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Help-Seeking Behaviors for Depression Among Native Hawaiian Women in the Western Region of the United States Mainland

Marlana Glover
Walden University

Walden University

College of Psychology and Community Services

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Marlana Glover

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Dr. Douglas McCoy, Committee Chairperson, Human Services Faculty
Dr. Eric Youn, Committee Member, Human Services Faculty
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Sue Subocz, Ph.D.

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Abstract

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MPhil, Walden University, 2019

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Human Services Disaster and Crisis Intervention

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Abstract

Help-seeking for depression, as with other mental illnesses is contingent upon stigmas that one perceives. Although causes for depression differ among indigenous populations, native Hawaiians suffer from the Western acculturation and colonization of their homeland. With lack of trust in the U.S. healthcare system, many native Hawaiians are reluctant to seek help for depression. Furthermore, research has shown that most studies on native Hawaiians are conducted in their native environment when many Hawaiians relocate to the U.S. mainland. Because of the current depression crisis, it is critical to explore depression among native Hawaiians, particularly women on the mainland to see how different environments influence help-seeking behaviors. Ajzen's theory of planned behavior was used to predict and explain behavior in specific contexts in this qualitative basic design study. Data were gathered from the semi-structured interviews of six female native Hawaiian participants and analyzed through open coding. Eleven main themes emerged, leading to findings on family dynamics and early childhood experiences, frustrations dealing with depression, stigma, cost, accessibility, and shame as barriers to treatment, family and support systems, community-based programs and where to seek help, job connections offering mental health support, availability of help in Hawaii versus the mainland, developing relationships with providers, comfort with providers, provider qualifications, and caring for children's mental health. Findings may inform mental health professionals and contribute to social change by understanding native Hawaiian populations residing outside of Hawaii, cultural concerns, therapy preferences, and extent and customization of treatment programs as an employee benefit.

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Dedication

I dedicate my educational pursuits to my grandmother, mother, and close family members to include several friends that I consider family who have supported me throughout my journey. I would also like to dedicate this writing to all the native Hawaiian women who live in Hawaii and across the U.S. mainland and the participants who shared their experiences.

Acknowledgments

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Chapter 1: Introduction to the Study

The indigenous population of the Hawaiian Islands is the largest group of Pacific Islanders in the United States of America (USA), accounting for 43% of the Pacific Islander population (Ta Park et al., 2018). Native Hawaiians have suffered racial inequality and discrimination since the US occupation of their homeland, where the presence of Anglo migration led to a White oligarchy and military rule between the 19th and 20th centuries (Mossakowski et al., 2017). With acculturation and discrimination resulting from the US occupation of Hawaii, many Hawaiians have suffered and continue to suffer adversities that can affect their mental health and wellbeing (Ta Park et al., 2018). Furthermore, native Hawaiians are at a disadvantage when it comes to health and wellbeing. More specifically, native Hawaiians have higher risks of diabetes and mental illness compared to other racial and ethnic groups in the US, and those with strong cultural ties are more susceptible to depression (Ka'apu & Burnette, 2019; Ta Park et al., 2018). Hence, it is conceivable that individuals who cannot wholly embrace and live their cultural experiences because of subjugation and discrimination may experience frustrations that lead to depressive symptomology.

Because of frustrations that may be attributed to depressive symptomology related to acculturation, perceived racism, and discrimination, native Hawaiians may be reluctant to seek mental health care when needed (Antonio et al., 2016; Ta et al., 2010). Additionally, native Hawaiian women are known to internalize their frustrations more than men and are at an increased risk of depression (Ta Park et al., 2018; Ta et al., 2010). Thus, the notion of help-seeking for depression may be less apparent among native

Hawaiian women because of cultural perspectives and disparities in mental health resulting from distrust in the Western healthcare system in Hawaii (Antonio et al., 2016). However, many native Hawaiians live in the Western region of the U.S. mainland, and their help-seeking behaviors for depression may differ because of the different environment. Therefore, examining help-seeking behaviors for depression among native Hawaiian women who have lived both in Hawaii and the Western region of the United States mainland may help in terms of understanding native Hawaiians' experiences in different environments.

Background

Help-seeking for mental illnesses such as depression has been met with a wide range of stigma. Reluctance to seek help results from outward and personal stigmas, lack of options, and lack of trust in doctors to render compassionate care to individuals who are in need (Clement et al., 2015; Jennings et al., 2015; Snell-Rood et al., 2017; Ta et al., 2010; Talebi et al., 2016). Depression is still an ongoing issue and is predicted to be the cause of the highest disease burden by 2030 (Todd & Teitler, 2018), and affects indigenous populations because of prior acculturation and colonization of their homeland (Mossakowski et al., 2017; Ta Park et al., 2018; Ta et al., 2010). Specifically, native Hawaiians are an indigenous population who have disproportionally suffered lack of mental and physical healthcare because of a lack of trust in the U.S. healthcare system that stemmed from racial discrimination, loss of cultural identification, and occupation of their homeland (Antonio et al., 2016; Kaholokula et al., 2012; Mossakowski et al., 2017).

Many studies on indigenous people tend to be in their native environment (Antonio et al., 2016; Kaholokula et al., 2012; Mossakowski et al., 2017; Ta Park et al., 2018; Ta et al., 2010). Because depression is a mental disorder that is reported by more women than men (Ta Park et al., 2018; Ta et al., 2010), and different environments may constitute different levels of prevalence involving help-seeking for depression, it is imperative to investigate whether native Hawaiian women's propensity to seek help for depression is different in different environments.

Problem Statement

Native Hawaiian women do not often seek support for depressive symptomology, which is a significant concern. Given the current depression crisis, it is critical to address depressive symptomology, because it is debilitating and contributes to the global disease burden that can lead to suicide (World Health Organization [WHO], 2020).

Because depression is a form of mental illness, there is an underlying stigma, and this is a barrier to treatment (Clement et al., 2015; Jennings et al., 2015; Snell-Rood et al., 2017). Barriers to treatment interfere with help-seeking behaviors, and the stigma of mental illnesses can further perpetuate reluctance to seek help (Ta et al., 2010; Talebi et al., 2016).

Indigenous populations and racial and ethnic minorities in the US have long experienced mental healthcare disparities due to stigma and lack of access to treatment (Ka'apu & Burnette, 2019; Subica et al., 2019; Ta Park et al., 2018; Talebi et al., 2016). Specifically, native Hawaiians experience lower mental health outcomes and have had higher rates of depression (Ta Park et al., 2018). Depression rates for native Hawaiian

women were at 17 percent compared to native Hawaiian men at 12 percent (Ta Park et al., 2018). In a general U.S population, 6.7 percent reported depressive symptomology in 2015 while 8.9 percent were indigenous (Ka'apu & Burnette, 2019). Higher rates of depression among native Hawaiians may stem from acculturation following the US occupation of their homeland. Such political and social disenfranchisement and discrimination has adverse effects on wellbeing (Ta Park et al., 2018; Ta et al., 2010).

Moreover, such adversities which interfere with native cultures can give way to distrust in the health system employed by Western cultures, as well as a propensity to reject Western influence. For example, Alaska natives and Native Americans were subjected to adverse effects of colonization and marginalization that left them with cultural loss, forced relocations, and assimilation into the American way of life (Payne et al., 2018; Subica et al., 2019). Historical trauma due to colonization can lead to a heightened increase in mental illnesses such as depression (Subica et al., 2019). Thus, because of political and social disenfranchisement, discrimination, and acculturation by the mainland US, many native Hawaiians are reluctant to seek help they need in terms of their mental health and wellbeing, which is a major problem.

According to Ta Park et al. (2018), help-seeking behaviors for depression among native Hawaiian women are influenced by culture, discrimination, and the degree of alienation and stigmatization as demonstrated by other social groups. Consequently, reluctance to seek Western healthcare could indicate that these women are at a disadvantage when seeking help for their mental and emotional wellbeing. Further, many native Hawaiian women report they prefer to seek help from spiritual and cultural leaders

because of perceived racism and discrimination due to the Western occupation of their homeland (Mossakowski et al., 2017; Ta Park et al., 2018). Moreover, Ta Park et al. (2018) said native Hawaiian women living in Hawaii were more likely to talk about their help-seeking behaviors and reported more depressive symptomology when interviewed compared to when completing a survey on depression symptoms. . Native Hawaiian women who live in the Western region of the U.S. mainland might differ in terms of their views of help-seeking behaviors for depression, indicating a gap in research. Gaining an understanding of experiences of native Hawaiian women living in the Western region of the United States mainland and their help-seeking behaviors for depression may bring about important insights regarding help-seeking for depression outside of the normal cultural environment.

Purpose of the Study

The purpose of this general qualitative study was to investigate the extent to which different environments influence help-seeking behaviors for depression among native Hawaiian women who have lived both in Hawaii and the Western region of the U.S. mainland. Examining experiences of native Hawaiian women who live outside of the Hawaiian Islands may foster significant findings on cultural adaptation, environmental influences, and possible barriers that may interfere with help-seeking behaviors for depression. Results of this study may contribute to social change by providing a thorough perspective of how native Hawaiian women view help-seeking for depression outside of their native environment. This would allow human services organizations and mental health care agencies to better assist this population.

Research Questions

RQ1: What are lived experiences involving help-seeking for depression among native Hawaiian women between 18 and 65 who moved from Hawaii to live in the Western region of the U.S. mainland?

SQ1: What are the factors that prevent or have prevented native Hawaiian women in the Western region of the U.S. mainland from receiving help from a mental health professional?

SQ2: What opinions do native Hawaiian women in the Western region of the U.S. mainland have regarding their community's view of seeking help for depression from mental health professionals?

SQ3: What different opinions do native Hawaiian women have regarding seeking help for depression in the Western region of the U. S. mainland compared to Hawaii and why?

SQ4: What views do native Hawaiian women in the Western region of the U.S. mainland have regarding their level of comfort with sharing personal and private information regarding their depression with a mental health professional?

Theoretical Framework

This study's theoretical framework is Ajzen's theory of planned behavior (TPB) and was used to predict and explain behavior in specific contexts. An individual's intention to perform a given behavior can most likely lead to the behavior's performance if the intention is strong (Ajzen, 1991). Likelihood of the behavior being performed can depend on some nonmotivational factors such as availability of resources, time, money,

and skill (Ajzen, 1991). Moreover, perceived behavior control dictates the likelihood of behavioral achievement by way of people's perception of how easy or difficult it might be (Ajzen, 1991).

Help-seeking as a behavior, perception of barriers, and intention can influence one's ability to seek help such as mental health services for depression (Bohon et al., 2016). Intentions and perceptions of control must be assessed in relation to the behavior for predicting behavior or likelihood of help-seeking for depression (Ajzen, 1991). Perceptions of barriers and intention to seek help can be used to explore the nature of help-seeking among native Hawaiian women who now live outside of Hawaii. Thus, the TPB was used to understand help-seeking as a behavior in terms of intention, motivational factors, or opportunities and resources available from different environments.

Nature of the Study

This study involved using a generic qualitative design that allowed for a unique understanding of experiences of native Hawaiian women and their propensity for help-seeking behavior for depressive symptomology in the Western region of the U.S. mainland. A qualitative design was used to provide the platform for participants to tell their stories and relate their experiences as descriptive data, from which the researcher extrapolates meaning. Other methods of qualitative inquiry such as phenomenology and ethnography are used to consider inward exploration of lived experiences and ethnicity of participants and cultural ties (Patton, 1999).

The study involved adult women who met criteria for reporting depression symptomology. Participants came from outside the state of Hawaii in the Western region of the U.S. mainland who previously lived in Hawaii. Participants came from Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Their selected age range was between 18 and 65. The sample size consisted of 6 participants, However,12 is usually indicative of data saturation for qualitative studies using a semi-structured interview or focus group (Guest et al., 2006). Data sources for this study consisted of semi-structured interviews that were conducted online to a group of participants who fit the criteria . Analysis of themes that emerge from the data were based on RQ1. I used NVivo qualitative coding software and hand-coding. Thematic analysis allowed for interpretation of meaning from data.

Definitions

Acculturation: Changes that take place due to exposure to culturally dissimilar people, groups, and social influences (Schwartz et al., 2010). Acculturation involves assimilation of one culture into another, or a separation of the influencing culture in order to maintain one's heritage culture (Schwartz et al., 2010).

Behavioral Risk Factor Surveillance System (BRFSS): A telephone-based data collection tool for addressing preventative health practices and risk behaviors that are linked to chronic illness, infectious diseases, and injuries among adults and mental health indicators (Hawaii Indicator-Based Information System, 2020).

Discrimination: Unfair treatment because of race and ethnicity, age, gender, socioeconomic status, or sexual orientation (Mossakowski et al., 2017).

Depression: Depression is a mood disorder characterized by sadness, lack of vitality, and an inability to enjoy life that can be responsive to various treatments such as cognitive behavioral therapy, medications, and hypnotherapy (Chaves et al., 2017; Yu et al., 2020). Depression is a common illness worldwide, affecting more than 264 million people, and at its worse can lead to suicide (World Health Organization, 2020).

Help-seeking: The act of looking for or going in search of a relief or cure to fulfil a need, or an intentional action to solve a problem that is beyond one's personal abilities (Cornally & McCarthy, 2011).

Indigenous: Geographically and culturally distinct groups with diverse histories who share a common history of experiences and oppression as a result of European colonization (Burnette et al., 2019).

Marginalization: An aspect of acculturation in which one does not identify with their own culture or the influencing culture (Schwartz et al., 2010; Ta Park et al., 2018).

Native Hawaiian: Descendants of the original inhabitants of the Hawaiian Islands, a territory under U.S. control (Kaholokula et al., 2012).

Mo'opuna: Grandchild (Wight, 2005).

Stigma: Belief that one is flawed or unacceptable because of society's view of a situation, also known as self-stigma (Vogel et al., 2006). Another form of stigma is perceived stigma, or the belief that others will hold stigmatizing views about people (Barney et al., 2006; Vogel et al., 2006).

Assumptions

The main assumptions that were made were that participants were truthful about their experiences with help-seeking for depression while living in Hawaii as well as the mainland USA. I assumed that participants truthfully expressed any differences in terms of their experiences with help-seeking for depression in different environments. Additionally, I assumed native Hawaiian women had different viewpoints involving receiving mental health care for depression.

Delimitations

Participants were native Hawaiian women who lived on the Hawaiian Islands and relocated to the Western region of the U.S. mainland. The Western region of the United States mainland includes Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming, and may not be generalizable to other locations.

Limitations

Potential limitations of this study involve three underlying issues. The first limitation was finding native Hawaiian female adult participants on the mainland USA who relocated from Hawaii and fit criteria for reporting depressive symptomology and help-seeking for depression. Some Hawaiian women may not have grown up in Hawaii. The next limitation concerns collection of data from personal interviews: time constraints such as being available at times that the participants were available because of time zone differences. Face-to-face methods used to collect the data were impacted by the global COVID-19 pandemic because social distancing necessitated rendering online methods of

data collection via video conferencing. Finally, the small sample size which can limit generalizability, and my bias towards the topic of depression may interfere with my interpretations of the data.

Significance of the Study

This study involved addressing the critical gap in research involving help-seeking behaviors for depression among native Hawaiian women living in the Western region of the U.S. mainland. Most researchers who study native Hawaiian women have conducted these studies among native populations in their native environments. This research will extend the body of knowledge to native Hawaiian women who now live outside of Hawaii in the Western region of the U.S. mainland. Investigating help-seeking behaviors for depression among this population may lead to insights regarding cultural influences and environmental constructs that may impact help-seeking behaviors for depression.

Summary

Native Hawaiian women's help-seeking behaviors for depression may or may not be influenced by their environments. Because seeking help for depressive symptomology can be delayed due to stigma, and depression contributes to the global burden of disease, particularly among indigenous populations, it is imperative to explore help-seeking behaviors for depression in native Hawaiian women. Many factors affect indigenous populations, such as colonization and acculturation due to occupation of their homeland, resulting in racial discrimination and subjugation, which affects mental health and wellbeing. Research of native Hawaiian women is usually conducted within their native environment, but many native Hawaiians relocate to the U.S. mainland. This study

involved exploring help-seeking behaviors of native Hawaiian women who have lived in Hawaii and relocated to the mainland US to see if different environments influence help-seeking. In Chapter 2, I review literature that supports help-seeking for depression among native Hawaiian women as well as effects of acculturation on indigenous populations as it contributes to the depression crisis.

Chapter 2: Literature Review

Help-seeking for depression has been an ongoing issue due to the stigma involving mental healthcare. Depression in general is a comorbid condition that can occur with a primary health condition such as back pain, chest pain, shortness of breath, and fatigue with a high prevalence; it is projected to be the leading cause of disease globally (Hirschfeld, 2001; WHO, 2020). Additionally, indigenous populations such as native Hawaiians suffer disproportionally in terms of physical and mental healthcare. Problems result from their frustrations with acculturation and colonization of their homeland (Ka'apu & Burnette, 2019; Kaholokula et al., 2012; Ta Park et al., 2018). Moreover, native Hawaiian women report more depressive symptomology compared to men (Antonio et al., 2016; Ka'apu & Burnette, 2019; Kaholokula et al., 2012; Ta Park et al., 2018; Ta et al., 2010). Nevertheless, many native Hawaiians decide to relocate to the U.S. mainland. Research on native Hawaiians who live outside of their native environment is limited. Thus, the purpose of this general qualitative study was to explore help-seeking behaviors of native Hawaiian women who have relocated from Hawaii to the U.S. mainland to better understand the nature of help-seeking for depression in different environments.

This chapter includes the literature search strategy, theoretical framework, and literature review on help-seeking behavior for depression among native Hawaiian women who have lived in Hawaii and are currently living in the U.S. mainland.

Literature Search Strategy

To understand issues involving depression and help-seeking among native Hawaiian women, I explored literature on depression and help-seeking as well as native Hawaiians. In this study, I used the following databases: Thoreau, EBSCOHost, PsycArticles, PsycInfo, socINDEX, Social Work Abstracts, and Academic Search Complete via the Walden Library. To find articles, I used the following key terms: *depression*, *females and depression*, *native Hawaiians*, *Hawaiians and depression, indigenous populations, Pacific Islanders and depression*, *help-seeking*, and *theory of planned behavior*. I also used Google Scholar.

Theoretical Framework

To examine the help-seeking behaviors of native Hawaiian women with depressive symptomology, I used Ajzen's TPB. Help-seeking for depression among native Hawaiian women in their homeland may differ compared to those populations living on the U.S. mainland. Therefore, to explore potential effects, help-seeking behaviors among native Hawaiian women with depressive symptomology who had relocated to the U.S. mainland from Hawaii were examined using the TPB.

the TPB involves the concept that people have incomplete volitional control over behavior. A behavior can be expressed when it is under volitional control which leads to the intention to perform a behavior by choice (Ajzen, 1991; Bosnjak et al., 2020). Consequently, making a decision or preference towards a behavior or the intention to perform a behavior that a person has under volitional control is determined by attitude towards the behavior and subjective norms or social pressures to perform a behavior

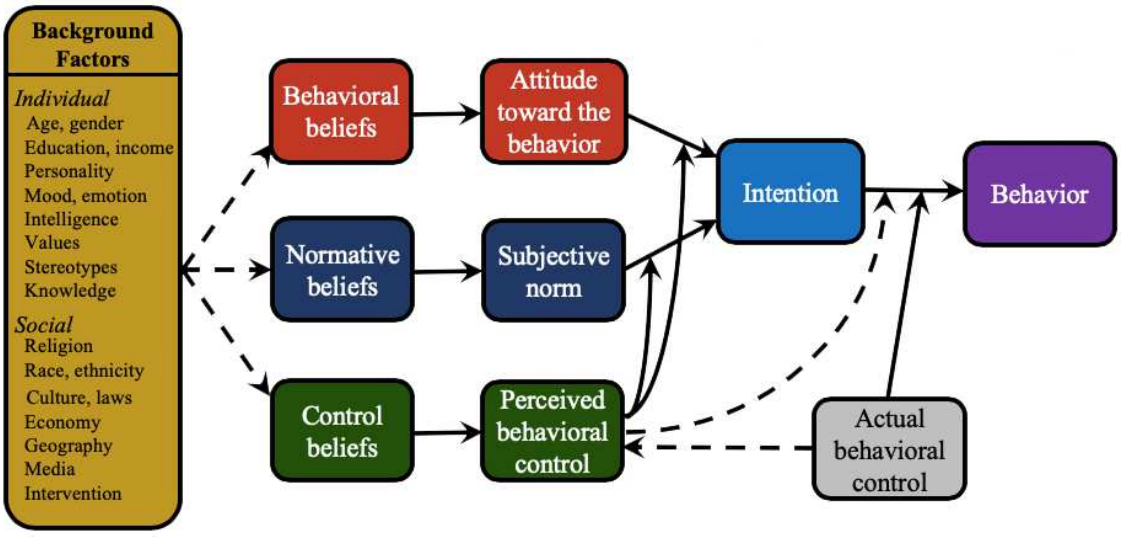
(Ajzen, 1991; Groot & Steg, 2007). Subjective norms are what a person perceives about what others may think or their expectations (Ajzen, 1991; Bosnjak et al., 2020), which are modified by behavioral control (Bosnjak et al., 2020). When considering help-seeking behavior according to the TPB, there are three considerations that guide behavior. First, there are behavioral beliefs (favorable or unfavorable attitudes towards behavior) about likely consequences of the behavior. Next, there are normative beliefs (subjective norms) that stem from expectations of others. Lastly, there are control beliefs (perceived behavioral control) where presence of factors facilitates or impedes performance of the behavior (Bosnjak et al., 2020).

The TPB has been applied in many studies involving help-seeking behavior in the context of mental health such as a public service announcement media intervention on mental health help-seeking (Demyan & Anderson, 2012), Interventions to seek psychological help (Westerhof et al., 2008), depressive symtoms on help-seeking behavior (Nagai, 2015), and self-stigma related to help-seeking behavior (Vogel et al., 2006). For example, Kauer et al. (2017) developed the Link program, an online navigation tool for mental health help-seeking for young adults. Because young adults may be reluctant to seek help for mental issues due to various reasons, such as stigma (Vogel et al., 2006), embarrassment, and availability of services. Online tools such as the Link program can facilitate help-seeking through anonymity (Kauer et al., 2017). Younger people may be more likely to utilize the online tools for mental health concerns if they are available.

For his study, Kauer et al. (2017) recruited 23 young adults between the ages of 18 and 25 via an online advertisement with the goal to set up a platform based on the TPB to change one's attitude towards help-seeking by increasing an individual's awareness of issues, improve subjective norms or expectations of others by decreasing stigma, and improve perceived behavioral control by increasing knowledge about mental health services.

Figure 1

TPB



Note. Adapted and reprinted with permission from Icek Aizen (Ajzen), TpB Diagram (https://people.umass.edu/aizen/tpb.background.html).

TPB is used to comprehend individual behavioral changes as it relates to attitudes, intention, and actual behavioral control. This in turn would aid in developing a deeper understanding of how it relates to the improvement of help-seeking behaviors (Ajzen, 1991). Examining beliefs that foster an attitude towards behavior, ultimately leads to the intention to perform the behavior. Demyan and Anderson (2012) found positive attitudes towards help-seeking of mental health services with a media-based intervention such as a public service announcement which was relevant to younger people. However, Westerhof et al. (2008) findings suggest older adults are less inclined to seek assistance from professionals for psychological issues; however, their intentions to seek preventative care are slightly higher.

The TPB is a suitable theory for exploring help-seeking behaviors among native Hawaiian women with depressive symptomology because of the concepts that help influence behavioral changes through intent (Ajzen, 1991). Beliefs about consequences of behavior, expectations of others, and the factors that facilitate or impede the performance of behavior are the basis for predicting if changes in behavior are likely to occur (Ajzen, 1991; Bosnjak et al., 2020). Thus, by applying this theory, help-seeking for depression among native Hawaiian women can be understood from the participants' points of view and the effect, if any, of different environments (native Hawaii versus the U.S. mainland) on help-seeking behaviors can be studied among this population.

Depression Crisis

Mental illnesses such as depression can affect the day-to-day functions of many individuals. The depressive symptomology can be subtle and indescribable. Depression is

a blanket term that encompasses a wide range of manifestations, including sadness and grief (Harriss et al., 2018). Depression is a mood disorder characterized by sadness, a lack of vitality, and an inability to enjoy life. Depression can be managed using several treatment approaches such as cognitive behavioral therapy, medications, and hypnotherapy (Chaves et al., 2017; Yu et al., 2020). Depression is also a common comorbid condition associated with chronic illnesses such as asthma, diabetes, and cardiovascular disease (Lin et al., 2020). The onset of depressive symptoms can occur at any age and can be triggered by socioeconomic status, poverty, acculturation, discrimination, family relationships, and various health issues that are a challenge to overcome (Lee et al., 2017; Mossakowski et al., 2017; Ta Park et al., 2018). Globally, depression is projected to be the leading cause of health disability (WHO, 2020), and will rank second behind human immunodeficiency virus/acquired immunodeficiency syndrome (HIV-AIDS) in terms of the leading cause of disability-adjusted life years lost by 2030 (Maj, 2012). Depression will be the leading cause of disease globally by 2030 (Todd & Teitler, 2018; Weinberger et al., 2017). By 2020, the global disease burden will increase by 5.7%, with depression ranking second behind ischemic heart disease (Yu et al., 2020). Roughly, 46.6 million individuals 18 years and older report having a mental illness and 24.4 million (52%) are women 18-49 years (Lin et al., 2020). It is apparent that the severity of depression is a global issue that cannot be ignored.

Women and Depression

As mental health conditions, such as depression, are often associated with chronic diseases, many women of reproductive age may be at risk depending on their physical

health status. For instance, women who report depressive symptomology are negatively affected when chronic diseases are evident because of the comorbidity of other illnesses that occur with a primary condition (Hirschfeld, 2001; Lin et al., 2020). In addition, Hirschfeld (2001) reported that between 20 and 50 percent of patients with chronic health conditions are at a higher risk of developing depression, and are thus, negatively affected because depression can slow their recovery. In 2017, 40.8% of females (or 2.9 million women) of reproductive age reported depressive symptomology (Lin et al., 2020). As a result, prevalence of depression among adults aged 40-64 years was 21.39% between 2015-2016, while severe depression was more prevalent among adults aged 65 years and older during 2005-2016. In additions, adults aged 40-64 years were stable over time meaning that there was no significant increase in depression (Yu et al., 2020). These statistics demonstrate the severity of the national and global burden of depression.

Women currently carry a higher burden of depression than men because depression is more prevalent among women indicating a gender effect on depression (Lim et al., 2018; Weinberger et al., 2017). Yu et al. (2020) stated that gender was found to be a risk factor for depression, with females reporting more depressive symptomology than males. Some of the reasons that could contribute to depressive symptomology may consist of one's perception of health and the things that could negatively impact health. For instance, modern health worries (MHWs) may be associated with depression and depression may cause MHWs (Rief et al., 2012). MHWs include health perceptions related to things such as pesticides in food, cell phone tower radiation, and environmental pollution (Rief et al., 2012). The researchers found that depression mediated MHWs and

physical components of quality of life and partially mediated mental components of quality of life, with females reporting higher MHWs than males (Rief et al., 2012). Therefore, this study displays that depression was associated with MHW.

Indigenous Populations and Depression

Stress among indigenous women in Canada is purported to be the result of acculturation and adaptation or adjustment (Benoit et al., 2016). Stress is a result of an emotional response to life events. Chronic stress may influence the pathology of disease, including mental health (Benoit et al., 2016). Effects of acculturation on indigenous peoples brings about mental insufficiencies, depression, and physical ailments among these peoples. Indigenous people are often the subject of study because of disparities in mental and physical health that continue to afflict these groups of people (Benoit et al., 2016; Burnette et al., 2019; Ka'apu & Burnette, 2019; Mossakowski et al., 2017; Ta Park et al., 2018). Moreover, it is imperative that the complications of any malady causing stress that perpetuates depressive symptomology, especially among the indigenous be explored.

Stress

Stress is behavioral reactive response that is displayed when a person or thing feels threatened. Chronic stress is a constant negative occurrence to that prevents the body from maintaining a homeostatic status. Chronic stress contributes to the progression of mental disorders and physical disorders, including pain, headaches, high blood pressure, anxiety, depression, and substance abuse (Benoit et al., 2016). Stress is a negative behavioral response pervasive among the indigenous people because of

colonialism, separation from family, forced assimilation leading to a lack of self-determination, lack of health support, cultural trauma, violence, prejudice attitudes, and beliefs linked to indigenous women's identities (Benoit et al., 2016; Ta Park et al., 2018; Ta et al., 2010). Indigenous people commonly report stress and health concerns, childhood trauma, violence, adverse childhood events (ACEs), and gender inequalities (Benoit et al., 2016). They are also two to five times more likely to experience mental health concerns, of which depression is one. Benoit et al. (2016) studied indigenous people living with and without HIV and found that many had depression before their HIV diagnosis. Moreover, 80% had post-traumatic stress disorder and depressive symptoms, with no difference between those living with or without HIV (Benoit et al., 2016). Hence, just being indigenous indicated a propensity towards depressive symptomology among men and women.

Indigenous Males and Stress

Globally, there is a great focus on overcoming the health disadvantages that affect mostly male indigenous people. Mental and emotional health are common factors to improving health disadvantages such as ill health (Brown et al., 2012). In Australia, men experience a disproportionate burden of ill health from just about any cause and at any age and have the lowest life expectancy (Brown et al., 2012). The key contributors that increase the burden of ill health include mental illnesses. Chronic stressors include racism, family, and community disfunction, loss of land, culture, and identity, marginalization, and powerlessness (Brown et al., 2012). Indigenous Australian men report excessive sadness, irritability, worry and blame colonizers for their weaknesses

and injury to their spirit that in turn leads to an ongoing effect of mental illnesses (Brown et al., 2012). Likewise, Harriss et al. (2018) suggested that intergenerational trauma influenced the burden of disease and ill health.

Indigenous Trauma

Intergenerational trauma as a result of forceful colonialism of indigenous Australians is consequently thought to contribute to the burden of disease, including depression and anxiety. A study conducted by Harris et al. (2018), displayed that one in five indigenous young people had moderate to severe symptoms of self-harm because of self-reported psychological distress. . Other groups such as the Aboriginal people in Canada also endured intergenerational trauma because of racism and discrimination that often plagues indigenous peoples globally (Menzies, 2010).

Ta et al. (2010) reported that cultural identity is an important factor in how one perceives their health and wellbeing. Therefore, exploration of indigenous peoples' cultural identities can contribute to the understanding of how they conceptualize their mental health. Ta et al. (2010) reported positive correlations between Hawaiian cultural identity and both depressive symptomology in adults as well as suicide attempts in adolescents (Ta et al., 2010). Racism was thought to mediate this relationship between cultural identification and mental health indicators (Brown et al., 2012; Ka'apu & Burnette, 2019;Ta et al., 2010). The authors reported that cultural conflict and acculturative stress due to western influence within one's homeland that does not support the traditional values may be viewed as threats to one's identity, which in turn, increases susceptibility to depression (Ta et al., 2010). Also, in this study, women reported more

depressive symptomology than men. Women who reported a higher sense of cultural identity had a higher degree of depression.

Racism and Discrimination on Health

Kaholokula et al. (2012) reported that perceived racism can contribute to poor physical health and stress because stress-related disorders such as high blood pressure, obesity, and heart disease are known to be exacerbated by racial/ethnic discrimination or oppression. Native Hawaiians are disproportionally affected by obesity (44%), hypertension (40%), and diabetes (19%). The prevalence of self-reported diabetes reported by the CDC on native Hawaiians and Pacific Islanders ranged from 12 to 19.1% compared to 9.4% in the general U.S. population (McElfish et al., 2019). Native Hawaiians are also socially alienated and stigmatized by other ethnic groups. Kaholokula et al. (2012) found that racism could "get under the skin" of native Hawaiians, therefore affecting their physical health. For example, cortisol levels were low among native Hawaiians and were comparable to those observed in PTSD, burnout, and atypical depression, while prolonged exposure to racism or discrimination was thought to lower cortisol levels (Kaholokula et al., 2012).

Similarly, discrimination is thought to have adverse effects on psychological health and can increase the risk of depression. Ethnic minority populations such as native Hawaiians are at risk of discrimination simply because of their ethnicity and poor economic status (Antonio et al., 2016). It is believed that the western influence and occupation of their land is the cause of such health disparities, mentally and physically (Antonio et al., 2016). From 2011 to 2013, the behavioral risk factor surveillance system

(BRFSS) reported that 13.7% of native Hawaiians were diagnosed with a depressive disorder compared to the state average of 11.2% (Hawaii-IBIS, 2020). Antonio et al. (2016) found that discrimination influenced depressive symptomology while cultural identity was not correlated with depression or discrimination. The sample for this study was mostly females (73%), with a mean age of 56.3 years.

Mossakowski et al. (2017) also studied discrimination and distress among the Hawaiian population and found that Asians reported lower levels of lifetime racial/ethnic discrimination than Whites in Hawaii. Whites reported similar levels of everyday discrimination as those reported by Pacific Islanders, native Hawaiians, and Filipinos. Asians are the largest ethnic group in Hawaii, comprising 37.6% of the population, while Whites comprise 25.5%, and Pacific Islanders and native Hawaiians comprise 10.1% each (Mossakowski et al., 2017). Furthermore, native Hawaiians are often aggregated with Asian Americans in population-based health data which conceals the disparities between these two groups (McElfish et al., 2019). Therefore, it is essesntial to use distinctive measures that will identify and focus on people of native Hawaiian descent so that their disparities are properly identified.

Although this study found no racial differences in psychological distress among college students in Hawaii, discrimination caused distress when race, age, gender, ethnic id, and socio-economic status was used to affect distress (Mossakowski et al., 2017). Women were subsequently found to be more distressed and gradual discrimination had a worse effect on distress than a one-time experience of discrimination. Nonetheless, it is

crucial to evaluate indigenous populations and the effects of historical oppression along with their experiences with working through oppression to generate resilience.

FHORT Scale

Ka'apu and Burnette (2019) reported that the greater health care disparities among indigenous men and women are related to cultural factors, history of oppression, trauma, racism, loss of language, and environmental deprivation. Likewise, disparities among the indigenous peoples of the U.S. are linked to historical oppression (McKinley et al., 2020). Using the framework of historical oppression resilience and transcendence scale (FHORT), they found a 13.2% to 25.4% increase in post-traumatic stress disorder (PTSD) among native Hawaiian women, compared to a 5.9% to 17.9% increase of PTSD in men. Among the general US population in 2015, 6.7% of people reported experiencing depression while 8.9% of indigenous Americans reported depression. The prevalence of depression among Alaska natives and American Indians ranged from 10-30% (Ka'apu & Burnette, 2019). Historical oppression was found to be related to increased mental outcome risks, such as PTSD, depression, suicide, substance abuse, and trauma while the protective factors were social support and tribal cultural activities (Ka'apu & Burnette, 2019).

Hawaiian Culture and Depression

Hawaii is an island nation with a diverse population. Many research studies have focused on the native Hawaiian population and their culture. Several research studies have been conducted on how people frequently suffer from sadness and depressive symptoms. These symptoms sometimes stem from work, school, and/or family life. Yet

some researchers argue that due to the adversities associated with the western influence on native Hawaiian people, including the occupation of their lands and the resulting of political and social disenfranchisement (Antonio et al., 2016; Ta Park et al., 2018; Ta et al., 2010), there is a need to study the mental health of native Hawaiians, specifically depression, and the adverse effects of the US western influence.

Ethnic Variations on Depression

Kanazawa et al. (2007) said Japanese Americans and native Hawaiians reported lower positive affect than European Americans. In contrast, native Hawaiians reported higher stressful life events and depressed affect than Japanese Americans and European Americans (Kanazawa et al., 2007). This suggests that the indigenous population of native Hawaiians, who have been affected by colonialism, acculturation, and marginalization, are at risk of depressive symptomology (Antonio et al., 2016). Given the increase of reporting stressful life events among native Hawaiians, there must be a preferred method of finding out more information where native Hawaiians feel comfortable in disclosing information of their experiences with depressive symptomology.

Help-Seeking and Depression

Most women who suffered from depressive symptomology were more likely to disclose information on their help-seeking and depression in a face-to-face interview as compared to a quantitative scaled survey. (Ta Park et al., 2018). In studying the mental health of native Hawaiians, cultural identity is an important consideration because of their unique views and perceptions of mental health and wellbeing that could be

influenced by perceived lack of trust in the healthcare system as well as frustrations with acculturation and discrimination (Mossakowski et al., 2017; Ta Park et al., 2018; Ta et al., 2010). Nonetheless, strong cultural identities among the native Hawaiians are strongly tied to ethnic discrimination and the propensity to suffer from depressive symptomology regardless of how it is reported (Ta Park et al., 2018).

Although the basis of depressive symptomology among native Hawaiians may stem from experiences of acculturation and discrimination (Antonio, et al., 2016; Ka'apu & Burnette, 2019; Kaholokula, et al., 2012), it is apparent that one must consider ways to influence help-seeking behavior. There have been many instances, situations, and adversities that have contributed to the affect help-seeking behavior, to which acculturation is a prime example. Sun et al. (2016) said ethnic minorities are disadvantaged when seeking help for mental illness and do not complete treatment if they do. This is related to a lack of culturally competent caregivers, mistrust of health systems, and poor access to treatment. This causes ethnic minorities to adopt negative attitudes which impacts their decision to seek help and frequently results in them not seeking help (Sun et al., 2016). These negative attitudes are behavioral beliefs which are the motivations or intentions that one has involving help-seeking behaviors. It was speculated that these people may be reluctant to seek help from the system that enslaved them.

Stigma and Help-Seeking

The concept of stigma has been known to be a major deterrent on help-seeking behavior for mental illnesses such as depression. Talebi et al. (2016) reported that the stigma of mental illness produces a reluctance to seek help and is unfavorable when

society values self-reliance. Stigma is an example of a subjective norm, such as a perceived social pressure or expectation of what others think (Ajzen, 1991). Support from family, peers, or healthcare professionals help to increase wellbeing and people who do not have support when they are distressed experience perpetuating distress (Talebi et al., 2016). When support is negative, it gives way to stigma which in turn, decreases self-esteem and increases feelings of inferiority. Talebi et al. (2016) found that depression and stigma associated with receiving an unsupportive or negative response were linked to emotion-focused coping efforts, such that people were more vulnerable to help-seeking stigma from self and others. Similarly, discriminatory attitudes such as, self-stigmatization can hinder help-seeking (Schomerus et al., 2009). These findings indicate that greater support promotes problem-solving and less stigma for help-seeking.

Supportive measures such as encouragement from others can promote help-seeking behavior. Vogel et al. (2006) indicated that several factors keep people from seeking help, such as the need to talk about distressing or personal info, the avoidance of painful feelings, and the overall stigma of seeking treatment. Similarly, Clement, et al., (2015) indicated that stigma was a barrier to help-seeking.

Vogel et al. (2006) conducted five studies predicting help-seeking attitudes. The authors reported that stigma makes people believe that they are flawed because of society's view of the situation; thus, they believe that they are socially unacceptable. Apparently, this stigma comes from discrimination, prejudice, and stereotyping, and results in people avoiding seeking help and having negative attitudes towards help-seeking (Talebi et al., 2016; Vogel et al., 2006). It was reported that self-stigma reduces

self-esteem because one may tend to label him or herself as socially unacceptable which is the product of internalizing of self-stigma (Vogel et al., 2006). Help-seeking can be a threat to self-esteem because seeking help can produce feelings of inferiority or inadequacy (Vogel et al., 2006). Thus, some people do not seek help because they think it is a sign of weakness or failure and is worse than the suffering (Vogel et al., 2006). Nevertheless, it is important to narrow down the factors that reduce help-seeking.

According to Judd et al. (2008) factors that influence help-seeking included accessibility, availability, gender, culture, attitudes towards treatment, and self-recognition. Women did not report suffering more problems than men in mental health, but men were less likely to express emotions overtly and seek help when needed because of personal stigma (Judd et al.,2008). Women were not usually worried about stigma (Judd et al., 2008). Clement et al. (2015) said stigma was lower in studies that included only women when comparing gender, indicating that stigma has a small to moderate deterring effect on help-seeking for mental health issues.

Prediction of Help-Seeking

The main component of the theory of planned behavior is to understand how to predict behavior. Because help-seeking behavior is predictable, Ajzen's TPB is based on the premise that behavioral intention is what motivates behavior and help-seeking is a behavior (Ajzen, 1991; Westerhof et al., 2008). However, some people are reluctant to seek help for psychological issues and others are not. In a study on help-seeking behaviors, Nagai (2015) found that subjective needs influence help-seeking indicating that positive relationships with family members on seeking help fosters positive attitudes

towards help-seeking. In addition, social networks such as friends, family, and teachers were found to foster greater help and help-seeking (Nagai, 2015).

According to Nagai (2015), depressive symptoms can inhibit help-seeking and are negatively related to intentions to seek help. There was a negative relation between attitudes toward psychological help-seeking and women were more likely to seek help than men. Ajzen (1991) said behavior is determined by behavior intentions and intentions can predict behavior. Because a person's attitude influences their behavior, it is apparent that help-seeking attitudes are predictable (Bohon et al., 2016). Nagai (2015) also found that subjective needs had a positive effect on behavior and intentions while depressive symptoms had a negative effect on intentions but a positive effect on behavior. Depressive symptoms may apparently reduce the motivation or intent to seek help.

Specifically, Castonguay et al. (2016) reported that only half of people with depression seek help for depression. Comparatively, attitudes towards help-seeking for mental illnesses and the propensity to seek future help provided a different statistic on help-seeking behavior. Mojtabai et al. (2016) found that 33% of the participants would seek help if they had a serious mental health issue compared to 20% who would not seek help. Because help-seeking is perceived as a need for assistance that is expected to be positive, getting help for depression might pose risks.

For example, the authors applied the framework of the health belief model (HBM). According to the HBM, the interaction of health behaviors such as self-efficacy, perception of benefits, susceptibility, severity, and cues to action are what one uses in determining behavior (Castonguay et al., 2016). If people do not think that getting help

for depression will actually benefit, they may or may not get help and that is the risk. Therefore, if getting help for depression is not under one's control then the intention to get help does not occur (Azjen, 2019). Moreover, Castonguay et al., (2016) purported that health-related behavior will increase if a perceived illness has severe consequences and the benefits outweigh the barriers to help-seeking. Barriers to help-seeking include stigma, loss of status, discrimination, and lack of resources (Castonguay et al., 2016).

Summary

The depression crisis is still an ongoing problem and continues especially among indigenous populations. Depression may stem from many adversities and for the indigenous, it stems from effects of acculturation and colonization of their homeland due to racial discrimination, marginalization, and loss of culture. In particularly, native Hawaiians have suffered loss of land, language, and cultural traditions that adversely affected their health and wellbeing as well as receiving proper healthcare. As the severity of depressive symptomology on native Hawaiian women increases, it is unethical for such a population of people to continue to suffer when the U.S. healthcare system is in place to serve their needs. Because of the U.S. occupation of the Hawaiian Islands and the western influence of language and culture, many native Hawaiians are frustrated, and this frustration has been met with racial discrimination, leading to inadequate care and undue suffering that leads to depressive symptomology.

Native Hawaiian women are reluctant to seek help for depression, and the importance of help-seeking behaviors among native Hawaiians is essential to understanding why depression is still a burden. Because many native Hawaiians have

been studied on their home island, it is essential to see if native Hawaiian women who have relocated to the U.S. mainland have different views of help-seeking behavior. Examining the effects of different environments on help-seeking behaviors among native Hawaiian women will help in terms of understanding what it takes to alleviate their experiences leading to depression.

In Chapter 3, I present the research design and rationale used to examine lived experiences involving help-seeking behaviors among native Hawaiian women who live on the mainland USA. The role of the researcher and data collection processes re explained. This study will fill a gap related to exploration of native Hawaiian women in different environments within the continental US via semi-structured interviews. Research trustworthiness and ethical considerations are also discussed.

Chapter 3: Research Method

Help-seeking for depression is a concept linked to the intention to find help, but research in this area with native Hawaiian women who live outside their native homeland is limited. Native Hawaiian women and other indigenous populations have been studied in their native environments. However, there is limited research on native Hawaiian women who migrate from their homeland and their experiences involving help-seeking for depression in different environments. Because of acculturation and colonization of the Hawaiian islands that brought about western cultural influence as well as healthcare systems, it is imperative to see how native Hawaiian culture can blend in with western culture and if acculturation has served its purpose particularily within the U.S. mainland. If a different environment poses better opportunities involving help-seeking behaviors for depression among native Hawaiian women, this could lead to relevant information about how native Hawaiian women feel about receiving care in their homeland versus the U.S. mainland, and if certain factors such as acculturation or cultural-specific care leads to better help-seeking behavior. In this qualitative study I examined the lived experiences involving help-seeking behaviors for depression among native Hawaiian women who no longer live in Hawaii. This general qualitative design consisted of semi-structured interviews used to explore the current gap in literature surrounding this topic.

This chapter will provide an overview of the general qualitative design adopted for the study and the importance of using the general qualitative design to explore help-seeking behaviors for depression among native Hawaiian women who have migrated to the Western region of the U.S. mainland. The sampling methods used for recruitment,

data collection, and data analysis were addressed along with the role of the researcher, including any potential biases and it was mitigated to capture accurate data from participants so it can be analyzed.. Issues of trustworthiness which included credibility, transferability, dependability, and confirmability are discussed.

Research Design

A qualitative research design was used to gain a better understanding of native Hawaiian women's help-seeking behaviors for depression. The general qualitative design provided a platform that allowed study participants to engage in discussions involving what help-seeking means to them. According to Creswell and Creswell (2018), it is imperative to extrapolate meaning from participants' viewpoints regarding help-seeking behaviors for depression and not what the researcher believes about these behaviors. The accurate depiction of participants' viewpoints helped mitigate biased accounts from the researcher and was done by verification of participants transcripts.

This qualitative approach allowed each participant to tell their story, in turn transforming their experiences into descriptive data from which the researcher can derive meaning (Gergen, 2015). The qualitative method along with the use of semi-structured interviews gave participants the ability to answer questions based on their interpretations and allowed them to openly put their experiences in their own words related to how they sought help for depression and whether different environments influenced help-seeking behaviors. Moreover, some phases of the process may change during data collection and analysis in order to enable me to explore a topic more deeply in terms of enhancing learning about the issue from participants. As open-ended questions are designed to

generate rich descriptions from participants, the qualitative approach was used for exploration of themes that were unique to the study's participants.

Research Questions

The following research questions were used to address help-seeking behavior for depression of native Hawaiian women outside their homeland:

RQ1: What are lived experiences involving help-seeking for depression among native Hawaiian women between 18 and 65 who moved from Hawaii to live in the Western region of the U.S. mainland?

SQ1: What are the factors that prevent or have prevented native Hawaiian women in the Western region of the U.S. mainland from receiving help from a mental health professional?

SQ2: What opinions do native Hawaiian women in the Western region of the U.S. mainland have regarding their community's view of seeking help for depression from mental health professionals?

SQ3: What different opinions do native Hawaiian women have regarding seeking help for depression in the Western region of the U. S. mainland compared to Hawaii and why?

SQ4: What views do native Hawaiian women in the Western region of the U.S. mainland have regarding their level of comfort with sharing personal and private information regarding their depression with a mental health professional?

Research Approach and Rationale

I conducted a qualitative general study with six female participants who shared their lived experiences involving help-seeking behaviors for depression among native Hawaiian women who live in the western region of the U.S. mainland. The interviews allowed the participants to express their feelings so I could develope a greater understanding of native Hawaiian women's experiences involving help-seeking and how to navigate systems to alleviate their depressive symptomology, as well as address the question of whether different environments had any influence on these help-seeking behaviors. The qualitative method is used to gather data that is visual or verbal that lends itself to a concept or thematic representation of information from participants (Long & Godfrey, 2004). A qualitative approach was ideal for this study as it allowed me to explore features of social settings and culture in terms of dynamics of social life, within a holistic perspective (Long & Godfrey, 2004). I conducted interviews in a setting of participants' choosing. The data I collected from the interviews provided insight regarding participants' lives as well as perspectives about how people thought about is specific phenomena. Moreover, the qualitative approach provided me with the opportunity to obtain data from participants as the researcher is the key instrument for gathering and interpreting data (Creswell & Creswell, 2018). Furthermore, the qualitative approach allowed me to explore the topic of interest by using specific questions involving participants' quality of life and what help-seeking for depression meant to them (Long & Godfrey, 2004). Data collection consisted of the use of a specific questionnaire tailored to extrapolate required responses from participants related

to the research questions. RQ1 was used to explore help-seeking for depression among native Hawaiian women on the mainland US. This allowed the participants to explain what help-seeking for depression meant to them and if there were any variations in terms of meaning or experiences in different environments. This is indicative to understand the dynamics of social life that a qualitative approach has to offer. RQ1 lead the discussion about how acculturation into other environments affect native women, and their propensities to maintain their cultural traditions. In addition, it was used to explore features of social setting and cultural aspects as well as how adaptation into other environments support or challenged their ability to seek help for depression.

SQ1 explored factors that prevented native Hawaiian women's help-seeking abilities for depression. The question was designed to understand barriers to help-seeking for depression. The barriers explored on help-seeking for depression and opinions on the community's viewpoint for seeking help from a mental health care professional helped to provide information on the stigmas and the influence of the community. In addition to the differences found with receiving care in Hawaii versus the U.S. mainland, SQ4 was based on the ease and comfortability of disclosing information to mental health care professionals.

Role of the Researcher

As the researcher, I identified participants' gender and the effect of stigma and cultural perceptions on their help-seeking behaviors regarding their depressive symptomology. Because the researcher is the instrument (Patton, 1999), it is important to understand my perspective as an individual who is of the same gender, has suffered from

depression, and lives in the participants' native homeland. Although my experience with this topic is limited, it does not detract from the respect and connection I developed with native Hawaiian people, nor with my choice to live in their homeland. It was discovered that some Hawaiians relocated to mainland U.S. due to receiving poor treatment in their homeland due to their depressive symptomology. Moreover, the perceptions of the study participants was not influenced or misinterpreted by any bias.

My goal was to exercise my objectivity so I could give an account for any unknown biases that may have affected the findings of the study. Patton (1999) indicated that the credibility in qualitative research starts with identifying anything that will affect data collection. I used member-checking and reflective journaling to monitor my personal biases. I solidified this approach by allowing participants to review transcripts containing their answers to the interview questions asked. Member-checking ensured accuracy of the data collected and helped validate the data as credible (Shenton, 2004). Member-checking also allowed me to explore my personal biases, and how it may potentially influence the data collection process and study findings.

Researcher Methodology

Native Hawaiian women's help-seeking behavior for depression was explored outside of their native environment of Hawaii and within the western region of the United States mainland. The native Hawaiian's experienced acculteration from the U.S. colonization of their homeland that resulted in discrimination and oppression which affected their mental and physical well-being (Mossakowski et al., 2017; Ta Park et al., 2018). Because of the established US health care system in Hawaii, the lack of trust in the

US health care system, and the overall increasing burden of depression world-wide (Todd & Teitler, 2018), there is a lack of resources to explore help-seeking among native Hawaiian women in a different environment. The western region of the United States mainland was chosen to explore the help-seeking behaviors among native Hawaiian women who have suffered from depression so that symptomology and other variations upon living in a different environment can be explored.

Participant Selection

The selection of participants was based on their willingnes to participate and determined by their eligibility for the study. Six female participants were selected and have suffered from depressive symptomology and migrated from Hawaii to the western region of the United States mainland. The sample population for the current study is native Hawaiian women who experienced difficulty with help-seeking behaviors for depression outside of Hawaii. This population was chosen because there is a lack of investigation in the current research on help-seeking behaviors for depression among native Hawaiian women in different environments (Ta Park et al., 2018; Ta et al., 2010). After evaluating the participants that met the study criteria , they were contacted by email and sent the consent form. An invitation for an interview was sent to participants after they consented to the study. The interview time convenient for them was then scheduled. Interviews were conducted until data saturation was met and the discovery of no new data collected. Data saturation in qualitative interviews can occur with six to twelve participants (or more), demonstrating the correct sample size enables meaningful patterns to emerge that in turn constitute data saturation (Guest et al., 2006). Obtaining

the right sample size was accomplished through the advertising of this study via social media outlets such as Facebook support groups.

Participant Identification

The method for selection of participants was conducted by posting a flyer on Facebook. For example, Facebook had specific groups that shared specific cultural characteristics such as the native Hawaiian culture. I asked for permission to post a flyer in their group so I would be granted access to recruit individuals who are interested in the study and fit the criteria.

Potential individuals interested in the study were contacted via email and evaluated for participation criteria developed for the study. The participants had the opportunity to participate in this study via video teleconference using skype or zoom. The participants were able to select a time slot that worked with their schedule and had the option to reschedule at any time. Questions that emerged around the study was answered so that if the individual wanted to participate, they could on a first-come, first-serve basis as long as they consented. The individuals who did not meet the criteria for the study, or did not want to participate were not contacted.

Sampling Method and Rationale

A purposive sampling method was used to explore help-seeking behaviors for depression among native Hawaiian women who reside outside Hawaii. According to Creswell and Creswell (2018), qualitative research involves purposefully selecting participants (including specific demographic information about them) for the study planned. The themes that emerged from a purposive sample provided a comprehensive

set of data findings for analysis (Cassell & Bishop, 2019). Following the institutional review board's (IRB) approval, social media outlets such as Facebook granted platform access for advertising a flyer on help-seeking for depression among native Hawaiian women aged 18–65, who had both lived in Hawaii and had relocated to the western region of the United States mainland. The western region included Arizona, California, Colorado, and Nevada, (Census Regions and Divisions of the United States, 2020). Participants interested in the study were instructed to send an email and choose a response via phone or email for confirmation to proceed with informed consent and scheduling of the interview. A $25 visa gift card was offered for participation in this study.

The study inclusion criteria consisted of a sample of native Hawaiian women aged 18 to 65 who first lived in Hawaii and sought help for depressive symptomology and later relocated to western region of the United States mainland. Males and Hawaiian women living in Hawaii were excluded. The age range of 18 to 65 years adopted for the study provided a broader account of native Hawaiian women's experiences of help-seeking behavior in their native environment as well as in the U.S. mainland, where many Hawaiian people reside.

Numerous studies have explored various aspects of Hawaiian women including studies of native Hawaiian women in their Hawaiian homeland communities, but limited research was found on native Hawaiian women's help-seeking behavior for depression outside of their homeland (Kaholokula et al., 2012; Kanazawa et al., 2007; Ta Park et al., 2018; Ta et al., 2010). Although the indigenous population in Hawaii includes men and

women, men were not included in the current study because their potentially different experiences and views of depression do not align with the primary research questions posed. The sensitive nature of mental illness, excluding participants who have suffered from severe mental illness such as post-traumatic stress disorder (PTSD) and/or bipolar depressive disorder, is imperative. There is a high level of distress that could be caused by reliving their experiences or reintroducing trauma as a result of participation in a research study. These exclusion requirements were listed on the flyer distributed to participants as well as on the consent form posted to participants during the recruitment phase.

Data Collection

An interview guide located in Appendix A, was used to ensure that the line of questioning during the interview remained aligned with the primary research question, and that the questions were broad and open-ended to allow participants to guide the direction of the study (Jacob & Ferguson, 2012). The interview guide contains five to seven questions and included prompts to encourage participants to answer the questions as freely as possible and notes were taken on the responses and observations made. The beginning of the interview guide had several questions so I could towards build rapport with participants and which provided a space in which they felt comfortable with the interviewing process (Creswell & Creswell, 2018).

Semi-structured face-to-face interviews will be the preferred method for data collection; however, video interviews were conducted, and audio recorded online (via Skype or Zoom) due to COVID-19 restrictions, using an interview protocol based on

travel constraints and the precautions implemented in the context of a global pandemic. The participants that received information about the study were provided with mental health resources when requested as well as the option to end the interview at any time due to the sensitive nature of the subject matter. The participants were assigned a pseudonym to maintain anonymity. The interviews lasted 45-60 minutes. The recorded data was transcribed using NVivo which is a computerized transcribing service. Notes were taken during interviews, and observations of the participants were also recorded, while they were answering questions. I confirmed the accuracy of the transcriptions by reviewing the transcripts while listening to the recordings. Concluding the interview, I asked the participants if they had any closing thoughts or questions to add. The participants were briefed on the method of data transcription, and the availability to view the transcript for clarity around their answers. I used member-checking for clarity and understanding of participants' responses to interview questions (Shenton, 2004). No follow-up interviews were conducted as the participants were able to complete the interview process.

Data Analysis Plan

Data analysis involved the use of a coding strategy. Creswell and Creswell (2018) noted the steps for the data analysis process include taking the data apart and identifying what is most useful. The purpose of coding the data is to determine whether there are emergent patterns that may later contribute to the identification of themes in participants' responses. After I collected the data from participant interviews, the observations made during the interview process, I used NVivo data analysis software and transcription service to transcribe and analyze the data. The recorded interviews were checked for

accuracy by verification with the participants (Shenton, 2004).

The synthesizing of data into a single word or short phrase known as a code was performed to create a representation of the responses given (Saldaña, 2016). The codes were used as a method for translating data, and its meaning was interpreted to categorize the information for later use (Saldaña, 2016). After the coding process was completed, the codes were organized by categories to develop themes that emerged. The themes were interpreted and explained in accordance with the research questions posed. The data analysis plan as suggested by Creswell and Creswell (2018) began by preparing for data analysis by organizing information drawn from transcribed interviews. The data collected from interviews were organized concisely. After the interviews were recorded, the data was transcribed, and any notes made during the interview process was included. Next, Creswell and Creswell's (2018) suggested plan is to read and look over the data obtained from the transcribed interviews. Creswell and Creswell (2018) note that the general ideas that arise from participants' responses once looked over are likely to have a specific tone and give an impression of the credibility of the information collected. Lastly, the coding process begins. The accumulated data from the interviews were organized into manageable segments and identified by a code word that was organized by category. The similarcode words that shared the same characterictics were grouped into a categories (Saldaña, 2016). The coding process helped me develop a more intimate understanding of the data and contributed to understanding of the overall tone which helped towards deriving meaning from the data (Creswell & Creswell, 2018). After the coding process, the data was categorized and the method of drawing out themes from category segments

was done. The categorizing of themes leads to the development of the description where the themes were developed (Creswell & Creswell, 2018). The themes resulted from the data analysis and provided insight into Hawaiian women's choices aimed at help-seeking for depression.

Coding of the transcribed data was performed using NVivo software and hand-coding (NVivo, n.d.). A thematic analysis followed the coding process and the data to be interpreted patterns and themes to emerge to aid in answering the primary research questions (Cassell & Bishop, 2019). For good measure, I kept a reflective journal (or analytical memo) on my understanding of the data from the transcripts as well as during the coding process, which is a practice commonly used in studies on mental health (Crowe et al., 2015). I used descriptive coding which allowed segments of data to be labeled based on what it entailed, where the segments were then organized into a category (Linneberg & Korsgaard, 2019). The categories then gave a clear picture of how to represent the data and explain the findings.

Issues of Trustworthiness

Establishing trustworthiness in this qualitative study involved displaying how credibility, transferability, dependability, and confirmability were incorporated so that findings from the data were deemed trustworthy (Linneberg & Korsgaard, 2019; Shenton, 2004). More specifically, it was used so I would address the accuracy of findings the study and, established what is known as qualitative validity (Creswell & Creswell, 2018). Qualitative validity is a determining factor for establishing trustworthiness in qualitative studies to ensure that findings are understood and presented as accurate between the

participants and researcher(s) (Creswell & Creswell, 2018). Interpretation of the data in the current study was authenticated via the process of member-checking, reflective journaling, and by using a rich, thick description on reported the findings, which is discussed further in a later section.

Credibility

To ensure credibility, I used member-checking allowing participants to verify their answers to the interview questions (Linneberg & Korsgaard, 2019). My interpretations of the participant's responses were verified by them by obtaining a thorough account of the meaning behind their answers while also allowing them the opportunity to clarify any misinterpreted data. I built credibility by being in close collaboration with participants (Creswell & Creswell, 2018). The participants views are what made the study of this kind credible because they represented their perspectives and response used to answer the research questions and to determine what is not known from their point of view. The collaboration between researcher and participants paved the way for thick rich descriptions which provide detailed accounts of their stories (Creswell & Miller, 2000).

Transferability

Transferability requires that the findings of a study are generalizable and can be applied to other situations (Shenton, 2004). Mygoal with this study was to explore and examine the unique experiences that the participants revealed. Because the current study looked at help-seeking for depressive symptomology among native Hawaiian women outside of Hawaii, the findings provided an understanding of the effects of different

environments on help-seeking behavior for depression in this population.

Dependability

Dependability referred to the ability of a study to be deemed trustworthy through detailed reporting of processes and the use of effective methods to gather, report, and analyze data. The data analysis and conclusions drawn from the data must be transparent to ensure credibility and trustworthiness is built into the study (Linneberg & Korsgaard, 2019). In order to warrant dependability in this study, I used reflective journaling to minimize any biases and assumptions that would interfere with the reporting of the data. By using reflective journaling, I was able to document my thoughts and opinions on how I interpreted the data which helped me to explore any biases I developed (Shenton, 2004). Another way I ensured dependability was the use of reflective journaling to conduct the member checks. Conducting the member checks along with the reflective journaling enabled me to compare my assumptions to mitigate any biases that I had so I was able to accurately report that data.

Confirmability

Confirmability ensured that the study findings represented the narrative that expressed the participants' responses to the research questions. To establish confirmability, I used reflective journaling to minimize biases and assumptions as to not interfere with the data analysis (Shenton, 2004). By reflective journaling, I was able to see how my background and overall world view influenced the whole research process by consciously reflecting on my own interpretations and background as I related to the data (Johnson & Rasulova, 2017). As reflective journaling and member checking goes hand

and hand, I was also able to use the process of member checking to ensure that I understood what the participants reported which helped me to ensure my objectivity. Achieving confirmability meant that the data is neutral and free from my personal biases as the researcher (Johnson & Rasulova, 2017).

Authenticity

As an extension of trustworthiness, the authenticity principle in qualitative research has been recognized to acknowledge that people have various value systems and interpretations of their world view that can affect their constructions about a particular phenomenon (Johnson & Rasulova, 2017). Using the authenticity principal with the phenomena of help-seeking for depression and what it means to native Hawaiian women living outside of their homeland allowed me to develop an understanding of their interpretations of help-seeking. A type of authenticity is tactile authenticity that lends itself to confidential measures and how the data will be collected, interpreted, and reported as well as the empowerment of the participants (Amin et al., 2020). Therefore, member checking was the only viableway to ensure tactile authenticity by verifying that the data collected best represented the participant's responses as well as their feelings of empowerment for getting their voices heard on the phenomena of interest.

Ethical Considerations

My proposed research explores depression and help-seeking behaviors among female members of an indigenous culture, which may be a sensitive matter to some participants. Consequently, adherence to ethical guidelines towards ensuring trust, confidentiality, informed consent, privacy, integrity, beneficence, and nonmaleficence is

imperative (American Psychological Association [APA], 2002). On upholding high ethical standards, ethics is about a standard of conduct for protecting the research participants and establishing integrity when dealing with the research participants (Aluwihare-Samaranayake, 2012). To ensure high ethical standards, I followed the ethical guidelines as outlined by Walden University's IRB processes that are required before participant recruitment and data collection. Upon completion of each interview, each participant was given a small denomination of twenty five dollars in the form of a gift card.

Participant Access

In considering the type of participants for this study that include native Hawaiian women who suffer from depressive symptomology, there were rules and regulations that rendered compliance with Walden's Institutional Review Board (IRB). The ethics process began by submitting Form A (Description of Data Sources and Partner Sites), for ethical guidance pertaining to data sources to mitigate any ethical challenges (Walden University, 2020). The IRB provided the guidance on the subsequent forms that need to be included for ethics approval of a research study before data collection and will also provide feedback until ethical standards are met (Walden University, 2020).

The participants were made aware of their rights around informed consent and their choice to participate in this study. The participants were informed that participation in this study is voluntary and that they could choose to opt-out at any time. The participants were told about the purpose and content of the study. It was my responsibility as the researcher to be open and sensitive to the information that is

disclosed by participants in the interview process and to do no harm to them (Barron, 1999). In the current study, to mitigate any potential harm, participants were provided with a list of mental health referral services. Participants were advised that all data will be kept confidential and electronic files will be password protected on my computer and backed up on a password protected cloud drive for safekeeping. They will also be notified that their identities will be kept confidential via the use of pseudonyms.

Interview and Data Collection

The interview and data collection process begun after the IRB's approval to conduct a study and the participants acceptance to be a part of this research study. The participants who were selected were contacted by email with the details about the study. Once they understood the processes regarding the criteria for participating in this study, they were sent an invitation to confirm their willingness to participate. Upon receiving an email of "I consent" to participate in this research study, a date and time selection was sent to them, and they selected the preferred day and time that was convenient for them. Before the data collection began, the participants understood that they would not be pressured to answer questions, and anytime that they desired to discontinue the interview, they may do so at any time. The interview lasted from 45 minutes to an hour. The participants were advised of the recording of the interview and ability to receive a copy of the transcript upon completion verification of the responses to the questions. A gift card of $25 wase given immediately upon completion of the interview for participation in this study. The interview data will be processed via NVivo software for coding and stored

on my password protected computer. All interview data is kept for a minimum of five years and then deleted from my electronic storage device.

Summary

This general qualitative study involved exploring the concept of help-seeking behaviors for depression among native Hawaiian women who migrated to mainland USA. The goal of the study was to determine whether different environments influence help-seeking behavior. The best way to explore lived experiences of native Hawaiian women aged 18 to 65 who engage in help-seeking for depression in the western region of the U.S. mainland was to adopt a qualitative research design. A qualitative design allows for open-ended questions during semi-structured interviews. Participants were given adequate opportunity to tell their stories as well as express their interpretations of what help-seeking for depression meant to them. The qualitative methodology design, IRB research ethics, data collection, trustworthiness, and participant selection criteria were described in this chapter. The research protocol was conducted following IRB ethical guidelines to ensure protection and confidentiality of participants. In Chapter 4, I discuss research findings.

Chapter 4: Results

The purpose of this qualitative study was to understand help-seeking behaviors for depression among native Hawaii women living in the western region of the U.S. mainland. The research questions for this study were:

RQ1: What are lived experiences involving help-seeking for depression among native Hawaiian women between 18 and 65 who moved from Hawaii to live in the Western region of the U.S. mainland?

SQ1: What are the factors that prevent or have prevented native Hawaiian women in the Western region of the U.S. mainland from receiving help from a mental health professional?

SQ2: What opinions do native Hawaiian women in the Western region of the U.S. mainland have regarding their community's view of seeking help for depression from mental health professionals?

SQ3: What different opinions do native Hawaiian women have regarding seeking help for depression in the Western region of the U. S. mainland compared to Hawaii and why?

SQ4: What views do native Hawaiian women in the Western region of the U.S. mainland have regarding their level of comfort with sharing personal and private information regarding their depression with a mental health professional?

In this chapter, I describe the setting for the study in which data collection took place, along with participants' demographics. Next, I explain the data collection process

and data analysis methods. Last, I discuss evidence of trustworthiness and present participants' responses.

Research Setting

The setting for this study was virtual via Zoom video conferencing. Because of the location of myself, participants, and restrictions due to the global COVID-19 pandemic, I was able to conduct interviews virtually, which provided secure, comfortable, and private settings for participants. I was in a shared apartment overseas and performed interviews in the privacy of my bedroom which was free from distractions. There was one interview that was conducted via an emailed questionnaire. Due to the subject's sensitivity, it was a challenge to gain the trust of group administrators on Facebook groups to allow advertising of my study. However, settings accommodated participant involvement.

Demographics

The study consisted of six native Hawaiian females who met criteria for analysis. A total of 14 individuals expressed interest in the study. However, only six participants consented, and five scheduled their interviews. After several follow-up emails, I was able to schedule the last participant. All participants learned about the study from the flyer posted on Facebook when I received permission to join their private groups. Participants were native Hawaiians who grew up in Hawaii on the island of Oahu, except one who was a product of the military and was born at a military base on the mainland but grew up in Hawaii, and later relocated to the western regions of the U.S. mainland.

Table 1

Participant Demographics

Participant	Age	Hawaiian Island	Mainland Residence
1	33	Oahu	Nevada
2	43	Oahu	Arizona
3	68	Oahu	California
4	46	Oahu	Colorado
5	33	Oahu	Colorado
6	49	Oahu	Nevada

Each participant interested in the study was emailed the consent form that explained study qualifications. Those who consented to the study were scheduled for interviews at their earliest convenience.

Data Collection

I began the recruitment process by conducting a search on Facebook for groups and organizations that were exclusive to Hawaiians and Hawaiian culture. I explained my purpose for joining these groups, which was explicitly to post information regarding my study. At times, it was challenging to get approval from the Hawaiian-associated Facebook group administrators; however, as time progressed, I was granted permission to join three groups, then another five, followed by an additional seven over the course of 5 months. One month following IRB approval and subsequent approvals on Facebook Hawaiian group pages, I began scheduling interviews.

I began to collect data within 2 months of posting flyers on Facebook. I interviewed three participants in the same month and three additional participants 3 months later. Semi-structured interviews were conducted over Zoom and lasted between 45 and 95 minutes. Most interviews were conducted with minimal disruptions. Because I

was in the Middle East at the time of interviews, Internet access was a minor issue. However, I conducted most sessions via video and switched from video to audio to maintain connectivity when bandwidth was weak. Participants were informed that interviews were recorded and transcribed for their approval. As interviews progressed, each participant provided their account of their cultural background, including what they wanted to disclose about their early family life. I was able to ask other questions that were relevant to get a rich description of their experiences.

Participants were easy to talk to and provided answers to interview questions without any issues. Two out of six participants did not want a follow-up interview after the initial interview was transcribed, which included emailing transcripts to participants for clarity. The other four participants were sent transcripts and asked if answers were transcribed correctly and whether there were any changes to be made. Two out of those four participants indicated they had nothing more to add. One other participant did not respond to the follow-up email, and the other participant who completed the questionnaire answered some follow-up questions via email. The transcription process took 3 to 4 days to get transcripts analyzed and emailed back to participants for clarity and accuracy of data. I transcribed my data using Otter.ai, ensured recordings matched transcripts, and finalized transcripts with minor editing.

Data Analysis

Data analysis began when I reviewed information from participant transcripts. During the transcription process, I listened to transcripts and annotated reactions of each participant by taking notes on voice inflections and noting keywords that were

emphasized. I conducted the coding process using the data analysis software Delve for qualitative data analysis. Each transcript was uploaded in Delve, and I started coding data line by line. At first, I started with initial codes and then proceeded to categorize codes in terms of associated research questions using pseudonyms for participants. Categorizing codes helped me keep track of large data sets collected from interviews. I was able to download structured information into a Word document to analyze how each participant answered specific questions, which enabled me to understand similarities and differences in terms of participants' unique perspectives.

As a backup measure, I used NVivo qualitative data analysis software. I uploaded the original data from Delve to NVivo because the software's user interface was formatted by the research question, created a file containing the answers per research question, coded the relevant data, and condensed the codes to make sense of the data. A frequency query of stemmed words and synonyms was executed to ascertain how the codes could be categorized into themes. I re-read the data in the context of the research questions to develop more concise themes that accurately reflect the participant's experiences. This process enabled me to inform the subsequent themes that emerged. I repeated this process for each question asked from my interview protocol for the six participants in the study.

The combined categories led to the themes, which are displayed in Table 2. Word Clouds were generated to depict the first impression and frequency of the words used by the study's respondents, indicated by the textual data's color, size, and style in Figures 2-11. Under the primary research question: What are the lived experiences of help-seeking

for depression among native Hawaiian women aged 18 to 65 who moved from Hawaii to live in the western region of the United States mainland? There were four sub-research questions (SQ). Below are the themes and subthemes that emerged from each research question.

RQ1: What are lived experiences involving help-seeking for depression among native Hawaiian women between 18 and 65 who moved from Hawaii to live in the Western region of the U.S. mainland?

Table 2

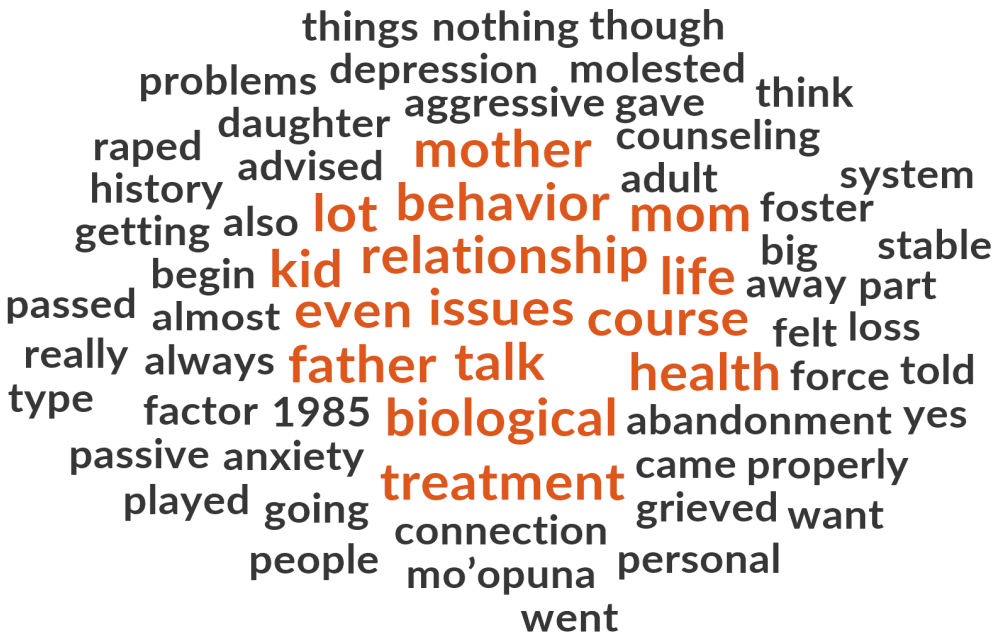
Themes and Subthemes

Themes	Subthemes
Family Dynamic	
Frustrations	
Stigma, Cost, Accessibility, Shame	
Family and Support Systems	Knowing you are not alone
Community-Based Programs	Employment benefits and affordability
Job Connections	Interactions with provider
Availability of Help in Hawaii Versus Mainland	Gender
Developing a Relationship with a Provider	Family as Support and Source of Stress
Comfort with the Provider	
Provider Qualifications	
Caring for Their Children	

Themes

Figure 2

NVivo Word Cloud Results for Theme 1



Theme 1: Family Dynamic

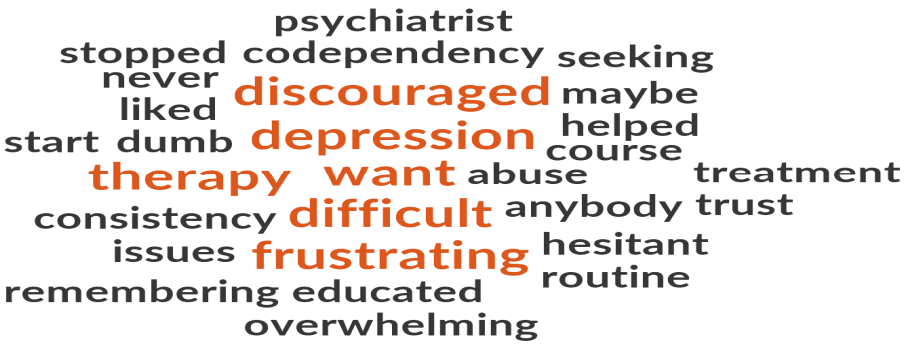
The overall family dynamic played a role in one's experience in help-seeking behavior for depression. The frequency of words mother, father, and kids related to childhood was mentioned nine times, respectively, and the word relationship, pertaining to a parental relationship, was mentioned three times. Participant 6 stated, "Because of a lot of what I went through as a kid, you know, like getting raped and molested and stuff, I couldn't even like talk about it until I was adult." Participant 5 stated, "I should have been in counseling, but my mom did not know that. No one advised her." And "I was told I had not properly grieved the loss of my biological father who passed away 1985, I was 11." Participant 4 stated, "All I knew was that when you're a kid, and you're in a foster

system, then they force you to go to this, this treatment behavior health type stuff to talk about your problems, which you don't want to talk about."

Participant 4 also stated that "I knew nothing about behavior, health stuff, even though like, of course, that stuff gave me issues all through life, you know, personal issues, depression, anxiety, all this stuff." Participant 3 stated, "I really didn't have that mother-daughter connection with my biological mother. People that knew our history, you know, I would always hear them saying, oh, that's the one that's the "mo'opuna" [grandchild], she's the one. So, that played a big factor in how I felt about myself, not having that relationship, yes, not knowing who my father was, and so that was part of what I discovered through treatment, you know, the things that was going on with me to begin with. So, I, you know, I think a lot of the abandonment issues, of course, I had, you know, came from that." Participant 5 stated, "My relationship with my mom is almost not the most stable. We have had a very passive, aggressive relationship for most of my life."

Figure 3

NVivo Word Cloud Results for Theme 2



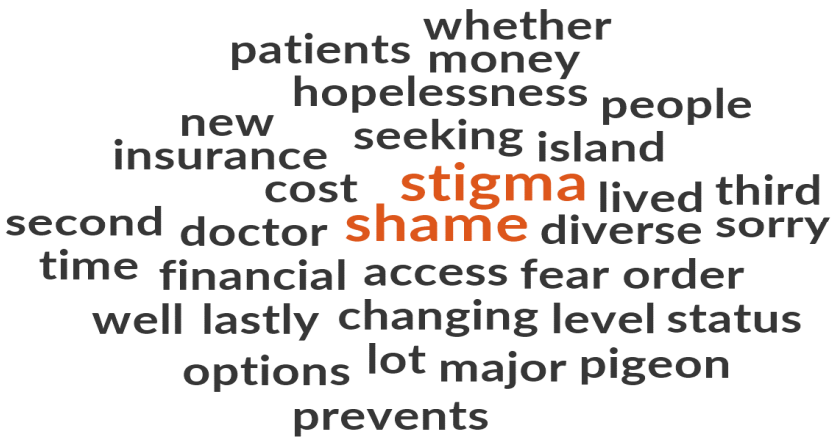
Theme 2: Frustrations

The frequency of the codes that led to the theme of frustration came up several times with the participants. The code need/want/wanted appeared four times. The words frustration, discourage, hard/difficult, and depression were mentioned twice, respectively. Participant 4 stated, “Because of some abuse that I went through, my thought was I’m not talking to anybody. No, I, nobody’s gonna help me anyway, this is dumb. Then because of that, I was pretty messed up all the way up until, until today, but never ever thought of seeking help. I didn’t know that help was out there.” Participant 3 indicated, “You know, I didn’t know I had depression, I didn’t even know what it was, I didn’t know what codependency was. I just didn’t know it until I got educated. The frustrating thing is, I think getting maybe the consistency in treatment.” Participant 1 stated that “Because I really don’t want to be on medication, it’s been hard to find somebody who isn’t a psychiatrist. I really wanted to talk therapy, that helped me before, and it’s been difficult, and so that has made me hesitant to get help.” Participant 5 stated that “I am so discouraged of having to find someone I like and or trust, and I really need it. I got discouraged because I liked her and did not want to start over again, so I stopped therapy.” Participant 2 indicated the frustrations with dealing with depression and other health issues “I have that periodic diabetic, what do you call that? appointments too, so I mean, depression and diabetes. And it's pretty rampant in the Native Hawaiian community I’m just getting of course remembering to you know, my routine, my medication. That’s, that’s a job. That’s a job, and tasking is overwhelming at times.”

SQ1: What are the factors that prevent or have prevented native Hawaiian women in the Western region of the U.S. mainland from receiving help from a mental health professional?

Figure 4

NVivo Word Cloud Results for Theme 3



Theme 3: Stigma, Cost, Accessibility, Fear, and Shame

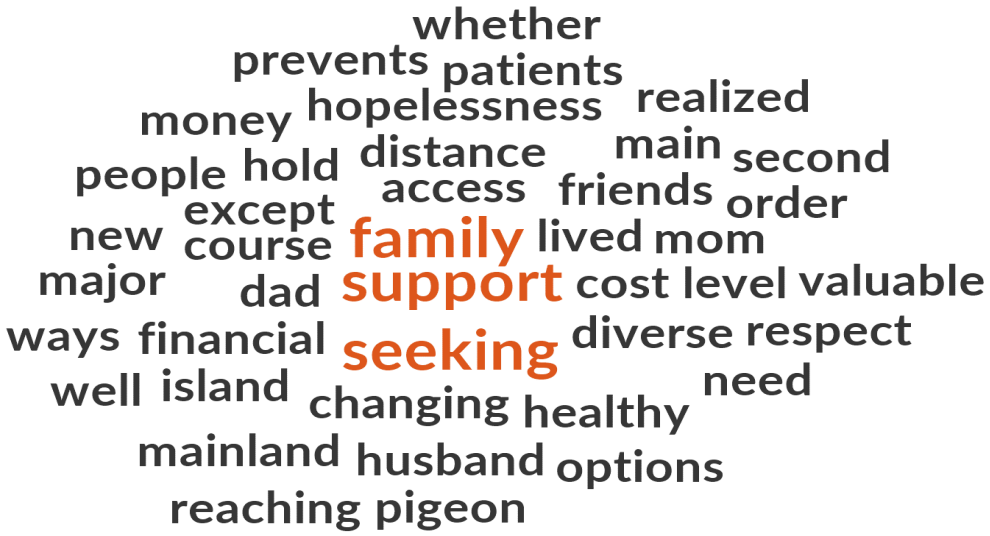
There were multiple uses for the words "stigma and shame," which both were mentioned three times. Words indicating "cost or finances" appeared three times, while "access" was stated twice. Participant 1 indicated that insurance and accessibility were significant factors in seeking help and "Whether the doctor is accepting new patients." Participant 4 stated, "Stigma. Stigma and lack of knowledge that it don't even exist but yeah, on my side, which is mostly Hawaiian mixed, a lot of Hawaiians have just ignorance of what's available. I would say money, financial status, education level because I lived on that island that was fluent in pigeon." Participant 5 stated, "First the stigma, second the cost, third the time, and lastly knowing where to go." Participants 2, 4, and 5 indicated stigma as a factor that prevents seeking help. Participant 6 stated,

"Shame. They're ashamed of the way that they feel. I mean, I get that, you know, there's, there's been gaps where I wasn't in therapy because I was ashamed of the decisions I was making." Participant 3 stated, "Fear and shame, hopelessness, I think shame, a lot of it is shame-based." Participant 2 also indicated, "Then the stigma is like you think more and more White. Sorry to say this, but more White people access it. I mean, that shouldn't be, I mean times are changing; there are more diverse options."

SQ2: What opinions do native Hawaiian women in the Western region of the U.S. mainland have regarding their community's views of seeking help for depression from mental health professionals?

Figure 5

NVivo Word Cloud Results for Theme 4



Theme 4: Family and Support Systems

The word "family" appeared three times, and the word "support" appeared five times. Participant 1 stated that "Your family sometimes doesn't know how to support in other ways except respect and distance," while participant 4 said, "Family can hold you back from getting the help that you need." Participant 2 indicated that "It's very valuable to seek out healthy support systems, especially being, you know, living on the mainland." However, participant 3 stated, "My main support is my family." Participant 6 indicated that "I only have friends who are supportive. I have my mom, dad, and husband." Participant 5 stated that "Over the course of my life, I have realized who is good for me to be around and who will support me. It's just me actually reaching out and not suffering in silence, which is about 75% of the time."

Subtheme 1

Participant 1 indicated that concerning her depression involved "Being open about it on social media and seeing other people feel the same way that I felt made me realize that I wasn't actually alone as I was." Participant 5 stated, "It's nice to know that I'm not alone."

Figure 6

NVivo Word Cloud Results for Theme 5

Theme 5: Community-Based Programs

The term "mental health" was mentioned four times while "community" was mentioned seven times. The word "services" was mentioned twice, and the word "online" was mentioned four times. Participant 1 stated that "There isn't a lot of mental health advertised in my community, for any kind of mental health support. It's all through social media, and it's all through like online services or online communities." Participant 2 indicated, "Everything has an app but no resource in my community in like where I live, but I look online." Participant 3 mentioned that help was available at the community health centers. Participant 5 stated that there was a lot of help in the community because she looks it up as well as get information from her employment assistance page. Participant 4 was unsure of any community advertisements on mental health but indicated that she was already connected to a mental health system with the Veterans Administration (VA), as well as participant 6, who was also associated with the VA. Participant 6 mentioned that there was a mental health crisis center open 24 hours a day and NAMI, which can be accessed through Facebook for immediate service.

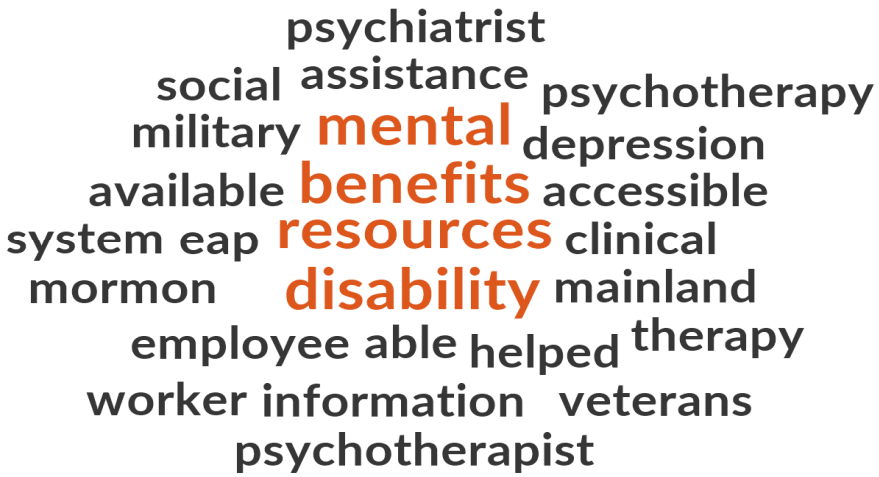
Subtheme 1: Employment Benefits and Affordability

Participant 5 stated that the use of the Employee Assistance Program (EAP) was limited to one's current issue and the availability of a counselor. "There are conditions of getting the service. I was only given five teleconferences; after that, I would have had to have given the EAP a new reason to get more visits." Participant 3 said, "Financially, can one support, get the support. There came a time where when I came back to Hawaii, I didn't have financial support in financial meaning insurance or anything like that." Participant 3 indicated the importance of the avenues taken to get the support needed. "You know, what I could afford, and it was going into the community health centers is where I found treatment." Participant 2 indicated that she is very fortunate to have her job benefits like EAP when she needs to seek help. "Just seeking help through my PCP and then do my EAP with counseling appointments."

SQ3: What different opinions do native Hawaiian women have regarding seeking help for depression in the Western region of the U. S. mainland compared to Hawaii and why?

Figure 7

NVivo Word Cloud Results for Theme 6



Theme 6: Job Connections

When looking at experiences with help-seeking on the mainland, resources were a key benefit associated with one's job connections. The words "resources" appeared three times, "benefits" and "assistance" together appeared three times, while "disability" appeared twice, and "veteran/VA" appeared twice. Participant 2 indicated that "Here on the mainland, it's more open, and there's lots of resources, plenty more. I can see more resources here, especially through my job, my benefits, and of course, the Mormon faith." Two participants were already connected through the Veterans Affairs (VA) health system. Participant 4 stated, "I'm already connected to a mental health system, I'm already connected really, really well with the VA military." Participant 6 "There's tons of resources for veterans too here, I went and got, went and started seeing someone at the VA." Participant 5 utilized benefits through her Employee Assistance Program, indicating that information on mental health is "Easily accessible through my job's EAP page." Participant 3 indicated "I did apply for disability and was able to procure temporary disability based on my severe depression." However, Participant 1 stated that

"I just have not been successful at finding it that through whether it be like a licensed clinical social worker or psychotherapy psychotherapist that has, that is available with my schedule. For me, it's been hard to find somebody who isn't a psychiatrist. Because that's what I wanted, I really wanted to talk therapy that helped me before. And it's, it's been difficult."

Figure 8

NVivo Word Cloud Results for Theme 7

Theme 7: Availability of Help in Hawaii Versus the Mainland

Access to behavioral health information in Hawaii was dependent on one's knowledge of mental health care, posing differences between help-seeking in Hawaii versus help-seeking on the mainland. The frequency of the word "Hawaii" appeared six times, while access/accessibility/availability came up four times and cared was mentioned twice. Participant 6 stated, "I didn't have nothing in Hawaii, nothing was available to us as kids, you know going through divorce, and you know social, the social things that you go through growing up, like my kids have all of that now, you know?"

Participant 5 said, “It appears in Hawaii, I had access to everything. I felt like I had doctors who ‘cared’ and tried to help me.” Participant 4 indicated, “So, in Hawaii, no help at all. Not where I came from.” Participant 3 had health insurance, “I went because I was working. I had health insurance.” Participant 2 indicated that she had open communication with her parents, “My parents are both counselors, and I have always had the support of the church.” Participant 1 stated, "Um, I would say that accessibility to help was easier to come by in Hawaii. Whereas in Nevada like driving, for example, driving 30 minutes, you're, you're driving to the other side of the city, which is extremely far, and very, very inconvenient.”

Subtheme 1: Interactions with Providers

Participant 1 stated that interactions with physicians are different “In Hawaii, there’s a lot of conferences and there’s a lot of communication, and the community of physicians in Hawaii is a lot stronger than it is here in Nevada.” Participant 5 stated that “I felt like I had doctors who “cared” and tried to help me.”

Subtheme 2: Gender

Participant 3 stated, “In Hawaii, I had a male therapist. I had issues with men. On the mainland, I had a female therapist. I would have chosen to, you know, be in treatment with the female in Hawaii, um, that, that was number one.” Participant 2 stated that “I have a male, male doctor. I mean, he’s great. But sometimes it’s like hard talking to him because he’s a man. I’ve had female PAs [Physician Assistants] or female doctors. At times it’s easier to talk to them most of the time.”

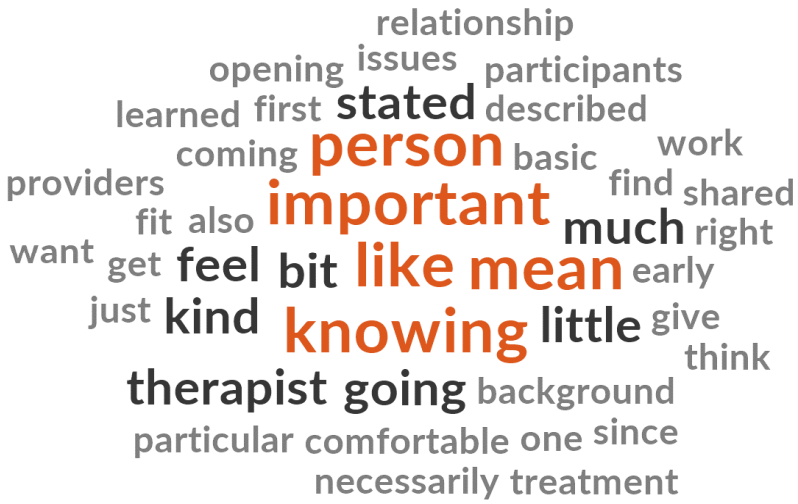
Sub-Theme 3: Family as Support and Source of Stress

Participant 2 stated, “In Hawaii, I mean, I have parents and your extended family there and also the Mormon community, it is still like, stressful living in Hawaii, and family drama, family drama, to be honest, and here on the mainland, I mean, it’s more open.” Participant 6 indicated, “My mom was in the military, and it just wasn't a thing. I, you know, I couldn't even ask my mom for help.” Participant 3 mentioned that “I didn't even feel comfortable at the time I was living on the Big Island with mother and my sister. You know, they didn't, they both my mom and my sister, they don't believe in that stuff, treatment. And so, it was if you don't have that support, it's hard. And at that time, it's also kind of shameful. But at that point for me, I'm saying, um, it was lonely, because, you know, I didn't have that support of that was lonely. Not having the support of, “Oh yeah this is good.” You're going to you know, get treatment for your needs, mental needs.” And even though I put my son in a rehab when we were living with my mom and sister and her husband at the time on the Big Island, you know, they just knew it. “Okay, that's what she's doing.” But, you know, they didn't really understand the need for treatment, and the benefits of it.” Participant 1 stated, “My core support system a lot of times as friends, my family while, they aren't as, I don't want to say not supportive, but they don't know how to be supportive. And my family giving me the respect to understand that like, hey, I'm not feeling well, right now, this is what's going on, and this is how I feel. And having them just kind of respect me, instead of like, calling me dramatic, or just missing my emotions. That is a big step for my family.”

SQ4: What views do native Hawaiian women in the Western region of the U.S. mainland have regarding their level of comfort with sharing personal and private information regarding their depression with a mental health professional?

Figure 9

NVivo World Cloud Results for Theme 8



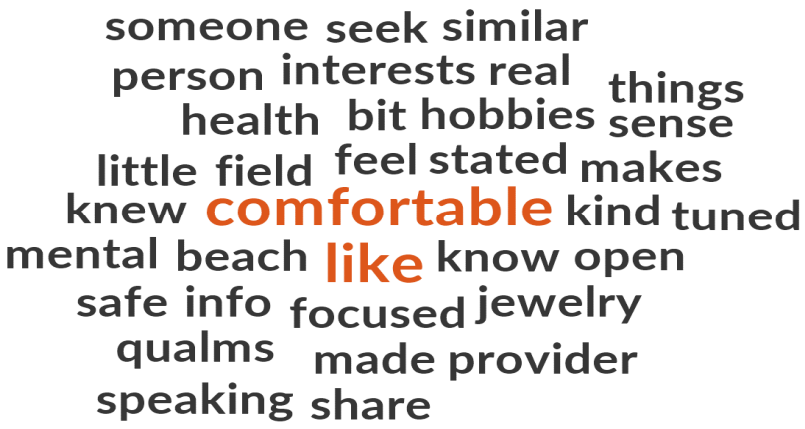
Theme 8: Developing a Relationship with a Provider

Some participants described the importance of knowing a little bit about their providers. The words "knowing/know", "important/importance" and "person/personally" was mentioned three times, respectively. Participant 1 stated that "I feel like since I'm going to be opening much so much of myself, I mean it's kind of like, I feel like I should have a relationship with this therapist, and I want to be comfortable with this person." Participant 2 also shared, "For me personally, like, get to know a little bit about their background like, like, basic just knowing who what kind of person they are. I mean, are what, where they're coming from. I mean, I think that's important." Participant 3 stated, "I learned early on that you had to go through a few therapists and to find the right fit.

And that's very important is that you don't give up each treatment. The first one is not going to necessarily work out for your particular issues."

Figure 10

NVivo Results for Theme 9



Theme 9: Comfort with the Provider

Many of the participants expressed their level of comfort with talking to a provider and sharing personal information. The word "comfortable" appeared four times. Participant 4 stated, "I feel very comfortable when we only seek to share that info with our mental health provider." Participant 3 said, "Comfortable; I have no qualms about it. I know it's real." Participant 2 stated, "I would be more comfortable speaking to someone in that field, they're in that field, and you're more focused, and you know, more in tuned into that field." Participant 1 stated, "Feeling like I could open up to this person because I kind of knew about her, if that makes sense. I had similar interests like hobbies, like jewelry, the beach, things like that. It made me feel a little bit more safe and comfortable."

Figure 11

NVivo World Cloud Results for Theme 10

Theme 10: Provider Qualifications

Participants stated that there are key qualifications that they want in a provider. The words "listen/hear" appeared five times while "trust" appeared three times, and "caring/cares/military" was mentioned twice. Participant 6 "It's a neutral person. It's somebody that I don't have to be embarrassed, like tell you things you know. It's like a way of getting all of my crap off my chest, you know, and I remember distinctly that every single time I left therapy." Participant 6 also indicated that she has always been around military prior service. "I would definitely need a therapist that is, oh, I guess that would be like has experience with military veterans." Participant 5 stated, "First, someone who is 'open,' someone who 'listens,' someone who does not pass judgment. Someone who makes me feel like 'I matter.' Someone who is flexible. Someone who also thinks out of the box." Participant 4 stated, "A good listener in helping to direct you to some kind of homework or giving tips that will actually help with whatever you know

and someone that that listens, listens well enough to be able to focus on whatever issue that would actually help you improve."

Participant 3 indicated the importance of building trust with her provider "And, you can build that relationship of trust, because of course, I didn't trust that, you know, I was being heard," which ultimately led to "So, her validating my feelings and what, how I felt whenever I went in to talk to her." Participant 2 indicated what she looks for in a mental health care provider "That they're caring, and that they are there to offer help support and to ask the hard questions to help us through those, or help unpacking or help getting to the answers or getting I mean they can't lead you or like, show you everything but helping facilitate that or pushing you, pulling." Participant 1 stated, "Sometimes I just want like an expert, someone who knows the brain to like, hear me, and I don't have that."

Figure 12

NVivo Word Cloud Results for Theme 11

Theme 11: Caring for Children

Caring for children emerged as an additional finding. Three of the

participants mentioned that they were concerned about their children's mental health and made sure that they sought treatment for their children. The word "son" was mentioned four times, the word "daughter" was mentioned once, and the word "children" was mentioned twice. The words "mental" and "importance/important" was mentioned twice. Participant 6 shared, "I was able to put my daughters in therapy when they were like four and five years old, you know, to help them process our divorce and their dad moving away." Participant 2 shared, "I'm teaching the importance to my son like something's not going right go get, ask for help. And when I got older, you know, more important to take care of myself and my health, mental health and especially for you know, wellbeing of me and my, my son, you know, my family." Participant 3 shared, "Because I took my first son, he was going through a lot of trauma, I went back to Hawaii to get my older son treatment."

Evidence of Trustworthiness

In the course of conducting this study, I observed firsthand how vital trustworthiness is in qualitative studies. The sensitivity of the subject, coupled with the information collected from the participants, enabled me to explore my own biases and interpretations of the data. I conducted member checks and displayed the data in their own words to maintain credibility. I followed up for clarity and interpretation of the responses through the emailed transcripts. Two out of the six participants did not want a follow-up to review the transcripts, which possibly indicated they were confident in their interviews and trusted the data collection procedures. Also, I felt that the subject's sensitivity, which includes depression and help-seeking thereof, opened the need to

revisit some traumatic experiences that they were grateful to share but felt the need not to relive or retell their story. Therefore, credibility was established.

In looking at transferability, this study was unique to the indigenous population because it involved a personal account of their experiences. The interview protocol, data collection procedures, and analysis were explained in detail. These processes may provide an example of a step-by-step process that could be used to explore similar phenomena with other indigenous populations. The process of gathering, reporting, and analyzing the data and ensuring its transferability also leads to its dependability. Utilizing consistent methods to illustrate how the study was conducted and reflective journaling to document my thoughts to mitigate biases that interfere with the reporting of the data accurately ensured the processes of credibility, transferability, and dependability are relevant to the confirmability of this study. Therefore, reporting the data through verbatim transcription provides an accurate account of each participant's answer to the interview questions. How the data was interpreted while using reflective journaling to account for any biases confirms the evidence of trustworthiness in this study.

Summary

In Chapter 4, I presented findings of the study regarding help-seeking behaviors for depression among native Hawaiian women in the western region of the U.S. mainland. I described the research setting, demographics, data collection, and data analysis, as well as trustworthiness issues. Each participant gave a detailed explanation of their help-seeking behaviors for depression while in Hawaii and on the U.S. mainland.

Participants presented certain factors that influenced how they perceived help-seeking such as their motivations and preferences that contributed to confidence to seek help. Participants explained challenges of help-seeking in different environments and how they were able to overcome those obstacles.

Study findings revealed answers to research questions by way of 11 themes which were family dynamics, frustrations, stigma, cost, accessibility, and shame, family and support systems, community-based programs, job connections, availability of help in Hawaii versus the mainland, developing a relationship with a provider, comfort with the provider, provider qualifications, and caring for children. Participants described key elements of their early childhood and how that contributed to their depressive symptomology and subsequent frustrations with coping in everyday life. Participants explained their understanding of barriers to help-seeking for depression and how to overcome them. Differences in terms of help-seeking for depression in Hawaii versus the mainland were discussed in detail by each participant as well as preferences for providers along with qualifications. Participants also indicated their concerns about their children's mental healthcare.

Moreover, I acknowledged the value of trustworthiness in this study by documenting participants' experiences while validating them via member-checking. I also kept a journal of my thoughts and feelings to mitigate any biases that would affect authenticity of the study. Because of overall sensitivity of the topic, it is important that I remained objective, notice when I was subjective, and dealt with biases accordingly.

In Chapter 5, I discuss and interpret study findings in relation to the literature review and theoretical framework. I also discuss study limitations, recommendations for future research, and how this study contributes to social change.

Chapter 5: Discussion, Conclusions, and Recommendations

This qualitative study on help-seeking behaviors for depression among native Hawaiian women in the Western region of the U.S. mainland involved accounts of participants' personal experiences with help-seeking for depression. Depression affects more than 264 million people and is estimated to cause the highest disease burden by 2030 (Todd & Teitler, 2018; WHO, 2020). I conducted this study because research was limited in terms of exploring indigenous cultures in their natural environment. Therefore, exploring help-seeking behaviors for depression among native Hawaiians in the Western region of the U.S. mainland could lead to different perspectives regarding how indigenous cultures perceive their experiences in other environments.

Using a general qualitative approach, the research questions were:

RQ1: What are lived experiences involving help-seeking for depression among native Hawaiian women between 18 and 65 who moved from Hawaii to live in the Western region of the U.S. mainland?

SQ1: What are the factors that prevent or have prevented native Hawaiian women in the Western region of the U.S. mainland from receiving help from a mental health professional?

SQ2: What opinions do native Hawaiian women in the Western region of the U.S. mainland have regarding their community's view of seeking help for depression from mental health professionals?

SQ3: What different opinions do native Hawaiian women have regarding seeking help for depression in the Western region of the U.S. mainland compared to Hawaii and why?

SQ4: What views do native Hawaiian women in the Western region of the U.S. mainland have regarding their level of comfort with sharing personal and private information regarding their depression with a mental health professional?

After data were collected, I used Delve for software analysis along with NVivo, which enabled me to create initial coding and understand frequency of terms to derive themes that resulted from the interview guide that was used with this small group of participants. I interviewed a total of six native Hawaiian women, and several themes emerged which ultimately led to one overarching theme: empowerment.

Interpretation of the Findings

Theme 1: Family Dynamic

Foundational upbringing was a significant factor. ACEs played a major role in terms of conditions of help-seeking behavior. ACEs included childhood trauma that included rape, abuse, foster care, loss of a loved one, and an inability or no relationship with primary caregivers. P6 stated, "Because of a lot of what I went through as a kid, you know, like getting raped and molested and stuff, I couldn't even like talk about it until I was adult." P5 stated, "I should have been in counseling, but my mom did not know that. No one advised her." P3 stated:

> I really didn't have that mother-daughter connection with my biological mother. People that knew our history, you know, I would always hear

> them saying, oh, that's the one that's the mo'opuna, she's the one. So, that played a big factor in how I felt about myself, not having that relationship, yes, not knowing who my father was, and so that was part of what I discovered through treatment, you know, the things that was going on with me to begin with. So, I, you know, I think a lot of the abandonment issues, of course, I had, you know, came from that.

Repercussions or detrimental effects of ACEs led the victim to an inability to acknowledge that those were valid reasons to seek help. According to Remigio-Baker et al. (2014), ACEs significantly contribute to mental health disorders such as depression and include but are not limited to household dysfunction (Benoit et al., 2016), as well as verbal, physical, and sexual abuse.

Theme 2: Frustrations

Many participants voiced their frustrations after the fact because they either did not want to talk about their experiences, did not know they had depression or never thought about seeking help. For example, P4 stated, "Because of some abuse that I went through, my thought was, I'm not talking to anybody, I didn't know that help was out there." P1 said, "Because I really don't want to be on medication, it's been hard to find somebody who isn't a psychiatrist. I really wanted to talk therapy that helped me before, and it's been difficult, and so that has made me hesitant to get help." P3 said:

> You know, I didn't know I had depression. I didn't even know what it was. I didn't know what codependency was. I just didn't know it until I got educated. The frustrating thing is, I think getting maybe the

consistency in treatment.

Overall, colonization and acculturation of indigenous people can lead to depressive symptomology (Antonio et al., 2016; Mossakowski et al., 2017; Ta Park et al., 2018; Ta et al., 2010). Since women internalize their frustrations more than men (Lin et al., 2020; Weinberger et al., 2017), it is apparent that women are more susceptible to depression, and the promotion of help-seeking for depression is taken more seriously (Ta Park et al., 2018; Ta et al., 2010). Furthermore, these frustrations show that help is needed to meet individual needs knowingly or unknowingly.

Theme 3: Stigma, Cost, Accessibility, and Shame

P2, P4, and P5 indicated that stigma was the main factor that prevented help-seeking for depression. Stigma is a barrier to seeking help for depression (Clement et al., 2015; Schomerus et al., 2009; Talebi et al., 2016; Vogel et al., 2006). P3 and P6 mentioned that shame was the primary determinant, and P3 noted fear. P1 said insurance coverage and accessibility were factors that prevented help-seeking for depression. According to TPB, normative beliefs are beliefs about what others think or expect, indicating whether or not help is easy to get or available. Thus, these beliefs deter help-seeking behaviors. No participants indicated that stigma, shame, fear, insurance, cost, or accessibility was a factor in seeking help for depression because either they were in therapy early on or were exposed to help if needed as adults via health insurance from the military or employment assistant programs.

Theme 4: Family and Support Systems

The support of the family may be in ways that are beneficial or not because some families may not openly engage or know how to discuss depression. Nagai (2015) indicated that positive family relationships on seeking help promote positive attitudes toward help-seeking behavior. Three participants indicated that family could hold them back from seeking counsel because their mental health was not a subject of discussion or they just did not know how to offer support. For example, P1 stated, "Your family sometimes doesn't know how to support in other ways except respect and distance," while P4 said, "Family can hold you back from getting the help that you need." P2 said, "It's very valuable to seek out healthy support systems, especially being, you know, living on the mainland." However, P3 stated, "My main support is my family." This response might be related to stigmatizing beliefs that prevent families from discussing mental illnesses like depression. Stigma is a known barrier to help-seeking (Talebi et al., 2016).

Stigmas, misconceptions, and stereotypes are among the concepts agreed upon by the participants on depression. The belief is that stigmas exist around talking about depression can affect sufferers by making them feel isolated and less likely to seek help, even if it means talking to family members. However, depression is a mental illness, and one participant indicated that an illness is a limitation to living a full life. Another participant indicated that almost everyone has some form of mental illness, and she is very proactive in speaking about it. Two participants indicated that it was helpful to know that they are not alone and that mental health support groups are helpful. P1 stated,

“Being open about it on social media and seeing other people feel the same way that I felt made me realize that I wasn’t actually alone as I was.” P5 stated, "It’s nice to know that I’m not alone.”

Theme 5: Community-Based Programs

Although two participants mentioned that there were not many resources or knew of any, they found available avenues for mental health resources through online tools such as social media and Facebook. According to Ajzen (1991), perceived behavioral control means that an individual intends to seek help, and help is under their control and does not foresee barriers. For example, P1 stated, “There isn’t a lot of mental health advertised in my community for any kind of mental health support. It’s all through social media, and it’s all through like online services or online communities.” At the same time, P2 referenced the availability of online communities and said, “Everything has an app but no resource in my community in like where I live, but I look online.” This response is comparable to online tools that support mental health and offer anonymity to increase help-seeking among young adults, such as the Link program. Media-based interventions for help-seeking were also favorable among college students (Demyan & Anderson, 2012).

Three participants, P2, P3, and P6, were familiar with community resources, including NAMI, also available online, and various community centers supporting mental health efforts. P2 indicated that her church is a support system she can depend on. Therefore, there are many avenues available to seek the help needed when needed. P3

indicated that help was out there, “I do know, at any time, there's help in the community, but you have to be willing to go and find it.”

Theme 6: Job Connections

P4 and P6 were connected to the VA because they were prior military. P4 noted that while she was in the military, help was available and offered to her. For example, P4 indicated, “I’m already connected to a mental health system, I’m already connected really, really well with the VA military,” while P6 stated, “There’s tons of resources for veterans too here. I went and got, went and started seeing someone at the VA.” Three other participants benefited through their medical insurance employer’s assistance program page. P2 indicated that she is very fortunate to have job benefits like EAP when she needs to seek help. “Just seeking help through my PCP and then do my EAP with counseling appointments.” P3 indicated the importance of the avenues taken to get the support needed. “You know, what I could afford, and it was going into the community health centers is where I found treatment.” Although P5 used her EAP, she indicated that “There are conditions of getting the service. I was only given five teleconferences; after that, I would have had to have given the EAP a new reason to get more visits. I was discouraged because I honestly did not have it in me to come up with another excuse just to get another five visits.” Upon follow-up, P5 was asked to elaborate more about using the employee assistance program EAP, as it is an available avenue for help-seeking. According to Judd et al. (2008), accessibility, availability, and attitudes toward treatment are factors supported in the literature that help influence help-seeking.

Theme 7: Availability of Help in Hawaii Versus the Mainland

Mental health services were more accessible to participants in Hawaii compared to the accessibility of services on the mainland. Two participants reported having nothing available while growing up in Hawaii or not knowing it existed. P6 stated, “I didn’t have nothing in Hawaii. Nothing was available to us as kids.” P4 said, “So, in Hawaii, no help at all. Not where I came from.” P2 had parents who were counselors. P5 said, “It appears in Hawaii; I had access to everything. I felt like I had doctors who ‘cared’ and tried to help me.” P1 stated, "Um, I would say that accessibility to help was easier to come by in Hawaii.” P3 returned to Hawaii as a young adult and sought help because she preferred it over seeking help on the mainland. P3 had health insurance, “I went because I was working. I had health insurance.”

P2 had her family, extended family, and the church for support in Hawaii but indicated that family drama causes stressful times versus being on the mainland away from them. Interactions with physicians were a factor in Hawaii, indicating a close-knit stronger community of physicians compared to the mainland and gender preferences were for females over males.

Seeking help from spiritual and cultural leaders was preferable to seeking help from Western healthcare providers because of perceived racism and discrimination from the US occupation of their homeland (Mossakowski et al., 2017; Ta Park et al., 2018). Therefore, the overall difference between help-seeking in Hawaii and help-seeking on the mainland could be that most participants felt more comfortable with help-seeking in Hawaii because of their cultural background.

Theme 8: Provider Relationships

Two participants, P1 and P2, indicated the importance of getting to know their providers and developing a relationship with them, such as reading their biographies and interests to feel more comfortable disclosing information. P1 stated, "I feel like since I'm going to be opening much, so much of myself, I mean, it's kind of like, I feel like I should have a relationship with this therapist, and I want to be comfortable with this person." P2 also shared, "For me personally, like, get to know a little bit about their background like, like, basic just knowing who what kind of person they are." P3 stated, "I learned early on that you had to go through a few therapists and to find the right fit. And that's very important is that you don't give up each treatment. The first one is not going to necessarily work out for your particular issues." It is apparent in the literature that cultural identification is essential and developing a solid relationship with a provider is vital. Ta Park et al. (2018) reported lack of trust in the US healthcare system because of the frustrations and discrimination that native Hawaiians endured.

Theme 9: Comfort with the Provider

There were no issues with talking to a provider competent in counseling or mental health, as this overlaps with developing a relationship with the provider. P4 stated, "I feel very comfortable when we only seek to share that info with our mental health provider." P3 said, "Comfortable. I have no qualms about it. I know it's real." P2 stated, "I would be more comfortable speaking to someone in that field. They're in that field, and you're more focused, and you know, more in tuned into that field." Sun et al. (2016) said that a lack of culturally competent caregivers and poor access to treatment leads to

negative attitudes towards help-seeking for depression. Therefore, seeking help was not an issue, and each participant was open to speaking to a provider.

Theme 10: Provider Qualifications

Participants 1,4,5 and 6 indicated that a qualified provider should be someone who overall is a good listener. Someone who "listens, does not pass judgment, and who is a neutral and open person." there are key qualifications that they want in a provider. P6 said, "It's a neutral person. It's somebody that I don't have to be embarrassed, like tell you things you know." Flexibility, caring, supportive, and trustworthiness were qualifications also mentioned. P5 stated, "First, someone who is 'open,' someone who 'listens,' someone who does not pass judgment. Someone who makes me feel like 'I matter.' Someone who is flexible." P1 stated, "Sometimes I just want like an expert, someone who knows the brain to like, hear me, and I don't have that." Because two participants, P4 and P6, were affiliated with the military, it is crucial to have a provider with experience counseling military verterans. Therefore, the provider needs to be someone who can relate to the client. The participants have unique needs and sensitivities that subsequent providers should consider crucial to aid in their continual help-seeking behaviors.

Theme 11: Caring for Children

As an additional finding, three participants mentioned concerns for their children's mental health. Two of the participants, P3 and P6, were able to put their children in therapy, while P2 was adamant about her son's mental health. Moreover, this will help address and decrease the effects of adverse childhood events known to lead to

depressive symptomology if not treated. This theme contributes to the empowerment of a group of individuals who are confident in their children's mental health and well-being because they know the importance of help-seeking.

Limitations

The major limitation of this study was the small sample size. Recruitment for this study was met with many obstacles, one being gaining the trust of an indigenous gender-specific group of people. Because of the Covid-19 pandemic, advertisements for recruitment of this study were limited to Facebook and gaining acceptance into groups specific to native Hawaiian peoples. Several individuals questioned my racial and ethnic association and why I was interested in conducting a study involving native Hawaiian women.

Other limitations include the sample, which was limited to native Hawaiian women who suffered from depression and lived in the western region of the USA mainland. This limitation decreases the generalizability to other cultures that may suffer from depression. After data collection, I found that all the participants were from the same island, Oahu. None of the other Hawaiian Islands were represented. Therefore, participants from other Hawaiian Islands regions could have affected the findings.

In looking at the interview process, each participant was asked detailed questions from the interview protocol, which led to subsequent topics of their concern related to their experiences with help-seeking for depression. Although the transcripts were sent back in a timely manner, two participants did not want to read the transcript and were thankful for the interview. I can only speculate that this was because of the sensitivity of

the data in disclosing their experiences, indicating that they did not want to relive or be reminded of their experiences. This speculation poses a limitation because I would not be able to ask any follow-up questions or get the transcript verified. One other participant did not respond to the transcribed data when emailed to her for clarity. The three remaining participants responded to the follow-up emailed transcript that everything was accurately stated, including the emailed questionnaire. The participant who completed the emailed questionnaire answered the follow-up questions promptly.

Another limitation is my understanding of depression. I am cognizant that people want help and want to talk about their problems or experiences with depression, and I would like to offer support. I have dealt with depressive issues and had to make sure to mitigate any biases I have knowingly or unknowingly while conducting interviews for this study. However, my sensitivity toward the participants dealing with depression may have influenced my interpretation and understanding of the data.

Recommendations

Recommendations for this study were to gather a larger sample of native Hawaiian women who suffer from depression and live in other areas, such as the east coast and the southern United States. About the limitations, larger sample size and a variation in demographic locations could provide a deeper understanding of how different environments might influence help-seeking behaviors among native Hawaiian women living on the U.S. mainland. Another suggestion would be to compare the help-seeking behaviors for depression among native Hawaiian women living on one of the Hawaiian Islands, such as Oahu, with native Hawaiian women living on the mainland. All

participants were from Oahu, so I would recommend a variation of the demographic criteria being their native island.

The findings of this study revealed emergent themes that led to the following recommendations on family dynamics and support systems, EAP programs, alternative forms of support, and barriers to treatment for depression. One recommendation was to explore the theme of Hawaiian family dynamics as a source of support for depression and a source of stress. All participants mentioned the effects of family and the support system. Some participants felt they could not talk to family members about their experiences and internalized their frustrations. Others had surrogates such as friends as their support system.

The theme related to EAPs was prevalent among several participants. Although EAP offers a wide range of benefits, one participant complained that she only had a set number of sessions with a therapist. The participant would have had to give a new reason to get more help, and would need start over, so she got discouraged and stopped therapy. I would recommend conducting a mixed-methods study on EAPs that help with mental health care and how individuals feel about using them or examining the program's pros and cons, which could uncover barriers to treatment.

Another recommendation would be to explore alternative forms of support in reference to the theme of community-based programs such as talk therapy apps, online mental health services, and talk therapy therapists' availability. One participant mentioned that she had challenges finding help on the mainland who was not a

psychiatrist. She stated that talk therapy apps helped her get through some challenges when she needed to talk to somebody, but it was not the same.

Furthermore, when participants were asked about the barriers to seeking help for depression, their responses led to the theme of stigma, cost, accessibility, and shame. Since the depression crisis is on the rise, it is apparent that more studies need to be done on the barriers to treatment and the preferences that will lead to increased help-seeking for depression.

Implications for Social Change

This study on help-seeking behaviors for depression among native Hawaiian women living in the mainland USA was conducted because there was a limited amount of literature on native Hawaiian women's help-seeking behaviors for depression outside of Hawaii. The implication for social change for this study is dependent upon its purpose to explore the help-seeking behaviors for depression among native Hawaiian women who live on the United States mainland and if the environment is favorable to meet the needs of these women who grew up in Hawaii. The help-seeking behaviors for depression among native Hawaiian women living on the mainland may give mental health professionals a better understanding of how to provide services to women of indigenous culture from an island nation. Because most of the participants suffered from an ACE, this study could help inform mental health practitioners about the effects of ACEs among Hawaiian women. This study could also help inform scholar-practitioners and mental health care professionals on a deeper exploration of native Hawaiian women living on the mainland. Such indications include cultural adaption, expectations of resources,

providers' expectations, and if they carry cultural burdens of the colonization of their homeland. The overall implication for social change is empowerment. All the participants were empowered to seek help for their depression and to continue to find alternative ways to supplement their mental health needs. They were confident in seeking help for themselves and their children. They understood the barriers to treatment, such as stigmas, shame, fear, and accessibility to mental health care. Therefore, their voice in this study can help inform mental health care professionals on the importance of reducing stigmas to mental health care and contribute to decreasing the overall disease burden of depression.

Conclusion

In this general qualitative study, I explored the help-seeking behaviors for depression among native Hawaiian women living on the U.S. mainland. Depression is predicted as the cause of the highest disease burden globally by 2030 (Todd & Teitler, 2018), and because it presents a detriment to one's well-being, help-seeking for depression must be explored. Indigenous cultures, such as native Hawaiians, suffered disproportionately in mental and physical health because of a lack of trust in the US health care system as well as the acculturation, racial discrimination, loss of cultural identity, and colonization of their homeland (Antonio et al., 2016; Kaholokula et al., 2012; Mossakowski et al., 2017). Therefore, it was imperative to explore the help-seeking behaviors for depression among native Hawaiian women living on the U.S. mainland.

This study consisted of six participants recruited through a purposeful sampling technique willing to share their perspectives on their help-seeking behaviors for

depression. I gained an understanding of their perspectives by documenting their answers to the research question: What are the lived experiences of help-seeking for depression involving native Hawaiian women aged 18 to 65 who moved from Hawaii to live in the Western region of the U.S. mainland? Eleven themes emerged that led to the overall theme of empowerment. Each participant acknowledged the factors that contributed to their help-seeking for depression and other factors that would be considered a barrier to help-seeking. Each participant revealed information on family dynamics, frustrations, stigmas, family and support systems, community-based programs, job connections, availability of help in Hawaii versus the mainland, developing a relationship with a provider, comfort with the provider, provider qualifications, and caring for their children.

Each participant was very expressive about their experiences with help-seeking for depression, and their experiences with living and coping with depression. Being in their natural environment in Hawaii offered more support than being on the mainland which may indicate that a cultural environment is essential, as well as being comfortable in their chosen environment. The findings of this study gave a voice to a group of native Hawaiian women who suffered from depression outside of their native homeland. Although unique in their experiences with depression and help-seeking for depression, they were all adamant about making their thoughts and feelings known and were very appreciative of participating in this study.

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Appendix A: Interview Protocol

Introduction: *Good morning/Good afternoon. It is a pleasure to meet you and I appreciate your participation in this interview. My name is Marlana Glover, and I am a doctoral student at Walden University. I am conducting research on help-seeking behaviors for depression among native Hawaiian women in the western region of the United States mainland. The purpose of this research is to understand help-seeking behaviors for depression in different environments.*

Instructions: Your participation in this interview is voluntary and you are under no pressure to complete this interview and at any time if you want to conclude the interview, or reschedule, you may do so at any time. Thank you. This interview will be recorded, and the information will be kept confidential and under my care. You will be asked to provide a pseudo-name to protect your identity. This interview will last between 45 to 60 minutes or longer if needed. I will be taking some minor notes and upon the completion of the interview, the recorded transcript will be sent to you for your verification.
Do you have any questions? I will now start the recording.

Start the Recording
Building rapport questions:

1. What can you tell me about your cultural background?
2. How long were you in Hawaii before you moved to the western region of the United States mainland?
3. How long have you lived in the western region of the United States mainland?
4. Where do you live now?

Interview questions:

Primary research question: RQ_1: What are the lived experiences of help-seeking for depression among native Hawaiian women aged 18 to 65 who moved from Hawaii to live in the western region of the United States mainland?

Will be answered with the following questions:

1. How would you describe your inclination for seeking help for depressive symptomology?

   a) Please explain your experience with help-seeking for depression in Hawaii.

   b) Please explain your experience with help-seeking for depression in the western region of the United States mainland.

   c) What are the differences that you have notices between seeking help for depression in Hawaii versus seeking help for depression in the western region of the United States mainland?

Sub-Research Question SRQ_1 What are the factors that prevent, or have prevented, native Hawaiian women in the western region of the United States mainland from receiving help from a mental health professional?

Will be answered with the following questions:

2. What do you think causes people to not get help for sadness or depression?
   a) How likely are you to seek help if you were feeling sad or depressed?
   b) Have you ever felt sad or depressed and contemplated seeking help?
      i. Please tell me about it.
      ii. How many times have you contemplated seeking help before you got help?
      iii. What were the reasons that made you decide to get help?

iv. Is there anything else that you would like to add?

Sub-Research Question 2: SRQ2: What opinions do native Hawaiian women in the western region of the United States mainland have on their community's view on seeking help for depression from a mental health professional?

Will be answered with the following questions:

3. How do you feel about depression as a mental illness?
4. What are some of the things that your family and friends say about depression?
5. How have if any, your friends, or family influenced how you feel about depression?

a) How often do you get support from friends or family about depression?

b) How important is it to get support from friend or family on depression?

c) What information on depression or mental illnesses is available in your community?

d) Where is this information advertised?

i. Is the information on mental illnesses easily accessible?

ii. If so, have you inquired about any services that they offer?

Sub-Research Question 3: SRQ3: What are the differences if any, of native Hawaiian women's opinion on seeking help for depression on the mainland compared to seeking help on Hawaii and why?

Will be answered with the following questions:

6. Tell me about your experiences with seeking help for depressive symptomology while living in Hawaii?
    a) Tell me about your experiences with seeking help for depressive symptomology while living on the mainland?
    b) How does seeking help in Hawaii differ from seeking help on the mainland?

Sub-Research Question 4: SRQ4: What views do native Hawaiian women in this region have regarding their level of comfort with sharing personal and private information regarding their depression with a mental health professional.

Will be answered with the following questions:

7. How comfortable are you with talking to a mental health care provider concerning depression?
    a) In what ways would talking to a mental health care profession aid in the likelihood of you seeking help (more or less) if needed?
    b) What are the qualities that you seek in a mental health professional?

Is there anything else you would like to add?

Thank you for providing information on your experiences with help-seeking for depression, is there anything else that you would like to share?

This concludes the interview. Thank you for your time. End of recording.