

Assimilation and Acculturation in Native Hawaiian and Other Pacific Islander (NHOPI) Health and Well-Being

Teruya SA^{1,2*}, Pang J³, Pang K³

¹Department of Medicine, David Geffen School of Medicine, University of California, Los Angeles, California, USA

²Department of Internal Medicine, College of Medicine, Charles R. Drew University of Medicine and Science, California, USA

³Pacific Islander Health Project (PIHP), Orange County, California, USA

Received Date: January 03, 2020 **Accepted Date:** January 28, 2020 **Published Date:** February 03, 2020

Citation: Teruya SA, Pang J, Pang K (2020). Assimilation and Acculturation in Native Hawaiian and Other Pacific Islander (NHOPI) Health and Well-Being. *POJ Nurs Prac Res.* 4(1):1-5. DOI: <https://doi.org/10.32648/2577-9516/4/1/1>

***Corresponding Author:** Stacey A. Teruya, EdD, MS, Assistant Professor, Department of Internal Medicine, College of Medicine, Charles R. Drew University of Medicine and Science, 1731 East 120th Street Los Angeles, California 90059, USA, Tel:+310-463-0332; Email: staceyteruya@cdrewu.edu.

Abstract

Our recent scoping review revealed a general scarcity of Native Hawaiian and other Pacific Islander (NHOPI) research, and a disproportionately high number of studies on different interpretations of “culture.” Because this area appears to be significant in NHOPI health and well-being, we examined the applicability and effect of assimilation and acculturation on this population.

The literature suggests that NHOPI assimilation is not pervasive, given wide-spread, even institutionalized discrimination and bias in housing and employment. NHOPI may also resist assimilation for a variety of reasons, including ethnic and national pride. Knowing how acculturation may improve or compromise NHOPI health and well-being is constrained by a lack of studies on traditional modalities and practices compared against Western or non-indigenous methods. Moreover, even if we could unequivocally identify health disparities that arise from low assimilation or “bad” acculturation, forced assimilation and acculturation into the dominant culture may be both unethical and ineffective.

Assimilation and acculturation constructs also seem inadequate in addressing NHOPI health disparities caused by structural and social barriers. NHOPI cultural and physical assimilation may be challenging, due to differences in race, socioeconomic status, and distinguishing traditions. For many NHOPI, acculturation may even be irrelevant. A highly acculturated indigenous person, for example, may still encounter the same discrimination, racism and challenges as a low-accultured peer. Common acculturation models are also limited in that they do not reveal factors that predict specific negative outcomes, nor do they offer exact solutions. In addition, there is no universal consensus on acculturation’s indicators, measures and proxies. However, the following three processes in acculturation seem significant in NHOPI health and well-being.

Ghettoization induced by living on an island with relatively poor infrastructure and limited resources and opportunities may in itself compromise health and introduce health disparities. Even those NHOPI who have left their island homelands may experience isolation in poor and underserved neighborhoods due to social and economic factors. NHOPI may also pursue separation by maintaining traditional behaviors and practices, and reject those from the dominant culture, even if more effective and beneficial.

Keywords: Native Hawaiian, Pacific Islander, NHOPI, health disparities, assimilation, acculturation, enculturation, NHOPI culture, separation, isolation, marginalization, ghettoization.

INTRODUCTION

In a recent scoping review, we surveyed and reported on current Native Hawaiian and other Pacific Islander (NHOPI) health and health disparities research [1]. We found studies on “culture” to be the most numerous. Permutations and interpretations varied widely, and included diet and feasts, perceptions of a history

of colonization, large ideal body weight and size, preserving traditions and customs, and a connection to place. “Culture” was also naturally seen as an integral part of community-based, culturally-sensitive and culturally-appropriate research approaches and service programs, designed with stakeholder feedback.

Based on the literature, “culture” therefore seems highly significant in NHOPI health and health disparities. However, we found no studies on the effect of assimilation and acculturation. Although these processes are often thought to involve immigrants, NHOPI culture will also invariably merge, interact, and sometimes clash with those of other native and non-native populations. In previous research, we even examined similarities and differences between traditional, non-native newcomers to the USA, or *aspirational immigrants*, and native-born homeless populations, or *urban immigrants* [2]. Clearly, intracultural differences exist, and the interaction of both native and non-native groups with dominant and other cultures, it seems, can create stress and conflict.

Conventions and Limitations

According to the United States Office of Management and Budget (OMB), “Native Hawaiian or other Pacific Islanders” are those with origins in “Hawaii, Guam, Samoa, or other Pacific Islands” [3]. In current research, “Native Hawaiian and other Pacific Islanders” and “NHOPI” are generally used to refer to those of Polynesian, Melanesian and Micronesian ancestry. In this article, “NHOPI” may refer to an individual, or to the population as a whole.

NHOPI ethnicities are numerous and diverse. Among others, these include Tongans, Samoans, Tahitians, Native Hawaiians, Māoris, Chuukese, and Marshallese (or Marshall Islanders). The aboriginal people of Australia are generally not included in the NHOPI designation, as they do not reside in, or originate from Polynesia, Melanesia or Micronesia. However, stressors, processes and strategies that affect NHOPI may also apply to these indigenous people.

ACCULTURATION AND ASSIMILATION

Broadly speaking, *acculturation* is any change that results from contact between individuals, or groups of individuals, and others of different cultural backgrounds [4]. It has also been characterized as a process of attitudinal changes and responses that result from adapting to unfamiliar, and often uncomfortable environments and settings [5]. In *assimilation*, the ethnological, and even certain physical traits of the non-dominant culture become more and more like those of the dominant mainstream [6].

Voluntary assimilation may be challenging for Polynesians, Micronesians and Melanesians, as they often differ physically and culturally from the usually White mainstream, and from other minorities. Even those who attempt to “pass” will probably find that native values and traditions such as large body size and Māori facial tattoos are easily discerned. Many NHOPI, on the other hand, may resist assimilation in attempting to preserve cultures that have suffered from discrimination, racism, and past colonialism. NHOPI may also have nativist feelings and thoughts of national, native independence [1].

Identifying and assessing acculturation in NHOPI is compromised and complicated by several factors. Firstly, we must account for individual and collective attitudes, values, perspectives, and strategic choices in rejecting, adopting or adapting to a

different culture [7]. This is especially true in light of the many different ethnicities, histories, cultures, languages and individual variation of the people we collectively call Native Hawaiian and other Pacific Islanders.

Acculturation and assimilation models also do not seem optimal in addressing health disparities caused by structural and social barriers. Berry’s taxonomy and Ward’s model, for example, are well known and often cited [7]. However, they do not describe how forces in acculturation can yield adverse effects and outcomes, nor do they offer any explicit solutions as to how these may be mitigated or eliminated [7].

Integration and Enculturation

In adapting to any new or challenging environment, *integration* can bring together native traditions and culture with that of the established mainstream. This process or strategy is thought to result in the least amount of conflict and stress [8]. However, integration is somewhat loosely defined, and is often interpreted in the context of bi- or multiculturalism [9]. In these, whole parts of different cultures are incorporated, voluntarily or involuntarily. For example, this may mean embracing Western medicine in its entirety, while adhering exclusively to a traditional Hawaiian diet. A better option may be *enculturation*, [10] through which people consciously “pick and choose” exactly which aspects of the dominant culture they wish to adopt or reject, and to what degree.

Clearly, it is in the individual’s best interest to adopt behaviors and components which lead to better outcomes. Unfortunately, there is scant research on traditional practices and modalities such as NHOPI healing rituals [7]. It is therefore difficult to determine exactly what indigenous practices or aspects should be maintained or (re)adopted, and what should be abandoned in favor of those of the dominant culture.

Separation and Marginalization

Another way of adapting to challenging environments is to employ *separation*, through which people physically and/or mentally distance themselves from the prevailing culture and society [7]. Whereas integration and enculturation may theoretically incorporate the best of both worlds, separation would preserve indigenous health behaviors and exclude Western practices, for example. However, given the lack of studies on non-native versus traditional methods and practices, the objective benefits of separation are also uncertain. Without these, we cannot know exactly what should be preserved, excluded, or separated culturally to achieve the best outcomes.

A separation strategy also carries the risk of *marginalization*, [11] when the mainstream and other cultures react negatively to the apparent refusal of an individual or group to adopt prevailing customs and practices. The majority of NHOPI may be at special risk, given their history of discrimination, a possible inability to easily assimilate, and generally low socioeconomic status [1]. The marginalization of NHOPI populations, in fact, may already be seen in ongoing poverty, [12] the lack of employment opportunities, [13,14] barriers to social advancement, [15] and political disenfranchisement [16].

Ghettoization and Isolation

Ghettoization arises when groups of people are isolated physically, socially and culturally [10]. For the majority of NHOPI, ghettoization may be involuntary, often with severe negative outcomes. Island people are of course naturally isolated, and may be expected to enjoy few employment and educational opportunities, limited technology and infrastructure, and at best only fair medical and social services, compared to those who live in large urban, mainland communities. Even those who do not live on islands may be at risk. Unless isolated populations are well-off, thriving, and have access to adequate resources, it is reasonable to expect at least some socioeconomic and health disparities between them and surrounding communities. It seems though that most NHOPI live in poverty [12] regardless of where they live, and that isolation makes their circumstances even worse.

Marshall Islanders, for example, have established communities in Arkansas, where they have resettled for employment. People living in these “ghettos” suffer from poverty, [17] food insecurity, and cultural barriers [18]. Besides their low socioeconomic status, they face communication and language barriers, have poor educational opportunities, little or no health insurance, live in crowded conditions conducive to the spread of disease, and have limited access to transportation [17,18].

Acculturation, Assimilation, and NHOPI Health and Well-Being

NHOPI who preserve a healthy traditional diet [19-27] and participate in physical activities or exercise as did their ancestors [19,20,28-33] were shown to enjoy better health than those deemed more acculturated, who consumed Western “junk” food, [34,35] and who lead more sedentary lifestyles [36]. Despite such research, it is largely unclear exactly which practices and behaviors, besides the obvious, should be excluded, and which should be maintained or adopted.

Our review, for example revealed no credible studies on the efficacy of traditional NHOPI healing modalities [1]. Similarly, cultural traditions such as feasting and family gatherings are thought to be beneficial for NHOPI [1]. However, research has not yet identified which components are the most significant, why, and how these may be leveraged to improve NHOPI health and well-being. We expect that findings may even prove somewhat contradictory, as in encouraging feasting events while discouraging positive perceptions of obese status.

DISCUSSION

NHOPI may be less able to assimilate physically and culturally than Caucasians or other races due to discrimination and racism. Understandably, NHOPI in autonomous or semi-autonomous island countries such as Tonga and Samoa may also have no desire or need to assimilate with races and cultures of other areas or nations. NHOPI may also wish to retain their cultural identity as much as possible, out of ethnic pride, a sense of community, past experiences of discrimination and racism, nativist and nationalist feelings, and past colonialism. These considerations indicate that assimilation as a strategy in improving NHOPI health and well-being may prove largely ineffective.

Using acculturation also seems limited and impractical. Acculturation is “personal” and “human,” and must account for the attitudes, values, perspectives, and choices of the individual, and of the many different subgroupings of the people we call NHOPI. Moreover, there is a scarcity of research in this area, and no universal consensus on the indicators, measures and proxies of acculturation. Except for the obvious, there is no general agreement on exactly what in acculturation is “good” and “bad” for individuals, for each of the many different subgroupings of NHOPI, and for this population as a whole.

It is also unclear whether we can demonstrate an unequivocal association between purported components and measures of acculturation, and health or social outcomes. High acculturation, for example, may be determined as adopting a non-indigenous diet. However, this does not necessarily mean that what a non-traditional individual eats is unhealthy, or less healthy than traditional island fare. NHOPI health seems more severely compromised by voluntary behaviors such as high rates of smoking, [25-27,29,30,37-39] which appear to be a conscious, [40] if not cultural choice.

Acculturation may also be practically irrelevant in NHOPI communities where poverty, the lack of basic services, and limited resources would seem to better predict poor health outcomes and major health disparities. While low acculturation may not satisfactorily explain living in NHOPI mainland “ghettos,” for example, poverty, limited opportunities, disenfranchisement, and discrimination may. Even if we could identify a specific health disparity caused by the lack of assimilation, it is debatable as to whether public policy and practice should encourage or enforce NHOPI assimilation into the dominant mainstream as a corrective measure. Similarly, if some highly acculturated individuals were shown to have better health outcomes, should all NHOPI be forced to abandon or reject their traditional practices and behaviors?

CONCLUSIONS AND RECOMMENDATIONS

Acculturation and assimilation would seem highly relevant given the large amount of NHOPI “culture” research found in the literature. It therefore seems natural to assume that processes and strategies in both could be leveraged to improve NHOPI health and well-being. However, assimilation for many NHOPI does not seem widespread. This is understandable given differences in race, socioeconomic status, and distinguishing cultural traditions. NHOPI may also resist assimilation for a variety of reasons, including ethnic and national pride.

Likewise, the value of acculturation as a tool or strategy in improving NHOPI health and well-being is equivocal. There is a general scarcity of research, especially on native modalities, traditions and interventions compared to Western or non-indigenous methods. Besides the obvious, we simply do not know objectively which parts of NHOPI “culture” should be preserved, adopted, or rejected. Moreover, acculturation and assimilation models do not seem directly aligned, or consistent with, the serious social, structural and policy barriers that negatively affect NHOPI health and well-being.

The literature suggests, however, that three acculturation processes or strategies may contribute to NHOPI health disparities. Living on an island with relatively poor infrastructure and limited resources in itself implies involuntary ghettoization. Even those who have left their island homelands may also find themselves isolated in poor and underserved neighborhoods due to social and economic factors. Some NHOPI may also pursue voluntary cultural separation, in which traditions and native practices are maintained, and possibly beneficial Western behaviors and modalities are excluded.

The literature indicates that it may be more practical and effective to examine NHOPI lifestyle and health behaviors in predicting health outcomes, rather than employ acculturation and assimilation constructs and measures. However, the negative effects of ghettoism, isolation, and separation appear significant and applicable for all NHOPI and subgroups.

REFERENCES

1. Teruya S. Native Hawaiian & Other Pacific Islander Health & Health Disparities. Riga, Latvia: Lambert Academic Publishing; 2019.
2. Teruya S. The homeless as urban immigrants. *Cogent Psychology*. 2019;6(1):1571728.
3. Centers for Disease Control and Prevention. Minority health. 2013. Available from: <http://www.cdc.gov/minorityhealth/populations/REMP/nhopi.html>. Accessed October 1, 2015.
4. Sam DL, ed. Acculturation: Conceptual Background and Core Components. Cambridge: Cambridge University Press; 2006. The Cambridge Handbook of Acculturation Psychology.
5. Ward C. Thinking outside the Berry boxes: New perspectives on identity, acculturation and intercultural relations. *Int J Intercult Relat*. 2008;32(2):105-114.
6. Gordon M. Assimilation in American life: The Role of Race, Religion and National Origins: Oxford University Press; 1964.
7. Teruya S, Bazargan-Hejazi S. Acculturation Research: A Health Outcomes Approach. In: Merton J, ed. *Acculturation: Psychology, Processes and Global Perspectives*. Hauppauge, NY: Nova Science Publishers; 2014:29-45.
8. Berry J. Stress Perspectives on Acculturation: Cambridge University Press; 2006.
9. Boski P. Five meanings of integration in acculturation research. *Int J Intercult Relat*. 2008;32(2):142-153.
10. Weinreich P. 'Enculturation', not 'acculturation': Conceptualising and assessing identity processes in migrant communities. *Int J Intercult Relat*. 2009;33(2):124-139.
11. Berry JW. Acculturation: Living successfully in two cultures. *Int J Intercult Relat*. 2005;29(6):697-712.
12. Tanjasiri SP, Takahashi L, Sablan-Santos L. Financial distress among Pacific islanders in southern California. *AAPI Nexus*. 2015;13(1-2):14-24.
13. Ponce NA, Tseng W, Ong P, Shek YL, Ortiz S, Gatchell M. The state of Asian American, native Hawaiian and Pacific islander health in California report. 2009.
14. Ka'opua LS, Braun KL, Browne CV, Mokuau N, Park C-B. Why are native Hawaiians underrepresented in Hawai'i's older adult population? Exploring social and behavioral factors of longevity. *Journal of Aging Research*. 2011;2011:8.
15. Mau MK, Sinclair K, Saito EP, Baumhofer KN, Kaholokula JK. Cardiometabolic health disparities in native Hawaiians and other Pacific islanders. *Epidemiol Rev*. 2009;31:113-129.
16. McElfish PA, Ayers BL, Purvis RS, et al. Best practices for community-engaged participatory research with Pacific islander communities in the USA and USAPI: Protocol for a scoping review. *BMJ Open*. Jan 24 2018;8(1):e019653.
17. Haselow DT, Fields VS, Safi H, McElfish PA. Addressing social contexts and determinants of health in Marshallese communities - authors' reply. *Lancet Infect Dis*. Apr 2019;19(4):358-359.
18. Ayers BL, Hawley NL, Purvis RS, Moore SJ, McElfish PA. Providers' perspectives of barriers experienced in maternal health care among Marshallese women. *Women Birth*. Oct 2018;31(5):e294-e301.
19. Kaholokula JK, Townsend CK, Ige A, et al. Sociodemographic, behavioral, and biological variables related to weight loss in native Hawaiians and other Pacific islanders. *Obesity (Silver Spring)*. Mar 2013;21(3):E196-203.
20. Moy KL, Sallis JF, David KJ. Health indicators of native Hawaiian and Pacific islanders in the United States. *J Community Health*. Feb 2010;35(1):81-92.
21. Mau MK, Keawe'aimoku Kaholokula J, West MR, et al. Translating diabetes prevention into native Hawaiian and Pacific islander communities: the Pili'Ohana pilot project. *Prog Community Health Partnersh*. Spring 2010;4(1):7-16.
22. Fujita R, Braun KL, Hughes CK. The traditional Hawaiian diet: A review of the literature. *Pac Health Dialog*. Sep 2004;11(2):250-259.
23. Lassetter JH. The integral role of food in native Hawaiian migrants' perceptions of health and well-being. *J Transcult Nurs*. Jan 2011;22(1):63-70.
24. Novotny R, Vijayadeva V, Grove J, et al. Dietary intake among native Hawaiian, Filipino, and White children and caregivers in Hawai'i. *Hawaii J Med Public Health*. Dec 2012;71(12):353-358.
25. Novotny R, Williams AE, Vinoya AC, Oshiro CE, Vogt TM. US acculturation, food intake, and obesity among Asian-Pacific hotel workers. *J Am Diet Assoc*. Oct 2009;109(10):1712-1718.
26. Shintani T, Beckham S, O'Connor HK, Hughes C, Sato A. The Waianae diet program: A culturally sensitive, community-based obesity and clinical intervention program for the native Hawaiian population. *Hawaii Med J*. May 1994;53(5):136-141, 147.

27. Wong KA, Kataoka-Yahiro MR. Nutrition and diet as it relates to health and well-being of native Hawaiian Kupuna (elders): A systematic literature review. *J Transcult Nurs*. Jul 2017;28(4):408-422.
28. LaBreche M, Cheri A, Custodio H, et al. Let's move for Pacific islander communities: An evidence-based intervention to increase physical activity. *J Cancer Educ*. Jun 2016;31(2):261-267.
29. Moy KL, Sallis JF, Ice CL, Thompson KM. Physical activity correlates for native Hawaiians and Pacific Islanders in the mainland United States. *J Health Care Poor Underserved*. Nov 2010;21(4):1203-1214.
30. Moy KL, Sallis JF, Trinidad DR, Ice CL, McEligot AJ. Health behaviors of native Hawaiian and Pacific islander adults in California. *Asia Pac J Public Health*. Nov 2012;24(6):961-969.
31. Madan A, Archambeau OG, Milsom VA, et al. More than black and white: Differences in predictors of obesity among native Hawaiian/Pacific islanders and European Americans. *Obesity*. 2012;20(6):1325-1328.
32. Felix H, Li X, Rowland B, Long CR, Yeary KHK, McElfish PA. Physical activity and diabetes-related health beliefs of Marshallese adults. *Am J Health Behav*. Sep 1 2017;41(5):553-560.
33. Van Duyn M, McCrae T, Wingrove BK, et al. Adapting evidence-based strategies to increase physical activity among African Americans, Hispanics, Hmong, and native Hawaiians: A social marketing approach. *Preventing chronic disease*. 2007;4(4):A102-A102.
34. Barnes SS, O'Carroll DC, Sumida L, Shafer LA, Yamada S. Evidence for a continuing gap in rural/urban adult obesity in the Samoan archipelago. *J Community Health*. Aug 2011;36(4):534-537.
35. Duncan KL, Lassetter JH, VanServellen G, et al. The relationship between select demographic characteristics and body mass index among native Hawaiian and other Pacific islander caregiving adults. *Journal of Transcultural Nursing*. 2015;26(1):31-38.
36. Wang D, Hawley NL, Thompson AA, et al. Dietary patterns are associated with metabolic outcomes among adult Samoans in a cross-sectional study. *J Nutr*. Apr 2017;147(4):628-635.
37. Seiden A, Hawley NL, Schulz D, Raifman S, McGarvey ST. Long term trends in food availability, food prices, and obesity in Samoa. *Am J Hum Biol*. 2012;24(3):286-295.
38. Baumhofer NK, Panapasa SV, Francis Cook E, Roberto CA, Williams DR. Sociodemographic factors influencing island foods consumption in the Pacific islander health study. *Ethn Health*. Dec 28 2017:1-18.
39. Theodore R, McLean R, TeMorenga L. Challenges to addressing obesity for Maori in Aotearoa/New Zealand. *Aust N Z J Public Health*. Dec 2015;39(6):509-512.
40. Gifford H, Tautolo el S, Erick S, Hoek J, Gray R, Edwards R. A qualitative analysis of Maori and Pacific smokers' views on informed choice and smoking. *BMJ Open*. May 17 2016;6(5):e011415.