Native Hawaiians' Views on Depression and Preferred Behavioral Health Treatments: a Preliminary Qualitative Investigation

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Abstract

Behavioral health issues, especially depression, are a major health disparity concern for Native Hawaiians in Hawai'i. Following the cultural safety framework and contextual behavioral science approach to intervention development, the present preliminary qualitative investigation aimed to

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gather better insight into Native Hawaiians' views of depression and its causes as well as their preferred forms of behavioral health services. Data were initially collected from a 2-hour virtual focus group with three behavioral health service providers working with Native Hawaiians, followed by a total of 38 online one-on-one in-depth interviews with Native Hawaiian clients with depression (n = 19), behavioral health service providers working with Native Hawaiian adults (n = 9), and Native Hawaiian cultural leaders (n = 10). Our qualitative data suggested that Native Hawaiians tend to view depression contextually and socioculturally as the manifestation of one's vital connection to the 'āina (land), 'ohana (family; continuity from ancestry and future generations), community, culture/spirituality, and one's authentic self being disrupted. Our findings also suggested that Native Hawaiians often attribute these disruptions to disparities due to the ongoing impact of colonization, historical trauma, and cultural loss. As a preferred form of treatment for depression, participants recommended various Hawaiian cultural practices to be integrated into existing behavioral health services to nurture the above-mentioned vital connection.

Keywords Native Hawaiian · Depression · Mental health · Cultural safety · Treatment · Qualitative

Introduction

Depression is a major public health concern for Native Hawaiians living in Hawai'i.[1,2] For example, in 2019, 16% of Native Hawaiian adults self-reported being diagnosed with depression—nearly twice more so than other major racial and ethnic minority groups in Hawai'i (i.e., Chinese = 8.9%; Japanese = 8.8%, and Filipino = 7.7%).[3] Among Native Hawaiian adults, depression is a known risk factor for chronic illnesses and other behavioral health concerns, including obesity, diabetes, heart disease, and substance use, which also disproportionally impact them.[4–8] Despite these disparities, Native Hawaiian adults are three times less likely to seek behavioral health services than their White counterparts,[9] and they are said to have a strong mistrust toward existing behavioral health services.[1,10] Extant evidence also suggests that Native Hawaiians prefer their traditional and indigenous healing methods over the exclusive use of Western approaches for their behavioral health and wellbeing.[11,12]

Native Hawaiians and their historical context

Native Hawaiians are descendants of the original inhabitants of the Hawaiian islands,[13] and their history resembles that of American Indians/Alaska Natives in the USA.[14] That is, before Western contact, Native Hawaiians were generally healthy with a rich cultural heritage. In the 1800s, following Western contact, they were decimated by infectious diseases; displaced from ancestral lands; forced to abandon their native practices, including language and spirituality; and marginalized through legislative acts and compulsory assimilation policies.[15] The cumulative effects of this tumultuous history have resulted in a collection of traumatic experiences expanding over a person's life and across generations, which is often referred to as *historical trauma* or *cultural loss*.[16] Today, intergenerational trauma/loss is purported to be a major social determinant for mental illness among Native Hawaiians, particularly for depression.[1,10] This historical trauma/loss is also thought to explain Native Hawaiians' ongoing mistrust of current Euro-Western approaches to behavioral health[10] and their preference for traditional indigenous healing practices.[1]

Cultural safety framework

Within this socio-historical climate, experts have advocated for a *cultural safety framework* for the behavioral health of Native Hawaiians, which embraces their indigenous worldview and cultural practices of healing.[10,16,17] The term *cultural safety* was first proposed in the 1990s within the field of nursing in New Zealand to offset the health disparities that Māori (Indigenous people of Aotearoa/New Zealand) faced, as well as the bicultural divide between Māori and non-Māori.[18,19] It is important to highlight that Māori and Native Hawaiians share ancestral relations, language, and history. In fact, the history of Māori with the British Crown mirrors the above-mentioned tumultuous history that Native Hawaiians have endured.

In theory and practice, the cultural safety framework considers the perspective of the Indigenous patients as "the norm" (e.g., fundamental validity of the patient's way of knowing and being).[10] From this bottom-up perspective, the cultural safety framework aims to promote the health and wellbeing of indigenous populations by revitalizing their cultural values and practices and cultivating a *critical consciousness* that healthcare professionals and organizations can hold to make themselves accountable for culturally safe and clinically effective care.[20,21] Experts have also argued that the cultural safety framework, rather than the cultural competence framework, which can often become overly provider-centered,[22] is particularly suitable for colonized populations, such as many Native Hawaiian patients, who face challenges arising from inherent power imbalances and historical trauma/loss.[10,23]

To date, various cultural safety education and training programs have been adapted within the field of nursing, social work, education, and medicine in Australia, Canada, New Zealand, and the USA.[24] A recent review also suggests that cultural safety programs are linked to better therapeutic relationships and better patient outcomes.[24] In this context, experts in Native Hawaiian health have advocated for the integration of a cultural safety framework specific to Native Hawaiian patients within existing behavioral health services in Hawai'i.[10,25,26]

The present study

One way to promote the cultural safety framework specific to Native Hawaiians and their depression is to gather in-depth insights into their perspective/worldview concerning the (a) nature and manifestation of depression, (b) causal attributions of depression, and (c) culturally responsive remedies for depression. For this set of inquiries, ideal groups of stakeholders were Native Hawaiian patients with depression, behavioral health service providers (e.g., licensed psychologists) working with Native Hawaiian patients with depression, and Native Hawaiian cultural leaders who are closely knitted into local Native Hawaiian communities. Given the limited evidence currently available, a preliminary qualitative investigation with a combination of a focus group and a series of in-depth interviews was deemed an adequate initial step.[27]

Method

Participants

The present preliminary qualitative investigation was part of a larger project, which was led by the first author (A.M.). The aim of this larger project was to develop and examine a cultural safety training protocol for behavioral health service providers who regularly work with Native Hawaiians with depression. For the present qualitative investigation, three behavioral health service providers (licensed psychologists; one woman and two men) were initially recruited for a 2-hour focus group, which was followed by one-on-one in-depth interviews with 38 stakeholders. Of those, 19 stakeholders were Native Hawaiian patients with depression (16 women and three men), nine were behavioral

health service providers (seven women and two men), and ten were Native Hawaiian cultural leaders (six women and four men). Participants in all three stakeholder groups were recruited through I Ola Lāhui. I Ola Lāhui was an ideal recruitment site because, as one of the largest non-profit behavioral health organizations in Hawai'i, it serves Native Hawaiians across all major Hawaiian islands (see the Study Materials and Procedures for participant recruitment).

All participants across the three stakeholder groups were adults aged 18 years old or older (see Table 1 for demographic information of study participants). To be eligible as a Native Hawaiian patient with depression, a person must have self-identified as a Native Hawaiian who had been receiving professional behavioral health services for their depression at the time of the study. To be eligible as a behavioral health service provider, a provider must have offered behavioral health services to Native Hawaiian patients as a clinician for at least 1 year. To be eligible as a Native Hawaiian cultural leader, they must have been recognized as Native Hawaiian cultural leaders in Native Hawaiian communities in Hawai'i.

Focus group and in-depth interview materials

Informed by the cultural safety framework[10,20–22] and contextual behavioral science (CBS) approach to treatment development,[28,29] the focus group and in-depth interview materials (i.e., questions and format) were initially developed by the first and senior authors. More specifically, on this initial task, the cultural safety framework highlighted the importance of approaching the topic of interest (i.e., depression and culturally responsive remedies for depression) from the perspective of the target indigenous population (i.e., Native Hawaiians).[21] At the same time, following the "person-in-situational and historical context" framework, the CBS approach to treatment development offered the guideline for the types of information to be gathered for the development of the above-mentioned cultural safety training protocol.[28] At the time of the study, the first author (A.M.) was a licensed psychologist and a full professor of psychology (Clinical Psychology) in his affiliated academic institution with expertise and over 20 years of experience in CBS-informed intervention development. Besides being the Executive Director of I Ola Lāhui, the senior and ninth author (A.A.A.S.) is a Native Hawaiian licensed psychologist, who has expertise and over 30 years of clinical experience in serving local Native Hawaiian populations.

As noted above, the focus group and in-depth interview materials were developed to gather insights on the three specific topics: (a) Native Hawaiians' view of depression in terms of its nature/manifestation, (b) causal attributes of depression, and (c) their ideal and preferred forms of behavioral health services for depression. Procedurally, these three themes were explored with two sets of semi-structured questions. The first set of questions was general, and it was asked to all participants regardless of their participant type (e.g., "What are some common features of depression among Native Hawaiians?" "What would you say are some root causes of depression?" "If you could design an ideal wellbeing program to address depression for Native Hawaiians, what would it look like?"). The second set of questions was geared toward specific stakeholder types (e.g., "What would you say are some obstacles for delivering effective treatment in the current mental health system" for the behavioral health service provider group). The focus group/in-depth interview materials were then tentatively finalized by the group of the investigation team, including the first, second (L.N.), sixth, seventh, eighth, and senior author. At the time of the study, the second author was an undergraduate research assistant in the first author's research lab (see the description of sixth, seventh, and eighth authors below).

Procedures

All study procedures were approved by the University of Hawai'i Human Studies Program. Regarding the participant recruitment, the senior author, the Executive Director of I Ola Lāhui,

Table 1
Demographic information of study participants

	Native Hawaiian patients with depression	Behavioral health service providers	Native Hawaiian cultural leaders	Total
Sample size	19	12	10	41
Gender				
Woman	16	8	6	30
Men	3	4	4	11
Age				
Average	43	43	48	44
Range	22-72	30-55	36-67	22-72
Race/ethnicity				
Native Hawaiian	4	0	3	7
Mixed-ethnicity Native Hawaiian	15	7	7	29
Non-Native Hawaiian	0	5	0	5
Socioeconomic status (SES)				
Lower class	4	0	1	5
Middle class	10	8	5	23
Upper class	0	3	3	6
Did not report	5	1	1	7
Education history				
Earned a high school diploma/GED	4	0	1	5
Completed an associate degree/some college	3	0	2	3
Completed a bachelor's	6	0	1	7
Completed a master's	3	2	3	8
Completed a doctorate degree	2	10	3	15
Birth place				
Born in Hawaii	18	9	7	34
Born in "other" place	1	3	3	7

Table 1
(continued)

	Native Hawaiian patients with depression	Behavioral health service providers	Native Hawaiian cultural leaders	Total
Upbringing location				
Raised in Hawaii	18	10	5	33
Raised in Hawaii and other places	0	1	3	4
Raised in “other” place(s)	1	1	2	4

and clinic staff initially identified and reached out to (a) their Native Hawaiian patients as well as (b) behavioral health service providers and (c) cultural leaders working closely within I Ola Lāhui services as potential participants. Once potential participants expressed interest, the study coordinator, the seventh author (S.S.), reached out to them individually via phone or email for scheduling purposes. Participants provided informed consent online prior to anonymously and voluntarily completing a focus group or an in-depth interview online. The online demographic form of age, gender, race/ethnicity, and socioeconomic status was also completed at the time of informed consent.

Focus group and in-depth interviews The focus group was 2 hours long and the duration of the in-depth interview varied across participants, ranging from 30 minutes to over 1 hour. In the present study, two clinical psychology post-doctoral fellows and one doctoral student in clinical psychology served as focus group facilitators/interviewers. One of the post-doctoral fellows was the sixth author (K.S.) and the doctoral student was the eighth author (J.Q.). Following the cultural safety framework,[10,20–22] a particular focus was placed on validating participants and their ways of knowing and being throughout the focus group/in-depth interviews.

As noted above, the present data collection began with a 2-hour focus group with three service providers. The selection of these three service providers for the initial data collection was intentional. More specifically, all three service providers were (a) either Native Hawaiian themselves, who were born and grew up in Hawaii, or the non-Native Hawaiian individual who was born and grew up in Hawaii; (b) had over 10 years of clinical experience serving economically disadvantaged Native Hawaiian populations in community behavioral health services settings; and (c) had regularly worked with Native Hawaiian adults with depression in their clinical settings. Because of the significant involvement in this qualitative investigation, initially as study participants and then later as consultants, they are credited as the third (H.P.), fourth (S.H.), and fifth (L.M.) authors of this manuscript.

Data recording All focus group and in-depth interviews were video recorded via Zoom and transcribed by five undergraduate research assistants in the first author's research lab who were familiar with local English dialects and Hawaiian Pidgin. The second author (L.M.) was one of them. Each transcript was then reviewed, line-by-line, by a second research assistant for quality assurance. Interviews were analyzed using a computer-assisted qualitative data analysis software called NVivo Version 12.[30]

Data analysis plan

Qualitative data of the focus group discussion and in-depth interviews were analyzed using a flexible coding strategy.[31] More specifically, six in-depth interviews, two from each of the three stakeholder groups, were first coded by a pair of researchers to create a codebook. Transcripts for this initial coding process were chosen randomly. The initial codebook contained a priori codes that emerged out of the data from the first six transcripts, as well as definitions and examples of each code.

Throughout the study, the codebook was updated weekly, by a team of five research assistants (i.e., L.N., J.Q., K.S., and S.S.) who coded the rest of the transcripts while referencing the codebook. Creating the codebook was an iterative process.[31] The coding team met weekly to discuss changes in the codebook and engage in reflexive practice. For an emerging code to be added to the codebook, it must have been found in three different transcripts. As emerging codes were added to the codebook, prior transcripts were back-coded using the "text search query" function of NVivo. Aligned with recommended qualitative research methods,[32] the coding team continually engaged in reflexivity-based practices in which preexisting assumptions and belief systems were explored and questioned.

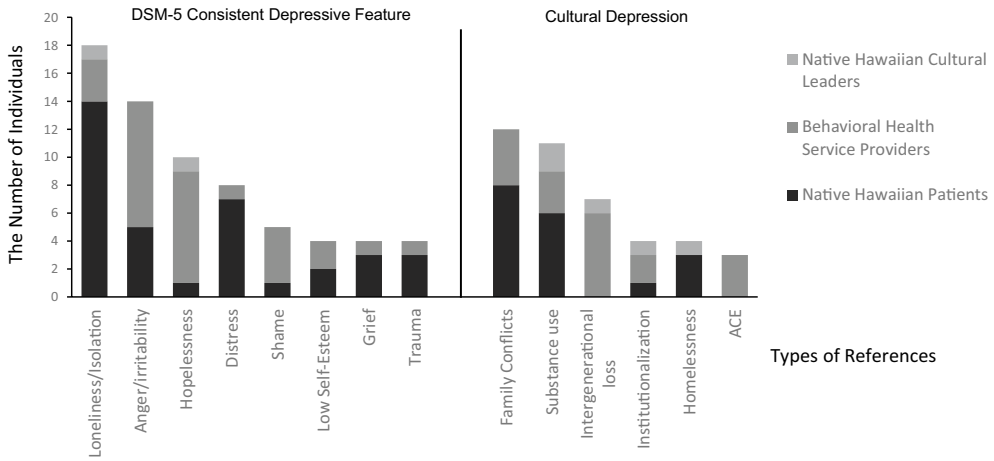

Fig. 1

Common features of depression in Native Hawaiian communities. Note. ACE, adverse childhood experience

After all of the transcripts were coded, the codes were organized into themes or processes for each set of three major questions mentioned above. Subsequently, themes and processes per question were then identified and summarized based on the number of participants who stated them during the meeting (e.g., in-depth interviews or focus group) or the total number of times they were stated across all participants during the meeting, primarily by the second and eighth authors.

Besides following the cultural safety framework, we did not pre-determine a specific conceptual model to be used to organize and interpret qualitative data gathered. However, to understand our findings in light of extant literature on Native Hawaiian behavioral health, we referred to extant indigenous frameworks, such as *Mauli Ola*[10,16] and *Pilinahā*,[12] where appropriate, when we discussed and interpreted our findings.

Results and Discussion

As summarized below, participants across the three stakeholder groups reported a collective and ecological worldview of Native Hawaiians, wherein the depression is understood socioculturally and ecologically through this cultural lens.[1,12] As detailed elsewhere,[33] a Native Hawaiian worldview is known to be quite different from the one that is often followed by the field of Western behavioral health.[33] In the present qualitative study, this collective and ecological worldview emerged consistently throughout inquiries in the focus group and in-depth interviews.

Depressive symptoms

For the "common features of depression in Native Hawaiian communities" inquiry (i.e., "What does depression look like in Native Hawaiian communities?"), a total of 108 references emerged (see Fig. 1). Of those, 54 references were identified by the Native Hawaiian patient group, followed by 47 references by the behavioral health service provider group and seven references by the Native Hawaiian cultural leader group. Of these, (a) *DSM-5 consistent depressive features* and (b) *cultural depression* emerged as two major themes.

DSM-5 consistent depressive features Over 60% of depressive features identified (i.e., 67 references) overlapped with symptoms of major depressive disorder listed in the DSM-5, the most widely used psychiatric nosology in the USA.[34] These included (a) loneliness/isolation, (b) anger/irritability, (c) hopelessness, (d) distress, and (e) low self-esteem. Interestingly, sadness and anhedonia, the central diagnostic features of major depressive disorder in DSM-5, were not identified as common features of depression.

Cultural depression The remaining 38% of the references (i.e., 41 references) identified were psychological and psychosocial phenomena that are not necessarily viewed as key diagnostic features of depression by major Western psychiatric classification systems. These were (a) family discord/conflict, (b) substance use, (c) intergenerational loss, (d) institutionalization, and (e) homelessness. Interestingly, in Native Hawaiian health literature, these identified features of depression are often discussed as the signs or outcomes of cultural depression or *kaumaha* (heaviness and sadness in English).[33] According to the participants, depression among Native Hawaiians often manifests interpersonally and psychosocially in various forms at multiple levels (e.g., individual, family, community, system), and it cannot be understood or treated separately from the above-mentioned issues. For example, a Native Hawaiian patient in her 30s described her depression as well as depression experienced collectively by Native Hawaiians as follows:

> It's a deep generational trauma. It's not even trauma, I mean it is …like everything around me just doesn't sound right. There's no balance and so it hurts, …it's not even like a physical pain, …is the aftermath of it, but it's such a deep like …in your *na'au* (gut/heart in English). You know it's in that like in that depth that it's in that place, so when I allow myself to sit and listen, then it overtakes me …and I cannot go anywhere.

Similarly, a Native Hawaiian cultural leader in her 30s described depression as an intertwined manifestation of various psychosocial issues as follows:

> Like, there is this convergence of a lot of tension that um, I think we as practitioners can really identify in the system. How it affects individuals and how it affects families and that's the one thing about *ho'oponopono* ('making things right' in English), right? It's really meant to *look at more of the social unit than it is the individual* and that's where you'll see a lot of depression; you'll see a lot of stress and anxiety. Yeah, a lot of maladaptive behaviors in families.

Furthermore, using a Native Hawaiian term, *kaumaha* (heaviness and sadness in English), another cultural leader in his 40s noted depression and intergenerational loss as follows:

> …That *kaumaha* is not just today. We dealing with *kaumaha* of.. like loss of land, loss of spirituality, loss of access…. What I see before me is the problem. 'You the problem, you Hawaiians… You guys uh weigh on our systems…, but it wasn't always like that. …

Finally, this contextual and collective account of depression parallels a recently proposed social and cultural determinant model of *Mauli Ola* (i.e., wellbeing) for Native Hawaiians (hereinafter referred to as the "*Mauli Ola* model").[10,16] Worth noting is that the *Mauli Ola* model conceptualizes depression through a framework of "person-in-historical and situational context."

Causal attributes of depression

For the "root causes of depression" line of inquiry ("What would you say are some root causes of depression?"), a total of 316 references were identified (see Fig. 2). Of those, 152 references

were identified by the Native Hawaiian patient group, followed by 77 references by the behavioral health service provider group and 67 references by the Native Hawaiian cultural leader group. Once again, Native Hawaiians' contextual and collective account of depression continued to emerge in this line of inquiry, which was summarized into six interrelated themes. These were (a) *disparities in resources*; (b) issues related to '*ohana* (family); (c) *individual (personal)/behavioral factors*, such as substance use and loss of Native Hawaiian identity; (d) *historical factors*, including colonization and historical trauma; (e) *culture and systems*, such as cultural loss and homelessness; and (f) *political disparities*, such as marginalization in state politics.

It is also worthwhile to note that these identified root causes overlap with various intermediary, sociocultural, socioeconomic/sociopolitical, and historical determinants highlighted in the *Mauli Ola* model.[16] For example, a behavioral health service provider in her 40s described these root causes of depression and their intertwined nature as follows:

> When the whole socioeconomic structure changed, and the model was, you leave your family to work, instead of you as a family system work to thrive. We lost our way of knowing what our good work was. *Cuz* (Hawaiian Pidgin, because in English) our whole way of knowing, and organizing in our families, was around this, you know, very elaborate and detailed social structure system. And so, we didn't have those guide rails…So, but it was just this, just this lens and the lens being different. So, um, we say okay they (Hawaiians) were tossed into a different system. …Hawaiians weren't really supposed to be in the plantations anymore, right? So where were they? They were on the fringes of society in many ways, already from that time. So, when we fast forward to now and we understand that there was also very explicit and harsh and intentional dismissal of things Hawaiian… eroding their sense of their culture and their identity and saying that, no it's so much better to wear clothes … the only way to be is to have one God not to see God in all things... their psyche was being eroded … I mean all of this was happening, it was very intentional colonization.

Relatedly, a Native Hawaiian patient in her 50s noted as follows:

> What would be the cause? In my family, the cause of depression, the cause of drug use, the cause of lack of motivation um I think with eight kids in our family, we've run the gamut of people who got in trouble with the law and drugs- it was poor guidance, it was poor foundation.

Key features in preferred forms of remedies/healing practice for depression

The third set of inquiries, key features in preferred forms of therapy/healing practice for depression (e.g., "If you could design an ideal program to address depression for Native Hawaiians, what would it look like?"), yielded 185 references. Of these, (a) *Hawaiian cultural activities/spirituality*, (b) *connection/harmony*, and (c) *integration* emerged as three major themes (see Fig. 2). More importantly, participants' responses to this inquiry seem to offer insight into Native Hawaiians' *meta-accounts* of *Mauli Ola*, as well as the nature of depression and ideal healing practices for depression from this meta-account.

Additionally, worth noting is that many participants used the terms *wellbeing*, *spirituality*, and *(vital) connection/harmony* synonymously and interchangeably in this "healing practices for depression" line of inquiry. As detailed below, the perceived sense of vital connection to/harmony with the land, community, continuity from ancestry and future generations, and one's authentic self seems to be at the core of spirituality, which also reflects Native Hawaiians' (holistic) optimal health and wellbeing (*Mauli Ola*).

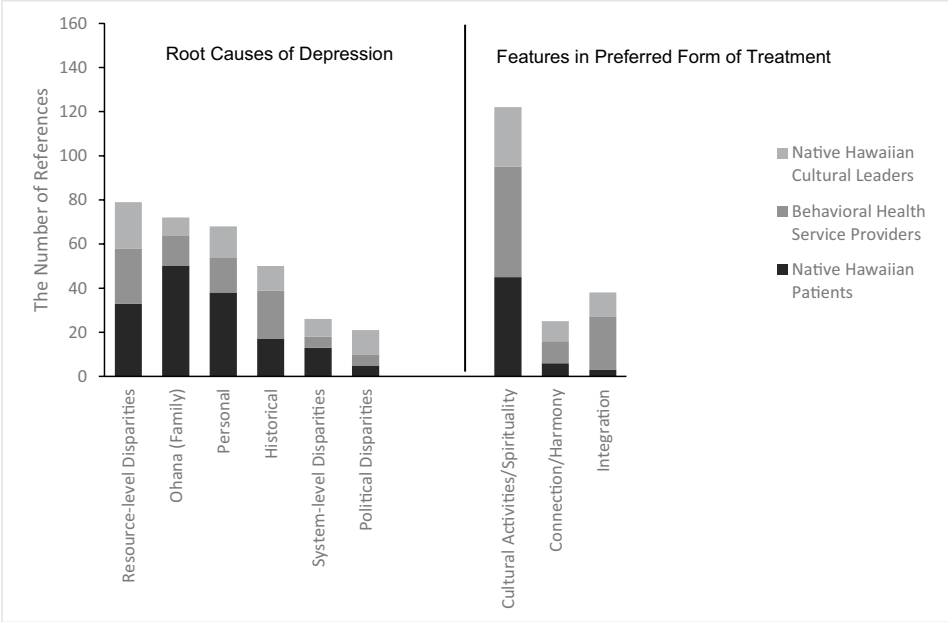

Fig. 2
Root causes of depression and features of preferred forms of treatments for depression

Hawaiian cultural activities and spirituality From the above-mentioned meta-account, the *Hawaiian cultural activities* theme that emerged seems to represent methods/practices that promote spirituality—and therefore their sense of vital connection/harmony and wellbeing. To that end, this theme received 122 references. Of those, 50 references were identified by the behavioral health service provider group, followed by 45 references by the Native Hawaiian patient group and 27 references by the Native Hawaiian cultural leader group. It appears that, for Native Hawaiians, many cultural activities are in and of themselves spiritual. A behavioral health service provider in her 40s explained this point as follows:

> …would be a lot of cultural practices like not just like, like you know it wouldn't just be therapy like talk therapy or a psychiatrist… it would go beyond that … activities that range anywhere from like canoeing to like *hula* um to playing music um you know sort of having a range of these like leisure, what we consider in the Western culture, leisure activities, but I think in the Hawaiian culture they have more, they're not just fun but they're spiritual nourishment.

Relatedly, a Native Hawaiian cultural leader in her 30s explained how being in the *kai* (ocean) and *loʻi* (i.e., an artificial pond where *kalo*/taro, the center of spiritualism for Hawaiians, is cultivated) allows her to feel connected to her *kūpuna* (the elderly or ancestors), thereby contributing to her spiritual wellbeing:

> …my outlet really is the ocean but being in the *loʻi* is like one of the most valid and important places for me because it's where my work began um and it's also where we connected to our *kupuna* right and it's what feeds us in the spiritual and the physical

Connection and harmony From the perspective of the *meta-accounts* of *Mauli Ola*, the *connection/harmony* theme, the second major theme with 25 references, seems to offer insight into qualitative aspects of Native Hawaiian optimal health, wellbeing, and spirituality, as well as a cultural framework through which depression can be understood and treated. Within this theme, participants noted *connections to*'*āina* (land), *culture* (sometimes through *kupuna* or the *ancestral realm*), '*ohana* and *community*, and *identity* (self, and Native Hawaiian identity) as the essence of *pilina* (vital/mutual connection and harmony in English), which represents an optimal state of wellbeing. Importantly, the theme of vital connection/harmony that emerged from the present qualitative investigation parallels the essence of Native Hawaiian wellbeing and spirituality discussed elsewhere as *Pilinahā* (four vital connections).[12]

A review of transcripts also suggested that depression is often understood through the framework of *pilina* (e.g., depression as the manifestation of disruptions to the above-mentioned vital connections). In fact, common features of depression identified by the present participants, such as loneliness/isolation, family discord/conflict, and intergenerational loss, seem to reflect the disruption of these vital connections. Furthermore, it seems that Hawaiian cultural and spiritual practices, such as the ones mentioned above, were identified as preferred forms of remedy for depression in part because they are thought to restore and nurture *pilina*. For example, a Native Hawaiian cultural leader in his 50s emphasized the importance of connection for one's own *mauli ola*:

> I'm a true believer in uh, reconnecting to '*āina*, reconnecting to place, reconnecting to family, reconnecting to *kupuna*. And so, you know who you are, where you come from, y'know. I think a lot of times, we-we so focus about, y'know, what's right in front of us. …Sometimes we forget what-what we need to help fill our *'apu* (the Hawaiian name for a cup fashioned out of the halves of the shell of the coconut, here it metaphorically means spirituality and wellbeing) um and I think that's where we come in. We-we (cultural leaders)'re basically just guides and servants to help them, remind them what is needed for their own *mauli ola*.

Relatedly, a behavioral health service provider in his 50s noted:

> Connecting usually is like a basic for me. connecting with 'āina, connecting with family, … what I say about family is like I said the idea of our *kupuna* are behind us that we are the product of them is to connect them that way so that's one of the basics when it comes to cultural practices . . . those types of things but for now many things are available, *oli* (traditional chanting) classes, *kupuna* there's much more programs for them to take part in *hula* is a great thing because it includes a whole lot of different varieties of things.

Integration Finally, *integration* emerged as the third major theme when participants were asked about treatment for depression (38 references). As seen in Fig. 2, the distribution of references on this theme suggests that behavioral health service providers and Native Hawaiian cultural leaders were the primary sources of these references. This was perhaps because they had been exposed to behavioral health issues at organizational, community, and system levels more so than the patient group.

From the above-mentioned meta-account, the *integration* theme seems to represent ways to which their *mauli ola* can be promoted further in the existing behavioral healthcare system.

More specifically, the integration theme encompassed (a) the limitation of individual-focused approaches in the Western treatment model, (b) the integration of Hawaiian *cultural practices and values into the behavioral healthcare system*, (c) a *holistic* view of clients across dimensions of health (biological, psychological, social, spiritual), and (d) treatment approaches designed to

promote the vital connection/spirituality described above. For example, one of the behavioral health service providers in the focus group (a mixed-ethnicity Native Hawaiian woman in her 40s) shared her thoughts on extant Western behavioral health service and its limitations as follows:

> … Definitely family a sort of an ecological conceptualization where multilayered, not just the sort of Western psychology individualist approach and sort of symptom treatment approach medical model. That's not sufficient.

Additionally, one of the two other providers in the focus group (i.e., a non-Hawaiian man in his 30s) stated:

> The recognition that the Western medical sort of machine has not always been helpful to Hawaiians, and accessible to Hawaiians, and has been dismissive of the realities of things that Native Hawaiians face. I'm part of that um because I'm part of a Western sort of style ah intervention thing and and yet I wanna open the door for 'how do you feel about that.'

Furthermore, the third provider (i.e., a mixed-ethnicity Native Hawaiian man in his 30s) noted:

> I think therapists in the Western sort of traditional approach have been trained to see themselves as if they're objective and neutral and that they're not a factor but it's like the just being in there can change things. And so, I think training therapists in any kind of intervention like this there has to be - I would really strongly advise some sort discussion of the selves involved and what that means for working together, you know.

During the focus group, these three providers also collectively advocated for the application of a cultural safety framework to the extant behavioral healthcare system for Native Hawaiian populations in Hawai'i.

Finally, participants suggested ways to address the historical roots of Native Hawaiian depression (e.g., historical trauma) through the integration of Hawaiian history, *'Ōlelo* (language), and *mo'olelo* (stories). A Native Hawaiian patient in her 40s shared how learning through stories (e.g., the history of *kalo*) helped them reconnect to their Native Hawaiian identity and genealogy, appreciate the resilience of their ancestors, and view history from a strengths-based lens:

> Learning from the history of the past of the positive of like where our ancestors came from and not only like, I do appreciate that I am Hawaiian, I appreciate that in all of this population, my ancestors,
> many many of them, have not only survived but the thriving of to have the next generations after me.

Likewise, learning how historical factors contributed to current systemic inequities may promote critical consciousness among clients and behavioral health service providers, which is in alignment with a cultural safety framework.[22] For example, a cultural leader in his 40s noted how learning about Hawaiian history may inform ways to address the causal attributes of depression outlined previously:

> The important part of learning history for Native people is you gotta really understand your history, you gotta embrace it at the same time and the tendency is for us to look at the-the trauma, right? The deficit. Cause we're taught that in the colonial structures. We're taught to look for sickness, right?… That deficit that we were stuck in, and the trauma that has happened to us because it-it is a clear path of understanding of how to reclaim what you lost, right? So, like we know we lost our uh was taken away, our language, right? We know land was taken away. We know cultural practices were frowned upon, right? Or even outlawed, right? How do you go back rebuilding a-a person, or a people then you re-rebuild those aspects, right?

Similarly, one of the Native Hawaiian patients (i.e., a mixed-ethnicity Native Hawaiian woman in her 20s) nicely summarized the integration of Hawaiian cultural activities, like being out picking *kalo* (taro plant), would address identity issues as well as their ability to nurture the vital connections:

> I think that like back down to the *lo'i* stuff and like especially because sustainability in Hawai'i is such a big thing that it would be really awesome if you could incorporate the mental health, addressing mental health while doing that because so many people too where you don't want to be you don't want its helpful when you know you're not the only one going through it and then like so have some but then like get people out in the nature and the mud and like working together or something because I think that as a whole that just brings you back and you're like you can be all up in the air, thoughts are everywhere but ground yourself and be like kay I am here this is the present this is what I'm working on and like and then it also will bring back to the identity part.

Limitations and strengths

The present study has several notable limitations. First, we cannot rule out the possibility of biases that might have influenced the organization and summary of the present findings, especially those of the first author. To minimize the biases, we utilized reflexive practices in the process of qualitative data analysis, as well as intentionally based our summary and interpretation of findings on the number of participants who stated a given coded event during the meeting (e.g., in-depth interviews or focus group) or the total number of the time these coded events were stated across all participants. Second, the present findings may be limited in external validity given the nature of the study design with a convenience/snowball sample. More specifically, the extent to which the present findings represent the voice of Native Hawaiians and behavioral health service providers working with Native Hawaiian patients with depression in Hawai'i is unclear. Relatedly, the present sample was skewed in certain demographic characteristics, including gender, SES, and educational history. Nevertheless, our study was community-informed, recruiting study participants through a community partner (i.e., I Ola Lāhui), which is well-connected to local Native Hawaiian communities and behavioral health services in Hawai'i. Finally, the interview questions were designed and refined based on feedback from the study participants on an ongoing basis, which was also a notable strength of the present study.

Implications for Behavioral Health

Although depression is a major health disparity concern for Native Hawaiian adults living in Hawai'i,[1,2] they are known for the underutilization of, and mistrust toward, behavioral health services.[9,10] Several implications for behavioral health can be drawn from the present qualitative study for addressing these issues. First, Native Hawaiian service underutilization and mistrust might be due, in part, to the sharp contrast between a generic Western European approach to behavioral health and Native Hawaiian views on depression and its preferred remedies.[33] Native Hawaiians, according to the findings of the present study, also tend to view depression more collectively at interpersonal and systemic levels, which goes beyond the individual focus commonly held in Western behavioral health. As such, consistent with the cultural safety framework,[10] behavioral health services designed to treat depression in the Native Hawaiian community should be intergenerational, involving one's *'ohana*, as well as community-based. Furthermore, participants also emphasized the importance of integrating Native Hawaiian cultural and spiritual practices into behavioral health services, which promote one's *pilina* (vital connection) to their culture and identity, thereby contributing to *mauli ola*. Lastly, as part of culturally safe and responsive intervention delivery,[22] behavioral health services ideally should address

the historical determinants of Native Hawaiian depression (e.g., colonization, historical trauma, loss of sovereignty) in assessment, case formulation, treatment, and community outreach. The findings of this preliminary qualitative study may also lend support for the development of cultural safety-based therapist training programs to better prepare behavioral health providers for working with Native Hawaiian patients with depression in a culturally sensitive manner.

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Declarations

Conflict of Interest The authors declare no competing interests.

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