these well-established risk factors. However, longitudinal research is needed to better confirm our contention that positive family life plays a causal role in promoting the well-being of NH youths.

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Notes

1 Throughout this article, we use the term *Native Hawaiian* to refer to families and persons of both full and partial Native Hawaiian ancestry.

2 Some items, for example, how often youths share accurate information with their parents about their companions and whereabouts, are only available through youth self-report.

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