Prejudice, Stigma, and Oppression on the Behavioral Health of Native Hawaiians and Pacific Islanders

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Abstract

In this chapter, we provide an historical and demographic overview of Native Hawaiians and Pacific Islanders in the USA, their exposure to oppression and prejudice, and their most prevalent behavioral health problems compared to other ethnic groups. We review the psychosocial perspectives offered to explain the role of oppression, stigmatization, and prejudices in their behavioral health problems and highlight their resiliency and protective family factors. We also provide a review of the extant literature examining the effects of historical trauma, oppression, and discrimination on a range of behavioral health problems among Native Hawaiians and Pacific Islanders to include depression, psychological distress, physiological stress indices, general mental health, suicidality, and substance use. A conceptual model of the pathways from oppression and discrimination to behavioral health problems is offered. Finally, we discuss culturally responsive approaches to providing behavioral health services to Native Hawaiians and Pacific Islanders that focus on issues related to prejudice, stigma, and oppression.

Keywords

Pacific Islanders · Prejudice · Stigma · Oppression · Native Hawaiians

Pacific Islanders are the indigenous peoples of the regions of the Pacific known as Polynesia (e.g., Hawai'i, Tonga, Sāmoa, and Aotearoa New Zealand), Melanesia (e.g., Fiji and Vanuatu), and Micronesia (e.g., the Marshall Islands, the Federated States of Micronesia, Guam, and Palau) (Fischer, 2002). Since arriving in the Pacific over 4000 years ago, the ancestors of Pacific Islanders have been living and thriving on the over 25,000 islands and atolls linked by the Pacific Ocean that, together, comprises 180 million square kilometers and includes more than 1500 languages. They developed unique cultures and sophisticated forms of government and resource management systems that were conducive to an island ecosystem. They traversed the Pacific on double-hulled canoes visiting other Pacific Island groups for centuries before Europeans set sail across the Atlantic (Low, 2013). When Capt. James Cook, the British explorer, and his expedition came across the islands of the Pacific and their peoples between

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1769 and 1779, they were impressed by, if not envious of, the physical, emotional, and social well-being of many of these Pacific Island nations (Beaglehole, 1967).

In this chapter, we first provide a post-Western contact, historical overview of Native Hawaiians and Pacific Islanders because their history is often overlooked in US history courses and thus unfamiliar to most people in the USA, especially as it relates to the emphasis of this book – prejudice, stigma, and oppression. We then describe their emerging demographics and exposure to stigmatization and discrimination in the USA. We then follow with a review of the behavioral health status of Native Hawaiians and Pacific Islanders and the psychological perspectives and scant studies pertaining to the effects of prejudice, stigma, and oppression on behavioral health outcomes. We then discuss the provision of culturally responsive, behavioral health services to Native Hawaiians and Pacific Islanders. Finally, we conclude with a summary and recommendations for future research with Native Hawaiians and Pacific Islanders.

Despite our collective discussion of Native Hawaiians and Pacific Islanders in this chapter, we want to emphasize that they represent a diverse group of peoples with different languages, customs, acculturation statuses (e.g., indigenous, immigrant, and migrant), and aspirations. Although the US Office of Management and Budget (OMB) aggregates them into a single ethnic/racial category called Native Hawaiians and Other Pacific Islanders, we eliminate the word "Other" in this chapter to avoid minimizing the importance of any one of the diverse Pacific Islander groups living in the USA.

History of Exploitation, Oppression, and Displacement in the Pacific

Following Cook's Pacific expedition in the late 1700s, an influx of European (e.g., British, Germans, Spanish, and French) and American foreigners followed with the intent of Christianizing the natives, exploiting their resources, and developing commerce (e.g., whaling and plantations). These foreigners also introduced infectious diseases (e.g., gonorrhea, measles, influenza, and Hansen's disease) against which the aboriginal populations had no natural immunity to ward off, thereby decimating many of their populations to near extinction throughout the 1800s (Bushnell, 1993). In Hawai'i, as an example, Native Hawaiians went from a population of roughly 650,000 in 1778 to barely 35,000 by 1898, which is over a 95% decline in the matter of a century (Goo, 2015; Stannard, 1989). Many Pacific Island nations succumbed to Western control by countries, such as the USA, France, Germany, and England, as either colonized or occupied territories. They asserted their Western values, norms, and notions of governance, land ownership, and commerce on the aboriginal populations, which were counter to their traditional worldviews and practices that emphasized communal cooperation, living in balance with others and nature, and strict resource management. Thus, Western imposition led to population decline, cultural suppression, social marginalization, and economic deprivation for many Pacific Islanders (Spickard, Rondilla, & Hippolite Wright, 2002). A Hawaiian saying from this time period exemplifies the sentiment of Pacific populations in regard to their experience with Western foreigners: *Lawe li'ili'i ka make a ka Hawai'i, lawe nui ka make a ka haole;* translating as *Death by Hawaiians takes a few at a time; death by foreigners takes many* (Pukui, 1983).

In the late 1800s and early 1900s, there was an increase in military conflicts in the Pacific, which brought further marginalization, displacement, and hardship for the aboriginal populations (Davis, 2015). Spain and Imperial Japan had taken possession of many Pacific Islands in the South and Western Pacific, which led to US intervention. The Spanish–American War of 1898 between the USA and Spain over the latter's territories in the Pacific, and Imperial Japan's occupation of many Micronesian Islands during World War II, led to the USA eventually acquiring control over much of the Western and Northern Pacific. The Pacific Campaign of World War II was fought literally in the "backyard" of many

Pacific Islander communities with Imperial Japan's occupation of their islands (e.g., Guam, Saipan, Kiribati, and Nauru). The USA entered World War II after Imperial Japan bombed the U.S. Naval Base at Pearl Harbor on the island of O'ahu in the Hawaiian archipelago on December 7, 1941. Between 1946 and 1962, the USA conducted nuclear testing in places such as the Bikini Atoll in the Marshall Islands, which destroyed and contaminated the surrounding islands and waters, thereby displacing many Pacific Islanders in the area and placing them at an increased risk for various cancers that persist to the present day (Yamada & Akiyama, 2014). Throughout the Pacific, Pacific Islanders were forced to abandon their subsistence and communal lifestyle and practices of traditional land stewardship (Palafox, 2011).

With US militarization in the Pacific came oppression and discrimination directed toward Pacific Islanders by these foreign settlers in their homeland, as exemplified by the Massie Affair from Hawai'i (Stannard, 2005). By the 1930s, a white oligarchy had formed with the militarization of Hawai'i, which included high-ranking senior Naval officers and their families. In September 1931, five local men – three Native Hawaiian and two Japanese men – were wrongfully arrested and accused of gang raping Thalia Massie, the daughter of a wealthy and politically connected family and wife of Lieutenant Thomas Massie, a US Naval officer. The case pitted the Native Hawaiian and Asian local community against the elite White "haole" (foreigner) community. Thalia Massie falsely accused these five local men of the crime. The Massie trial made national news in the USA, with Massie represented by one of the most prominent lawyers of the time, Clarence Darrow. Thalia's mother, Grace Hubbard Fortescue, arranged for two of the five men to be kidnapped by US Navy personnel to beat a confession out of them after the initial trial ended in a hung jury, which resulted in one of them, Joseph Kahahawai, a Native Hawaiian, being murdered. The Massie Affair exposed the deep-rooted racism that existed in the islands, primarily toward Native Hawaiians at the time, which mirrored what was happening to African-Americans in the Southern United States.

Throughout the Pacific, a century of wars, exploitation, and turmoil by foreign powers altered the island homes and way of life for Pacific Islanders and placed them at a political, social, and economic disadvantage in their own homelands. Many of the types of commerce Westerners were engaged in (e.g., whaling and plantation farming) brought more foreigners, mainly of East Asian descent (e.g., Chinese, Japanese, and Filipino), into their island communities as hired labor, which further marginalized Pacific Islanders. Compulsory acculturation strategies and stigmatization of Pacific Islander worldviews and practices (i.e., banning of native language and dances) by Christian missionaries and Western-imposed laws and lifestyles had significant adverse physical and mental health consequences for contemporary Pacific Islanders. For example, the highest rates of obesity, diabetes (Hawley & McGarvey, 2015), and suicide (Else, Andrade, & Nahulu, 2007) in the world are found in Pacific Islander communities, which are in sharp contrast to the health status observed by Cook and members of his expedition prior to Western intrusion. Consequently, these adverse conditions, to include the loss of atolls and islands to sea level rising due to global warming, led to a Pacific Islander diaspora to countries such as the USA, New Zealand, and Australia in search of educational and economic opportunities (Ahlgren, Yamada, & Wong, 2014; Spickard et al., 2002). However, they continue to face discrimination, stigmatization, acculturative stressors, and economic deprivation in these countries.

Emerging Presence of Native Hawaiians and Pacific Islanders in the United States

Native Hawaiians are the Indigenous People of the Hawaiian Islands, territories now occupied by the USA as the 50th state in the union and collectively called Hawai'i. Hawai'i was a sovereign nation under the Kingdom of Hawai'i from the time the islands were united under one

government by King Kamehameha I in 1810 to the illegal US-supported overthrow of Queen Liliu‘okalani in 1893 (Dougherty, 1992). Interestingly, those who conspired to overthrow the monarch were descendants of the early missionaries to Hawai‘i who had become part of the wealthy elite. Two American presidents recognized the overthrow of the Hawaiian monarchy as illegal: Grover Cleveland in 1893 based on the findings of the Blount Report and Bill Clinton in 1993 with the Apology Resolution (U.S. Public Law 103–150). Under international law, Hawai‘i is considered to be occupied by the USA since Native Hawaiians never relinquished their claims to their inherent sovereignty over their national lands to the USA (Sai, 2015) “either through the Kingdom of Hawai‘i or through a plebiscite or referendum,” as stated in U.S. Public Law 103–150.

Despite the tenuous acquisition of Hawai‘i by the USA, Native Hawaiians do not share a similar political status as an indigenous population like that of American Indians and Alaska Natives with the US government. They do not have federal recognition or a mechanism to exercise their sovereignty and are not eligible for support from Indian Health Services. Although it was never enacted, there has been an attempt to introduce federal legislation for the recognition of a Native Hawaiian governing entity with the Native Hawaiian Government Reorganization Act of 2009. However, three federal policies have been enacted to improve the living (i.e., Hawaiian Homes Commission Act), educational (i.e., Native Hawaiian Education Reauthorization Act), and physical and mental health (i.e., Native Hawaiian Health Care Improvement Act) conditions of Native Hawaiians. They have also been included in the other federal legislation as part of American Indian and Alaska Native policies (e.g., the Native American Programs Act and the Native American Languages Act). In 1978, the State of Hawai‘i also established the Office of Hawaiian Affairs (OHA) to manage assets set aside for the betterment of Native Hawaiians (Article XII of the Hawai’i State Constitution). These legislations were established to address past injustices and their negative consequences on Native Hawaiians. Nonetheless, many Native Hawaiians have been actively protesting the US occupation of their islands and seeking restoration of their government since 1893 up to the present (Goodyear-Ka‘opua, Hussey, & Wright, 2014; Silva, 2004). They are also actively revitalizing their cultural values and practices (e.g., native language) and asserting their aspirations, but often face discrimination and opposition from the settler society in these endeavors (Goodyear-Ka‘opua et al., 2014).

The circumstance that brought other Pacific Islanders under US influence varies. For most Pacific Islanders, educational and economic opportunities were the primary reason for emigration to Hawai‘i and the continental US. After World War II, Samoans emigrated from American Sāmoa, an incorporated territory of the USA since 1900, and Sāmoa (formally known as the Independent State of Sāmoa) for agricultural and factory work. It was a similar case for Tongans who came from the Kingdom of Tonga in Polynesia. Guam, from which Guamanians/Chamorro people come from, has been a territory of the USA after Spain ceded control to the USA in 1898. After international condemnation regarding USA’s geopolitical involvement in Micronesia (Riklon, Alik, Hixon, & Neal, 2010) in the late 1980s, the USA and three Micronesian nations – the Federated States of Micronesia, the Republics of Marshall Islands and Palau – signed the Compact of Free Association (COFA) treaties (U.S. Public Law 180–188). These treaties gave the USA exclusive military access to the region in exchange for the responsibility to build their health and education infrastructures and provide COFA citizens entry into the USA without visas. However, the US government has failed to live up to their obligations under COFA, and despite the fact that COFA migrants are required to pay taxes, the USA has revoked Medicaid coverage for many of these Pacific Islanders (Yamada & Akiyama, 2014). This barrier is especially devastating as Micronesians have a high burden of infectious and chronic diseases and thus healthcare has been a reason many of them moved to Hawai‘i and the continental US (MacNaughton

& Jones, 2013). At the same time, military occupation and damage from radiation continue to disrupt Micronesia's traditional economies, cultures, and subsistence diets, leading to Western-diet-related chronic diseases (Palafox, 2011).

Today, Native Hawaiians and Pacific Islanders make up roughly 1.2 million of the total US population, with Native Hawaiians making up a majority (43%) of all Pacific Islanders followed by Samoans (15%) and Guamanians/Chamorros (12%; Hixson, Hepler, & Kim, 2012). About half of all Native Hawaiians and Pacific Islanders in the USA report mixed-ethnic ancestry. Native Hawaiians have the highest percentage of individuals reporting mixed-ethnic ancestry, with 30% reporting Hawaiian-only ancestry. Despite the large ethnic admixture among Native Hawaiians, it is estimated that over 90% of them strongly identify with their Native Hawaiian ancestry, regardless of their degree of Hawaiian ancestry (Kaholokula, Nacapoy, & Dang, 2009). Native Hawaiians and Pacific Islanders are any individuals having origin in any of the original inhabitants of the Pacific Islands from which they claim ancestry.

The fastest-growing Pacific Islander groups in the USA come from the Federated States of Micronesia (e.g., Chuukese and Kosrae), the Republic of the Marshall Islands (Marshallese), and the Republic of Palau (Hixson et al., 2012). A majority of Pacific Islanders in the USA reside in Hawai'i (355,816), California (286,145), and Washington State (70,322), but they can be found in all US states and in high concentrations in places like Springdale, Arkansas. Arkansas has the second largest Marshallese population outside of Hawai'i, many of whom emigrated to Arkansas for economic opportunities (McElfish, Hallgren, & Yamada, 2015). For many Pacific Islanders in the USA, whose religious faiths for the most part are Protestant, Mormon, and Catholic, churches serve as the focal point and major source of support for them to deal with the acculturative stressors they experience and to maintain a sense of community (Aitaoto, Braun, Dang, & So'a, 2007).

Shifting Forms of Stigmatization and Discrimination

Although initially characterized by Capt. Cook and his men as "humane," "friendly," and "hospitable," Native Hawaiians and Pacific Islanders were eventually stigmatized by negative stereotypes held by Western foreigners. They were labeled as "savages," "heathens," and "wretched creatures," often by Christian missionaries seeking to convert the natives to Christianity (McCubbin & Marsella, 2009). These early Christian missionaries perhaps wanted the natives to be perceived, true or not, as "savages" in need of salvation to justify their existence and presence in the Pacific. Overtime, other negative categorizations were assigned to Native Hawaiians and Pacific Islanders that continues today, such as being labeled as "lazy," "unintelligent," "violent," and "unmotivated." Ironically, there also exist positive stereotypes assigned to them, such as in the case of Native Hawaiians. They are known to show much *aloha* (affection, love, hospitality, and respect) toward others. In fact, the concept of "aloha spirit" is widely promoted in Hawai'i where it is a slogan used to attract tourist and codified in state law to promote civil behavior. Of course, what appears to be a positive stereotype may actually be another form of oppression designed to subtly placate the natives by encouraging passive indigenous values while suppressing those that may empower them.

Needless to say, the overt and covert racial discrimination experienced by Native Hawaiians and Pacific Islanders have had profound adverse effects on their self-identity and psychological well-being. For many Native Hawaiians living in the early to mid-1900s, their Hawaiian phenotype and language were often the target of discrimination, as they became a minority in their own homeland with the influx of European American and Asian settlers to Hawai'i. The speaking and teaching of Hawaiian language was outlawed in government and the school systems by the US-supported provisional government after the overthrow in 1893 (Act 57, sec. 30 of the 1896 Laws of the Republic of Hawai'i; Kahumoku, 2003). This suppression of the Hawaiian language

(as well as many cultural practices) carried on under US control. Native Hawaiian youth were physically disciplined (e.g., struck on their knuckles with a ruler) by their schoolteachers for speaking their native language in the classroom. As a result, many Native Hawaiian parents raised their children with English as their first, and often the only language, with the hopes that they would easily assimilate into the American-dominated mainstream. This led to an entire generation of Native Hawaiians not acquiring fluency in their native language, which almost led to the disappearance of the language. Ironically, these schoolteachers who enforced these discriminatory policies against Native Hawaiians were often of Asian ancestry and descendants of immigrants to Hawai‘i, who themselves were also the target of discrimination by Whites.

A suppressed version of Hawaiian history from the colonizer's perspective was also being taught in the school systems that cast a positive light on America and its presence in Hawai‘i while patronizing or demonizing the lifestyle and practices of Native Hawaiian ancestors. Native Hawaiians were made to feel ashamed of their Hawaiian ancestry because facts about their history and culture were distorted in order to justify the US occupiers' agenda of manifest destiny. Many Native Hawaiians who also had Asian or White ancestry would try to pass themselves off as these other ethnic groups and conceal their Hawaiian ancestry in order to avoid being discriminated against. Private and certain public (e.g., English standard schools) schools were established to separate the social elite, often White students, from the Indigenous and Asian immigrant students. This educational segregation has had lasting effects on the educational system in Hawai‘i and the socioeconomic status of many contemporary Native Hawaiians and Pacific Islanders (Benham & Heck, 1998; Okamura, 2008).

For Native Hawaiians, a turning point in this history of oppression was the Hawaiian Renaissance of the 1970s when there was a resurgence of pride in being Native Hawaiian and a pushback against nearly a century of cultural, psychological, and physical oppression and marginalization. From the Hawaiian Renaissance emerged cultural and political movements that eventually led to the revitalization of the Hawaiian language and other indigenous practices (e.g., hula, traditional Hawaiian dancing, and chanting); the protection of cultural and natural resources (e.g., stopping the Navy's bombing practices on the island of Kaho‘olawe); the return of traditional voyaging canoes and navigation that confirmed the technological and scientific sophistication of Hawaiian ancestors; and the creation of Hawaiian studies and language centers at the University of Hawai‘i and other educational opportunities for Native Hawaiians (Goodyear-Ka‘opua et al., 2014). As Tengan (2008) asserts, in describing the significance of the Hawaiian Renaissance, "despite the fact that Hawaiian control over land, government, and resources has not materialized, there has been a paradigmatic shift in thinking since the 1960s on the reality of sovereignty and decolonization for Hawaiians" (p. 57).

Some argue that explicit or overt racism has declined over the past 50 years in the USA and morphed into more of a subtle or implicit racism that thrives because of its incorporation into our systems and policies (e.g., Levy, 2016). Others argue that explicit racism has reemerged stronger than ever in the USA (e.g., Perrin, 2018). Perhaps, both the institutional racism that maintains the status quo of inequities and the renewed attacks on ethnic minorities as their numbers and influence grow in the USA are operating simultaneously. Whether it is overtly or covertly experienced, many Native Hawaiians and Pacific Islanders deal with some form of racial discrimination on a regular basis. For example, it is estimated that 48% of Native Hawaiians are discriminated against "often" to "most of the time" while 52% experience discrimination "sometimes" over a 12-month period (Kaholokula, 2014).

As contemporary Native Hawaiians and Pacific Islanders assert their unique cultural worldviews and indigenous prerogatives, and revitalize their cultural practices and institutions, they often find themselves being challenged by the larger dominant society. Native

Hawaiians, for example, seeking to protect their sacred lands from further desecration currently find themselves in opposition with certain policymakers, university leaders, and some in the astronomy community over the proposed development of a Thirty Meter Telescope (TMT) on the top of Mauna Kea, one of the world's tallest mountains on the island of Hawai'i. If developed, the TMT would be a formidable structure standing about 217 feet in diameter and 180 feet in height. Some believe the TMT would provide an unprecedented view of the universe, allowing for more scientific advances, while also boosting Hawai'i's economy. However, TMT opponents, mainly Native Hawaiians, are concerned about the long-term environmental damage this structure could cause and, most importantly, the disrespect to Mauna Kea's status as a *wao akua* (sacred site) and *piko* (portal to the ancestors) for Native Hawaiians. It is important to note that there already exist several observatories on top of Mauna Kea, although they are considerably smaller in scale than the TMT. Individuals and organizations representing the interests of Native Hawaiians seeking to protect Mauna Kea and those seeking to develop TMT are currently engaged in a legal battle over this contentious issue. Many other indigenous communities, such as Māori of New Zealand and American Indians/Alaska Natives on the continental US, have come out in strong support of Native Hawaiians in their opposition to the TMT development.

The strife over the development of TMT on Mauna Kea is only of many that Native Hawaiians have had to contend with over the last several decades to protect their indigenous values, practices, lands, and aspirations in Hawai'i. It is a struggle that other Pacific Islanders will likely face as they to seek to reverse the effects of US colonialism and occupation on their island homes. The chronic and persistent stressors from cultural loss, economic deprivation, and discrimination are likely the underlying causes of the poorer behavioral health status of Native Hawaiians and Pacific Islanders when compared to other ethnic groups in the USA.

Behavioral Health Status of Native Hawaiians and Pacific Islanders

Native Hawaiians and Pacific Islanders have among the highest prevalence of behavioral health problems compared to other US ethnic groups to include depression, anxiety, suicide, substance use, interpersonal violence, and accidents. It is often difficult to ascertain specific behavioral health data among Native Hawaiians and Pacific Islanders because they are usually aggregated with Asian populations in many epidemiological studies and public health reports because of concerns regarding small sample size (Panapasa, Crabbe, & Kaholokula, 2011). We present studies that disaggregated Native Hawaiians and Pacific Islanders from Asian samples to highlight the most prevalent behavioral health inequities.

Studies indicate that depression is higher in Native Hawaiians and Pacific Islanders compared to other ethnic groups and the general population. Adult Native Hawaiians living in Hawai'i have a higher prevalence of current depression (13%) compared to Filipinos (9%), Whites (9%), Japanese (6%), Chinese (5%), and the overall state's population (8%; (Salvail & Smith, 2007). Across the USA, Native Hawaiians and Pacific Islanders are more likely to report experiencing serious psychological distress in the past 30 days (4%) when compared to Asians (2%) and the general US population (3%) (Galinsky, Zelaya, Barnes, & Simile, 2017). According to the 2009 Youth Risk Behavior Survey (YRBS), Native Hawaiian and Pacific Islander high school students reported feeling sad or hopeless more frequently over a 12-month period (33%) than did their American Indian/Alaska Native (31%), Asian (24%), Black (28%), and White (24%) counterparts across the USA. The prevalence of severe or moderately severe depression is higher in Native Hawaiians and Pacific Islanders of ages 65 and older (4.8%) compared to Asians (1.5%) and the overall population of Hawai'i (2.7%) (Aczon-Armstrong, Inouye, & Reyes-Salvail, 2013). Depression in Native Hawaiians and Pacific Islanders is strongly associated with anxiety, aggression (Makini Jr. et al., 1996), substance

use (Kaholokula, Grandinetti, Crabbe, Chang, & Kenui, 1999), and suicide (Yuen, Nahulu, Hishinuma, & Miyamoto, 2000).

Lowry, Eaton, Brener, and Kann (2011) examined pooled behavioral health data from several years (2001, 2003, 2005, and 2007) of the YRBS. They found that Native Hawaiians and Pacific Islander high school students ($n = 56,773$) had higher rates of substance use, sexual activity, carrying a weapon, engaging in a physical altercation, and suicidal ideations and attempts than students of other ethnic groups, which were the same when stratified by gender. As an example, the substance use among Native Hawaiians and Pacific Islander students was 44% for alcohol, 32% for heavy drinking, and 23% for marijuana use. A study by Sasaki and Kameoka (2009) showed that Native Hawaiian adolescents were at least two times more likely to engage in lifetime sexual intercourse, recent sexual intercourse, and sexual initiation before the age of 13 years compared to White adolescents. Substance use in Native Hawaiian youth is associated with many other behavioral health issues, such as depression, anxiety, suicidality, conduct disorders, unsafe sex with multiple partners, and experiencing violence (Edwards, Giroux, & Okamoto, 2010).

Klest, Freyd, and Foynes (2013) found that Native Hawaiians were exposed to greater trauma related to accidents and abuse and reported more symptoms of trauma (e.g., depression, anxiety, PTSD, and sleep disturbances) over the life course than Japanese, Filipinos, and Caucasians in Hawai‘i, which did not differ by gender as it did with other ethnic groups. Goebert et al.’s (2000) study of 4164 adolescents found that Native Hawaiian adolescents experienced greater family adversity than non-Hawaiian adolescents, and that family adversity was associated with substance use by a family member, which strongly influenced adolescent use. Examples of family adversity that were greater in Native Hawaiians included family disruption (e.g., death or separation of family member), family criminality (e.g., arrest of a family member), and poor family health (e.g., a family member with a severe illness or injury).

Ye and Reyes-Salvail (2014) examined adverse childhood experiences (e.g., physical, verbal, sexual abuse, domestic violence) among Hawai‘i adults using data from the 2010 Behavioral Risk Factor Surveillance System (BRFSS). Seventy-five percent of Native Hawaiian adults reported one or more adverse childhood experiences compared to 64% of Whites, 52% of Filipinos, 45% of Japanese, 40% of Chinese, and 69% of others. The gap between Native Hawaiian adults and their ethnic counterparts widened with increasing number of adverse childhood experiences reported. The largest difference between Native Hawaiians and other ethnic groups was in the adverse childhood experiences of living with a family member with substance abuse (39%), having a family member in prison (13%), witnessing interpersonal violence (31%), and experiencing physical (25%) and verbal abuse (47%).

Most concerning are the extremely high suicide rates among Native Hawaiians and Pacific Islanders. Among Native Hawaiians of 15–44 years of age, suicide rates per 100,000 range from 52.8 to 72.4 compared with 22 to 47.2 for Caucasians, 21.5 to 49 for Japanese, and 27.4 to 37.5 for Filipinos, rendering the overall suicide rate among Native Hawaiians to be the highest in the USA (Else et al., 2007). There is very little information regarding suicidality among other Pacific Islander groups in Hawai‘i and the continental US. However, the suicide rates reported in the US-Affiliated Pacific Islands are among the highest in the world. In some Micronesian communities, such as in Chuuk, completed suicide rates are at 194 per 100,000 for ages 15–24 (Booth, 1999). Elsewhere in the US-Affiliated Pacific Islands, the rates are as high as 59 per 100,000 in Guam and 99 per 100,000 across all of Micronesia (Else et al., 2007). For the most part, the suicide rates are higher for Pacific Islander males than females, with the exception of Sāmoa.

The Behavioral Health Consequences of Prejudice, Stigma, and Oppression

Psychosocial Perspectives

Several psychosocial perspectives have been advanced to explain the disproportionate rates of behavioral health problems observed among Native Hawaiians that directly link these problems to issues of cultural loss and conflict, acculturative stressors, stigma, and oppression (Kaholokula, 2007; Kaholokula et al., 2009). In a 1983 report prepared by the Native Hawaiian Education Assessment Project (NHEAP), it was determined that "Modern Hawaiians seem to suffer from a new kind of depression, a being 'beaten down', but not by rain, rather, by a sense of enormous personal loss.…caused by two centuries of rapid change away from Hawaiian culture…" (p. 212).

Hammond (1988) presented the *cultural loss/stress hypothesis*, which was used as the conceptual framework for the NHEAP report, to explain the concerning educational outcomes and associated behavioral problems observed in Native Hawaiian youth. Based on the ecological systems theory by Bronfenbrenner (1979), this hypothesis describes a causal mechanism that starts with an unbalanced cultural contact between Native Hawaiians and Westerners, in favor of the latter, which resulted in cultural conflicts (macro system level) leading to Hawaiian cultural loss (exo system level) and to negative social outcomes (meso system level). The negative social outcomes then lead to increased family and community stressors (micro system) and to individual risk for physical and mental health problems (individual development). As long as an individual or group is preoccupied in dealing with significant physical and mental health issues, the other parts of this system in this causal mechanism, such as the meso- and micro systems, remain problematic and unchanged – a perpetual cycle of adversity.

Rezentes (1996), a Native Hawaiian psychologist, described the psychological distress and range of interrelated behavioral health problems caused by oppression and cultural disruptions as the *kaumaha syndrome*. Kaumaha is the Hawaiian word for heavy, but figuratively means sad or depressed. The symptoms of the kaumaha syndrome include sadness, sense of hopelessness, anger, and hostility. Rezentes asserts that contemporary Native Hawaiians share a "collective sadness and moral outrage" from centuries of oppression and cultural discord with Westerners and the 1893 overthrow of the ruling monarch. He states:

> Hawaiians were coerced into submitting to foreign institutions, laws, and cultures and forced to either give up or be punished for practicing their traditional culture. Some Hawaiians have internalized their oppressors' messages. They have become trapped in vicious cycles of poor health practices, abuse of 'ohana [family] members, neglect or prostitution of traditional Hawaiian culture, and the abandonment of their spirituality.' (p. 37)

Crabbe (1999), another Native Hawaiian psychologist, speculated that many contemporary Native Hawaiians suffer from a form of depression that he refers to as *hō'ino'ino* or broken-spirit. Hō'ino'ino in Hawaiian literally means to abuse or injure. Crabbe writes, "This type of depressed 'broken-spirit' may be the psychological repercussion from years of cultural conflict with Westerners, acculturative discord, and progressive cultural regress" (p. 125).

The type of depression that NHEAP (1983), Rezentes (1996), and Crabbe (1999) described are consistent with the theory of learned helplessness postulated by Seligman (1974). Miller, Rosellini, and Seligman (1985) described it as the actions of "passive people who have negative cognitive sets about the effects of their own actions, who become depressed upon the loss of an important source of gratification" (p. 182–183). It is a reactive type of depression caused by environmental events (e.g., oppression) influencing internal events (e.g., negative thoughts about self-worth or efficacy). Learned helplessness is associated with behavioral health problems, such as depression (Smallheer, Vollman, & Dietrich, 2018), posttraumatic stress disorder (PTSD) (Hammack, Cooper, & Lezak, 2012), substance abuse (Thornton et al., 2003), and risky sexual

behaviors (Pittiglio, 2017). Learned helplessness as a form of depression may be an adaptive response to subjugation and exploitation among conquered peoples (Gilbert, 2000; Sloman, 2000).

Many behavioral health professionals working with Indigenous populations promote the concept of *historical trauma* to describe the type of psychological wounding experienced by Indigenous communities because of past and present transgressions. These transgressions include interpersonal violence, forced displacement from ancestral lands, cultural and language loss, compulsory acculturation strategies (e.g., forced removal of children to boarding schools), and overt and covert discrimination (Sotero, 2006). Historical trauma can be transmitted from one generation to the next (e.g., cross-generational cycle of trauma) and relived by many Indigenous persons in both narrative forms (e.g., stories passed down) and through their lived experiences of stigmatization (e.g., drunk or lazy native) and other prejudices and violence directed toward them by others. Thus, it is a chronic race-based type of trauma with serious psychological consequences, such as depression, anxiety, anger, shame, grief, and social isolation (Mohatt, Thompson, Thai, & Tebes, 2014).

Resilience, Family Support, and Behavioral Health

These notions of depression as an adaptive response to oppression and the idea that Native Hawaiians and Pacific Islanders are simply "helpless" and "traumatized" fail to take into account their resilience and ability to flourish, despite these adversities. They also fail to recognize that a majority of them do not suffer from a significant behavioral health issue. They are revitalizing their traditional values and practices (e.g., native language; traditional diets, forms of physical activities, and resource management; and ocean voyaging traditions) and utilizing these cultural assets to support their aspirations and for health promotion (Aitaoto et al., 2007; Look, Kaholokula, Carvhalo, Seto, & de Silva, 2012). Over 90% of Native Hawaiians strongly identify with their Native Hawaiian heritage and culture (Kaholokula, 2017), and 80% strongly believe it is important to maintain their unique cultural values and practices for psychological well-being (Kamehameha Schools, 2014). Since Christianization and the loss of their traditional leadership structures, churches have served as the focal point and major source of support for many Pacific Islanders living in the USA. Their religious or spiritual faith is a source of strength and support in dealing with the acculturative stressors they experience and in organizing Pacific Islander communities (Aitaoto et al., 2007). Native Hawaiian and Pacific Islanders have formed civic, sports clubs, and other nonprofit organizations to engage, support, and celebrate their communities.

Native Hawaiians and Pacific Islanders share similar cultural values and notions of well-being. Familial and social relations are interdependent in nature, with families encompassing a vast extended social network that goes beyond the immediate family to include their community, clan, and village, whether in their islands of origin or in the continental US. As mentioned earlier, they hold a high reverence for the church, but they also have a strong connection to their lands, practice reciprocity, and adhere to authority and protocols (Braun, Kim, Ka'opua, Mokuau, & Browne, 2015). Samoans, for example, practice *fa'asāmoa,* or to behave Sāmoan, which requires fidelity to family, ancestral lands, and the church (Aitaoto et al., 2007). Native Hawaiians practice *mālama 'āina* or land stewardship and resource sustainability that is genealogically linked and an ancestral responsibility (Kaholokula, 2017). The ability of Native Hawaiians and Pacific Islanders to adhere to these cultural values and practices central to their identity and social relations is intimately tied to their physical and emotional well-being.

Studies show that strong positive family relations are protective against behavioral health problems in Native Hawaiian and Pacific Islander youths. Among 155 Native Hawaiian adolescents living in poverty, DeBaryshe, Yuen, Nakamura, and Stern (2006) found that those who believe in

the importance of respecting family members and whose parents provide a supportive environment (versus creating a harsh environment) were less likely to exhibit behavioral problems. Carlton et al. (2006) examined the effects of resilience and family adversity indicators on internalizing (i.e., depression and anxiety) and externalizing (i.e., aggression) symptoms over 2 years among 1832 Native Hawaiian (64%) and non-Native Hawaiian (36%) adolescents. They examined a range of individual, family, and community-level resilience indicators (e.g., academic achievement, family support, and extracurricular activities) and family adversity (e.g., family discord). Although Native Hawaiian adolescents were found to experience more family adversity (i.e., low socioeconomic status and higher family discord, stress, psychopathology, and poor health), they reported higher levels of family support (i.e., emotional support) compared to non-Native Hawaiian adolescents. For both groups of adolescents, they found that the resiliency factors of greater family support and physical fitness were strongly associated with less internalized symptoms, whereas the resiliency factors of greater academic achievement and family support were strongly associated with less externalizing symptoms. However, physical fitness had a greater effect on externalizing symptoms for Native Hawaiian adolescents than their non-Hawaiian counterparts, but academic achievement had a greater effect on internalizing symptoms for non-Hawaiian than for Native Hawaiian adolescents.

The Effects of Oppression and Discrimination on Behavioral Health Indicators

Lending support to the psychological theories previously reviewed, scientific studies are slowly mounting showing the deleterious effects of oppression, as manifested in the experience of historical trauma, racism, and cultural discord, on behavioral health indices in Native Hawaiians and Pacific Islanders, albeit most focused on Native Hawaiians. They range from psychophysiological to epidemiological studies, aimed at elucidating the relationship between various indices of oppression on suicidality, psychological distress, substance use, and physiological measures of distress.

Yuen et al. (2000) examined the effects of Hawaiian cultural identification, socioeconomic status, and psychiatric symptoms on suicidality in 3094 Native Hawaiian high school students. They found that Native Hawaiian adolescents had higher rates of suicide attempts (13%) compared to non-Hawaiian adolescents (10%). The higher rates among Native Hawaiian adolescents were associated with greater Hawaiian cultural identification (odds ratio [OR] = 1.99), depression (OR = 1.07), substance abuse (OR = 1.39), and grade levels. The finding that a stronger Hawaiian cultural identity was associated with more suicide attempts among Native Hawaiian adolescents, independent of the psychiatric measures, was counter to what the researchers expected. One plausible hypothesis they offered to explain this finding was that Native Hawaiian youth with a stronger cultural identity were mostly at odds with the dominant Western culture in Hawai‘i and thus they were experiencing higher levels of cultural conflicts and acculturative stress, which in turn placed them at a greater risk for suicide.

Subsequent studies among adult Native Hawaiians have lent support to the notion that Hawaiian cultural identity may be a marker for the cultural discord and acculturative stress they are experiencing as measured by perceptions of oppression. Kaholokula et al. (2012) examined the effects of perceived ethnic oppression on physiological stress indices in 146 adult Native Hawaiians. The physiological stress indices measured were salivary cortisol levels (i.e., a hormone of the hypothalamic–pituitary–adrenal [HPA] axis) and systolic and diastolic blood pressure (as an indicator of sympathetic-adrenal-medullary activity). Ethnic oppression was measured using a modified version of the Oppression Questionnaire (OQ), which measured two aspects of oppression: (1) felt oppression (i.e., the respondent's subjective experience of feeling oppressed and (2) attributed oppression (i.e., oppression attributed to an oppressive

social group by the respondent) (Victoroff, 2005). First, they found that a stronger Hawaiian cultural identity had a significant positive correlation with both attributed (r = *0*.17) and felt oppression (r = 0.21), lending support to Yuen et al.'s (2000) hypothesis regarding their aforementioned findings. They further found a significant negative correlation between attributed oppression and diurnal cortisol levels ($r = -0.21$), which persisted after adjusting for the effects of sociodemographic (e.g., age, sex, and education level), biological (e.g., body mass index and blood pressure), and psychosocial factors (e.g., cultural identity and psychological stress). They also found a significant positive correlation between felt oppression and systolic blood pressure (r = 0.22). However, this correlation was attenuated after adjusting for body mass index (BMI), a measure of obesity. McCubbin and Antonio (2012) have found an association between overt discrimination and overweight/obesity (BMI $\geq$ 25) status in Native Hawaiian adults.

The negative correlation between perceived oppression and cortisol levels found by Kaholokula et al. (2012) may be indicative of oppression as a chronic stressor versus an acute stressor in which cortisol is expected to increase to prepare the body for "fight or flight" (Fries, Hesse, Hellhammer, & Hellhammer, 2005). A lower, flattened, or blunted cortisol output occurs after a prolonged period of HPA axis hyperactivity (i.e., long period of elevated cortisol levels) due to chronic stress (Susman, 2007). A similar cortisol activity is found in persons with PTSD (Heim, Ehlert, Hanker, & Hellhammer, 1998), burnout (Pruessner, Hellhammer, & Kirschbaum, 1999), and atypical depression (Gold & Chrousos, 2002). Lower cortisol levels have also been found to be associated with depression linked to learned helplessness (Croes, Merz, & Netter, 1993).

Hermosura, Haynes, and Kaholokula (2018) reported the findings from a psychophysiological laboratory experiment examining the possible role that racism may play in the risk for cardiovascular disease (CVD) among Native Hawaiians. They examined the cardiovascular reactivity and recovery responses of 35 Native Hawaiian college students to subtle and blatant racist stimuli (i.e., vignettes depicting subtle or blatant racism toward a Native Hawaiian individual) and their subjective levels of distress to these stimuli. These participants were previously categorized into either a high- or a low-perceived racism group based on their self-report on a racism measure. During participants' exposure to the blatant and subtle racist stressors, frequent blood pressure and heart rate measurements were collected. The investigators found that systolic blood pressure recovery following exposure to both types of stressors was significant for both groups. Overall, participants reported greater subjective distress following blatant stressor exposure compared to subtle stressor exposure. Albeit nonsignificant, interesting trends in the high-perceived racism group were observed. Specifically, participants had greater reactivity to the subtle stressor exposure compared to the blatant stressor, incomplete heart rate recovery after exposure to both stressors, and partial systolic and diastolic blood pressure recovery following exposure to the subtle stressor compared to the participants in the low-perceived racism group. Researchers suggested that interventions aimed at increasing the self-awareness of the physiological reactions to racial stressors and using effective coping strategies by individuals who report greater experience of racism may reduce their risk for CVD development.

Pokhrel and Herzog (2014) examined the effects of historical trauma and perceived discrimination on substance use (i.e., past 30 days of cigarette, alcohol, and marijuana use) in 128 Native Hawaiian college students using structural equation modeling (SEM). They measured two aspects of historical trauma using a self-report instrument originally developed for American Indians: One aspect was the historical traumatic events experienced by the students and relatives and the other aspect related to historical loss (e.g., thoughts about lost land and culture) and their emotional reactions to the thoughts of historical loss (e.g., depressed, sad, or angry) (Whitbeck, Adams, Hoyt, & Chen, 2004). Perceived ethnic discrimination was measured based on the experience of day-to-day unfair

treatment because of their ethnicity (Williams, Yan, Jackson, & Anderson, 1997). Interestingly, they found a direct negative path from historical trauma to substance use (−0.21; $p < 0.05$), but a direct positive path from historical trauma to perceived discrimination (0.49; $p < 0.001$) and then from perceived discrimination to substance use (0.32: $p < 0.01$), with age, sex, and income as covariates. These findings suggest that the effects of historical trauma on substance use risk in Native Hawaiians appear to operate through their experience of discrimination.

Antonio et al. (2016) examined the relationship between the experience of discrimination and depression symptoms in 104 Native Hawaiians who were residents of a Hawaiian homestead community. The discrimination measure used in this study was the Everyday Discrimination Scale, the same used by Pokhrel and Herzog (2014). The depression measure was the 10-item version of the Center for Epidemiologic Studies Depression (CES-D) Scale (Hertzog, Alistine, Usala, Hultsch, & Dixon, 1990). They found a significant positive correlation between perceived discrimination and symptoms of depression ($r = 0.32$), which persisted after adjusting for differences in sociodemographics and degree of both Native Hawaiian and American cultural identity, separately. Unlike previous studies, Hawaiian cultural identity did not have a significant correlation with perceived discrimination, which could be due to the small sample size (i.e., not enough statistical power to detect a significant correlation) or due to characteristics unique to Hawaiian homestead communities. Under the Hawaiian Homes Commission Act, lands in Hawai‘i were set aside in public trust for homesteading by Native Hawaiians to enable them to return to their lands to promote self-sufficiency and the preservation of their cultural values and traditions. Only Native Hawaiians with 50% blood quantum and greater are eligible for Hawaiian homestead, which currently includes about 9450 individuals who hold Hawaiian Home Land lessees.

Kaholokula et al. (2017) examined the potential mediating effects of 14 coping strategies on the relationship between perceived racism and psychological distress among 145 Native Hawaiians using structural equation modeling. The same sample and oppression measure was used as in Kaholokula et al.'s (2012) study. Coping strategies were measured with the Brief Coping Orientation to Problems Experienced (COPE) (Carver, 1997) and psychological distress was a composite measure based on the 10-item version of the CES-D Scale (Hertzog et al., 1990) and the 10-item Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983). They found that two types of coping strategies – venting and behavioral disengagement – were independently significant mediators. Controlling for the effects of age, gender, educational level, and marital status, perceived racism had significant positive paths to both venting ($\beta = 0.23$) and behavioral disengagement ($\beta = 0.25$) coping strategies and, in turn, these coping strategies had significant positive paths to psychological distress ($\beta = 0.17$ and 0.31, respectively). Thus, perceived racism had a significant indirect effect on psychological distress, mediated through these two coping strategies.

As described by Kaholokula et al. (2017), venting is a form of anger expression while behavioral disengagement might be an indicator of learned helplessness (i.e., a person giving up or withdrawing from any effort to deal with a stressor). Understandably, anger expression is a prevalent coping strategy when dealing with the experience of racism for many racial and ethnic minority groups in the USA. Anger expression has also been found to mediate the relationship between perceived racism and psychological distress in African-Americans (Nyborg & Curry, 2003; Pittman, 2011) and general health in Aboriginal youth of Australia (Priest, Paradies, Stewart, & Luke, 2011). Brown, Phillips, Abdullah, Vinson, and Robertson (2011) used the Brief COPE to examine what coping strategies African-Americans used in response to racism-specific stressors and found that venting and religion were the most common coping strategies. However, anger expression and behavioral disengagement as a means of coping with racist stressors may only serve to maintain or "relive" the emotional distress (anger or helplessness); thus,

exacerbating the adverse effects of racism on a person's psychological well-being.

Ta, Chao, and Kaholokula (2010) conducted a qualitative study to explore the conceptualization of depression among 30 Native Hawaiian women who were either college students or residents of a Hawaiian homestead community. Based on semi-structured interviews, they found that a majority of the women (63.3%) identified strongly with their Native Hawaiian heritage and reported that family traditions and educational environments that incorporated Native Hawaiian language and cultural practices were integral in shaping their Native Hawaiian identity. Ta et al. found that the predominant themes among these women involved a link between depression and issues of cultural loss and identity, loss of lands and nation, and diminished social status resulting from US occupation and other traumatic life events. A quote from one of the women in response to a question about the common causes of depression exemplifies this point, in which she stated, "Bringing someone down…oppression, I think is another one. In a Hawaiian perspective in Native Hawaiian men and women, we still feel through colonization and the overthrow of the kingdom and stuff like that."

Inada et al. (2018) were perhaps the first and the only group to formally study the issue of racism among Micronesians, the most recent Pacific Islander group to come to Hawai'i and the continental US. Anecdotal reports of racial discrimination toward Micronesians have been documented (Yamada, 2011), including an article published in a Hawai'i-based news outlet titled, "No Aloha for Micronesians" (Blair, 2011). In the article, they noted "that the Micronesian is defined by exclusion – that the group has become Hawaii's newest underclass, with all the negative connotations that come with the term." To explore this issue of racial discrimination on the health status of the Chuukese community in Hawai'i, Inada et al. conducted in-depth interviews with 12 Chuukese and eight healthcare providers who serve this community. Chuukese come from the islands of Chuuk, a state within the Federated States of Micronesia. Interviews revealed that Chuukese experienced high levels of interpersonal racial discrimination and oppression as a collective group both in the larger society and in the healthcare system. The Chuukese participants noted that these experiences adversely impacted their emotional well-being and their ability to access essential healthcare, housing, employment, and education services. They also expressed that these issues "hurt their heart" to know their children were witnessing and experiencing these prejudices against them. They reported that the strategies they employ to deal with these experiences include turning to their religious faith and the larger Chuukese community for emotional support. Healthcare providers commented on the need for a change in society's attitude toward Micronesians and viewed racial discrimination as a disease of society and healthcare as a human rights issue.

Hagiwara (2016) conducted a study to examine the effects of both interpersonal experiences of racial discrimination and oppression as a collective group experience with 71 Chuukese migrants. Modified versions of the Experience of Discrimination measure (Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005) and the Oppression Questionnaire (Victoroff, 2005) were used, which had a significant positive correlation (r = 0.41) in this study. Physical and mental health status were measured based on items from the BRFSS. It was found that self-reported poor physical and mental health status were significantly associated with higher oppression and racial discrimination scores. After controlling for demographics, access to healthcare, and tobacco use, oppression and racial discrimination, analyzed separately, were significantly associated with mental health status (OR = 1.25 and 1.03, respectively). When both measures were examined together, only oppression remained significantly associated with mental health status (OR = 1.20). These findings highlight the importance of considering racial discrimination, in particular oppression and social justice issues, when addressing health inequities in this community.

To summarize our review, most of the studies to date that have examined the effects of oppression and discrimination on behavioral health variables focused primarily on Native Hawaiians.

Aside from Hagiwara's (2016) study with Chuukese, the effects of oppression on behavioral health outcomes have yet to be empirically examined among other Pacific Islander groups. Notwithstanding, the studies reviewed here, collectively, indicate that a greater sense of historical trauma, oppression, racist experiences, and cultural discord are associated with higher levels of depression symptoms, psychological distress, suicidality, and substance use among Native Hawaiians and Pacific Islanders. The psychophysiological studies done by Kaholokula et al. (2012) and Hermosura et al. (2018) demonstrate how the experience of oppression and racial discrimination gets "under a person's skin" through activation of their physiological stress responses (e.g., elevated blood pressure, heart rate, and cortisol dysregulation), both during and long after exposure to a racist event.

Although in this chapter, we focus on Native Hawaiians and Pacific Islanders residing in the USA and its territories, studies of Māori, the Indigenous Polynesian population of New Zealand, also find that perceived racial discrimination and socially assigned Māori ethnicity are associated with both poorer physical and mental health status (Harris et al., 2006; Harris, Cormack, & Stanley, 2013). Among Native Hawaiians, perceived oppression is also associated with hypertension risk (Kaholokula, Iwane, & Nacapoy, 2010). Nevertheless, more rigorous studies among other Pacific Islander groups are needed that examine the deleterious effects of oppression and stigma on behavioral health problems, especially on co-occurring behavioral health problems. The few epidemiological studies conducted show that Native Hawaiians and Pacific Islanders may suffer from multiple, interrelated behavioral health issues (e.g., Lowry et al., 2011). It is also important to examine these relationships among distinct Pacific Islander groups because of likely differences in the frequency and intensity of oppressive experiences, the type (i.e., institutional versus interpersonal) and nature of these experiences (e.g., overt versus covert), the contexts in which these experiences occur (e.g., workplace versus public places), and the coping strategies and cultural assets used to deal with these experiences across specific Pacific Islander groups. As Kaholokula et al.'s (2017) study found, certain coping strategies, such as anger expression and behavioral disengagement, may actually exacerbate the negative effects of oppression and racism experienced by Native Hawaiians and Pacific Islanders.

Pathway from Oppression to Behavioral Health Outcomes

No doubt, there is a tremendous sense of cultural loss and suppression, feelings of marginalization and oppression, and associated psychological distress that ranges from outrage to depression among many Native Hawaiians and Pacific Islanders. The psychosocial theories reviewed and the notion of cultural trauma provide an explanation for how experiences of oppression and discrimination are associated with behavioral health problems and their transgenerational and cumulative effects. And, the empirical studies reviewed lend support to the notion that historical trauma, oppression, and discrimination are adversely associated with a range of behavioral health problems in these populations. Although not reviewed here, studies are emerging to suggest that mental health factors associated with racism may precede chronic disease development (Kaholokula, 2016).

Integrating conceptual models from both Paradies et al. (2013) and Walters and Simoni (2002), Fig. 1 illustrates a hypothesized pathway from oppression and racism to behavioral health outcomes consistent with the extant literature and specific to Indigenous populations. The figure shows that the interpretation of an environmental event as oppressive or racist can lead to elevated psychological and physiological distress. Whether or not this distress eventually leads to serious behavioral health problems depends on the coping strategy employed to deal with these stressors and the presence of other chronic environmental stressors due to economic deprivation and lack of needed resources and services to effectively manage these multiple sources of stress. The psychological stress or distress

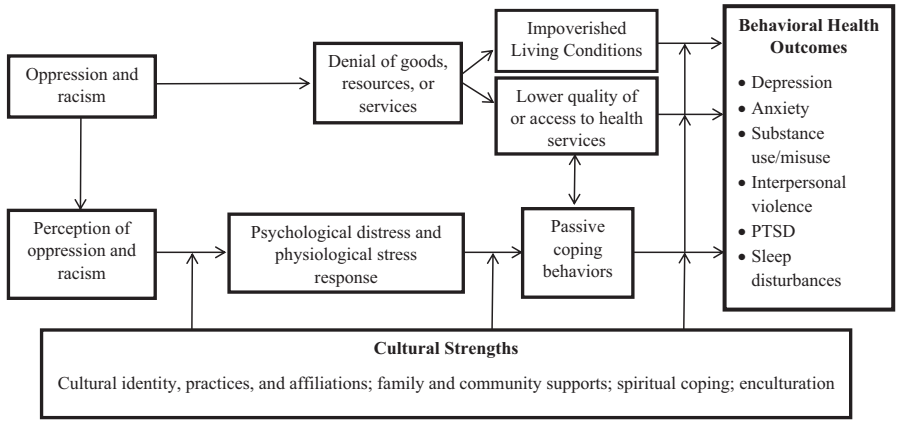

Fig. 1 Modified from Paradies et al. (2013) and Walters and Simoni (2002) to illustrate the pathways from oppression and racism to behavioral health outcomes with cultural strengths serving to moderate (i.e., buffer against) the effects of this pathway

resulting from oppressive or racist experiences can include subclinical depression and anxiety, emotional unrest, anger, resentment, hypervigilance, suspicion, and mistrust. If not addressed effectively, they can lead to major behavioral health issues. For a discussion on the psychological processes (e.g., relational schemas) involved in the relationship between racism and psychological distress, we refer the reader to Brondolo, Ng, Pierre, and Lane (2016).

Also included in Fig. 1 are the cultural strengths of Native Hawaiians and Pacific Islanders that can serve to buffer them against the adverse effects of oppression and racism. For many Native Hawaiians and Pacific Islanders, like those of other Indigenous populations, the preservation and practice of cultural traditions (e.g., native language, values, and practices), protecting and accessing sacred places and ancestral lands, a strong cultural and secure identity, and cultural participation and affiliations are important to their quality of life and psychological well-being (Kaholokula, 2017). However, their cultural values, practices, and aspirations are often at odds with those of the dominant society leading to cultural conflicts and marginalization. Barriers to accessing or expressing these cultural strengths only serve to remind, if not relive, past transgressions and trauma, which is an example of the contemporary effects of historical trauma.

Culturally Responsive Behavioral Health Services

Culturally responsive behavioral health services require providers to be mindful of their own cultural worldviews, identities, and biases and how they may affect the care they provide to persons of diverse cultural backgrounds. At the same time, it also requires providers to be sensitive to the cultural worldviews, identities, and aspirations of clients from diverse cultural backgrounds. In the act of being mindful of these cultural factors and interactions, it further requires providers to avoid stereotyping and overgeneralizing these cultural factors by not assuming that all persons with the same ethnocultural background are similar in other aspects as well. Recall that there is much cultural diversity among Native Hawaiians and Pacific Islanders, such as in languages, worldviews, acculturation status (e.g., native versus migrant), enculturation and acculturation strategies (e.g., assimilation versus integration), and sociopolitical aspirations (e.g., political self-determination). They may also have their own explanatory models and preferred healing modalities for their behavioral health issues.

In this final section, we focus on issues related to providing culturally responsive behavioral health services to Native Hawaiian and Pacific

Islander clients. There is a dearth of information on behavioral health assessment and treatment issues in these populations. The information that is available is often aggregated with Asian populations, making it difficult to discern what is relevant to Pacific Islander populations. Thus, we draw from our collective and extensive clinical experience working with Native Hawaiians and Pacific Islanders and discuss these issues in three broad areas: (1) Provider Issues, (2) Client Issues, and (3) Therapeutic Issues.

Provider Issues

It is important for providers to have the knowledge and skills necessary to be culturally responsive to the behavioral health needs of Native Hawaiians and Pacific Islanders. Much attention has been given, and standards proposed, to developing "cultural competence" among mental health providers, but there is limited evidence of training in this regard showing better client experience and outcomes (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). In fact, cultural competency training may lead to a complacency that may be more of a disservice to clients and perpetuate stereotypes. A cultural safety paradigm, rather than a cultural competence paradigm, may be more appropriate in addressing behavioral health issues among Native Hawaiians and Pacific Islanders because it relies on a sociohistoric lens to understanding the biases and injustices the clients experience (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012).

The concept and practice of cultural safety originated from the field of nursing in New Zealand to address the bicultural divide between Māori (the Indigenous population) and non-Māori (Doutrich et al., 2012). It emphasizes the examination of repression, social domination, and the differential social class and power between indigenous populations and the Western-dominated society. The cultural safety framework not only focuses on increasing a provider's knowledge of different cultural practices and traditions, but also emphasizes the importance of understanding the inherent power imbalances, the existence of institutional discrimination, and the effects of colonization on a client's health concerns. Providers are encouraged to examine their own conscious and unconscious racial/ethnic biases and how they may affect the therapeutic relationship with their clients. Implicit and explicit bias among behavioral health providers, as with other healthcare providers, has the potential to do real harm to clients by adversely influencing provider–patient interactions, treatment decisions, and thus treatment outcomes. Recent systematic reviews of various studies highlight differences in the treatment of minority and non-minority patients based on whether or not the healthcare provider holds an implicit bias toward certain ethnic minorities, albeit these studies have been mostly conducted with medical professionals (Dehon et al., 2017; FitzGerald & Hurst, 2017; Hall et al., 2015).

Guidelines and training curricula for cultural safety are still being examined and refined, but they offer a promising approach to improve the cultural responsiveness of healthcare providers (Gibbs, 2005). Ensuring cultural safety in the provision of behavioral health services can pose some challenges because it is based on the client's perceptions regarding whether the services are culturally safe or not. The client's perceptions can be influenced by the characteristics and behaviors of the provider and whether he or she is perceived by the client as being placed at a cultural risk (Wepa, 2005). Thus, cultural safety approaches emphasize the importance of self-reflection by the provider, such as being aware of their position of power in relation to the client's experience with oppression and discrimination and his or her cultural values and beliefs.

Part of providing culturally safe care is the examination of a provider's implicit bias. Implicit bias is defined as an "attitude, thought, or feeling that often exists outside of our conscious awareness" (Hall et al., 2015, pg. e60). Implicit biases may contradict one's explicit values and beliefs and are usually created because of societal messaging (Sabin, Nosek, Greenwald, & Rivara, 2009). Implicit racial biases have been implicated as a contributor to health disparities as observed in the differential diagnoses and treatment and in

levels and quality of care provided to different racial and ethnic groups (FitzGerald & Hurst, 2017). The implicit biases of a provider can lead to condescending or paternalistic treatment of patients that negatively impact provider–patient relationship and treatment recommendations offered (Hall et al., 2015).

The most widely used and robust test of implicit biases is the Implicit Association Test (IAT; Greenwald & Banaji, 2017). The IAT is a response-latency measure that examines the relative speed with which a person is able to pair two different concepts with an attribute. A concept that is more quickly associated with an attribute is considered to be stronger than another concept associated with the same attribute. Many IATs have been developed to examine implicit biases toward African-Americans and Hispanics but, to our knowledge, there are no IATs that have been created to examine implicit biases toward Pacific Islander groups in relation to other ethnic groups in the USA. An IAT relevant for Māori in the New Zealand context is available (Harris et al., 2016; Harris et al., 2018). Efforts are underway to develop an IAT to examine implicit biases toward Native Hawaiians and Micronesians compared to Caucasians and Japanese-Americans, the two dominant ethnic groups in Hawai‘i.

Client Issues

It is important to keep in mind that the experience of oppression and discrimination may or may not directly affect a Native Hawaiian or Pacific Islander client's behavioral health problem. However, it is likely to be an underlying and ever-present stressor associated with other socio-environmental (e.g., economic deprivation and unsafe living conditions) and interpersonal stressors (e.g., family and work-related challenges). As Perry, Harp, and Oser (2013) point out, a person can face multiple disadvantages based on their race, social status, and even gender that reduces his or her capacity for avoiding stress or defusing its effects.

In working with Native Hawaiians and Pacific Islanders where oppression and discrimination are believed to be affecting a client's behavioral health, several factors need to be understood and taken into account. These factors include, but are not limited to, the following:

- Client's and family's ethno-cultural heritage and identity.
- Client's level of acculturative stress and adjustment.
- Degree of cultural or other loss and traumatic experience.
- Family, financial, and work stressors.
- Family dynamics, problems, and strengths.
- Physical health and medication history.
- Client's understanding of his or her presenting problem, help-seeking behavior, and treatment expectations.
- Client's previous interactions with the healthcare system.

The cultural identity (e.g., degree of pride and practice of Hawaiian cultural values and practices) of Native Hawaiians and Pacific Islanders in relation to their affiliation and engagement with American mainstream culture can vary. For example, studies among Native Hawaiians show that 70–77% report highly identifying with both their Hawaiian culture and that of the American mainstream; 17–23% highly identify with only their Hawaiian culture; 1–2% highly identify with only the American mainstream culture; and 4–6% identify with neither their Hawaiian culture nor that of the American mainstream (Kaholokula et al., 2009). Native Hawaiians, more so than other Pacific Islanders, have a diverse racial/ethnic ancestry due to a high degree of intermarriage stemming back to the 1800s. As mentioned earlier, many of them are of mixed Native Hawaiian, Asian, and European ancestries. Yet, a vast majority of Native Hawaiians strongly identify with their Hawaiian heritage and culture, despite their degree of Hawaiian ancestry. Overall, identity is really a construct to be defined by the individual or group collectively and should not be imposed upon them by the therapist, healthcare system, or institution.

For Native Hawaiians, skin color as an indicator of blood quantum has been a difficult issue for

many. For most other Indigenous groups, any trace of Indigenous genealogy or genotype allows one to claim status within that group without much explanation or hindrance. Unfortunately, legislation introduced by the U.S. Congress in 1921 in regard to ownership of Hawaiian Homelands defined Native Hawaiians as those "with at least one-half blood quantum of individuals inhabiting the Hawaiian Islands prior to 1778" for that purpose. Although not the definition for other federal programs or endorsed by most Native Hawaiians, it has had adverse social and psychological affects for some Native Hawaiians when they do not possess the typical phenotype associated with being Native Hawaiian. It has also created an indiscriminate divide within the community that is not based on acculturation status or cultural identity, but based on unsubstantiated biological constructs imposed by the dominant culture (Kauanui, 2008).

Because of differences in socioeconomic conditions and cultural aspirations, Native Hawaiian and Pacific Islander clients can vary in how oppression and discrimination affect their behavioral health problems. A subset of Native Hawaiians and Pacific Islanders experience anxiety and depression as a result of disenfranchisement. Many are unemployed or employed in multiple low-paying jobs, struggling to afford housing and healthcare, and are food insecure. These clients typically need some form of state assistance, such as food stamps, welfare, or housing assistance. However, they teeter on the edge of eligibility for these services, leading to another source of stress as they struggle to comply with this system in an effort to maintain services. This group of Native Hawaiians and Pacific Islanders often have a high degree of trauma exposure and report having suicidal thoughts. Therapy and a mental illness diagnosis itself carry a particular stigma, often resulting in a delay in seeking services. As a result, symptoms are typically more severe at the time of presentation and complicated by multiple co-occurring behavioral health problems.

Another subset of Native Hawaiians and Pacific Islanders represent an emerging type of client seeking services, especially among Native Hawaiians. Having benefitted from higher levels of education and advancing into good paying jobs or professions, their sources of stress are typically the result of a more internal conflict. Attainment of higher education typically requires an adoption of Western values with regard to individual achievement. There may be criticism from others around them and external judgment that the individual is a "sell-out" or now feels superior to others. Internally, the clients often feel an increased sense of *kuleana* or responsibility to promote the Native Hawaiian or Pacific Islander agenda in the workplace or other settings where others are not always responsive or sensitive to these issues, leading to interpersonal conflicts. Having more affluence, such clients often feel they need to "fight" to create more opportunities for others from their ethnic group, educate non-Pacific Islanders on issues important to Pacific Islanders, or counsel other non-Pacific Islanders on their offensive behaviors toward Pacific Islanders. This strong sense of responsibility often causes overwhelming stress that affects their mood and sense of self-efficacy.

Pacific Islanders from Micronesia, such as Marshallese and Chuukese, face tremendous hardships to accessing a range of health services to include the needed behavioral health services. Some of the barriers include language and health literacy issues (i.e., lack of interpreters or providers who speak their language), discrimination in the healthcare system (both overt and covert), and cultural safety issues regarding providers (e.g., providers' lack of understanding of the geopolitical history between Micronesia and the USA). Compared to Pacific Islanders from Polynesia, those from Micronesia tend to be more reticent to seek health services (Choi, 2008). Exacerbating these issues are their poor socioeconomic circumstances coupled with barriers to accessing appropriate healthcare coverage.

As stated earlier, originally the COFA migrants were eligible for Federal Medicaid, a program to help ensure access to healthcare for individuals with limited incomes. However, due to changes in this policy, the majority of COFA migrants do not qualify for this program due to

their migrant status. This means those who are not considered aged, blind, or disabled, or who do not obtain coverage through their employers, must purchase a plan through the Affordable Care Act, plans which were tailored for individuals who are 130% above the federal poverty line. In many cases, this situation results in individuals either remaining uninsured or enrolling in a plan but not being able to afford the co-pays attached to receiving health services and medications. This forces many Micronesians to not seek care or to withhold picking up their medications until they are experiencing intolerable pain or illness.

Pacific Islanders from Micronesia face daily discrimination and negative stereotypes not only within the healthcare system and from the dominant society, but also from other Pacific Islanders with well-established roots in the USA. A point of contention is the perceived competition among Pacific Islander communities for limited and scarce resources allocated for socially disadvantaged groups. This spawns a fear that COFA migrants are using up resources that would otherwise go to other Pacific Islanders, including employment, social, and housing services. In addition to the acculturative and economic stressors faced by COFA migrants, these types of discrimination toward COFA migrants by other Pacific Islanders are a serious issue because there is the potential of a higher exposure and conflict because they are likely to live in the same neighborhoods, work in similar job settings, and attend the same schools.

Therapeutic Issues

Prior to Western contact, Native Hawaiians and Pacific Islanders had developed their own health-related concepts, diagnostic classification systems, and healing modalities to address illnesses of both a physical and an emotional/spiritual nature. For example, the causes of illnesses according to Native Hawaiian healing traditions were broadly conceptualized as being either *ma‘i kino* (body sickness), *ma‘i ma loko* (illness within), or *ma‘i mai waho* (illness from outside; Pukui, Haertig, & Lee, 1979). Ma‘i kino were illnesses due to physical causes, whereas mai‘i ma loko and ma‘i mai waho were the result of interpersonal transgressions or spiritual and supernatural forces. Various treatment modalities existed based on the specific diagnosis, which included *lā‘au lapa‘au* (medicinal plants and herbs), *lā‘au kāhea* (calling medicine), and *pule* (prayers), to name a few examples. Many of these healing practices were considered *huna,* or not for general public viewing or knowledge, and under the purview of the *Kāhuna* who were the experts and keepers of their specific healing tradition. Many of the Indigenous healing practices in the Pacific were either outlawed or discounted by Western settlers during the 1800s and early 1900s, which led many to practice in secrecy for some time.

Hawaiian healing practices, as an example, have since been revitalized by contemporary healers and recognized under both Hawai‘i State and U.S. Federal law as important to the health and well-being of Native Hawaiians (Donlin, 2010). The United Nations Declaration on the Rights of Indigenous Peoples also calls for the recognition of Indigenous healing practices and their role in improving the health and well-being of Indigenous Peoples (United Nations, 2008). Although these traditional healing practices are often preferred over Western approaches among many Indigenous Pacific Islanders, they have grown in popularity among nonindigenous peoples. Unfortunately, with their rise in popularity come the exploitation and commercialization of such practices mostly by outsiders who are not properly trained or sanctioned based on accepted cultural protocols and traditions.

Although there have been attempts to integrate traditional Hawaiian healing practices into Western clinical settings and to form a credentialing body to govern their practices, it is a contentious issue among many Indigenous healers. Many believe that no financial compensation should be received for their services, and that the person seeking healing needs to find their way to the healer; thus, referrals from Western practitioners are not acceptable in many cases. These preferred practices are beginning to change with the younger generation of Indigenous healers who

seek to make these practices a viable profession or livelihood and, as a result, are making them more accessible and legitimizing their use as a healthcare option. However, for the most part, many traditional healing practices are not easily accessible by the general public. Only a small number of community health centers and Native Hawaiian Health Care Systems in Hawai'i offer traditional Hawaiian healing services, two being the Wai'anae Coast Comprehensive Health Center on the Island of O'ahu and Hui No Ke Ola Pono – Native Hawaiian Health Care System on the island of Maui.

In Hawai'i, and relevant to behavioral health, the traditional Native Hawaiian practice of *ho'oponopono* has long been used as a form of family, community, and group therapy for addressing interpersonal conflicts. Ho'oponopono literally means "to make right" and is often conceptualized as a therapeutic approach for reconciliation or forgiveness or as an interpersonal problem-solving process (Ito, 1985). It has been applied and/or recommended for use in clinical (Mokuau, 2002), organizational (Patten Jr, 1994), school (Brinson & Fisher, 1999), and criminal justice settings (Hosmanek, 2005). It is used to address issues of substance use and abuse (Mokuau, 2002), interpersonal violence (Smith, 2002), and historical trauma (Paglinawan & Paglinawan, 2012). There are many how-to books written on ho'oponopono and workshops offered to teach this healing method and in becoming a *haku* (facilitator/convener), which can vary in their approach from each other and from its original intended applications. Despite variations in how ho'oponopono is practiced, most involve several key features: (1) prayers or ceremonies for opening and closing the reconciliation process, (2) stating the specific problem or *hihia* (entanglement) and its offense to all parties involved, and (3) working to disentangle the hihia to include admission of problem, atonement (*mihi*) for its negative effects, and forgiveness (*kala*).

Although Indigenous healing practices are now in greater demand and positively regarded, there remains an absence of research into their treatment efficacy for illnesses, whether of a physical or psychological nature. Many of these traditional healing practices are now being applied to a wide range of contemporary physical (e.g., diabetes) and mental health (e.g., depression) issues. Aside from their potential treatment efficacy, some argue that traditional healing practices could be used to incentivize Native Hawaiians and Pacific Islanders to seek Western-based medical care or to enhance the effectiveness of Western medical treatments by addressing the spiritual aspect of a problem – an aspect often believed to be lacking in Western treatments. Whatever the case may be, Indigenous healing practices can play an important role in addressing the health inequities experienced by Native Hawaiians and Pacific Islanders.

Despite the resurgence of Indigenous healing practices, Native Hawaiians and Pacific Islanders seeking behavioral health services are most likely to have access to Western treatment modalities based on biomedical (e.g., psychopharmacological treatments) and psychological (e.g., cognitive-behavioral therapy) models of care. And, like Indigenous healing modalities, there has been an absence of research into common behavioral health interventions for Native Hawaiians and Pacific Islanders found efficacious in other populations, such as cognitive-behavioral therapy (CBT) or interpersonal therapy (IT). Nevertheless, CBT and other "evidence-based" psychological therapies are often recommended for use with Native Hawaiians and Pacific Islanders, despite the fact that they have not been rigorously examined in these populations. They often need to be modified, so they are culturally responsive (e.g., emphasizing Pacific values and use of common Pacific Islander analogies) to Native Hawaiians and Pacific Islanders.

Native Hawaiians and Pacific Islanders report a preference for traditional healing practices and spiritual–/religious-based interventions when available (Aitaoto et al., 2007; Kaholokula, Saito, Mau, Latimer, & Seto, 2008). When considering Western-based treatments, there is the assumption that psychological therapies are preferred over psychopharmacological therapies. Research with other ethnic minority populations, including other Indigenous populations, suggests that cli-

ents prefer psychological therapies over medication use for certain behavioral health issues, such as depression. Depression is often seen as resulting not from biological factors but from external factors and thus some people are more responsive to counseling and prayer (Givens, Houston, Van Voorhees, Ford, & Cooper, 2007).

To illustrate the key components of CBT modified to be culturally responsive to Native Hawaiian and Pacific Islander clients, and the other points we previously made, we briefly present the case of a Native Hawaiian client named, Ikaika. Ikaika is a 25-year-old male who was referred to a community provider after a change in his insurance coverage. Ikaika reported that he began having severe panic attacks 6 years earlier that resulted in paranoid and intrusive thoughts. He was treated at another clinic for a period of time and was placed on heavy antipsychotics that resulted in what he described as a "zombie-like" state. He eventually stopped these medications because of the side effects and terminated care there, switching his care over to a private practitioner who diagnosed him with obsessive compulsive disorder (OCD) and started him on a tricyclic antidepressant. At the time of intake, he reported that his OCD symptoms are well controlled with medication. However, he came in complaining of a recent increase in anxiety symptoms with a new job pending. He denied any current suicidal or homicidal ideation, but did report a brief period of suicidal ideation 1 year ago. At that time, he wrapped something around his neck but immediately took it off. Ikaika reported he grew up in a family in which yelling and conflict were an everyday occurrence. He reported that his current support system is relatively good.

The first few sessions focused on the assessment and building trust. Assessment included a discussion of his values, both in his family of origin and currently as an adult. It is important for the therapist to have a good understanding of the client's values, as these will often become the motivating factors that promote growth and healing. Moving into the therapeutic portion of treatment, the focus shifted to discussion of his cultural identity and why the beliefs of others resulted in extreme emotional reactions. Additionally, the therapy focused on behavior change and willingness to take medications. Throughout therapy, Ikaika was asked to identify his locus of control for issues that arose and focus his efforts only when it was perceived that he could affect the outcome.

Very early on, it became clear that the cultural identification and related issues were the most problematic issues. At his second session, he came in to the visit upset at his treatment by clinic staff. While he could have been written off as another "angry Hawaiian," he explained that after his intake appointment, he was given an After Visit Summary (AVS) by clinic staff and, when he read through it, he found they had assigned his ethnicity as "White," instead of asking for his self-report. As we discussed this interaction, he reported a long history of cultural identity issues. Ikaika is phenotypically white, but is part-Hawaiian and identifies strongly as a Native Hawaiian. He was raised mostly on the continental US but returned to live in Hawai‘i as an adult. He explained that he gets very upset when people question his "Hawaiianess," no matter if this is an outright or perceived judgment.

Through this assessment and treatment process, Ikaika was able to strengthen his own cultural identity through a series of activities that increased his cultural knowledge and foundation. After making the decision to stay in Hawai‘i, he is now focusing on activities that help him establish roots here and a connection to his ancestral lands. This vignette illustrates that trusted relationships, connection to the community, and consideration of spirituality are essential components to interfacing with Native Hawaiian and Pacific Islander clients.

Conclusion

Native Hawaiians and Pacific Islanders share a disturbing history of oppression, stigmatization, and prejudices against them as a result of exploitation, colonization, and occupation of their island homes by Western powers. In the USA and

its territories, they continue to face oppression, stigmatization, and prejudices in both subtle and blatant forms. They face discrimination in housing, education, employment, and in the healthcare system. Thus, they are at a greater risk for behavioral health problems, such as depression, substance use, suicide, interpersonal violence, adverse childhood experiences, and high-risk sexual behaviors. The psychological stress caused by such mistreatments and the experience of deprivation are hypothesized to adversely impact their psychological well-being. Although the number and scale of the extant studies are limited, they clearly link perceptions of oppression and discrimination to depression (Antonio et al., 2016), psychological distress (Kaholokula et al., 2017), general mental health status (Hagiwara, 2016), and substance use (Pokhrel & Herzog, 2014) as well as physiological indices of stress (Hermosura et al., 2018; Kaholokula et al., 2012) among Native Hawaiians and Pacific Islanders.

Whether or not issues of oppression and discrimination are directly associated with the behavioral health problems of Native Hawaiians and Pacific Islanders, most certainly their lower assigned social status and poorer socioeconomic conditions are due to past and present-day oppression and discrimination that places them at risk as well as present challenges to their treatment. The provision of behavioral health services to Native Hawaiians and Pacific Islanders needs to consider the effects of oppression, stigmatization, and racism in the etiology, progression, and/or treatment of their behavioral health concerns in the context of their sociocultural and socioeconomic circumstances. These services also need to consider the role of the provider and healthcare system in inadvertently perpetuating stereotypes and institutional discriminatory practices. Traditional explanatory models of illnesses and Indigenous healing practices offer the promise of acceptable and effective behavioral health treatment approaches. Notwithstanding, more studies are needed among specific Pacific Islander groups beyond Native Hawaiians to elucidate the effects of oppression, stigmatization, and prejudices across a range of behavioral health problems to include co-occurring problems (e.g., depression and substance abuse) and on the acceptance and effectiveness of different therapeutic modalities to include the use of traditional healing and psychopharmacology.

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