

**CHILDHOOD TRAUMATIC EXPOSURE AND BELIEF IN HAWAIIAN VALUES
AS CONTRIBUTING FACTORS TO IDENTITY FUNCTIONING**

A THESIS SUBMITTED TO THE GRADUATE DIVISION OF THE
UNIVERSITY OF HAWAI‘I AT HILO IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

IN
COUNSELING PSYCHOLOGY

MAY 2025

By

L. E. Bradley

Thesis Committee:

Sunyoung Kim, Chairperson

Anthony Papa

Steven Herman

Keywords: childhood adversity, Hawaiian cultural values, Indigenous peoples, ego-identity

Dedication

To the Kānaka community, who have always shown kindness, compassion, understanding, and aloha to myself and my family, dating back to my Omi's relocation to the Hawaiian Islands from Berlin over half a century ago;

To my fellow cohort, the University of Hawai'i at Hilo Counseling Psychology Class of 2025, who have consistently shown up for me and strengthened my work as a student and researcher through their curiosity and wisdom;

And to my family, who have forever been my biggest supporters, my source of motivation, and my inspiration, even during my most difficult moments. I would not be here if not for your endless love, mentorship, and encouragement.

Acknowledgments

I would first and foremost like to express my deepest appreciation to Sunyoung, my committee chair, for her assistance throughout the past two years. This work could not exist without her generous dedication of time and resources. I would also like to thank Tony, who has served as my mentor since I was an undergraduate student and inspired me to further pursue research, and Steve, who has consistently pushed me to aim higher as a student and as a researcher. Thank you all for serving on my committee and believing in me and my capabilities.

Words cannot express my gratitude to my dear friends, colleagues, and mentors Lehuanani, Mekaila, Kolopua, and Kekupu for their mana‘o and kōkua throughout this process. The openness, curiosity, and support you have extended towards my research has allowed me to grow leaps and bounds as a student, a researcher, and an individual. This work could not have been as comprehensive or informed without your unique perspectives and continuous feedback.

I am also forever grateful to my father, Brad, and my mother, Robin, for their never-ending love and guidance throughout this process and beyond. The late nights you spent with me discussing my ideas and examining my work were instrumental to my process, and this thesis would not be the same without you. Additionally, I wish to mention the two Dr. Shumakers in my life—my sister, Tiffany, and my grandfather, Robert—for inspiring me to shoot for the stars.

Finally, I would like to acknowledge some of my closest friends and biggest supporters - Claus, Marques, Leo, Valentino, Juyeon, Khris, Noelani, Cyl, Percy, Lee, and Andrew, for being by my side until the end of this long journey. The continuous compassion and encouragement you have poured into me and my work has always given me a reason to keep moving forward.

Thank you all for being a constant source of strength for me throughout this process.

Abstract

The development of an ego-identity is a crucial part in adolescence and early adulthood where a youth seeks to understand the answer to the question of “who am I?”. A disturbed (i.e., incoherent, unstable) identity and/or lack of identity has historically been linked to various mental illnesses, such as borderline personality disorder, depression, and PTSD. The focus of this thesis was to examine the relationship between childhood adversity, ego-identity, and Native Hawaiian cultural values. Researchers found that, within a Native Hawaiian population, belief in Hawaiian values moderated the relationship between childhood trauma and self-reported feelings of lacking an identity. Results generally support previous research showing that identification and engagement with one's own culture can lead to healthier identity outcomes. In the context of the State of Hawai‘i, results indicate that clinicians would be able to better serve their clients by being more knowledgeable about Hawaiian history, culture, values, and practices, and by engaging in the exploration of aspects of Hawaiian culture that resonate with their Native Hawaiian clients within session.

Table of Contents

Acknowledgments	iii
Abstract	iv
List of Tables	vi
List of Figures	vii
List of Abbreviations and Symbols	viii
Introduction	9
Trauma and Identity Functioning.....	11
Childhood Trauma Exposure and Identity Dysfunction.....	15
Kānaka Maoli and Indigenous Mental Health.....	17
Indigenous Values, Identity, and Resilience.....	18
Barriers to Indigenous Wellbeing.....	21
Gap.....	22
Methods	22
Participants.....	22
Instruments.....	23
Self-Concept and Identity Measure (SCIM).....	23
Adverse Childhood Experiences Questionnaire (10-item).....	24
Hawaiian Values Scale.....	24
Procedure.....	25
Data Analysis.....	26
Results	27
Discussion	34
Limitations.....	38
Implications for Behavioral Health.....	39
Appendix A	41
Appendix B	43
Appendix C	45
References	47

List of Tables

Table 1. Descriptive Statistics for Study Variables.....	28
Table 2. Pearson correlation coefficient table for Study Variables.....	30

List of Figures

Figure 1. Hawaiian Value Endorsement Moderates the Relationship Between Lack of Identity and ACE Score in the Kānaka Maoli Population.....	33
Figure 2. Hawaiian Value Endorsement Moderates the Relationship Between Lack of Identity and ACE Score in the Full Population.....	34

List of Abbreviations and Symbols

ACEs.....	Adverse Childhood Experiences
BPD.....	Borderline Personality Disorder
CSA.....	Childhood Sexual Assault
PTSD.....	Post-Traumatic Stress Disorder
SCIM.....	Self-Concept and Identity Measure
CI.....	Consolidated Identity
DI.....	Disturbed Identity
LI.....	Lack of Identity
ACE-Q.....	Adverse Childhood Experiences Questionnaire
HVS.....	Hawaiian Values Scale
KM.....	Kānaka Maoli
NKM.....	Non-Kānaka Maoli
HV.....	Hawaiian Values
UH.....	University of Hawai‘i
UHM.....	University of Hawai‘i at Mānoa
α	Chronbach’s Alpha
p	Probability Level
R^2	Coefficient of Determination
F.....	F-statistic
b.....	Unstandardized Beta
σ^2	Variance
M.....	Mean
SD.....	Standard Deviation
t	T-statistic
d	Cohen’s d
m.....	Slope

Introduction

The concept of identity is integral to many psychological disorders, yet is vastly understudied in the context of clinical psychology (Kaufman et al., 2014). One of the most well-known theories of identity development comes from Erikson's (1950; 1963) stages of psychosocial development (i.e., the stage of *identity vs role confusion*), in which adolescents find their role in society. Marcia (1966) further expanded on Erikson's work with his own theory of identity, focusing more on an individual's willingness to explore and/or commit to an identity. The majority of current research being done on identity in a clinical sense uses Erikson (1950) and Marcia's (1966) theories for their foundation and conceptualization of identity as a construct (Kaufman et al., 2014). While identity is multifaceted with many different dimensions—ethnic identity, gender identity, or familial identity, among others—the current study conceptualizes identity using the specific concept of ego-identity (also referred to as self-concept), defined by Erikson (1968) as “a sense of individual uniqueness ... an unconscious striving for a continuity of experience, and ... a solidarity with a group's ideals.” In essence, the idea of ego-identity is the answer to the question, “Who am I?”

Some research exists examining identity in relation to trauma (e.g., Kaufman et al., 2019; Wong et al., 2019; Labonté & Kealy, 2023), but few empirical studies have been conducted with regards to the potential relationship between one's identity functioning (e.g., consolidated, disrupted) and adverse childhood experiences (ACEs; childhood trauma). Additionally, one's cultural values, especially in Indigenous populations, appear to be a key aspect in not only developing and maintaining a stable identity (Mani'ole & Meyer, 1998; Oneha, 2001; Kana'iaupuni & Malone, 2006; Oliveira, 2014), but also in staying resilient after exposure to

trauma (Antonio et al., 2020; Harangody et al., 2022; Hoeltge et al., 2024). The current study seeks to explore the relationship between childhood trauma, ego-identity functioning, and identification with traditional Hawaiian values (e.g., taking care of the land, collectivism, genealogy, traditional spirituality).

Consolidated, Disturbed, and Lack of Ego-Identity

Through an extensive literature review, Kaufman and colleagues (2014) found two broad domains of ego-identity functioning: “consolidated,” or a healthy identity, where one feels connected to one’s self, past, and values; and “disrupted,” in which one’s identity is confused or fragmented. Consolidated identity encompasses Erikson’s idea of a *sense of inner identity*, which he describes as a “wholeness” as an adolescent; a continuity between the past, present, and future; and expectations imposed on a person by the self and others (Erikson, 1968). A secure, unified sense of inner identity (i.e., positive self-concept) has been linked to several positive psychological outcomes, such as adjustment, well-being, and intimacy (Campbell et al., 2003; Crawford et al., 2004).

Disrupted identity, in both Kaufman and colleagues’ (2014) study, as well as the current study, is broken down into two categories: *disturbed identity* and *lack of identity*. While the latter has not been the subject of much empirical research, the former is another concept that is linked to Erikson’s stages of development. Disturbed identity, or what Erikson called *identity diffusion*, encompasses regression, paralysis, dependency, and trouble committing (Erikson, 1968). Marcia (1966) similarly describes diffusion as being characterized by lack of commitment, writing: “although [the identity-diffused individual] may mention a preferred occupation, he seems to have little conception of its daily routine and gives the impression that the choice could be easily

abandoned should opportunities arise elsewhere.” A disturbed ego-identity is not only comprised of Erikson and Marcia’s definitions of diffused identity, but of an inauthentic self (i.e., *false-self*; Winnicott, 1958; Harter, 1997) and a non-cohesive, or fragmented, self (i.e., *self-concept differentiation*; Donahue et al., 1993). While identity diffusion may be normative during childhood and adolescence, Akhtar (1984) emphasized in his work that it can be clinically disruptive. He hypothesized that several clinical features encompass identity diffusion, including temporal discontinuity in the self, a lack of authenticity, and feelings of emptiness.

On the other hand, a reported lack of identity describes an individual who may feel broken, empty, or as if they do not exist at all, similar to symptoms seen in Borderline Personality Disorder (BPD; APA, 2013). Much of BPD literature refers to this as *identity disturbance*, in line with the relevant DSM 5 criterion. Linehan (1993) hypothesized that identity disturbance precedes the development of BPD, as the failure to develop a cohesive ego-identity may be due to unpredictable emotional lability. This emotional dysregulation has also been shown to be a result of, and a risk factor for, trauma and/or PTSD (Powers et al., 2015; Pencea et al., 2020). Different types of trauma have also been associated with certain facets of identity disturbance in BPD, specifically sexual trauma (Wilkinson-Ryan & Westen, 2000; Menon et al. 2016). Menon and colleagues (2016) looked more specifically at childhood sexual assault (CSA) in relation to BPD symptoms and found that 87.5% of their participants with BPD who had experienced CSA met the identity disturbance criterion. Lack of identity, outside of BPD literature, has not been studied at length.

Trauma and Identity Functioning

Existing research on identity and various domains of trauma has yielded mixed results

with regards to strength and direction of the relationship between the two constructs. Berman (2016; 2020) discusses the existence of a reciprocal relationship between trauma and identity; that is, trauma can cause role changes, disrupt one's pursuit or achievement of certain goals, or cause one to feel lost or disconnected from themselves or the world around them. At the same time, identity may change the way one perceives, manages, and experiences trauma; whether a traumatic event causes post-traumatic stress or post-traumatic growth may, in part, be due to one's identity. Additionally, a traumatic experience may become central to one's identity, or even define one's purpose or livelihood after the event.

The majority of the literature surrounding the link between trauma and identity, however, relates to the impact of trauma on identity functioning. Kouvelis and Kangas (2021) found that interpersonal trauma and trauma symptoms across the lifespan leads to worse self-concept outcomes; similarly, Berntsen and Rubin (2007) found that an enhanced integration of traumatic memories predicted more severe PTSD symptoms. In a study of 15 college students who had suffered trauma during their college experience, Shalka (2019) found that, while the trauma did not necessarily *define* their sense of identity, trauma did serve as a lens in understanding and expressing their identities following the traumatic event. For some participants, this was a positive thing: it helped them “feel more comfortable with ambiguity” or “make peace with the unpredictability of life”—however, this was not the case across the board. Other participants reported that life post-traumatic exposure was primarily fueled by vulnerability, and that they felt much less trustworthy of the world as a whole.

Waterman (2020) theorized that there are nine possible identity outcomes that may occur in the aftermath of a traumatic event: *identity resilience* (i.e., minimal alteration of one's

meaningful identity commitments); *identity affirmation* (i.e., one's identity commitments are reinforced by the traumatic event); *identity delay* (i.e., distress due to trauma causes an interruption in the pursuit of one's existing identity commitments, though the commitments themselves may not necessarily be abandoned); *identity threat* (i.e., one questions the ability to continue pursuing certain identity commitments); *identity loss* (i.e., rejection or abandonment of previous identity commitments); *identity replacement* (i.e., replacement of old identity commitments with new ones, unrelated to previous commitments and the trauma); *trauma-shaped identity* (i.e., identity commitments are significantly changed, with the inclusion of new commitments that are directly related to the trauma); and *trauma-centered identity* (i.e., the effective abandonment of all aspects of identity unrelated to the traumatic event). Waterman hypothesized that the specific outcome a person experiences depends on the nature of the traumatic event (e.g., type, frequency, duration), variables related to the traumatic event (e.g., losses, stress experienced, PTSD), person-related variables (e.g., developmental level, locus of control, character strengths) and variables related to the social context in which the person is functioning (e.g., cultural group, social support). This theory suggests that, while trauma may have an adverse effect on identity and lead to a loss of previous identity commitments, trauma may also have a positive effect on identity, similar to the outcomes of post-traumatic stress and post-traumatic growth.

Other research has found a weaker relationship between traumatic exposure and identity functioning. In a study of 1,614 first-year undergraduate students aged 18 to 29, Truskauskaite-Kuneviciene and colleagues (2020) found that there was no significant difference in identity outcomes (diffused, undifferentiated, and coherent) between those who experienced overall

lifetime trauma (measured by combining the endorsement of disaster-related trauma, accident-related trauma, physical abuse, sexual abuse, childhood abuse, serious disease and injury, and traumatic loss) and those who did not. However, on a raw level, researchers reported that there was a higher proportion of respondents who had not experienced lifetime trauma exposure that reported a coherent identity profile when compared to respondents who had experienced lifetime trauma exposure. Additionally, when examining each type of trauma individually, researchers found that sexual abuse in particular stood out from the others as a significant predictor of identity diffusion, a finding consistent with identity and BPD literature. Thus, despite primarily non-significant results in this study, the results still illustrate a familiar pattern of less stable identity post-trauma exposure—especially if the trauma exposure is severe (e.g., sexual abuse).

In colonized Indigenous populations, research suggests that prominent stereotypes such as the “noble savage” or the “drunk Indian” make it difficult for youth to develop a functional, whole identity without a strong knowledge of, or tie to, their Indigenous culture (Wexler, 2009). Additionally, higher rates of traumatic experiences, such as racism, physical abuse, and sexual abuse as a result of their ethnic identity may cause identity disruption and mental distancing from their ethnicity, such as believing they look “less Indian than they actually do” (Weaver & Hartz, 1999). However, movements to fight for Indigenous autonomy in the United States (e.g., the Red Power Movement, the Hawaiian Sovereignty Movement) have inspired many with Native ancestry to reclaim their identities as Indigenous people. The use of cultural symbols within these movements portray unity, voice dissent over injustice, and highlight additional, related grievances, which allows the Indigenous group(s) to reinvent themselves while fighting for their

culture and its history (Nagel, 1994). This not only provides Indigenous individuals with a sense of collective and cultural memory, but also allows Indigenous youth to properly incorporate their culture's history and heritage into their identities, despite historical and ongoing trauma. As stated by Wexler (2009), "affiliation with one's Indigenous culture can provide a framework in which individuals can locate themselves in relation to others, to a larger shared context, and to history."

Childhood Trauma Exposure and Identity Dysfunction

Childhood maltreatment and abuse has long been linked to lifetime psychopathology, including depressive disorders, anxiety disorders, personality disorders, substance use disorders, and PTSD (Johnson et al., 1999; MacMillan et al., 2001; Brady & Back, 2012). Exposure to childhood traumatic stress has shown to produce worse trauma and stressor-related symptom outcomes, even after controlling for traumatic and non-traumatic stress across the lifespan (Frewen et al., 2019). Outside of overall wellbeing and psychopathology, however, there is evidence that trauma exposure in childhood and adolescence may be linked to later identity dysfunction. If a child is repeatedly exposed to frightening, invalidating experiences—as is the nature of traumatic events—the child's view of themselves might be compartmentalized into "good" or "bad," leaving them with a negative or incohesive self-concept. Similarly, neglect or abuse from peers or adults in the child's life may cause the child to become isolated, limiting their exploration of their social environment and personal capabilities, such as participation in social or recreational activities, which in turn heavily inhibits their ability for ego-identity development (Carlson et al, 1997; Kaufman et al., 2014; Labonté & Kealy, 2023).

Likewise, Briere (1996) discusses the effects of abuse on a child's sense of self. Briere

proposes that the excessive avoidance (i.e., dissociation) a child may exhibit due to abuse disrupts normal attachment processes (i.e., learning and development), producing a symptom profile consisting of “characterologic’ difficulties associated with identity, relational, and affect regulation.” Carlson and colleagues (1997) expound upon this theory, suggesting that childhood abuse leads to avoidance of feared stimuli by means of cognitive avoidance, depersonalization, emotional numbing, and distorting self-perceptions to avoid emotional pain and reminders of the trauma. This, then, results in dissociative experiences. This theory also suggests that identity disturbance might be an associated response to childhood abuse or interpersonal trauma exposure, as disorders that relate to CSA (e.g., dissociative disorders, borderline personality disorder, eating disorders, somatization disorders) all share certain disturbances in one’s sense of self.

Current research into the impact of adverse childhood experiences and identity generally supports the above literature that childhood trauma exposure is related to, or perhaps predictive of, dysfunctional identity outcomes. Consistent with theory, research suggests that childhood traumatic exposure on the interpersonal level (e.g., abuse, neglect) may amplify feelings of shame and intensify existing negative self-representations, leading to further identity dysfunction (Labonté & Kealy, 2023). Penner and colleagues (2019) concluded that emotional abuse, emotional neglect, physical neglect, and total maltreatment exposure (i.e., physical, emotional, and sexual abuse; physical and emotional neglect combined) may also be risk factors for adolescent identity diffusion. Outside of interpersonal traumatic stress, Guler (2014) interviewed adolescent refugees from six different countries who were currently residing in the United States, and found that exposure to war and trauma in childhood was negatively correlated to identity

development and positively correlated to identity distress.

On the other hand, self-concept clarity (i.e., a coherent, stable sense of ego-identity) may be a protective factor for psychopathology in adulthood after childhood trauma exposure. Wong and colleagues (2019) found that self-concept clarity mediated the relationship between adverse childhood experiences and five different outcomes: suicidal behavior, depression, loneliness, perceived stress, and life distress. Further research has concluded that a low level of self-concept clarity after childhood trauma exposure may predict higher levels of dissociation, leading to a higher level of psychological distress (Paetzold & Rholes, 2021).

Kānaka Maoli and Indigenous Mental Health

Despite being the population indigenous to Hawai‘i, the Kānaka Maoli (Native Hawaiian) people have been vastly under-recognized in, if not entirely left out of, many US laws and programs at the State and Federal level (McGregor, 2007). This further extends to being understudied in terms of mental health research. From what is currently understood, Kānaka Maoli not only suffer from disproportionately more physical and mental health problems (e.g., obesity, cancer, substance use, depression, PTSD) than other ethnic groups in Hawai‘i, but also are exposed more frequently and severely to both childhood and lifelong trauma (Klest et al., 2013; Ye & Reyes-Salvail, 2014; Riley et al., 2022).

Existing research shows that generational and historical trauma, and the effects of colonization, cultural oppression, and cultural loss, have led to further trauma within the family system. Kānaka Maoli children and adolescents are often victims of domestic abuse, neglect, and/or family adversity, especially as compared to children of other ethnic groups (Mokuau, 2002; Carlton et al., 2006; Miller et al., 2013; Ye & Reyes-Salvail, 2014). Child maltreatment is

associated with substance use, psychiatric problems, and school-related behavioral problems, all of which Kānaka Maoli adolescents are among the highest rate in the State of Hawai‘i (Mokuau, 2002; Carlton et al., 2006). In addition, Kānaka Maoli students are more likely to attend low-quality schools, be classified as “missing” from the school system, require special education, and be absent from school, and are less likely to graduate from high school than students of other ethnic or racial backgrounds (Kana‘iaupuni & Ishibashi, 2003). Further research into the subject has found that these statistics are heavily attributable to intergenerational and historical trauma. The history of colonization, racism, and discrimination against the Kānaka Maoli people is deep-seated, both mentally and emotionally. The trauma is pervasive in the mindsets of Kānaka Maoli parents, causing them to make certain parenting decisions or question their ability to adequately care for their child (Ogilivie, 2021). Colonization and Western practices, including gender inequality and physical punishment, introduced and reinforced maladaptive parenting strategies and normalized familial discord and domestic violence across Indigenous populations in the United States, including Kānaka Maoli (Horejsi et al., 1992; Kanuha, 2007; Rose, 2016). The internalized anger experienced by many Kānaka Maoli, fueled by further discrimination, oppression, and cultural loss, gets passed on intergenerationally. As explained by a Kānaka Maoli participant as a part of a study by Ogilivie (2021), “I feel like sometimes there’s just so much anger in the hearts of some Hawaiian families. That anger gets passed on from generation to generation and it kind of just stumps some kids.”

Indigenous Values, Identity, and Resilience

Ka maui o ka ‘āina a he maui kānaka is an ‘ōlelo no‘eau (Hawaiian proverb) translating to “the life of the land is the life of the people” (Oneha, 2001). Identity, in Hawaiian culture, is

intrinsically linked to place. Connection to the ‘āina (land) and connection to one’s ancestors are important to how a Kānaka Maoli adolescent forms their identity and creates lasting social relationships on both an individual and group level (Kana‘iaupuni & Malone, 2006). In her book *Ancestral Places*, Oliveira (2014) writes: “Hawaiian intellect is not separate from the body because the body is a conduit of knowledge that internalizes and memorizes intergenerationally.” To Oliveira, every bodily sense, plus one’s na‘au (gut, instinct), kulāiwi (connection to homeland), au ‘āpa‘apa‘a (ancestral timekeeping), and mo‘o (succession) are a part of generational knowledge; part of one’s self, but also part of past and future generations of Kānaka Maoli. Similarly, Mani‘ole and Meyer (1998) discuss the relationship between identity, epistemology, and culture: “The recovery of historical memory via epistemology has to do with recovering not only the sense of one’s own identity and the pride of belonging to a people but also a reliance on a tradition and culture, and above all, with rescuing those aspects of identity which served yesterday, and will serve today, for liberation.” From an Indigenous Hawaiian perspective, identity is inherently intertwined with, and comprised of, culture, history, and generational knowledge. Recent psychological research into this population has found similar perspectives: identity as a Kānaka Maoli individual is enhanced by engaging in cultural practices, customs, and beliefs. In the face of oppression and colonialism, continued resistance by means of connecting to one’s Indigenous values creates a strong identity and fosters resilience (Hoeltge et al., 2025).

The limited research conducted on resilience in Kānaka Maoli populations has shown that a strong identity, community support, belief in Indigenous values, and involvement in Indigenous practices all contribute to resilience after experiencing both interpersonal and disaster-related

trauma. After the Kaua‘i floods in 2018, Harangody and colleagues (2022) interviewed individuals living on the island who were impacted by the flooding. One of the most distinct, recurring themes was the relationship with ‘āina—including being aware of environmental changes and maintaining the land—being paramount to resilience on both an individual and a community level. Furthermore, Hoeltge and colleagues (2025) found that continuing to uphold Indigenous values and practices (e.g., mālama ‘āina, working in the lo‘i, hula, ‘oli, and connecting with one’s ancestry and birthplace) after enduring personal and generational trauma fostered resilience. Being able to connect more deeply with one’s community has also been shown across studies to aid in Kānaka Maoli resilience following trauma and disaster (Antonio et al., 2020; Harangody et al., 2022; Hoeltge et al., 2025).

Research into other Indigenous populations, both within and outside the United States, has consistently shown that engaging in culturally relevant beliefs and practices have a positive effect on resilience and wellbeing after individual and/or historical trauma. Fleming and Ledogar (2008) found that involvement in traditional Aboriginal culture and spirituality served as a protective factor in preventing alcohol abuse and aided in alcohol abuse recovery, and suggested that traditional Native American spirituality might be important to cultural resilience and youth suicide prevention. Consequently, in a study of rural Chinese left-behind children (i.e., caretaker is not a parent) in Mainland China, Guo and colleagues (2021) found that traditional Chinese values, especially traditional Chinese spiritual values, facilitated flourishing (i.e., positive psychosocial functioning, positive feeling).

Social Identity Theory posits that part of an individual’s self-concept is derived by their identification with certain social groups; this includes, but is not limited to, ethnicity, gender,

sexuality, and religion (Tajfel, 1970; Tajfel & Turner, 1979). While identification with one or more minority social groups may cause a person to face more prejudice or discrimination, research suggests that negative outcomes due to this prejudice may be, to some degree, reduced by the group identification. This would mean that, as long as the individual evaluates their minority group positively, the feeling of belonging, social support, and positive self-concept provided by group identification may alleviate the effects of devaluation from outside groups (Branscombe et al., 1999; Schmitt et al., 2002; Hughes et al., 2015). To some extent, this may aid in resilience after trauma, especially trauma specifically related to prejudice.

Barriers to Indigenous Wellbeing

Throughout the years, larger institutions have been created to empower Kānaka Maoli and bring back Hawaiian culture and practices (e.g., Kamehameha Schools, Lili‘uokalani Trust, MA’O Farms). Many of these institutions have bought land in an attempt to teach and foster Hawaiian cultural identity in Kānaka Maoli youth. However, many young Kānaka Maoli are cut off from this knowledge and the ‘āina owned by these institutions due to poverty and location inaccessibility. Accessing culturally significant knowledge and resources is difficult for many Kānaka Maoli youth and families, with access prices approaching tens of thousands of dollars per year. With the Kānaka Maoli population experiencing a 13.5% poverty rate in the State of Hawai‘i, and the median income of a two-parent Kānaka Maoli household being \$35,200 (Kam et al., 2019), accessing expensive education or resources that could assist Kānaka Maoli youth in connecting with their cultural history and identity is a nearly impossible task for many families. In addition to the poverty rate, 76% of the Kānaka Maoli and Pacific Islander population in Hawai‘i live in rural areas, and may be unable to physically access these resources (Center on

Rural Innovation, 2023). Thus, many youth—likely the ones who are most vulnerable and would benefit the most from the opportunity to practice traditional Hawaiian culture and connect with their community—“fall through the cracks.” This, in turn, puts a barrier between many Kānaka Maoli youth and their ability to be as resilient and secure in their identities as they could be.

Gap

There is little empirical research that has been conducted examining ego-identity in Kānaka Maoli populations and examining strictly Hawaiian values in regards to identity, be it ego-identity or ethnic identity. Additionally, the relationship between childhood adversity and identity disruption has minimal research outside of the context of BPD. The current study seeks to better understand the relationship between these three constructs. Consistent with the literature presented above, I hypothesize that:

- I. Across groups, increases in ACE exposure will predict increases in identity disruption.
- II. ACE exposure will be more common in those who identify as Kānaka Maoli than in other ethnic groups.
- III. In those who identify as Kānaka Maoli, belief in Hawaiian values will serve as a protective factor for identity after experiencing adverse childhood events.

Methods

Participants

Participants were required to be 18 years or older and affiliated with the University of Hawai‘i system (i.e., enrolled as a part-time or full-time student at UH Hilo, UH Mānoa, UH West Oahu, and/or Hawai‘i Community College). Prior to initiating the survey, participants were asked to identify their age, gender, sexual identity, whether they identify partially or fully as

Native Hawaiian (yes or no), whether they feel they are “local” to Hawai‘i (yes or no), race and ethnicity, marital status, education level, employment status and occupation, and mental illness diagnosis and treatment history.

Instruments

The scales included in the survey relevant to the current study include the Self-Concept and Identity Measure (SCIM), Adverse Childhood Experiences Questionnaire (ACE-Q), and the Hawaiian Values Scale (HVS).

Self-Concept and Identity Measure (SCIM)

The SCIM is a 27-item self-report questionnaire developed by Kaufman and colleagues in 2014, designed to measure identity functioning. Items are rated in a likert-scale format, from 1 (strongly disagree) to 7 (strongly agree). The items fall under three subscales, which are consistent with the aforementioned identity domains: *consolidated identity*, consisting of items such as “I know what I believe or value” and “When I look at my childhood pictures I feel like there is a thread connecting my past to now”; *disturbed identity*, consisting of items such as “I imitate other people instead of being myself” and “My opinions can shift quickly from one extreme to another”; and *lack of identity*, consisting of items such as “I am broken” and “I feel lost when I think about who I am.” In their article discussing the factor structure and validation of the scale, Kaufman and colleagues (2014) found excellent internal consistency for the scale as a whole (Cronbach’s $\alpha = 0.89$), and strong internal consistency for its subscales individually (CI: $\alpha = 0.73$; DI: $\alpha = 0.84$; LI: $\alpha = 0.87$). The SCIM has been replicated and validated in normative and clinical samples as well as adult and adolescent samples internationally (e.g., Kaufman et al., 2019; Bogaerts et al., 2021; James et al., 2023; Bogaerts et al., 2023).

Adverse Childhood Experiences Questionnaire (10-item)

The 10-item ACE-Q is a self-report questionnaire developed by Felitti and colleagues in 1998 designed to measure exposure to adverse experiences in childhood (before turning age 18). The items are classified under four subscales: psychological abuse, physical abuse, sexual abuse, and household dysfunction (including violence against mother, household substance abuse, household mental illness or suicidality, and household member incarceration). The items are written as questions (e.g., “Was a household member depressed or mentally ill? or Did a household member attempt suicide?”), and participants are asked to mark “yes” or “no” according to whether or not the respondent has experienced the event in the item. Murphy and colleagues (2013) found excellent internal consistency (Cronbach’s $\alpha = 0.88$) in a clinical and community sample of urban women. The 10-item ACE-Q, along with other versions of the instrument, have been replicated and validated in adolescent and adult clinical and normative samples internationally (Wingenfeld et al., 2010; Oláh et al., 2023). Much research has been done on the relationship between ACE score and health outcomes in adulthood; in the scale’s pilot study, Felitti and colleagues (1998) found that adults scoring four or higher on the ACE measure were at a disproportionately higher risk of mental (e.g., addiction, depression, suicidality) and physical (e.g., smoking, STDs, disease) health conditions than those with three or less. More recent studies have also shown that ACE exposure may be related to decreased productivity in adulthood (Anda et al., 2004) and mood and personality disorders in older adulthood (Raposo et al., 2014).

Hawaiian Values Scale

The HVS is a 20-item self-report questionnaire developed as a part of the current study,

designed to measure the extent to which participants agree with a set of Native Hawaiian cultural values. To create this scale, researchers extracted factors from Hishinuma and colleagues' (2000) Hawaiian Culture Scale - Adolescent, and used Kim and Hong's (2004) Asian Values Scale for structure. The items are categorized under four subscales: collectivism, customs and beliefs, connection to the land, and spirituality. Items are written as statements, and participants are asked to rate their level of agreement with each statement. The items are rated on a 1-6 point Likert-type scale, with 1 being "strongly disagree" and 6 being "strongly agree"; there is no "undecided" or "neutral" option. Example items include "Having many hands (laulima) to work towards a greater cause is key for the survival of a community" and "One should understand their responsibility (kuleana) towards their family (ohana)." Both 'Ōlelo Hawai'i (Hawaiian language) terms and their English equivalents were used to ensure all participants can understand the items. The current study, which was the HVS's pilot study, found the measure to have good internal consistency ($\alpha = .86$).

Procedure

The data was collected via a survey containing all three of the above scales. The survey was distributed through Qualtrics to students in the University of Hawai'i system. The data was collected from students at the University of Hawai'i who are 18 years of age or older, as an adult population is essential to the core of the study (i.e., the term adverse childhood experiences describes trauma occurring prior to age 18 years). All data collected was anonymous, with no identifiable information collected or stored. Students enrolled in one or more psychology courses at the University of Hawai'i at Hilo and the University of Hawai'i at Manoa were offered extra credit in their psychology course(s) for taking the survey.

Data Analysis

In line with my hypotheses, I conducted three main statistical analyses: a set of multiple linear regressions, a t-test, and a moderation. Additional follow-up analyses were conducted as needed. All analyses were conducted using IBM SPSS Statistics 19.0.

Prior to conducting my first analysis, I ran basic correlations examining the potential relationships between the HVS, the ACE-Q and its subscales (physical abuse/neglect, emotional abuse/neglect, sexual abuse, household dysfunction) and the SCIM and its subscales (consolidated identity, disturbed identity, lack of identity). I then conducted four separate multiple linear regressions using participants' total ACE-Q score as the independent variable, and the four facets of the SCIM as dependent variables (i.e., total score, disrupted identity subscale score, consolidated identity subscale score, and lack of identity subscale score). Potential confounds (i.e., age and gender) were entered in the model as additional predictor variables. I expected to find that a higher ACE-Q total score would predict a significantly higher SCIM total score, a significantly higher disrupted identity score, and a significantly lower consolidated identity score.

My second major analysis examined the relationship between Kānaka Maoli identity and ACE-Q total score by means of a t-test. I expected to find that, overall, participants identifying as Kānaka Maoli would have a significantly higher ACE score than participants who do not identify as such.

My final major analysis was a moderation, in which I expected to find that belief in traditional Hawaiian values would significantly moderate the relationship between ACE exposure and identity dysfunction in individuals who identify as Kānaka Maoli. As follow-up,

exploratory analyses, I tested for the above moderation model substituting lack of identity for total identity dysfunction (i.e., SCIM total score), and probed for simple slopes afterwards to further examine significance. I also examined the effect of traditional Hawaiian values on the relationship between ACE exposure and identity (i.e., SCIM total score and lack of identity subscale score) within the full sample.

Results

On a whole, participants ($N = 847$) mainly identified as female ($N = 614$), heterosexual ($N = 662$), Asian ($N = 468$), and “local” to Hawai‘i ($N = 436$), and were on average 20.7 years old ($SD = 5.1$). 80% of the sample ($N = 678$) reported being non-Hispanic, and 16.9% of the sample ($N = 143$) identified as part-Native Hawaiian. Most participants reported low ACE exposure ($M = 2.08$), above average endorsement of Hawaiian values ($M = 85.09$), and average levels of identity functioning ($M = 86.5$). Full descriptive statistics for the relevant scale values can be found in Table 1.

Table 1.
Descriptive Statistics for Study Variables

Variable	<i>n</i>	Min.	Max.	<i>M</i>	<i>SD</i>
Hawaiian Values Scale Total Score	847	0	132	85.09	9.17
Self-Concept and Identity Measure Full Score	847	0	173	82.72	22.26
SCIM Consolidated Identity Score	847	0	70	52.02	8.41
SCIM Disturbed Identity Score	847	0	77	37.58	11.26
SCIM Lack of Identity Score	847	0	42	17.58	8.18
ACE Questionnaire Total Score	847	0	10	2.08	2.31
ACE-Q Physical Abuse/ Neglect Score	847	0	2	.30	.54
ACE-Q Emotional Abuse/ Neglect Score	847	0	2	.67	.79
ACE-Q Sexual Abuse Score	847	0	1	.14	.35
ACE-Q Household Dysfunction Score	847	0	5	.97	1.27

A Pearson correlation coefficient was calculated to examine the relationships between the three constructs of interest: belief in Hawaiian values, identity functioning, and adverse childhood experiences. Both total score and subscale scores of the SCIM (consolidated identity, disturbed identity, lack of identity) and ACE-Q (physical abuse/neglect, emotional abuse/neglect, sexual abuse, and household dysfunction) were entered into the table alongside the full score of the HVS. The lack of identity subscale was the only construct to be significantly associated with all other constructs, $p < .05$. Additionally, emotional abuse/neglect was the most significantly associated with identity dysfunction out of all of the types of ACEs. Neither the ACE-Q total score nor any of its subscales were found to be significantly correlated with the disturbed identity subscale of the SCIM. Physical abuse/neglect, sexual abuse/neglect, and household dysfunction were similarly unassociated with identity functioning. Total ACE score and all of the ACE subscales were highly correlated at the $p < .01$ level, as were the total SCIM score and all of its subscales. Endorsement of Hawaiian values was significantly positively associated with all facets of the SCIM ($p < .01$), ACE total score ($r(847) = .07, p < .01$), and emotional abuse/neglect ($r(847) = .10, p < .01$), but did not correlate with physical abuse/neglect, sexual abuse, or household dysfunction. The full correlation table can be found in Table 2 below.

Table 2.
Pearson correlation coefficient table for Study Variables

Variable	1	2	3	4	5	6	7	8	9	10
1. Hawaiian Values Scale Total Score	—									
2. Self-Concept and Identity Measure Full Score	.36**	—								
3. SCIM Consolidated Identity Score	.40**	-.62**	—							
4. SCIM Disturbed Identity Score	.57**	.85**	-.23**	—						
5. SCIM Lack of Identity Score	.50**	.88*	-.46**	.66**	—					
6. ACE Questionnaire Total Score	.07*	.08*	-.07	-.03	.17**	—				
7. ACE-Q Physical Abuse/Neglect Score	.04	.05	-.04	-.03	.12**	.73**	—			
8. ACE-Q Emotional Abuse/Neglect Score	.10**	.14**	-.09*	.04	.20**	.80**	.59**	—		
9. ACE-Q Sexual Abuse Score	.05	.01	.01	-.04	.07**	.51**	.29**	.32**	—	
10. ACE-Q Household Dysfunction Score	.04	.03	-.05	-.07	.11**	.87**	.45**	.49**	.33**	—

Note. * $p < .05$, ** $p < .01$

Four separate multiple linear regression models were then calculated to examine the effect of ACE score on SCIM total score, consolidated identity score, disturbed identity score, and lack of identity score when controlling for age and gender. The model predicting SCIM total score was significant, $R^2 = .05$, $F(3, 843) = 13.24$, $p < .001$. Increases in ACE score were associated with increases in total SCIM score ($b = .13$, $p < .001$). Age ($b = -.19$, $p < .001$) and gender ($b = .07$, $p < .01$) both significantly predicted SCIM total score. The model predicting consolidated identity was significant, $R^2 = .02$, $F(3, 843) = 5.45$, $p < .001$. Increases in ACE score were associated with decreases in consolidated identity score ($b = -.10$, $p < .01$). Age ($b = .10$, $p < .01$) and gender ($b = -.07$, $p < .05$) both significantly predicted consolidated identity score. The model predicting disturbed identity was significant, $R^2 = .05$, $F(3, 843) = 14.98$, $p < .001$. Increases in ACE score did not predict disturbed identity SCIM score ($b = .02$, $p > .05$). Age ($b = -.22$, $p < .001$) and gender ($b = .07$, $p < .05$) both significantly predicted disturbed identity score. Finally, the model predicting lack of identity was significant, $R^2 = .04$, $F(3, 843) = 13.31$, $p < .001$. Increases in ACE score were associated with increases in lack of identity score ($b = .20$, $p < .001$). Age ($b = -.19$, $p < .001$) significantly predicted lack of identity score, but gender ($b = .06$, $p > .05$) did not.

An independent samples *t-test* was conducted to examine the differences in ACE exposure between Kānaka Maoli (KM) and non-Kānaka Maoli (NKM) participants. Prior to conducting this analysis, researchers found that both samples' ACE score was normally distributed ($p < .001$) with similar variances (NH $\sigma^2 = 6.73$; NNH $\sigma^2 = 5.02$). As predicted, Kānaka Maoli participants reported higher levels of ACE exposure ($M = 2.60$, $SD = 2.60$) compared to non-Kānaka Maoli participants ($M = 1.97$, $SD = 2.24$), $t(845) = -2.97$, $p < .001$,

with a small to medium effect size ($d = -.27$).

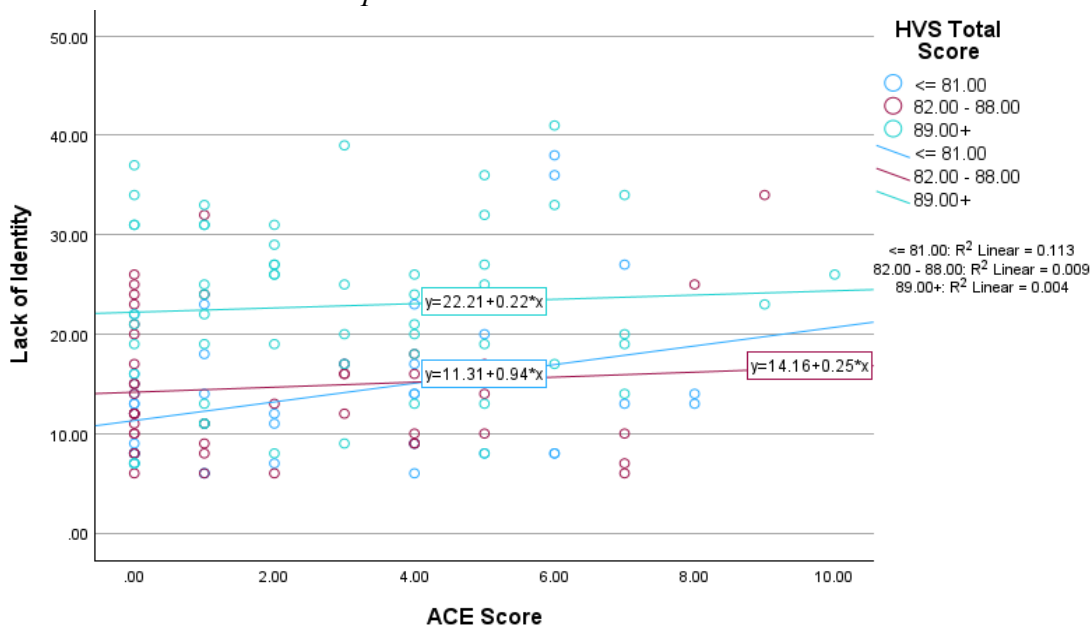
Finally, a multiple linear regression was conducted in order to examine the effect of Native Hawaiian value endorsement on the relationship between trauma exposure in childhood (i.e., ACE score) and identity dysfunction (i.e., SCIM total score) in a Kānaka Maoli population. The moderation model was significant, $R^2 = .21$, $F(5, 137) = 7.12$, $p < .001$. Increases in Hawaiian value endorsement were associated with increases in dysfunctional identity outcomes ($b = .42$, $p < .001$). There was no main effect of ACE exposure ($b = .14$, $p > .05$), and the interaction with HV endorsement was not significant ($b = -.13$, $p > .05$). Age and gender were entered into the model as control variables; age was found to be a significant predictor of identity functioning ($b = -.21$, $p < .01$), while gender was not ($b = -.02$, $p > .05$).

In conducting a moderation in the full population, the model was significant, $R^2 = .14$, $F(3, 843) = 43.70$, $p < .001$. Increases in Hawaiian value endorsement were similarly associated with increases in dysfunctional identity outcomes ($b = .36$, $p < .001$), as was ACE exposure ($b = .10$, $p < .01$). However, the interaction between ACE exposure and HV endorsement was not significant ($b = .03$, $p > .05$). Both age ($b = -.18$, $p > .001$) and gender ($b = .09$, $p > .01$) significantly predicted identity functioning.

Further probing through exploratory analyses focused on examining the proposed moderation model using different subscales of the SCIM in both the Kānaka Maoli and full populations were conducted to examine how the interaction between ACE exposure and Hawaiian value endorsement may change depending on the subscale examined. The model predicting lack of identity in the Kānaka Maoli population was significant, $R^2 = .33$, $F(5, 137) = 13.77$, $p < .001$. Increases in ACE score were associated with increases in lack of identity

outcomes ($b = .58, p < .001$). The interaction between ACE exposure and HV endorsement was significant, $b = -.16, p = .05$. Simple slopes analysis revealed that the main effect of ACE score on lack of identity score was only significant for individuals falling within the first tertile of HVS scores, $b = .34, p < .05$. Similarly, the steepest slope was found in the first tertile ($m = .94$), with the least steep slope being found in the third tertile ($m = .22$), as seen in Figure 1 below.

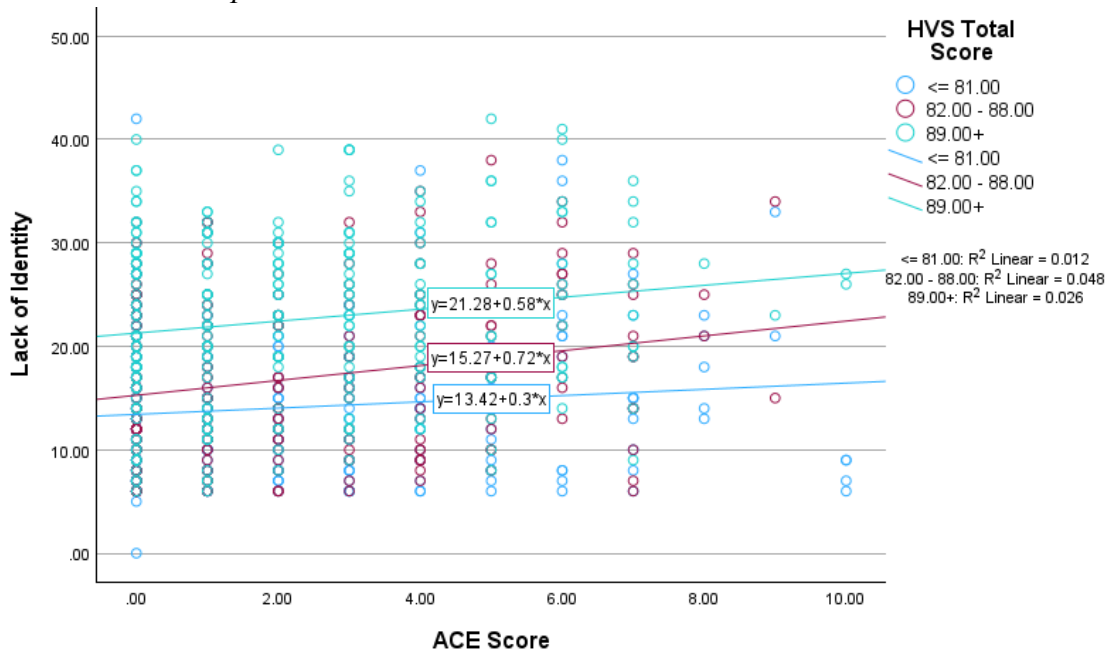
Figure 1.
Hawaiian Value Endorsement Moderates the Relationship Between Lack of Identity and ACE Score in the Kānaka Maoli Population



In conducting a moderation using the same variables in the full population, the model was significant, $R^2 = .28, F(5, 841) = 66.83, p < .001$. Both increases in ACE score ($b = .17, p < .001$) and HV endorsement ($b = .49, p < .001$) predicted increases in lack of identity outcomes, and the interaction between ACE exposure and HV endorsement approached significance ($b = .05, p = .07$). Probing for simple slopes showed that the 2nd tertile of participants had the steepest slope ($m = .72$). A regression comparing the effect of ACE score on lack of identity score

showed that ACE score did not significantly predict lack of identity score in participants falling within the first tertile of HVS scores ($b = .11, p = .06$). However, the main effect of ACE score was significant in the second ($b = .22, p < .001$) and third ($b = .16, p < .01$) tertiles. See Figure 2.

Figure 2.
Hawaiian Value Endorsement Moderates the Relationship Between Lack of Identity and ACE Score in the Full Population



Discussion

Findings

Hypothesis 1. Findings generally support the aforementioned prediction that exposure to traumatic events in childhood (i.e., ACEs) would positively predict symptoms of overall identity dysfunction, indicated by SCIM total score. Measures of consolidated identity were significantly predicted by a smaller number of endorsements to traumatic event exposure, whereas a larger number of ACE endorsements significantly predicted both the overall measure of identity dysfunction and the lack of identity measure. Interestingly, the disturbed identity measure does

not necessarily reflect the same outcome. Despite the measures of overall identity dysfunction, lack of identity, and disturbed identity being significantly positively correlated, the disturbed identity subscale was not significantly predicted by ACE endorsement. However, the lack of identity measure was predicted by increased ACE endorsement of all kinds (i.e., physical abuse/neglect, emotional abuse/neglect, sexual abuse, and household dysfunction). This implies that individuals reporting a higher level of traumatic exposure, regardless of the type of traumatic exposure, are left feeling more “broken” or “empty.” This finding provides additional support to previous research (e.g., Labonté & Kealy, 2023; Penner et al., 2019) showing that childhood adversity may have negative impacts on identity formation, even within a non-clinical population.

Hypothesis 2. On a whole, Kānaka Maoli participants reported higher levels of ACE exposure when compared to non-Kānaka Maoli participants. The small to medium effect size, as shown by Cohen’s *d*, implies a meaningful difference in ACE exposure between the two groups. This finding is in line with previous research showing that, within the state of Hawai‘i, the Kānaka Maoli population is more likely to be exposed to trauma both in childhood and over the lifespan.

Hypothesis 3. Contrary to prediction, belief in Native Hawaiian values predicted increases in dysfunctional identity outcomes (i.e., a higher SCIM score), while ACEs did not; additionally, no evidence was found to support the moderation model as it was originally proposed. These findings held true both in participants who identified as at least partially Kānaka Maoli and in the surveyed population as a whole. However, exploratory analyses showed evidence pointing towards HV endorsement moderating the relationship between ACE exposure

and self-reported feelings of lacking an identity (e.g., feeling broken or like a person without a soul) in the Kānaka Maoli population. The results of this analysis show that increased belief in Hawaiian values leads to healthier, more comprehensive identity outcomes (i.e., lower levels of lack of identity item endorsement) despite higher levels of ACE exposure. Follow-up analyses revealed that ACE score only significantly predicted lack of identity in individuals in the lowest tertile of HV endorsement, showing that stronger belief in Hawaiian values causes the relationship between ACE score and feelings of lacking an identity to weaken. This supports the hypothesis that belief in Hawaiian values is beneficial towards Kānaka Maoli individuals' self-concept, and may assist in identity formation peri- and post- traumatic exposure. The same analysis in the larger population also had promising results, though only approached statistical significance. In probing for simple slopes, researchers found that individuals falling within the second tertile of Hawaiian value endorsement had the strongest and most significant relationship between ACE score and lack of identity, while individuals within the first and third tertiles had a weaker, and less significant, relationship between the same constructs. Researchers speculate this result may demonstrate that belief in culturally-relevant values may assist an individual in feeling that they have a sense of identity. Some Hawaiian values overlap with other cultures (e.g., Asian cultures, other Indigenous cultures) due to their focus on collectivism, the family, and nature. Thus, despite not identifying as Kānaka Maoli, it is possible that individuals within the highest tertile endorsed a high amount of Hawaiian values due to them overlapping with their own personal set of cultural values. Similarly, individuals falling within the lowest tertile who endorsed the least amount of Hawaiian values, yet still showed better identity outcomes than the middle tertile, may reject more collectivist Hawaiian values in favor of values that are more

culturally relevant to them (e.g., values prioritized within a more individualistic society).

Overall, results show that consistency with one's values system is beneficial for ego-identity functioning, regardless of cultural identification or background.

Additional Findings. Notably, within the Pearson's correlation table, we found that all measures of identity (SCIM total score, consolidated identity, disturbed identity, and lack of identity) were positively associated with Hawaiian value endorsement. We speculate that this could be due to many students being of younger age ($M = \sim 21$ years old) and thus still in the *identity vs. role confusion* stage of Erikson's psychosocial stages, causing increased feelings of identity disruption despite aligning with a specific set of cultural values (i.e., Hawaiian values). Similarly, the concept of "dual identity" suggests that individuals often hold two different identities—that of their ethnic background and their national background (Dovidio et al., 1998). Additionally, Social Identity Theory (Tajfel & Turner, 1979) and the Common Ingroup Identity Model (Dovidio et al., 2007) both posit that the rejection of one or both of these identities may lead to more negative self-evaluations and, thus, more negative mental health outcomes. It is possible that participants, especially minority group (i.e., non-White) participants had more negative evaluations of their ethnicity, in turn negatively evaluating values associated with their ethnicity (e.g., collectivism), due to a lack of identity integration. These negative self-evaluations would only be compounded by the lasting effects of colonization, and could result in cognitive distancing from their ethnic identity (see Weaver & Hartz, 1999). These factors, in turn, could influence the relationship between Hawaiian value endorsement and negative identity outcomes in some participants.

Limitations

Due to the nature of the current study, several limitations were present that leave room for vulnerabilities with generalizability and bias in the data.

Sampling Method. Participants were recruited by convenience sampling using the University of Hawai‘i system, resulting in a fairly small, non-clinical sample. Additionally, due to increased incentive via the SONA system, most participants were undergraduate psychology students attending the University of Hawai‘i at Mānoa (UHM), a four-year college. Individuals enrolled at UHM often come from more privileged backgrounds in comparison to other schools (e.g., UH community colleges) and thus results may be skewed as a result. Additional analysis could be conducted separating the two populations (UHM students versus students from other schools) to examine possible differences in trauma exposure, identity outcomes, and Hawaiian value endorsement. Though the SCIM has been shown to be reliable and valid in community samples prior (e.g., Kaufman et al., 2014), results may not reflect clinical levels of identity disruption and may be vulnerable to bias. Choosing to recruit participants attending higher education in the State of Hawai‘i also inherently leads to bias within the study, as many Kānaka Maoli are unable to pursue higher education due to financial constraints, location or proximity to universities, and/or belief in values resulting in a prioritization of one’s family over the pursuit of higher education. Thus, the results of this study specifically examining individuals identifying as Kānaka Maoli may not be generalizable to the entire population; rather, they are only generalizable to Kānaka Maoli who have the resources, ability, and support needed to pursue a college degree or higher.

Data Collection Method. To keep the questionnaire accessible on a larger scale, researchers in the current study opted to use self-report measures, which introduced the possibility of self-report bias. Furthermore, due to the majority of the questionnaire being multiple choice, it is possible for respondents to have selected randomly rather than being entirely honest about their responses. Though bad data, such as consistently repetitive cases (e.g., answering the same number for every question) and cases that sped through their responses (e.g., total response time under five minutes) were screened out as accurately as possible, there is still the possibility that some responses are not entirely truthful to the individual's experience, thus creating possible issues with reliability in the dataset.

Scale Reliability. Because this was the pilot study of the Hawaiian Values Scale, it is still difficult to accurately determine reliability of the scale. Although the current study revealed a good level of reliability in the population of interest ($\alpha = .86$), further research is necessary to refine the scale and more accurately pinpoint reliability of the HVS.

Implications for Behavioral Health

Taken together, results generally support the a priori hypotheses that, although Kānaka Maoli experience higher rates of childhood trauma as a whole, belief in and implementation of Hawaiian values contributes to healthier identity outcomes (i.e., a lower degree of self-reported feelings of brokenness, emptiness, or being without a soul). The current study supports previous research showing that it is essential for behavioral health providers to be aware of their clients' cultural backgrounds, encourage experimentation with practices their clients deem culturally relevant, and be mindful of their clients' cultural values in and out of the therapy room. In the State of Hawai'i, exploring Native Hawaiian cultural values and practices within the therapy

space may be beneficial to clients' mental health, particularly in working with Kānaka Maoli clients who report childhood or lifetime trauma exposure. The current study showed that a relationship exists between traumatic exposure in childhood and feelings of lacking an identity in Kānaka Maoli university students when they endorse lower levels of belief in Hawaiian values. Thus, practitioners working with Kānaka Maoli individuals would be able to better serve their clients by being knowledgeable about Hawaiian history, culture, values, and practices, and by being open to explore aspects of Hawaiian culture that resonate with their clients within session.

Appendix A

The Self-Concept and Identity Measure

Kaufman, Cundiff, & Crowell (2015)

This appendix contains the instructions and items of the Self-Concept and Identity Measure (SCIM) used in this study, created by Kaufman et al. (2015). The Consolidated Identity subscale is composed of items 1, 2, 3, 5, 9, 11, 14, 16, 17, and 19; the Disturbed Identity subscale is composed of items 4, 6, 7, 10, 12, 18, 21, 23, 25, 26, and 27; and the Lack of Identity subscale of items 8, 13, 15, 20, 22, and 24. The full-scale score is calculated by reverse scoring items in the Consolidated Identity subscale, then adding all items together.

Please read each statement carefully. Circle the number 1 through 7 that best represents your level of agreement for each statement.

	Strongly Disagree	Disagree	Some- what Disagree	Neither Agree Nor Disagree	Some- what Agree	Agree	Strongly Agree
1. I know what I believe or value	1	2	3	4	5	6	7
2. When someone describes me, I know if they are right or wrong	1	2	3	4	5	6	7
3. When I look at my childhood picture I feel like there is a thread connecting my past to now	1	2	3	4	5	6	7
4. Sometimes I pick another person and try to be just like them, even when I'm alone	1	2	3	4	5	6	7
5. I know who I am	1	2	3	4	5	6	7
6. I change a lot depending on the situation	1	2	3	4	5	6	7
7. I have never really known what I believe or value	1	2	3	4	5	6	7
8. I feel like a puzzle and the pieces don't fit together	1	2	3	4	5	6	7
9. I am good	1	2	3	4	5	6	7

10. I imitate other people instead of being myself	1	2	3	4	5	6	7
11. I have been interested in the same types of things for a long time	1	2	3	4	5	6	7
12. I am so different with different people that I'm not sure which is the "real me"	1	2	3	4	5	6	7
13. I am broken	1	2	3	4	5	6	7
14. When I remember my childhood I feel connected to my younger self	1	2	3	4	5	6	7
15. I feel lost when I think about who I am	1	2	3	4	5	6	7
16. At least one person sees me for who I really am	1	2	3	4	5	6	7
17. I always have a good sense about what is important to me	1	2	2	4	5	6	7
18. I am so similar to certain people that sometimes I feel like we are the same person	1	2	3	4	5	6	7
19. I am basically the same person that I've always been	1	2	3	4	5	6	7
20. I feel empty inside, like a person without a soul	1	2	3	4	5	6	7
21. My opinions can shift quickly from one extreme to another	1	2	3	4	5	6	7
22. I no longer know who I am	1	2	3	4	5	6	7
23. I am more capable when I am with others than when I am by myself	1	2	3	4	5	6	7
24. No one knows who I really am	1	2	3	4	5	6	7
25. I try to act the same as the people I'm with (interests, music, dress) and I change that all the time	1	2	3	4	5	6	7
26. I am only complete when I am with other people	1	2	3	4	5	6	7
27. The things that are most important to me change pretty often	1	2	3	4	5	6	7

Appendix B

The Adverse Childhood Experiences Questionnaire

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., ... & Marks, J. S. (1998).

This appendix contains the instructions and items of the Adverse Childhood Experiences Questionnaire (ACE-Q) used in this study, created by Felitti et al. (1998). The Physical Abuse and Neglect subscale is composed of items 2 and 5; the Emotional Abuse and Neglect subscale is composed of items 1 and 4; the Sexual Abuse subscale is composed of item 3; and the Household Dysfunction subscale is composed of items 6, 7, 8, 9, and 10. The full-scale score is calculated by adding all items together. A warning and resources were included in the case that any questions elicited significant distress.

This section of the questionnaire examines adverse childhood experiences and may be distressing. If significant distress occurs, please consult one or more of the following resources:

National Suicide Prevention Lifeline: Call 1-800-273-8255 (En español: 1-888-628-9454)

To chat with a crisis counselor, visit <https://suicidepreventionlifeline.org/chat/>

Crisis Text Line: Text HOME to 741 741

Veterans Crisis Line: Call 1-800-273-8255 or Send a text to 838255

Call SAMHSA's National Helpline to find a therapist or treatment center for problems with mental health – 1-800-662-HELP (4357)

IN CASE OF AN EMERGENCY, PLEASE CALL 911

While you were growing up, during your first 18 years of life:

	Yes	No
Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? Act in a way that made you afraid that you might be physically hurt?		

<p>Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?</p>		
<p>Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral or anal intercourse with you?</p>		
<p>Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?</p>		
<p>Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?</p>		
<p>Was a biological parent ever lost to you through divorce, abandonment, or other reason?</p>		
<p>Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?</p>		
<p>Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?</p>		
<p>Was a household member depressed or mentally ill? or Did a household member attempt suicide?</p>		
<p>Did a household member go to prison?</p>		

Appendix C

The Hawaiian Values Scale

Bradley & Kim (2025)

This appendix contains the instructions and items of the Hawaiian Values Scale used in this study, created by Bradley and Kim (2025). No subscale scores were utilized in the analysis of the current study. The full-scale score is calculated by reverse scoring items 10, 14, and 18, then adding all items together.

Please use the scale below to rate the extent to which you agree with the value expressed in each statement. Native Hawaiian ethnic identity and/or knowledge of the Hawaiian language and culture are not required to complete this scale.

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1. One should create and maintain a stable environment for their family (‘ohana).	1	2	3	4	5	6
2. It is important to be welcoming, respectful, and loving (show aloha) towards others.	1	2	3	4	5	6
3. One should be aware of the earth’s limited resources and alter their behavior for the benefit and sustainability of the earth.	1	2	3	4	5	6
4. Having many hands (laulima) to work towards a greater cause is key for the survival of a community.	1	2	3	4	5	6
5. I continue to engage in my family’s traditional spiritual practices (‘aumakua).	1	2	3	4	5	6
6. One should understand their responsibility (kuleana) towards their community.	1	2	3	4	5	6
7. I can use the sound of my voice to converse with nature (oli/chants).	1	2	3	4	5	6
8. Forming a connection with my elders and ancestors is a priority for me.	1	2	3	4	5	6

9. One of my main priorities is to take care (mālama) of the land and ocean.	1	2	3	4	5	6
10. I prioritize my own values over my family's ('ohana) values.	1	2	3	4	5	6
11. Preserving stories through movement (hula) and oral tradition is important.	1	2	3	4	5	6
12. One should act in a righteous, morally correct manner (pono) for the wellbeing of others.	1	2	3	4	5	6
13. To achieve unity, balance, and harmony (lōkahi) with a higher power and nature is key for society.	1	2	3	4	5	6
14. Having a fulfilling and successful life is more important to me than supporting my family and community.	1	2	3	4	5	6
15. One should understand their responsibility (kuleana) towards their family ('ohana).	1	2	3	4	5	6
16. I find personal meaning in visiting spiritual and ceremonial sites or temples (heiau).	1	2	3	4	5	6
17. It is important to show patience and humility (ho'omanawanui), even when you are inconvenienced.	1	2	3	4	5	6
18. Forming a connection with the land is <u>not</u> a priority for me.	1	2	3	4	5	6
19. To set things right (ho'oponopono) with your family ('ohana) is important.	1	2	3	4	5	6
20. I personally value the use of alternative forms of medicine (lā'au lapa'au).	1	2	3	4	5	6

References

- Akhtar, S. (1984). The syndrome of identity diffusion. *The American Journal Of Psychiatry*, *141*, 1381–1385.
- Anda, R. F., Fleisher, V. I., Felitti, V. J., Edwards, V. J., Whitfield, C. L., ... & Williamson, D. F. (2004). Childhood abuse, household dysfunction, and indicators of impaired adult worker performance. *The Permanente Journal*, *8*(1), 30–38. <https://doi.org/10.7812/TPP/03-089>
- Antonio, M. C. K., Hishinuma, E. S., Ing, C. T., Hamagami, F., Dillard, A., ... & Kaholokula, J. K. (2020). A Resilience Model of Adult Native Hawaiian Health Utilizing a Newly Multi-Dimensional Scale, *Behavioral Medicine*, *46*(3-4), 258-277, <https://doi.org/10.1080/08964289.2020.1758610>
- Berman, S. L. (2016). Identity and Trauma. *Journal of Traumatic Stress Disorders & Treatment*, *5*(2). <https://doi.org/10.4172/2324-8947.1000e108>
- Berman, S. L., Montgomery, M. J., & Ratner, K. (2020). Trauma and identity: A reciprocal relationship? *Journal of Adolescence*, *79*, 275–278. <https://doi.org/10.1016/j.adolescence.2020.01.018>
- Berntsen, D., & Rubin, D. C. (2007). When a trauma becomes a key to identity: enhanced integration of trauma memories predicts posttraumatic stress disorder symptoms. *Applied Cognitive Psychology*, *21*(4), 417–431. <https://doi.org/10.1002/acp.1290>

- Bogaerts, A., Claes, L., Buelens, T., Gandhi, A., Kiekens, G., Bastiaens, T., & Luyckx, K. (2021). The self-concept and identity measure in adolescents: Factor structure, measurement invariance, and associations with identity, personality traits, and borderline personality features. *European Journal of Psychological Assessment, 37*(5), 377–387. <https://doi.org/10.1027/1015-5759/a000623>
- Bogaerts, A., Luyckx, K., Bastiaens, T., Sleuwaegen, E., Berens, A., & Claes, L. (2023). The Self-Concept and Identity Measure in Patients with Personality Disorders: A Psychometric Evaluation and Associations With Identity Processes, Core Domains of Self-Functioning, and Personality Disorder Symptoms. *Assessment, 30*(7), 2184-2197, <https://doi.org/10.1177/10731911221140313>
- Brady, K. T., & Back, S. E. (2012). Childhood trauma, posttraumatic stress disorder, and alcohol dependence. *Alcohol research : current reviews, 34*(4), 408–413.
- Branscombe, N. R., Schmitt, M. T., & Harvey, R. D. (1999). Perceiving pervasive discrimination among African Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology, 77*(1), 135. <https://doi.org/10.1037/0022-3514.77.1.135>
- Briere, J. (1996). A self-trauma model for treating adult survivors of severe child abuse. In J. Briere, L. Berliner, J. Bulkley, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment*. Thousand Oaks, CA: Sage.
- Campbell, J. D., Assanand, S., & Di Paula, A. (2003). The Structure of the Self-Concept and Its Relation to Psychological Adjustment. *Journal of Personality, 71*(1), 115–140.

- Carlson, E. B., Furby, L., Armstrong, J., & Shlaes, J. (1997). A conceptual framework for the long-term psychological effects of traumatic childhood abuse. *Child Maltreatment, 2*(3), 272–295.
- Carlton, B. S., Goebert, D. A., Miyamoto, R.H., Andrade, N. N, Hishinuma, E. S., ... & Nishimura, S. T. (2006). Resilience, Family Adversity and Well-Being Among Hawaiian and Non-Hawaiian Adolescents. *International Journal of Social Psychiatry, 52*(4), 291-308. <http://doi.org/10.1177/0020764006065136>
- Center of Rural Innovation. (2023, January 12). *Who lives in rural America? The geography of rural race and ethnicity*. <https://ruralinnovation.us/blog/who-lives-in-rural-america-part-2>
- Crawford, T. N., Cohen, P., Johnson, J. G., Sneed, J. R., & Brook, J. S. (2004). The course and psychosocial correlates of personality disorder symptoms in adolescence: Erikson’s developmental theory revisited. *Journal of Youth and Adolescence, 33*, 373–387. <https://doi.org/10.1023/B:JOYO.0000037631.87018.9d>
- Donahue, E. M., Robins, R. W., Roberts, B. W., & John, O. P. (1993). The divided self: concurrent and longitudinal effects of psychological adjustment and social roles on self-concept differentiation. *Journal of personality and social psychology, 64*(5), 834–846. <https://doi.org/10.1037/0022-3514.64.5.834>
- Dovidio, J. F., Gaertner, S. L., & Saguy, T. (2007). Another view of “we”: Majority and minority group perspectives on a common ingroup identity. *European Review of Social Psychology, 18*(1), 296–330. <https://doi.org/10.1080/10463280701726132>

- Dovidio, J. F., Gaertner, S. L., & Validzic, A. (1998). Intergroup bias: status, differentiation, and a common in-group identity. *Journal of personality and social psychology*, 75, 109–120.
<https://doi.org/10.1037/0022-3514.75.1.10>
- Erikson, E. H. (1950). *Childhood and society*. New York, NY: W. W. Norton & Company, Inc.
- Erikson, E. H. (1968). *Identity, youth and crisis*. New York, NY: W. W. Norton & Company, Inc.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, 14(4), 245–258.
[https://doi.org/10.1016/s0749-3797\(98\)00017-8](https://doi.org/10.1016/s0749-3797(98)00017-8)
- Fleming, J., & Ledogar, R. J. (2008). Resilience and Indigenous Spirituality: A Literature Review. *Pimatisiwin*, 6(2), 47–64.
- Frewen, P., Zhu, J., & Lanius, R. (2019). Lifetime traumatic stressors and adverse childhood experiences uniquely predict concurrent PTSD, complex PTSD, and dissociative subtype of PTSD symptoms whereas recent adult non-traumatic stressors do not: results from an online survey study. *European journal of psychotraumatology*, 10(1).
<https://doi.org/10.1080/20008198.2019.1606625>
- Guler, J. (2014). The Relationship Among Previous Exposure to War and Conflict, Acculturation, and Identity Formation Among Adolescent Refugees. *University of Central Florida*. <https://stars.library.ucf.edu/honorstheses1990-2015/1573>

- Guo, S., Ning, X., & Qin, T. (2021). "The interaction effect of traditional Chinese culture and ego identity exploration on the flourishing of rural Chinese children": Corrigendum. *Children and Youth Services Review*, 122, Article 105930. <https://doi.org/10.1016/j.childyouth.2021.105930>
- Harangody, M., Blach Vaughan, M. B., Richmond, L. S., & Luebke, K. K. (2022). Hālanā ka mana‘o: place-based connection as a source of long-term resilience. *Ecology and Society*, 27(4). <https://doi.org/10.5751/ES-13555-270421>
- Harter, S. (1997). The personal self in social context: Barriers to authenticity. In R. D. Ashmore & L. J. Jussim (Eds.), *Self and identity: Fundamental issues* (pp. 81–105). Oxford University Press.
- Hishinuma, E. S., McArdle, J. J., Miyamoto, R. H., Nahulu, S. B., Makini, Jr., G. K., ... & Yates, A. (2000). Psychometric Properties of the Hawaiian Culture Scale-Adolescent Version. *Psychological Assessment*, 12(2), 140-157.
- Hughes, M., Kiecolt, K. J., Keith, V. M., & Demo, D. H. (2015). Racial Identity and Well-Being among African Americans. *Social Psychology Quarterly*, 78(1), 25–48. <https://doi.org/10.1177/0190272514554043>
- Hoeltge, J., Bradley, L. E., Borge, O., Ko, D., & Lorinda, R. (2025). *Holu Kanaka Hawai‘i: Native Hawaiian Daily Pathways to Resilience* [Unpublished manuscript]. Department of Psychology, University of Hawai‘i at Mānoa.
- Horejsi, C., Craig, B. H., & Pablo, J. (1992). Reactions by Native American parents to child protection agencies: cultural and community factors. *Child Welfare*, 71(4), 329–342.

- James, R., Daukantaitė, D., Nilsson, M. (2023). A validation of the Swedish self-concept and Identity Measure (SCIM) and its association with mental health problems. *Heliyon*, 9(7). <https://doi.org/10.1016/j.heliyon.2023.e1815>
- Johnson, J. G., Cohen, P., Brown, J., Smailes, E. M., Bernstein, D. P. (1999). Childhood Maltreatment Increases Risk for Personality Disorders During Early Adulthood. *Archives of General Psychiatry*, 56(7), 600–606. <https://doi.org/10.1001/archpsyc.56.7.600>
- Kana‘iaupuni, S. M., & Ishibashi, K. (2003). *Left behind: The status of Hawaiian students in Hawai‘i public schools*. Honolulu, HI: Kamehameha Schools, PASE Report 02-03:13.
- Kana‘iaupuni, S. M., & Malone, N. (2006). This Land is My Land: The Role of Place in Native Hawaiian Identity. *Hūlili: Multidisciplinary Research on Hawaiian Well-Being*, 3(1). https://kamehamehapublishing.org/wp-content/uploads/sites/38/2020/09/Hulili_Vol3_14.pdf
- Kanuha, V. K. (2007). W.E.B. Du Bois Research Fellowship. U.S Department of Justice. <https://www.ojp.gov/pdffiles1/nij/grants/216951.pdf>
- Kam, S. B., Paikai, K. K., Carreiro, J. T. K., & Pacquiao, D. F. (2019). Sociohistorical Perspective on Health Vulnerability of Native Hawaiians. *Journal of Nursing Practice Applications & Reviews of Research*, 9(2), 28–36. <https://doi.org/10.13178/jnparr.2019.09.02.0906>
- Kaufman, E. A., Cundiff, J. M., & Crowell, S. E. (2015). The Development, Factor Structure, and Validation of the Self-concept and Identity Measure (SCIM): A Self-Report Assessment of Clinical Identity Disturbance. *Journal of Psychopathology and Behavior Assessment*, 37, 122–133. <https://doi.org/10.1007/s10862-014-9441-2>

- Kaufman, E. A., Montgomery, M. J., & Crowell, S. E. (2014). Identity-Related Dysfunction: Integrating Clinical and Developmental Perspectives. *Identity, 14*, 297–311.
<https://doi.org/10.1080/15283488.2014.944699>
- Kaufman, E. A., Puzia, M. E., Crowell, S. E., & Price, C. J. (2019). Replication of the Self-Concept and Identity Measure (SCIM) Among a Treatment-Seeking Sample. *Identity, 19*(1), 18-28, <https://doi.org/10.1080/15283488.2019.1566068>
- Kim, B. S. K., & Hong, S. (2004). A psychometric revision of the Asian Values Scale using the Rasch model. *Measurement and Evaluation in Counseling and Development, 37*, 15-27.
- Klest, B., Freyd, J. J., & Foynes, M. M. (2013). Trauma Exposure and Posttraumatic Symptoms in Hawaii: Gender, Ethnicity, and Social Context. *Psychological trauma: theory, research, practice and policy, 5*(5), 409–416. <https://doi.org/10.1037/a0029336>
- Kouvelis, G., & Kangas, M. (2021). Evaluating the association between interpersonal trauma and self-identity: A systematic review. *Traumatology, 27*(2), 118–148.
<https://doi.org/10.1037/trm0000325>
- Labonté, L.E., Kealy, D. (2023) Linking childhood maltreatment and depressive symptoms: identity, shame, and age effects. *Current Psychology*.
<https://doi.org/10.1007/s12144-023-05274-w>
- Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.
- MacMillan, H. L., Fleming, J. E., Streiner, D. L., Lin, E., Boyle, M. H., Jamieson, E., ... & Beardslee, W. R. (2001). Childhood abuse and lifetime psychopathology in a community sample. *American Journal of Psychiatry, 158*(11), 1878-1883.

- Mani'ole, J., & Meyer, M. A. (1998) Ka Maka o ka Ihe Laumeki – the point of the barbed spear: native Hawaiian epistemology and health. *Pacific Health Dialog*, 5(2), 357–360
- Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology*, 3(5), 551–558. <https://doi.org/10.1037/h0023281>
- McGregor, D. (2007). *Na kua'aina: living Hawaiian culture*. University of Hawaii Press.
- Menon, P., Chaudhari, B., Saldanha, D., Devabhaktuni, S., & Bhattacharya, L. (2016). Childhood sexual abuse in adult patients with borderline personality disorder. *Industrial Psychiatry Journal*, 25(1), 101–106. <https://doi.org/10.4103/0972-6748.196046>
- Miller, K. M., Cahn, K., Anderson-Nathe, B., Cause, A. G., & Bender, R. (2013). Individual and systemic/structural bias in child welfare decision making: Implications for children and families of color. *Children and Youth Services Review*, 35(9), 1634–1642. <https://doi.org/10.1016/j.childyouth.2013.07.002>
- Mokuau, N. (2002). Culturally based interventions for substance use and child abuse among native Hawaiians. *Public Health Reports*, 117(Suppl 1): S82–S87.
- Murphy, A., Steele, M., Dube, S. R., Bate, J., Bonuck, K., Meissner, P., ... & Steele, H. (2014). Adverse Childhood Experiences (ACEs) Questionnaire and Adult Attachment Interview (AAI): Implications for parent child relationships. *Child Abuse & Neglect*, 38(2), 224-233. <https://doi.org/10.1016/j.chiabu.2013.09.004>
- Nagel, J. (1994). Constructing Ethnicity: Creating and Recreating Ethnic Identity and Culture. *Social Problems*, 41(1), 152–176. <http://doi.org/10.2307/3096847>

- Ogilvie, T. (2021). Community Risk and Protective Factors Related to Child Maltreatment in Native Hawaiian Families: An Exploratory Study. *University of Washington ProQuest Dissertations Publishing*.
https://digital.lib.washington.edu/researchworks/bitstream/handle/1773/47580/Ogilvie_washington_02500_23122.pdf?sequence=1
- Oláh, B., Fekete, Z., Kuritárné Szabó, I., & Kovács-Tóth, B. (2023). Validity and reliability of the 10-Item Adverse Childhood Experiences Questionnaire (ACE-10) among adolescents in the child welfare system. *Frontiers in Public Health, 11*.
<https://doi.org/10.3389/fpubh.2023.1258798>
- Oliveira, K. A. R. (2014). *Ancestral places: Understanding kanaka geographies*. Oregon State University Press.
- Oneha, M. (2001). Ka maui o ka ‘āina a he maui kānaka: An ethnographic study from an Hawaiian sense of place. *Pacific Health Dialog, 8*, 299–311
- Paetzold, R. L., & Rholes, W. S. (2021). The Link from Child Abuse to Dissociation: The Roles of Adult Disorganized Attachment, Self-Concept Clarity, and Reflective Functioning. *Journal of trauma & dissociation, 22*(5), 615–635.
<https://doi.org/10.1080/15299732.2020.1869654>
- Pencea, I., Munoz, A. P., Maples-Keller, J. L., Fiorillo, D., Schultebrucks, K., ... & Powers, A. (2020). Emotion dysregulation is associated with increased prospective risk for chronic PTSD development. *Journal of Psychiatric Research, 121*, 222–228.
<https://doi.org/10.1016/j.jpsychires.2019.12.008>

- Penner, F., Gambin, M., & Sharp, C. (2019). Childhood maltreatment and identity diffusion among inpatient adolescents: The role of reflective function. *Journal of adolescence, 76*, 65–74. <https://doi.org/10.1016/j.adolescence.2019.08.002>
- Powers, A., Cross, D., Fani, N., & Bradley, B. (2015). PTSD, emotion dysregulation, and dissociative symptoms in a highly traumatized sample. *Journal of Psychiatric Research, 61*, 174–179. <https://doi.org/10.1016/j.jpsychires.2014.12.011>
- Raposo, S. M., Mackenzie, C. S., Henriksen, C. A., & Afifi, T. O. (2014). Time does not heal all wounds: Older adults who experienced childhood adversities have higher odds of mood, anxiety, and personality disorders. *The American Journal of Geriatric Psychiatry, 22*(11), 1241–1250. <https://doi.org/10.1016/j.jagp.2013.04.009>
- Riley, L., Su‘esu‘e, A., Hulama, K., Neumann, S. K., Chungdo, J. (2022). Ke ala i ka Mauiola: Native Hawaiian Youth Experiences with Historical Trauma. *International Journal of Environmental Research and Public Health, 19*. <https://doi.org/10.3390/ijerph191912564>
- Rose, S. D. (2016). *Challenging global gender violence: The global clothesline project*. United Kingdom: Palgrave Macmillan.
- Schmitt, M. T., Spears, R., & Branscombe, N. R. (2002). Constructing a minority group identity out of shared rejection: the case of international students. *European Journal of Social Psychology, 33*(1), 1–12. <https://doi.org/10.1002/ejsp.131>
- Shalka, T. R. (2019). Saplings in the Hurricane: A Grounded Theory of College Trauma and Identity Development. *The Review of Higher Education 42*(2), 739-764. <https://doi.org/10.1353/rhe.2019.0013>.
- Tajfel, H. (1970). Experiments in intergroup discrimination. *Scientific American, 223*, 96–102.

- Tajfel, H., & Turner, J. C. (1979). An integrative theory of inter-group conflict. In W. G. Austin & S. Worchel (Eds.), *The social psychology of inter-group relations* (pp. 33–47). Monterey, CA: Brooks/Cole.
- Truskauskaite-Kuneviciene, I., Brailovskaia, J., Kamite, Y., Petrauskaite, G., Margraf, J., & Kazlauskas, E. (2020). Does Trauma Shape Identity? Exploring the Links Between Lifetime Trauma Exposure and Identity Status in Emerging Adulthood. *Frontiers in psychology, 11*, 570644. <https://doi.org/10.3389/fpsyg.2020.570644>
- Waterman, A. S. (2020). “Now what do I do?”: Toward a conceptual understanding of the effects of traumatic events on identity functioning. *Journal of Adolescence, 79*, 59–69. <https://doi.org/10.1016/j.adolescence.2019.11.005>
- Wexler, L. (2009). The Importance of Identity, History, and Culture in the Wellbeing of Indigenous Youth. *The Journal of the History of Childhood and Youth, 2*(2), 267–276. <http://doi.org/10.1353/hcy.0.0055>
- Wilkinson-Ryan, T., & Westen, D. (2000). Identity Disturbance in Borderline Personality Disorder: An Empirical Investigation. *The American Journal of Psychiatry, 157*(4), 528–41. <https://doi.org/10.1176/appi.ajp.157.4.528>.

- Wingenfeld, K., Schäfer, I., Terfehr, K., Grabski, H., Driessen, M., ... & Spitzer, C. (2011). Reliable, valide und ökonomische Erfassung früher Traumatisierung: Erste psychometrische Charakterisierung der deutschen Version des Adverse Childhood Experiences Questionnaire (ACE) [The reliable, valid and economic assessment of early traumatization: first psychometric characteristics of the German version of the Adverse Childhood Experiences Questionnaire (ACE)]. *Psychotherapie, Psychosomatik, medizinische Psychologie*, 61(1), e10–e14. <https://doi.org/10.1055/s-0030-1263161>
- Weaver, H. N., & Hartz, M. Y. H. B. (1999). Examining Two Facets of American Indian Identity: Exposure to Other Cultures and the Influence of Historical Trauma. *Journal of Human Behavior in the Social Environment*, 2(1-2), 19–33. https://doi.org/10.1300/j137v02n01_03
- Wong, A. E., Dirghangi, S. R., & Hart, S. R. (2019) Self-concept clarity mediates the effects of adverse childhood experiences on adult suicide behavior, depression, loneliness, perceived stress, and life distress. *Self and Identity*, 18(3), 247–266, <https://doi.org/10.1080/15298868.2018.1439096>
- Ye, D., & Reyes-Salvail, F. (2014). Adverse childhood experiences among Hawai'i adults: Findings from the 2010 Behavioral Risk Factor Survey. *Hawai'i journal of medicine & public health: a journal of Asia Pacific Medicine & Public Health*, 73(6), 181–190.