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Factors Surrounding Mental Health Well-Being for Male Adolescent Pacific Islanders

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ABSTRACT

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Despite increasing mental health concerns, individuals from the Pacific Islands largely do not utilize the resources available to them (National Survey of Drug Use and Health, 2020). This is of particular concern among male adolescents within the population who are more at risk of mental health concerns. An interpretative phenomenological analysis focus group study was conducted in person with male adolescent Pacific Islanders (PI; ages 14–16) residing in one Western state (n = 3). Male adolescents reported that admitting to mental health concerns would greatly limit their academic, career, and personal ambitions due to the stigma attached. They also discussed religiosity as a protective factor and gave a number of individuals within their lives that could potentially be helpful to them in this area. In terms of stigma and perception, some participants described situations in which they discussed their mental health concerns to others within their community and their feelings were dismissed as being invalid or unimportant. In addition, several participants discussed the familial shame they would experience if they were to utilize mental health services. With regard to the cultural fit between practitioners and students, many students explained they felt uncomfortable being vulnerable with therapists outside their ethnic community. They felt that being open with their mental health concerns would give a poor impression of their PI community to therapists outside of their community. More research is needed to discover which groups to target within the community to impact the largest change in perception of mental health services across the community.

Keywords: Pacific Islander male adolescents, Native Hawaiian Pacific Islander, mental health perceptions, Polynesian

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CHAPTER 1

Introduction

In 2016, 11.8 million adults within the United States indicated that they were not receiving needed mental health services (Christidis et al., 2018). Individuals from this study gave many reasons for not receiving mental health services including costs, believing the problem would go away on its own, not knowing where to go, and not having time, but avoiding mental health services can cause mental health problems to worsen (de Girolamo et al., 2012). Research shows that children and adolescents with mental health issues such as anxiety, depression, self-harm, eating disorders, and hyperkinetic disorders, will continue to have said issues throughout adulthood if left untreated (Membride et al., 2015; Membride, 2016). Untreated mental health such as depression and anxiety can affect an individual both mentally and physically (Dhar & Barton, 2016; Strine et al., 2004). A study within the United Kingdom found that 10% of children and adolescents ages 5–16 years old have mental health problems so disruptive to their lives that when left untreated, their probability of positive physical health, education, employment, and life expectancy can be significantly decreased (Scottish Government's Mental Health Strategy, 2012; Department of Health and Social Care, 2015).

Minoritized groups within the United States such as Asian American, African American and Hispanic groups have lower rates of utilization of mental health services. Individuals from minoritized communities have been found to use mental health services at a significantly lower rate than those from White communities (Broman, 2012; Maura & Weisman de Mamani, 2017). There is research regarding underutilization of mental health services across minoritized groups (Arday, 2018), however, there is a lack of research specifically concerning Pacific Islanders (PIs). The bulk of research concerning PIs has grouped the PI community with the Asian

American community (Allen & Heppner, 2011). Asian Americans and PIs are very different culturally as well as in their pathophysiology (Hsu et al., 2012). More research is necessary to understand the specific barriers to mental health services for PIs.

The term PI refers to a racial group consisting of individuals whose origins include Hawaiian, Samoan, Guamanian or Chamorro, Fijian, Tongan, or Marshallese peoples and encompasses the people within the United States jurisdictions of Melanesia, Micronesia and Polynesia (Asian Pacific Institute on Gender-Based Violence, 2020). Throughout this paper, the term PI will be used to incorporate other terms such as Native Hawaiian Pacific Islander (NHPI), Polynesian American, and Polynesian which include the same ethnic groups as the term PI.

Statement of the Problem

Although mental health disorders are prominent throughout the United States, minoritized individuals have been found to have much lower rates of utilization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019; Wu et al., 2017). This is especially concerning as minoritized individuals have significantly more risk factors for mental health needs (Jang et al., 2010; Mezuk et al., 2010; Mossakowski, 2008; National Center for Education Statistics [NCES], 2015; Reeves et al., 2016). While there is limited research specific to the PI community, studies have shown that members of the PI community have higher risk factors for depression and suicide and greater risk for stigma and shame related to mental health and mental health services (Allen, Kim et al., 2016; Wyatt et al., 2015). High school students also have increased risks for mental health concerns (Reinke et al., 2011). Therefore, PI high school students may be especially at risk for mental health concerns (Benner et al., 2018; Cokley et al., 2013; Else et al., 2009; Felix & You, 2007; Tran et al., 2010). As stated, there is a deficiency in research regarding the PI community specifically, especially targeting PI high

school students and the barriers they face in accessing mental health services. Researchers from SAMHSA have stated that despite the enormous growth of Asian Americans and Native Hawaiian and Pacific Islanders within the United States, these ethnic groups "are often left out of data due to sample size limitations and reliability. The lack of data integrity fails to reflect the diversity of the populations and their needs" (Chau & Chan, 2021, p. 1). For this reason, much of the literature review will include other minoritized groups and their mental health perceptions, attitudes, and barriers. Research has found many similarities across other minoritized groups and the PI community in their feelings toward mental health and mental health services, especially with regard to high stigma and similarities in risk factors to mental health issues (Chau & Chan, 2021; Cummings & Druss, 2011; Eisenberg et al., 2009; Gary, 2005; Lasser et al., 2002). Some research generalizes minoritized groups to include any individual identifying as non-White, including American Indian, Alaskan Native, African American, Hispanic, Asian, and Pacific Islander or other ethnic groups (Population Reference Bureau, 1999). While there is insufficient data regarding the PI community in this arena, studies are referenced including other minoritized groups to help provide a framework and background to feelings toward mental health services across minoritized groups in general.

Statement of the Purpose

The purpose of this study is to examine how PI students within a Western state view mental health services. Researchers intend to explore how PI students think about mental health support. Researchers hope to gain a greater understanding of possible barriers and affordances that contribute to lower or higher utilization of mental health services among students within the Pacific Islander community in this Western state of the United States. With a lack of research regarding the PI community, and specifically high school students within the PI community, the

data found within this study will contribute to research targeting the PI community and their attitudes, perceptions, and barriers toward mental health concerns and mental health resources.

Research Question

This study will address the following research question:

1. How do male Pacific Islander adolescent students within a particular Western U.S. state think about mental health supports?

CHAPTER 2

Review of Literature

Importance of Mental Health Services

Mental health issues are common within the United States. The National Institute of Mental Health details that 20.6% of U.S. adults (51.5 million) report a mental health illness. Of those that reported a mental health illness, 44.8% (23 million) received mental health services within a year prior to the study (SAMHSA, 2019). Support for those facing mental health concerns can be successful. Therapy and medicine have been found to increase the quality of life of those with anxiety and depression (Bandelow et al., 2017; Kaczkurkin & Foa, 2015; Markowitz et al., 2020; Wright et al., 2019). Research has shown that those with a history of self-harm and suicidal behaviors are less likely to repeat these behaviors after receiving psychological therapy (Erlangsen et al., 2015).

While many mental health disorders have high rates of success with treatment, these disorders can be dangerous to an individual when left untreated. Depression and related behaviors are often recurrent. Those who have experienced an episode of depression are much more likely to have more episodes of depression (Burcusa & Iacono, 2007). Mental health disorders not only can cause psychological and social issues; these disorders can affect an individual's physical health. Depression, anxiety, and other mental health disorders are correlated with having higher rates of physical ailments including coronary heart disease, diabetes, and other physical health impairments (Dhar & Barton, 2016; Strine et al., 2004). There is a great need for mental health services to be prevalent throughout all populations in order to maintain mental and physical health.

Many mental health needs are not being met. An American Psychological Association (APA) study in 2016 found that nearly 12 million American adults felt they needed mental health services, and that those needs were unmet (Christidis et al., 2018). This is true internationally as well with studies within Australia and many European countries reporting severe underutilization of mental health services for individuals with mental health concerns (Burgess et al., 2009; Jenkins et al., 2009; Wittchen & Jacobi, 2005). As mental health services such as psychotherapy have been found to be highly effective in the treatment of mental health disorders including anxiety, depression, oppositional-defiance disorder, and panic disorder (Chambless & Ollendick, 2001), a higher utilization of mental health services would greatly benefit individuals with mental health concerns across the world.

Minoritized Groups and Mental Healthcare

Individuals from minoritized populations including non-Hispanic African American, Dominican, Puerto Rican, and other Hispanics have similar rates of mental health disorders as those of the majority population (Adams & Boscarino, 2005; SAMHSA, 2018a). However, individuals from minoritized populations are more likely to experience higher risk factors for mental health disorders such as lower socio-economic status, perceived discrimination, and lower quality education (Jang et al., 2010; Mezuk et al., 2010; Mossakowski, 2008; National Center for Education Statistics, 2015; Reeves et al., 2016). Asian Americans and Pacific Islanders (AAPIs) have many risk factors for depression and suicide. These risk factors include acculturative stress, enculturation, generational status, and poverty. AAPIs are also at heightened risk for stigma and shame associated with mental health and mental health services (Wyatt et al., 2015). Acculturation is the process of psychological change in values, beliefs, and behaviors when adapting to a new culture, and enculturation is the gradual process of acquiring

characteristics and norms of another culture (Takushi & Uomoto, 2001). Shame and stigma also correlate with lower utilization of needed mental health services (Wu et al., 2017).

Minoritized individuals face many barriers in accessing mental health services including stigma, distrust of care providers, lack of insurance, instances of racism among providers, and availability of appropriate resources (Miranda et al., 2002). Although many barriers to mental health services influence individuals within minoritized populations to avoid mental health services, research has shown that therapy has been similarly effective across ethnic and racial groups such as African American, AAPI, Latino/a, and Native American (Lambert et al., 2006). More research is needed to better understand barriers that limit mental health services for minoritized individuals.

Effects of Underutilization for Mental Health Services Among Minoritized Groups

Underutilization of mental health services is associated with many negative consequences. African Americans with mental health needs avoid mental health services for various reasons hoping that the situation will improve without intervention (Anglin et al., 2008). Although many individuals delay mental health services (Marshall et al., 2005) early intervention can lead to much greater improvements. Those that receive mental health services earlier are associated with improved outcomes to those that delay (Brunet et al., 2007).

Research has also found many disparities comparing ethnic minoritized populations and their relationship with inpatient care across ethnic groups. In England, one study showed that Black African, Asian, and non-White pregnant women have higher rates of involuntary inpatient psychiatric care (Jankovic et al., 2020). This leads to some ethnic minoritized groups having an overrepresentation in psychiatric inpatient care. Although there are much higher rates of many minoritized groups within inpatient care, this is not the case for outpatient care (Lawson et al.,

1994). Other research has found that minoritized groups, specifically AAPI individuals, were less likely to be admitted; however, their inpatient stays were significantly longer in comparison to those from the ethnic majority (Snowden & Cheung, 1990).

There is a large disparity in receiving mental health services among minoritized communities in comparison to the ethnic majority. In comparison to the White population, minoritized groups access mental health services at a significantly lower rate (National Survey of Drug Use and Health, 2020). PIs are a minoritized group that is less likely to receive mental health services when needed (Subica et al., 2019; Ta et al., 2008). Individuals within the PI community have been found to have a high need for mental health services, however, there are low levels of seeking help within the community. In a study among PI participants, 36% reported high levels of depression, anxiety, and alcohol use indicating the need for mental health services. However, 26% of the total participants reported that they were avoiding or delaying needed mental health services (Subica et al., 2019). Early identification could allow these individuals to receive the care they need in the early stages without needing to resort to more extreme measures (Brunet et al., 2007; McGorry & Mei, 2018).

Stigma of Mental Health Services Among Minoritized Groups

Individuals who believe that accessing mental health services may stigmatize them are significantly less likely to seek help when needed (Eisenberg et al., 2009). Additionally, in instances of psychological distress, those who feel high personal stigma or perceptions of high public stigma have a significantly lower likelihood of utilizing mental health services (Eisenberg et al., 2009; Wu et al., 2017). This stigma, paired with higher rates of social risk factors for mental health issues, leads to members of many minoritized groups such as African Americans, American Indians and Alaska Natives, Asian Americans, and Hispanic Americans having less

access to mental health services (Gary, 2005) . Stigma can include stigma within an individual or stigma within their community. This stigma can be reflected in attitudes, stereotypes, prejudice, and discrimination (Ciftci et al., 2013). Interestingly, within many ethnic communities, there can be a disparity in perceived public stigma and personal stigma toward mental health services. Research has shown that perceived stigma is higher than personal stigma (Eisenberg et al., 2009). This could mean that individuals within a community believe that there is higher stigma within their community than what is actually felt among members of the community. Regardless, stigma has a significant impact on the utilization of mental health services within the minoritized populations.

Perceptions of Mental Health Services

Underutilization of mental health services by minoritized individuals has been a long-standing issue (Anglin et al., 2008; Chu & Sue, 2011; Ta et al., 2008). This can be attributed to many different factors including the belief that mental health services are unnecessary. For example, research has shown that although African Americans believe that mental health services can positively impact an individual, they also had a greater belief that mental health issues will improve without the intervention of mental health services in comparison to their White counterparts (Anglin et al., 2008). Minoritized groups such as African Americans and Hispanics are significantly more likely than White individuals to hold negative perceptions of mental health services (Cai & Robst, 2016). Those within minoritized populations may avoid mental health services due to fear of mental health practitioners. Minoritized groups have been found to report a heightened fear of mental health treatment and higher rates of distrust for mental health professionals (Jankovic et al., 2020; Sussman et al., 1987). This fear may be based on the negative past associated with minoritized populations and the healthcare community.

Minoritized individuals have reason to distrust those within the healthcare industry. Historically, minoritized populations have had damaging experiences with healthcare practitioners (Brandt, 1978). Racial discrimination can still be found within mental health service environments. Even in recent history, medical practitioners have been found to hold false beliefs about racial differences in medical treatment such as the belief that African Americans have higher pain tolerance and therefore do not need as much anesthesia (Hoffman et al., 2016). Minoritized groups including African Americans, Hispanics, and Asians give reports of significantly higher perceived discrimination from healthcare in comparison to Whites (C. M. Lee et al., 2009). This perceived racism was found to affect health status, a delay in health seeking, and lower quality healthcare (C.M. Lee et al., 2009; Peek et al., 2011).

Availability of Mental Health Services for Minoritized Groups

Research has found that there is unequal access to mental health services among many minoritized communities including African Americans, Hispanic, and Asian groups (McGuire & Miranda, 2008). Minoritized groups including African Americans, Hispanics, and Asians within the United States receive mental health services less often (Cummings & Druss, 2011). African Americans have been found to have less knowledge about depression and the treatment resources available (Zylstra & Steitz, 1999). Underutilization of mental health services can be found across most minoritized groups. One study found that Asian Americans, African Americans, and Hispanics with severe depression had significantly lower rates of mental health service utilization when compared to the White population (S.Y. Lee et al., 2014).

Minoritized individuals also may not have as many high-quality mental healthcare options available to them in comparison to White individuals. Research has indicated that minoritized individuals have fewer resources available to them and the healthcare provided to

them is of lower quality (Primm et al., 2010). This can lead to minoritized individuals having far less trust in mental health services in general. For example, after discharge of inpatient mental health services, African Americans were far less likely to receive follow-up treatment than their White counterparts. Those without follow-up were found to receive lesser quality care (Carson et al., 2014).

Minoritized individuals in the United States whose first language is not English have another barrier when considering mental health services. Those who do not feel confident in their ability to speak English have the added difficulty of finding a mental health professional who speaks their chosen language. A census report with data collected from 2011 found that an estimated 13.3 million individuals within the United States reportedly spoke English "not well" or "not at all" (Ryan, 2013). An APA survey of psychology health service providers reported that 10.8% of respondents indicated they could provide services in a language other than English (Hamp et al., 2016). This can lead to many individuals being unable to access mental health resources from a practitioner who speaks their language.

Barriers to Mental Health Services

According to the APA, in 2016 almost 12 million Americans indicated that they had unmet needs with regard to their mental health, and nearly half of them said that they did not receive any mental health services at all. Of these individuals, 38% said the biggest barrier was cost, 28% said they thought the problem would go away on its own, 21% said they didn't know where to go for treatment, and 20% said that they did not have time to receive mental health services (APA, 2018).

As stated, one of the biggest reasons individuals do not receive necessary mental health services is the lack of financial resources. Many adults and youth within the United States do not

have adequate health insurance to allow individuals to receive mental health services. Of Americans with a mental health disorder, 11.1% are uninsured. The percentage of Americans without insurance has increased since previous years (Mental Health America, 2021). Those who do have health insurance are also affected, 8.1% of children have private health insurance that does not cover mental health services (Mental Health America, 2021). Most Americans believe that this type of insurance coverage is critical. A large percentage (85%) of Americans believe that health insurance should cover mental health services and 97% believe that mental health services are very important (APA, 2018).

Physical barriers such as cost can be particularly difficult for minoritized populations at heightened risk levels for socio-economic risk factors. Minoritized groups with mental health illnesses indicated that cost and inadequate health insurance is the biggest reason they cannot access mental health services (SAMHSA, 2015). This can create an even greater disparity in utilization of mental health services among minoritized populations.

Cultural Fit Within Therapy

Ethnic matching within therapy has been found to have an increase in treatment utilization and a decrease in dropout rates (Ibaraki & Hall, 2014). Clients paired with practitioners from their minoritized community have also been found to have lower need for crisis intervention, emergency services, and inpatient interventions (Ziguras et al., 2003). This can be problematic as there is a low percentage of minoritized mental health practitioners. Although 60% of the United States population identifies as White, 86% of mental health practitioners identify as white (APA, 2018; United States Census Bureau, 2021). This can provide fewer options to minoritized individuals hoping to find a cultural fit within therapy.

Many individuals from minoritized populations prefer mental health practitioners from their own ethnic community, and they feel more comfortable when dealing with practitioners that are familiar with their culture. Minoritized individuals have higher rates of continuing mental health services and staying in treatment longer when using ethnicity-specific mental health services (Takeuchi et al., 2013). This increased comfort in therapy with cultural fit is particularly true within the PI community. Clinicians who understand more about presenting concerns, utilization rates, and therapy outcomes of members of the PI community have greater outcomes (Allen, Cox et al., 2016; Allen & Heppner, 2011; Allen & Smith, 2015).

Student Mental Health Challenges

High school students are a vulnerable population dealing with a litany of new experiences, expectations, biological changes, and other issues that can overwhelm them including mental health concerns such as anxiety and depression. In a survey of adolescent participants across genders and socio-economic status, 70% indicated anxiety and depression were major problems among individuals their age in their community with 26% indicating anxiety and depression were minor problems (Horowitz & Graf, 2019).

Students have many stressors that can affect their mental and physical health as well as their education. A study conducted by Anda et al. (2000) found that some of these stressors include anxiety about their future and school, familial pressures, bullying, and substance abuse. The same study found that students do not utilize coping strategies very often, and those that do most frequently use distractions (e.g. reading a book, watching TV, listen to music) to cope with their stress and anxiety. These feelings can lead to a student dropping out of school. Some studies emphasize academic difficulties focusing on failure and disengagement. However, students can drop out for many different reasons. Some common reasons for dropouts are due to

severe bullying, social isolation, physical or mental health problems, and familial problems (Cornell et al., 2013; Dupéré et al., 2015).

Increased struggles for high school students may contribute to rates of mental health diagnoses within the United States. More than 27% of youth in the United States aged 3–17 years have been diagnosed with ADHD, a behavior problem, anxiety, or depression (Ghandour et al., 2018). In 2019, 11.1% of adolescents within the United States reported at least one major depressive episode (SAMHSA, 2021). Of those with major depression, around 60% did not receive any treatment for their depression (Mental Health America, 2021; SAMHSA, 2021). The same trend is found in the increased usage of antidepressants among adolescents. From 2015–2019, there was a 38% increase in the number of adolescents taking antidepressants (Express Scripts, 2020).

Minoritized Students

Mental health problems often go untreated within the adolescent population, especially among those from lower socioeconomic status and from minoritized populations (Lu et al., 2021). In a study of students across ethnicities from a high school with a school-based mental health clinic, 44% of students indicated symptoms of a depression disorder. Of the students with depression symptoms, White students were more likely to have previously received a diagnosis of depression and to have received treatment than minoritized students (Thomas et al., 2011). This implies that there are disparities in receiving mental health treatment even when mental health care is available to all ethnic communities within a population.

Minoritized students are at greater risk of developing mental health issues such as depression (Benner et al., 2018). This is due to risk factors including racial discrimination, increased rates of sexual harassment, bullying, lower socio-economic status, and higher rates of

physical health diseases (Benner et al., 2018; Cokley et al., 2013; Else et al., 2009; Felix & You, 2007; Tran et al., 2010). White students have been found to adopt help-seeking strategies more often than minoritized students from African American and Hispanic groups (Anda et al., 2000). Minoritized adolescents also face stigma toward mental health services within their ethnic populations. In a study across minoritized adolescents, their parents, and their local practitioners, all three groups found stigma to be one of the highest barriers toward utilizing mental health services (Gonçalves & Moleiro, 2011). This study suggests that although some attitudes may be different across generations, the younger generation is far from immune to the stigma toward mental health services.

Minoritized students in need of mental health services can have very different outcomes than White students experiencing mental health concerns. Evidence shows that minoritized youth with mental health needs from African American, Asian/PI, and Latino groups have lower rates of receiving outpatient care than White youth even when controlling for age, gender, functional impairment, and prior service use (Yeh et al., 2002). Furthermore, minoritized youth with mental health issues from many minoritized groups more often receive punitive measures such as school punishment or incarceration than their White counterparts (Marrast et al., 2016). Many studies have shown that 65–70% of youth within juvenile detention and correctional facilities are from a minoritized population (Cocozza & Shufelt, 2006). Within the juvenile justice system, minority youth are at the highest risk for underserved mental health needs. The first time many of these minoritized juveniles from African American and Hispanic populations receive mental health services is within the juvenile justice system in comparison to the White population (Rawal et al., 2004). In a study focusing on youth within the mental health system and what makes them most at risk for entering the juvenile justice system, being a member of a minoritized population

was found to be significantly associated with transitioning from mental health services to the juvenile justice system. Males from minoritized populations who use mental health services were found to be more likely than other adolescents to transition to juvenile justice detention or commitment (Scott et al., 2002).

PIs Within the United States

The United States is becoming increasingly diverse. The 2020 United States Census Bureau reports that over 40% of the country's population is part of a minoritized population (United States Census Bureau, 2021). Although the White population remained the majority, its population decreased while most other ethnic groups increased substantially. Specifically, the Native Hawaiian or PI group within the United States saw the third fastest population growth with a 61% increase.

Among any racial/ethnic groups, AAPIs were found to have the lowest rates of help-seeking in relation to mental health care (National Survey of Drug Use and Health, 2020). Of AAPI adults with mental health needs, 73.1% indicated they had not received treatment for these needs in comparison to 56.7% of the overall population (SAMHSA, 2018b). This has been found to be especially true within the PI community. PI university students were found to be just as likely to use counseling services as Caucasian students, but they were more likely to drop out sooner. During intake, these students indicated higher levels of presenting concerns, emotional, and psychological stress in comparison to Caucasian university students (Allen, Kim et al., 2016). Lack of insurance is an especially high barrier among the PI community. Though the White population within the United States has an uninsured rate of 7.8% and the overall AAPI population an uninsured rate of 7.4%, when narrowing down to the PI population alone, the PI community has an uninsured rate of 9.3% (Artiga et al., 2021).

AAPIs have increased risk factors for depression and suicide (Wyatt et al., 2015). These risk factors include acculturative stress, enculturation, generational status, and poverty (Wyatt et al., 2015). Many individuals within the AAPI community face racial discrimination (United States Department of Justice, 2021). Perceived racial discrimination among PI has been found to affect both mental and physical health (Allen et al., 2017; Kaholokula et al., 2012) and perceived racism among Native Hawaiians is associated with higher symptoms of depression (Antonio et al., 2016). Racial discrimination among PIs is associated with lower self-esteem and life satisfaction with higher rates of anger, depression, anxiety, and stress (Allen et al., 2017).

Individuals from the PI community have been found to have higher levels of stigma regarding mental illness with men reporting higher rates of self-stigma and women reporting higher rates of public stigma (Allen, Kim et al., 2016). PIs are at heightened risk for stigma and shame associated with mental health and mental health services. Shame and stigma within AAPIs correlate with lower utilization of needed mental health services. This is especially problematic as suicide becomes an increasing problem within Asian and PI communities. While suicide rates dropped among the White population between 2014–2019, suicide rates among AAPIs went up by 16% (Ramchand et al., 2021).

As stated, PIs have more risk factors associated with mental health needs. However, PIs have been found to use buffers to psychological distress and trauma. PIs, especially those with a strong relationship to their religion, are more likely to use collectivistic coping styles such as family support and religion/spirituality to have a positive psychological well-being (Allen & Heppner, 2011; Allen & Smith, 2015). One study found that during therapy, PIs appreciate a family-centered therapy approach that considers the needs of the entire family, therapist self-disclosure, and the sharing of personal backgrounds (Cutrer-Párraga et al., 2024). Not all coping

strategies commonly utilized by PIs are positive. Native Hawaiians are more likely to use venting and behavioral disengagement to mediate perceived racism and psychological distress. These strategies do not contribute to positive mental health, and might in fact worsen their psychological distress (Kaholokula et al., 2017).

Mental health services tailored for the cultural needs of Pis are associated with better results within the PI community (Allen & Smith, 2015). This was found for mental health services as well as physical health services (Kaholokula et al., 2018). Mental health professionals working with the PI community would greatly benefit by understanding the culturally specific needs of PI individuals and providing services that meet those needs (Allen, Cox et al., 2016).

PI Students

An article published in 2012 found that many males within Pacific Islander culture define themselves with strength, power, and respect, they often feel that those attributes define what it means to be a man (Irwin & Umemoto, 2012). Further, male Pacific Islander adolescents hoping to prove their power and that they deserve respect will employ violent masculinities. This can partly be attributed to the historical mistreatment of their ethnic groups, for example, through the colonization of their homelands. The article also found that this oppression in their cultural history has led to a generational need to defend.

PI students have the second highest rate of high school dropouts in comparison to other ethnically minoritized groups with a rate of 8% (NCES, 2019), and mental health concerns can be a factor for those who dropout of high school. Many studies have found that mental health concerns are linked with school dropouts with one Australian study reporting that students who have had a distress disorder are twice as likely to drop out of high school than those who have not had such disorders (Butterworth & Leach, 2018; Hjorth et al., 2016; Vaughn et al., 2014).

This is concerning because those that graduate from high school are more likely to find hold a job and maintain a livable wage (Rumberger, 2011).

Suicide rates are higher among the AAPI community, and this is especially true within those aged 15–24 years old. According to a study by the CDC (2020, as cited in Chau & Chan, 2021), of individuals aged 15–24 years old, the AAPI community was the only ethnic community where suicide was found to be the leading cause of death. Another study found that PI youth are three times more likely to attempt suicide than European youth and that adolescent PIs have the highest rates of suicide across PI ethnic age groups with more men dying by suicide than women (Tiatia-Seath et al., 2017).

In a report from a White House interagency task force, the Asian American and Pacific Islander Bullying Prevention Task Force, researchers found that students from PI communities experience bullying and harassment of all types (Thor, 2019). This same study found that many AAPI students and their parents are unaware of resources available to them. Among AAPI students, those associated with bullying have higher rates of suicide ideation; this includes the victim and the perpetrator (Else et al., 2009). To best meet the mental health needs among PI students, risk factors and barriers to mental health must be studied.

PIs are underrepresented in mental health research. Despite cultural and geographical differences among PIs and Asian Americans, the two groups have often been combined. It was not until 1997 that PIs and Asian Americans were separate ethnic categories on the United States Census (Office of Management and Budget, 1997). Asian Americans and PIs have many differences in their utilization of mental health services. For example, Asian Americans and PIs have been found to have similar levels of starting professional mental health services, however, Asian Americans are more likely to remain in therapy for a longer period of time. Also, though

their distress levels were similar at intake, PIs had more concerns related to their family (Hafoka Kanuch et al., 2019). The common grouping of these two very different ethnic groups has contributed to a deficit in research specifically targeting PI individuals (Allen & Heppner, 2011).

There is a clear underutilization of mental health services among PIs. This can be attributed to many factors including stigma, lack of cultural fit, and distrust of healthcare services in general among minoritized populations (Ibaraki & Hall, 2014; Miranda et al., 2002; Wong et al., 2016). It is critical that research reflects the importance of this expanding population and that efforts are made to help professionals better understand how to support individuals within this growing group.

CHAPTER 3

Method

This thesis is a sub study of a larger research investigation which was created at the behest of city council members and a Pacific Islander mental health coalition in a particular state in the Western United States. For the larger research study, the research team was tasked with exploring how Pacific Islanders (PIs) across multiple demographic factors thought about mental health services (Cutrer-Párraga et al., 2024). This thesis will focus on a subset focus group from the larger study that included only high school adolescent male student participants. Funding for the larger study was provided by a state agency.

Research Design

Although multiple inquiry designs were considered, ultimately the researcher decided that interpretative phenomenological analysis (IPA; Smith et al., 2009) focus groups were most fitting for the research question. Smith also explained that the purpose for IPA focus groups is to try and make sense of individuals' experiences using ideographical, phenomenological, and hermeneutic practices.

In following with IPA methodology, no formal hypotheses were formed during the process of the data collection. This allowed for greater examinations of participants' lived experiences (Reid et al., 2005). IPA focus groups gave researchers the opportunity to collect data as participants were in the process of making sense of their experiences.

IPA emphasizes the use of "reflexivity" throughout the entirety of a study. Reflexivity is done to recognize the effect the researcher may have on the participants during data collection and brings awareness to any biases the researchers may have during the entire process.

Throughout the data analysis and interpretation process, the researcher and her chair met collectively to reflect upon their experiences as they analyzed and interpreted the data.

Focus groups are a socially oriented research procedure which allow for group interaction. This creates a comfortable atmosphere wherein honesty and sincerity are inspired (Webster et al., 1992). Participants are free to express their agreement or disagreement. Focus group discussions can spark memories or experiences that participants may not consider mentioning in individual interviews. Focus groups give insight into vulnerable populations by giving a safe space to express ideas and opinions. Many ethnic populations feel a great deal of shame and self-stigma when discussing mental health issues (Wong et al., 2016). The smaller focus group size, with multiple reassurances of confidentiality, provided participants a more comfortable setting in which they shared their opinions and experiences regarding mental health support.

Participants

This study centered on Pacific Islander male adolescent students' experiences relative to mental health services. Given the vulnerable nature of participants relative to openly discussing mental health support, convenience sampling was incorporated to recruit participants via social media and word of mouth. Flyers were created with specific information regarding the topic of discussion, focus group locations, and times. The research team also reached out to Pacific Islander faith community groups, state Pacific Islander Facebook groups, and a state Pacific Islander Health Coalition to recruit participants for the focus groups. Participants were provided a meal and a $20 Amazon gift card as compensation for their time.

In accordance with IPA, the PI student focus group included participants who were homogenous in that they shared similar experiences in regard to the research question (Larkin et

al., 2018). Participants who did not identify as PI were excluded. All participants currently resided within the Western state where the study was conducted. The adolescents within this study had varying levels of religious activity. One participated very actively with his religious organization and attended church weekly. The other two participants did not engage in religious activity on a regular basis.

Experts within the Pacific Islander community explained that adolescents in the PI community are taught to respect their elders. This respect is often shown by remaining silent in the presence of elders. For this reason, high school male student participants were placed in a single focus group in the hope that they would feel more comfortable sharing their honest thoughts and opinions. There were three high school male student participants who met the selection criterion. Each spent time on a Pacific Island as well as the Western state where the study was conducted. At the time of the study, all three currently resided in the Western state where the study was conducted, all three were male and were between 14–16 years of age. Their PI heritage included Native Hawaiian, Tongan, and Samoan.

Setting

The focus group interview was held in a major city at an office space. All researchers were given the same protocol for each focus group to ensure that groups were held within the same conditions including the same questions, materials, and time frame. Participants were told that they would be needed for 3 hours. The first hour included time for participants to read through essential information and give consent and enjoy a meal together with the focus group facilitator and notetaker. Participants were greeted at a front desk. The two greeters at the front desk were given an interview protocol script to use when welcoming participants. Participants were given information regarding the purpose of the study, confidentiality, their ability to

withdraw at any time, and other relevant information. The high school students received assent forms and their parents signed consent forms giving permission for their child to participate. After completing necessary documentation, the participants were able to share a Pacific Islander meal as a whole group with the researchers. This allowed researchers and participants to spend time together and begin to build rapport with the participants. Parents of the high school students remained on site, in another room during the focus group interviews.

After the first hour, participants were moved into a separate room to participate in the focus group. In each room, participants were provided pens, notepads, and sticky notes to record any thoughts and feelings they might have during the focus group. They were also provided card decks to be used for card sorts during the focus groups. Because minoritized populations, including PI communities, have been found to respond more positively to therapists of their own race/ethnicity (Allen, Kim et al., 2016; Cabral & Smith, 2011), the facilitator for the focus group was from the PI community. In addition to the facilitator, a notetaker was present and observed and reported body language throughout the focus group session. The facilitator and notetaker were both trained prior to the study how to create a thoughtful, safe, open, atmosphere and asked pre-determined questions. The focus group was recorded by audio and video. Participants were instructed to say their name before any statements to help with the transcription process.

The facilitator and notetaker were provided an interview protocol script to use during the administration of the focus group (see Appendix A). This script included tasks, questions, and example follow-up questions. In the middle of the session, participants and researchers were given a 10-minute break during which time participants and researchers could socialize, use the bathroom, and eat snacks. At the end of the focus group, participants were given the opportunity to share anything that had not been discussed that they would like to share. Participants were

then given their $20 incentives and given information about available mental health resources for themselves or any friends or family members that might need mental health services.

Procedures

A hybrid card sort using categories of potential barriers was created based on a list of barriers in statement form (Cadigan & C. M. Lee, 2019; Kwan et al., 2020; Narcisse et al., 2018; Sarikhani et al., 2020). The statements were grouped into eight categories based on their similarities: stigma/perception, cultural fit, trust, knowledge of resources, time, access/availability, cost/insurance, and unnecessary/not needed. Each participant was instructed to mark the statements that applied to them personally and then each placed the eight cards in order based on which would be the largest barriers. The participants then discussed as a group the factors they considered as they were organizing their cards and the reasoning behind their order. Use of the cards was not evaluated. Rather, the cards served as a conduit to open and deepen conversations about this stigmatized topic.

The term “mental health” was not defined during focus groups. This was purposely done to allow participants to express their opinions and beliefs of mental health based on their perception of the meaning of that term. After the focus group was completed, the recording was transcribed verbatim. Noted body language was added to the transcriptions including non-verbal communications and behavior.

Cycles of Coding

IPA methodology was used to analyze the data (Smith, 2011). Alase (2017) explains that IPA data coding is traditionally conducted through three cycles. During the first cycle researchers analyze transcripts and break responses of the participants into meaningful chunks. In the first cycle of this study, researchers broke down participant responses into significant

quotes and organized them into four a priori codes: (a) What are the attitudes among Pacific Islanders regarding mental health? (b) What are the perceptions among Pacific Islanders regarding mental health services? (c) Are there any barriers to receiving mental health services among Pacific Islanders? (d) What would help Pacific Islanders receive necessary mental health services? Prior to the data analysis, the research team met together to discuss the meanings of the four a priori codes. The team decided to code attitudes among Pacific Islanders to mean the participant's personal beliefs and opinions surrounding mental health and to code perceptions among Pacific Islanders to mean the participant's perceptions of the community's beliefs and opinions surrounding mental health.

The second cycle of coding further condensed the initial chunky quotations from the participants in order to help researchers get closer to the "core essence" of the participants' lived experiences (Alase, 2017). During the second cycle of coding of this study, researchers took the initial meaningful chunks under each a priori code and categorized them. The main researcher individually read through the a priori codes and labeled and defined categories based on the most common key words, phrases, and ideas, found among group members. These categories were then organized on a worksheet separated by the initial a priori codes. They were then compiled together to show the common themes across the groups.

Trustworthiness

Within qualitative research, high standards of rigor are maintained to ensure credibility and trustworthiness in data collection and interpretation (Brantlinger et al., 2005). Standards of dependability, credibility, transferability, and confirmability techniques were suggested by Lincoln and Guba (1985) including peer debriefing to guarantee trustworthiness.

Credibility

To promote credible research, this project utilized many aspects of credibility including investigator triangulation, debriefing, member checking, and expert checking. Triangulation strategies help researchers reduce fundamental biases by including multiple locations, researchers, and data collection methods (Noble & Heale, 2019).

Peer debriefing allowed the research team to explore different ideas, check for bias, and experience cathartic release during data collection and data review. The research team also included individuals from the PI community and those outside of the PI community which allowed for multiple perspectives throughout. To ensure dependability and confirmability, a record was kept of training, process, and decisions which could be used to audit the findings of the research. The main researcher also wrote reflexive notes and used reflexive journaling and had group reflection. Reflexivity is especially important when individuals are studied as a research tool. Reflexive tools allowed the main researcher to express and disclose their positionality.

Statement of Positionality

As a member of the PI community, the main researcher resonated with many of the comments that participants made. During our discussion, the main researcher was surprised by some of the more extreme beliefs they held about mental health and the perceived stigma within the PI community. The main researcher shared membership of the community and common religious orientation which led her to question the intersection of religion and perceptions of mental health within the community. As a school psychology student, she felt a greater desire to understand their feelings toward mental health services and the resources available to them, especially at a school level. The main researcher being a part of the PI community is both a

benefit and a liability in this research project. Membership of the community allowed individuals to feel more comfortable being vulnerable and opening up about difficult experiences. The main researcher also had greater context of the cultural influences of their beliefs. However, experiences related to perceptions of mental health within the PI community may have influenced her understanding of the words of the participants. All researchers used reflexivity within themselves and with other members of the research team throughout the process of data collection and review in order to remain as objective as possible.

This topic is personally significant to me due to experiences I have had in my family. My grandfather was the two-time Pacific Rim Welter Weight boxing champion, held the title of chief, and was highly respected within his community. Following traumatic experiences earlier in his life, my grandfather dealt with many mental health difficulties. Unfortunately, he never felt comfortable discussing these mental health difficulties due to the high cultural cost within the PI community. Sadly, he died by suicide leaving his family and community in mourning. For this reason, I feel passionate about removing barriers faced by males within the PI community. It is important to note that my personal perception of mental health within the community may have influenced the direction of questions and made it more difficult to analyze the data without bias. In following with best qualitative research practices, this study was conducted without a hypothesis, but rather with a research question. As Brantlinger et al. (2005) have explained, researchers can have a "hunch" based on personal experience. The researcher's hunch going into this study was that there would be themes regarding the punitive perception of mental health issues among male adolescent Pacific Islanders based on previous research completed and based the researcher's personal experiences.

CHAPTER 4

Results

This study set out to gather perspectives around the research question: How do Pacific Islander students within a particular Western state think about mental health supports? This study was conducted with a qualitative IPA focus group research design. Qualitative research is exploratory with the researchers using an open mind to define the problem or develop an approach to the problem. The main researcher attempted to understand the experience of the high school male adolescent participants as they were understanding them throughout the focus group discussion. Focus group questions focused on attitudes and perceptions of mental health services, barriers to mental health services, and what was most helpful for individuals when in need of mental health services. Three participants were included in one focus group. The participants were all male and 14–16 years old. PI heritage included Native Hawaiian, Tongan, and Samoan.

The main researcher self-identifies as Samoan. With IPA methodology, the researchers' worldview, lenses, and personal experiences are considered part of the analysis as the researcher works to interpret the meaning-making of the participants. Hence the sharing of researcher positionality in the methods section to inform the reader about the background and worldviews of the interpreter.

Data analysis resulted in four main themes (attitudes, perceptions, barriers, and helps) and nineteen categories. Attitudes were coded when participants expressed personal opinions about mental health, and perceptions were coded when participants expressed what they perceived to be the opinions of the Pacific Islander community as a whole. Deidentified quotes have been included to illustrate the themes and categories (see Table 1). During the analysis process, three members of the research team discussed the common themes and how they would

be represented. It was decided that attitudes would be feelings surrounding mental health as felt by the participants themselves. The researchers defined perceptions by what adolescents perceived to be their ethnic community's beliefs about mental health issues and services. Barriers were defined as when participants discussed internal or external factors that would make it more difficult for a PI male adolescent to discuss mental health or access mental health services. Helps was coded when participants discussed helpful resources related to mental health.

Table 1

Themes, Categories, and Quotes

Theme	Category	Quote
Attitudes	Mental health issues are shameful and will hold you back	"They'll just see us as one of those good stars that just threw their life away."
	More comfort in Poly community	"In the [PI community], they try to embrace you and they love you and they wanna help you more. But over here it's like all separated … it's not as close as back home."
	Polys don't do that	"Our culture we don't really go to mental health places, we don't really know where to go or where to find it."
	Burdens family	"Maybe you want to go but your family doesn't have enough money … so you're just putting your family deeper down."
	Adults/Parents can help	"They've lived a teenage life; they know what we could be going through."
	Shutting down after lack of support	"You pick your most trusted person, they don't help you, so you just think to yourself, 'No one else can help me from here on out.'"
	Gender	"'Cause women know emotion more and like they're more sensitive and so it could go both ways."

Theme	Category	Quote
Perceptions	Mental health issues are a problem, and it's your fault	"My community, if you have a mental health issue, they view you as like someone less than you were."
	"Suck it up"	"They don't take it serious so they just tell them to 'suck it up' or something."
	You'll be sent away	"Most Polys you will get sent away to like where like your family is just to get yourself together figure out your problems."
	Familial support is helpful	"Family members they're more supportive to you so they can help you more."
	Community support is helpful	"What most polys would do is try to get like try to solve their problems with friends and stuff."
	Out of culture	"A PI therapist, he knows like what's going on with you but like it doesn't really matter to him."
Barriers	Mistrust of mental health professionals	"If you go to like someone to get help there could be rumors that start about, he has mental health problems."
	Shame (individual and familial)	"Once they know that you have to go to like a mental health place you're being put off as like a bad person."
	Cultural (lack of understanding)	"[Therapists] don't help you with your culture like if they don't know what your culture is."
What Helps	Faith leader	"He'll just get you on the right path and he'll always put God first and revelation from Him and church is a really big thing in my life."
	Family	"Close family members who know the struggle that you're going through, they will help you."
	Elders	"Experience is the main thing that adults really have."
	Coach	"When you build up your relationship with your coach, they want to see you strive and make it to the next level and see you do good."

Attitudes

Mental Health Issues are Shameful and Will Hold You Back

Stigma and shame were discussed repeatedly when participants discussed their feelings about mental health. The participants had a punitive perception when considering discussing mental health with others. All of the participants brought up that having mental health needs would be "throwing your life away." One high school participant involved in athletics said, "Going off of both of them, like going sports, they'll just see us as one of those good stars that just threw their lives away because of the things they go through. They get caught up in things. They'll just look at us like we just threw our lives away." Another participant stated, "When [others] see we're seeking help, they're just thinking, 'another good poly gone bad' and stuff." For the participants, stigma and shame were greatly associated with mental health issues and services. They felt that if they discussed mental health issues with anyone, there would be a negative impact on their future academic, athletic, and career prospects.

Difficult Away from PI Community

A majority of participants explained that they had a hard time dealing with their own mental health issues in the area that they live because they are in the ethnic minority. One participant stated, "Over here it's like all separated and I feel like it's not as close as back home." They felt that when they were in an area with more Pacific Islanders, for example Hawaii, there is more of a sense of unity and helping each other. One participant who had previously lived in a PI majority community said, "In [the PI community], they try to embrace you and they love you and they wanna help you more. But over here it's like all separated … it's not as close as back home." For the participants, living in an area with many PIs gave them a greater sense of unity, belonging, and togetherness.

PIs Don't Do That

The majority of the participants felt that receiving professional mental health services was something that Pacific Islanders just do not do. They felt that it was not part of their culture so they wouldn't feel comfortable receiving mental health services. One participant suggested that because it is not part of the PI culture, they would not know where to go to receive mental health services. He said, "I feel like cause Polynesians like our culture we don't really go to mental health places, so we don't really know where to go or where to find it." The participants felt that seeking mental health resources was rare within the PI community. Another participant stated, "In [PI hometown] you don't really go to mental health … you go to family members and community members." For these reasons, they did not have a lot of experience with accessing mental health resources, and therefore would not know where to go if they had a concern.

Burdens the Family

Another attitude commonly felt was that when an individual receives mental health services, they are burdening their family. One participant stated, "I would feel embarrassed that I go to mental health treatment and like how people would now look at my family." They were also concerned about the potential financial burden. One participant explained that PI adolescents may not seek mental health services because of the potential financial burden by saying, "Maybe you want to go but your family doesn't have enough money or can't cover the expense so you're just putting your family deeper down." The PI community has a strong emphasis on giving to others rather than taking. For this reason, many within the community would be uncomfortable using resources for seemingly personal gain.

Adults and Parents Can Help

One positive attitude that the adolescents brought up multiple times was the impact of adults and parents. While parents were said to be possibly helpful when there is a mental health issue, participants talked more about the positive impact of adults within their personal community other than their parents. One participant talked about adults being helpful by saying, "Because they've lived a teenage life, they know what we could be going through, and they have more access through other things than people our age do. So, they can contact people and stuff to get us help." Another participant agreed with this comment and added, "They have had friends or family members who have gone through it, so they already know like how to help you with your problems." Though the participants recognized that though it may be uncomfortable to discuss mental health concerns, adults in their lives would have access to more resources.

Shutting Down After Lack of Support

All of the participants brought up the pain that can be felt when they are shut down after bringing up a mental health concern. One participant explained this feeling by saying, "that you have to bottle it up and keep it to yourself instead of explaining it to other people." The participants explained that if they expressed a mental health concern and were not supported, they would be less likely to reach out again. One participant talked about how hurtful it would be to be dismissed when bringing up a mental health concern by saying, "If they just blew it off, I would probably just sink even deeper, but just keep to myself more and it would be harder to tell the next person what's really going on." The members of the group felt that discussing mental health concerns would make them very vulnerable. They felt that if someone within their community did not take their concerns seriously, they would shut down.

Gender

Interestingly, the participants did not agree on which gender would be more helpful when seeking mental health services. Two preferred female mental health support while one preferred a male. One participant who would prefer a female mental health therapist said,

> To be honest I think it be easier to talk to like a girl 'cause if you talk to a man then maybe they'll be like he's not like men like material maybe he's like not good enough like stuff like. That like he does he's not strong enough to handle the things that like men are supposed to like handle, and women understand like emotion more like better and stuff like that.

Another participant said he would feel more comfortable with a male saying, "I honestly feel myself, talking to a male person because I feel more comfortable from the same gender and how they probably play sports and like how they'll see the same things I see." The participants felt that a female may be more in touch with emotions and would feel more comfortable discussing feelings. However, they felt that a male would be more likely to understand the expectations within the community.

Perceptions

Mental Health Issues are a Problem and It's Your Fault

The participants brought up many times that mental health issues are a problem, and that mental health issues are the individual's fault. They felt that discussing a mental health issue would give a negative reflection on the PI community. One participant talked about the difference in receiving mental health services between the PI community and the White community:

> Well, the Caucasian community there's people that do too, but since we're Polynesians and like we're Colored around here they see it as different from them so when we do get caught it's more of a bigger deal than it is for like just White people cause then it's just like okay. But when Polynesians come over here 'cause we come for a like a different life we try to make better for ourselves but when we do get caught up in stuff like this it makes us look bad.

The members of the focus group talked about mental health concerns as if having a mental health issue was like committing a crime, two of them even referred to having mental health problems as "getting caught" making it sound like mental health issues equate to doing something wrong. One participant stated,

> You'll just be known as another person who just like went down the wrong path and the wrong road and is just getting caught up in other stuff they're not supposed to be getting caught up in to.

This sentiment can be especially problematic as the participants brought up that they felt a responsibility in representing their ethnic group. They did not want to represent their community poorly and discussing mental health concerns would do just that.

"Suck It Up"

Another common feeling was that Pacific Islanders are supposed to be strong, and that mental health issues are weaknesses. This means that PI should not need help. Two of them used the phrase "suck it up."

> Polys are more closer with each other they know more each other about their families and stuff so they'll feel like more embarrassed or they don't really want to open up 'cause it's

your own problem and you should like suck it up and just keep living and try to be as good as you can.

One participant said, "For Polynesians, sometimes when we struggle with your mental health like they don't take it serious so like just tell them to 'suck it up.'" They thought that talking about mental health made them appear weak and that weakness would not be acceptable within their community. This made them less likely to discuss mental health with others.

You'll Be Sent Away

Another perception was that if you admit to mental health needs, you'll be sent away. Within the Pacific Islander community, if you are struggling or getting into trouble, you will often be sent to live with another family member. Two of the participants explained that they would be afraid to bring up mental health issues because they thought they might be sent away either to a rehab facility or to live with another family member. One participant talked about mental health services and said, "I have like the therapist mental hospitals maybe rehab and then for like most Polys you will get sent away to like where like your family is just to get yourself together figure out your problems." They were afraid that if they brought up mental health concerns, there would be a greater likelihood that they would have to leave their home, their family, and their friends.

Community Support is Helpful

All of the participants talked about community support being helpful. They seemed to feel that their close community support, especially within their ethnic community, is more helpful than receiving professional help. One said, "What most Polys would do is try to get like try to solve their problems with friends and stuff." Another participant stated, "community members, so they'll help you and for free on their own time." The members of the group felt that

PIs relied more heavily on members of the community for help rather than seeking out professional help.

Familial Support is Helpful

Familial support, while not brought up as often as community support, was found to be helpful. They talked about discussing mental health concerns with their family by explaining that while they would not want to go to their parents, they felt that it would be good for them to talk to their parents. One explained,

> Most friends will easily come up to you first instead of the parents 'cause they feel more comfortable around you so they probably tell you not to tell like your parents or anything like that, but the best thing to do is to tell your parents and try to get your friend some help.

The participants felt some discomfort talking about mental health concerns with their family members, but they recognized that parents were likely the best resource. They said if a friend needed help, they would recommend that they seek out help from their parent. One participant said, "If I was having a mental health issue … family members especially would notice and they would probably reach out to me and, and then it goes my way to tell them what's going on."

Out of Culture

Another perception was that they felt more comfortable working with a mental health professional within their culture. One participant said,

> If your therapist or whoever is helping you get through this, of they're not like the same culture as you they won't really understand like where you're coming from and how you live your life … and things … how people judge you.

Another participant agreed with this attitude. He discussed out-of-culture therapists by saying, “They don’t know how like the pressures that’s on you and like what you’re going through and like the cultures very important that that plays it plays a big role in who you are.” The participants did not feel that a mental health professional outside of their culture would understand them as well as someone who had grown up within the PI community.

Barriers

Participants discussed the barriers that would keep them and members of their PI community from utilizing mental health resources.

Trust

A common theme was that the participants didn’t feel like they could trust mental health professionals or medicine. This theme of lack of trust can be broken into three categories: confidentiality, medicine, and mistrust of healthcare professionals.

Confidentiality. They shared a fear within the community that mental health professionals might share your personal information. “Some people think that when you go to like mental health places that your information can get leaked or like the uh like, the system that you don’t trust …”

Medicine. They also felt unsure about the effects of medication. One participant discussed the fear of using medicine to help with mental health concerns by saying, “You don’t know what it is so you don’t if it will affect you and like it’ll put your life more at risk or it would help you.”

Mistrust of Health Professionals. The participants discussed their mistrust for mental health professionals. This was especially true when they spoke about going to a PI mental health professional. They explained that because the PI community is so small, a PI mental health

professional would likely be connected to their community network. They feared that anything that they would discuss with a mental health professional, especially a PI mental health professional, would be spread throughout the community. One participant stated, “Some people think that when you go to like mental health places that your information can get leaked or like the uh like, the system that you don’t trust.”

This idea of trust of was very important to the participants. They wanted to be sure that their information would not be shared with others. They did not fully believe that a mental health professional would commit to confidentiality. They worried that others might find out that they are accessing help from a mental health professional, and that they would be judged for that decision. They were also uncertain about the trustworthiness of medication. The idea of medication and the potential side effects made them very uncomfortable.

Shame

Shame was one of the biggest barriers that the participants discussed when talking about reasons individuals would not access mental health services. This could be broken up into two categories: individual and familial shame.

Individual. The participants described the shame that they would feel if others within the community were to find out that they need mental health services. They explained that they would be embarrassed if other PI individuals found out that they were receiving mental health services. “When you tell a friend you always know that they have space to work with you but when you tell a relative you feel like you mess up or did them wrong or something like that.”

Familial. Representing your family name is an important aspect of the PI culture. Individuals within the PI community connect by saying their family name and talking about how they know each other’s families. During the focus group, the participants talked about the shame

they would bring to their families if they had mental health issues. One talked about how they would feel if someone found out that they were receiving mental health services and the impact it would make on their family by saying,

> I would feel embarrassed that I go to mental health treatment and like how people would now look at my family now that I'm going to mental health and just my cultural fits how they'll look at Polynesians now that you see multiple people that are Poly going to mental health.

Another participant agreed and stated, "If you have a mental health issue they view you, yeah, they view you as like someone less than you were." They worried that others might find out about them getting help, and that would be bad for their reputation. They felt a high responsibility to represent their family in a positive light, and expressed that seeking out help with mental health concerns would reflect very poorly on their families.

Cultural (Lack of Understanding)

Culture played a large and nuanced role in relation to mental health services. The participants talked about wanting to have a PI mental health professional. They thought that being of the same culture would help them feel more connected to their clinician. They also talked about how it would take off the pressure of having to represent their PI culture if the mental health professional was already familiar with the culture. One participant talked about the extra pressure they would feel if they were to go to a mental health professional outside of the PI community.

> [Non-PI therapists] don't know how like the pressures that's on you and like what you're going through and like the culture's very important that that plays, it plays a big role in who you are and so I feel like that really needs to be a … it's like a barrier.

They felt that a PI mental health professional would understand their specific concerns better than one outside of the community. They did not feel that they would have as much of an obligation to represent their PI community if their therapist was already a part of that community.

What is Helpful

Faith Leader

The participants talked about their faith as a protective barrier to mental health concerns. They specifically talked about the benefits of getting help from a faith leader. One talked about how a church leader could help them with mental health services by saying,

> [A church leader] could get you on the right, or he'll just get you on the right path and he'll always put God first and just getting revelation from him and church is a really big thing in my life.

The members of the group most frequently brought up positive experiences they had with their faith leader when discussing mental health. This was especially true when their faith leader was also a member of the PI community.

Family

The participants talked about various family members and how they could help with mental health concerns. One participant talked about family members potentially helping with mental health concerns by saying, "Close family members who know the struggle that you're going through so they will help you." They felt that not only was it their family's responsibility to look out for them, but their family knew their situation, loved them, and understood their identity best.

Elders

As adolescents, the participants were able to see the advantages of getting help from older individuals within their network. They talked about parents, church leaders, coaches, and other adults within their circle and how these individuals could be helpful if they were struggling. One participant explained the benefit of getting help from an adult by saying,

> Adults are like they've already lived this life. Like I already know that all adults aren't perfect so they already have, they must have had friends that have like gone through it, family members, or even themselves so they already know like how to help you with your problems.

They talked about many adults in their life that could help them. They understood that adults in their lives have had experiences that gave them knowledge and wisdom that could help them in their situation.

Coach

While the participants frequently brought up coaches as helpful resources when dealing with mental health concerns, they did not always agree that coaches would actually be helpful. They explained that they felt that a coach would have motivation to help you, however, that motivation could have ulterior motives. They worried that a coach might just be helping them so that they would play well. One participant talked about the war of these two ideas by saying,

> And like coach, cause when, when you build up your relationship coach, they want to see you strive and make it to the next level and see you do good. So, when they see that you're not doing good stuff they want to help you. And that's why this is possibly helpful, but some coaches they just tell you what you wanna hear, maybe they just want

to see you make it through their team like high school they want to do good for them but then after that they don't care.

The participants in this group were all actively involved in extra curriculars. They had strong relationships with their coaches. However, they were unsure if talking about mental health concerns would be a net positive or negative. This is because their coach would want to help them, but their coach might be less likely to rely on them.

Male adolescent PIs within this study had many negative attitudes about mental health. They felt that accessing mental health did not align with their culture's values. As they discussed their perceptions of the PI community's opinions about mental health, it was clear that they felt that their community did not support accessing mental health services. Though they perceived many barriers toward receiving mental health services, they also recognized that there were many individuals in their lives that could potentially help them under the right circumstances.

CHAPTER 5

Discussion

Like previous studies, this study also found that stigma and the shame were greatly associated with mental health issues (Gonçalves & Moleiro, 2011; Wong et al., 2016; Wyatt et al., 2015). Many adults within the PI community hold the perception that the stigma surrounding mental health is only held among much older individuals within the community (Cutrer-Párraga et al., 2024). The results of this study however, indicate that the stigma associated with mental health may also be held by the younger generation. In fact, adolescents in this study held an extremely punitive perception of mental health. They felt that even discussing mental health issues could hurt their future academic, college, and athletic goals. They felt deep stigma surrounding mental health within their community which made them less likely to access mental health resources if they needed them. They worried about the impact it would have on their own reputation as well as the reputation of their family.

The participants of this group often felt that their parents and other adults within their ethnic community would be the best resource for those looking for help with mental health issues. They thought that adults would have the most information about resources and would know what to do. Unfortunately, many adults within the PI community feel a lack of knowledge about mental health resources and how to help those within their community that need help with mental health problems (Cutrer-Párraga et al., 2024). Without further mental health education within the community, misinformation is more likely to be spread among PIs. This is problematic because the wide majority of mental health professionals belong to the ethnic majority (APA, 2020).

Participants discussed many helpful resources within their PI community. They felt very close with those within their community, and that those within their community would understand them best. This is a positive and a negative because while their community can help them, they can also feel uncomfortable accessing professional help. Also, when these types of issues are only brough up within the community, perceptions about mental health services can be passed down from generation to generation. In fact, when recruiting for this study, some of the families of adolescent males that we approached did not want to participate because they felt that it was not necessary to talk about mental health issues outside of the family. They felt that they could deal with any mental health issues within the family.

Religious leaders were the most frequently discussed helpful resource among the members of the group. This is interesting because the three participants had varying levels of religious engagement. Even those that did not attend religious events said that a religious leader would be helpful. Faith is an important part of the PI culture with one study finding that around 90% of PI individuals reporting that they actively participate in their faith (Herda et al., 2005). Because religion is central to many Pacific Islander cultures, religious leaders are often the first point of contact when individuals and families face mental health problems or traumatic events. This could mean that faith leaders could influence the perceptions of mental health within the community as even those that are not actively involved in religion recognize their leadership role.

Within the Pacific Islander community, there is a strong emphasis on giving and being selfless. Individuals get more respect based on the amount of money they give away rather than the amount of money that they have. The idea of utilizing money for your own personal mental health concerns can be considered selfish within the PI community because you are taking away

from the family in a financial way. The participants were very aware of the financial burden that accessing mental health resources can have on a family. Youth within the PI community would be more open to mental health services if they felt that attending to their mental health needs would be beneficial for their families as well.

Participants discussed the importance of cultural fit. They felt more comfortable talking to PI mental health professionals. This is problematic because the wide majority of mental health professionals belong to the ethnic majority (APA, 2020). Perhaps if there is less stigma surrounding mental health and greater awareness of the need for PI mental health professionals, more PIs would consider becoming trained mental health professionals. This would give more options for PIs hoping to work with an in-culture therapist.

The participants frequently discussed that males within the PI community are meant to be strong warriors. This warrior mentality is in line with previous research that says that PI adolescents view strength as being worthy of respect (Irwin & Umemoto, 2012). In fact, while recruiting participants, one researcher spoke to a mother of two male PI adolescents and one female PI adolescent. She explained that her daughter regularly attends therapy sessions, but her sons have refused to talk about mental health. PI male adolescents within the community will find significant amount of difficulty reaching out for mental health resources if they feel that it is not in line with their identity. The participants were in disagreement about whether they would prefer to work with a male or female professional This may be due to the different expectations for males and females within the PI community (Gender CC, 2014). Male adolescent PIs may find it difficult to find a therapist if they feel more comfortable discussing emotional topics with a female, but also feel that males would better understand the obligations placed on them.

Table 2

Findings That Support Existing Literature and New Findings

Review of literature	Findings of this study
Stigma and shame were the greatest barrier in accessing mental health services for the PI community (Wyatt et al., 2015).	Male adolescent PIs hold particularly punitive attitudes and perceptions of mental health services.
PIs often avoid disclosing problems or their participation in therapy if it may create emotional burdens for their family, bring shame to their family name, undermine family support, or create narratives that suggest they cannot fulfill family responsibilities or contradict certain gender roles (Allen, Kim et al., 2016).	Male adolescent PIs incorrectly believe that adults have a full knowledge of mental health resources.
PIs seem to share unique concerns regarding therapists' ability to practice within the context of their cultural heritage and socialize and engage with them in culturally appropriate ways (Sunderani & Moodley, 2020).	Stigma surrounding mental health within the PI community is not limited to the "older generation."
PI adolescents want to show themselves as powerful and deserving of respect (Irwin & Umemoto, 2012).	Male adolescent PIs feel most comfortable discussing mental health concerns with their religious leaders.

Limitations and Implications for Future Research

In contrast to quantitative research which relies on statistical power, qualitative research focuses on informational power (Malterud et al., 2016). Sample specificity (and homogeneity within IPA studies), quality of interview narratives, and analyses methods determine information power. Generally, information power increases when there is a better match between the research phenomenon and the participant's life. Three adolescent males with close association with the phenomena is sufficient for rigorous IPA studies. However, this study included male adolescent

PIs that were all highly involved in athletics. Though many male adolescent PIs are part of athletic teams, it is important to note that not all male adolescent PIs share that interest. All participants resided in an area with a low percentage of diversity, especially members of the PI community. It is possible that male adolescent PIs that live in an area with higher diversity and a higher percentage of PIs may have different views. This research did not include females so as to focus on the perceptions, attitudes, beliefs, and helpful resources of male adolescent PIs. Further research is needed to understand the experiences of PIs that are female, reside in diverse communities, and who are not on sports teams.

Implications for Community Leaders and Practitioners

Steps must be taken to reduce the stigma surrounding mental health within the PI community. Organizations within the PI community could help to destigmatize this topic by using campaigns to promote awareness of mental health concerns within the PI community. Due to the strong influence of religion within the PI community, religious leaders hold an important role. PI mental health professionals within the community can reach out to community leaders and religious leaders to help them understand the mental health issues within the PI community. Religions would benefit from training about how to talk about these topics with youth in their congregations. By reaching out to religious leaders to help relieve some of the stigma associated with seeking out mental health supports, religious leaders within the Pacific Islander community can be the pivotal bridging link for male adolescent PIs and mental health professionals.

Teachers and other adults working with PI youth can try to broach this difficult topic if they have a strong relationship with the youth. It may also be helpful for them to model talking about mental health in an appropriate way to make the youth feel more comfort discussing mental health. This may make them more likely to discuss their own concerns.

Practitioners working within the PI community need to emphasize the importance of a therapeutic relationship based on trust, support, and assurance of confidentiality. The participants were concerned that their information would be shared with others. Clinicians may benefit from discussing the extent of HIPAA laws and how it relates to confidentiality to help soothe the fears of clients from this community. Practitioners should also be aware that PIs appreciate using a family-centered approach (Cutrer-Párraga et al., 2024). Therapists will better understand their PI clients by taking a holistic view of the client's challenges and striving to build a genuine and warm relationship with them.

Conclusion

This study describes the attitudes, perceptions, barriers, and ideas for helps that three male adolescent Pacific Islanders held about accessing mental health resources. The findings of this study suggest that stigma is the largest barrier for male adolescent PIs in need of mental health services. Male adolescents within the PI community often view accessing mental health services as going against their cultural values. This is in part due to a warrior mentality that views mental health concerns as an unacceptable weakness (Irwin & Umemoto, 2012). Reaching out to religious leaders within the community may have the largest impact in reducing stigma surrounding this topic within the PI community. Clinicians who work with male adolescent PIs will allow for greater success by discussing confidentiality to ensure trust. Clinicians working with this population need to ensure a strong therapeutic relationship by learning about the PI culture and the stigma surrounding mental health. This will allow for deeper understanding of their clients and the barriers they may have had to overcome in order to attend psychotherapy.

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APPENDIX A

Institutional Review Board Approval Letter

Memorandum

To: Beth Cutrer
Department: BYU - EDUC - Counseling, Psychology, & Special Education
From: Sandee Aina, MPA, HRPP Associate Director
Wayne Larsen, MAcc, IRB Administrator
Bob Ridge, Ph.D., IRB Chair
Date: December 09, 2022
IRB#: IRB2022-174
Title: Barriers to Mental Health Well-Being for Male Pacific Islander Adolescents

Brigham Young University's IRB has approved the research study referenced in the subject heading as expedited level, categories 6 and 7. This study does not require an annual continuing review. Each year near the anniversary of the approval date, you will receive an email reminding you of your obligations as a researcher. The email will also request the status of the study. You will receive this email each year until you close the study.

The IRB may re-evaluate its continuing review decision for this decision depending on the type of change(s) proposed in an amendment (e.g., protocol change that increases subject risk), or as an outcome of the IRB's review of adverse events or problems.

The study is approved as of 12/09/2022. Please reference your assigned IRB identification number in any correspondence with the IRB.

Continued approval is conditional upon your compliance with the following requirements:

1. A copy of the approved informed consent statement and associated recruiting documents (if applicable) can be accessed in iRIS. No other consent statement should be used. Each research subject must be provided with a copy or a way to access the consent statement.
2. Any modifications to the approved protocol must be submitted, reviewed, and approved by the IRB before modifications are incorporated into the study.
3. All recruiting tools must be submitted and approved by the IRB prior to use.
4. All data, as well as the investigator's copies of the signed consent forms, must be retained for a period of at least three years following the termination of the study.
5. In addition, serious adverse events must be reported to the IRB immediately, with a written report by the PI within 24 hours of the PI's becoming aware of the event. Serious adverse events are (1) the death of a research participant; or (2) serious injury to a research participant.
6. All other non-serious unanticipated problems should be reported to the IRB within 2 weeks of the first awareness of the problem by the PI. Prompt reporting is important, as unanticipated problems often require some modification of study procedures, protocols, and/or informed consent processes. Such modifications require the review and approval of the IRB.

APPENDIX B

Recruitment Materials

Flyer

Email and Word of Mouth

"Barriers to Mental Health Services for Male Pacific Islander Adolescents"

Elizabeth Cutrer-Párraga (Principal Investigator)

IRB ID# IRB2022-174

My name is Melia Fonoimoana Garrett, and I am a student at Brigham Young University. I am conducting a research study about Pacific Islander male adolescents and their attitudes and perceptions about mental health services. I'm working with Dr. Elizabeth Cutrer-Párraga, who is a professor at Brigham Young University. We are working on a research project to understand the barriers that male Pacific Islanders feel in receiving mental health services.

We invite you to participate in this research project with us!! You have valuable insight about the feelings Pacific Islander male adolescents have toward mental health services.

We would like to hear your thoughts on these topics during one of the focus group sessions we will be holding in May and June. You will be asked a series of questions about your feelings toward mental health services. These focus groups will be recorded in person and recorded for data analyses. The attached flyer gives information about signing up to participate if you are interested in participating.

I want to reassure you immediately that you are not obligated to participate in this research project, though we hope you will. I also want to let you know that you will have the right to withdraw from the study at any time.

Participants will not be compensated for their time.

We hope to see you for a focus group. In the meantime, please go to the link on the flyer to sign up to participate. Please don't hesitate to reach out at melia.fonoimoana@gmail.com.

Qualtrics Survey Including Consent, Assent, and Parental Permission

Email

Name of Pacific Islander male adolescent (the focus group participant)

Name of parent of participant

Email of participant

Email of parent

Phone number of participant

Phone number of parent

In what city do you reside?

Participant identifies gender as

Female
Male
Transgender Female
Transgender Male
Non-binary/Non-conforming

Participant's ethnicity (check all that apply)

Fijian
Maori
Marshallese
Micronesian
Native Hawaiian
Niuean
Samoan
Tahitian
Tongan
Asian
Black/African
Caucasian
Hispanic/Latinx
Middle Eastern/North African
Native American or Alaskan Native

How would you like us to contact you regarding participation

Email
Phone call
Text message

Participant Age

Participant Date of Birth

Snacks will be given during the focus group, please list any allergies you have below.

Parental Permission for a Minor

"Barriers to Mental Health Services for Male Pacific Islander Adolescents"

Elizabeth Cutrer-Parraga (Principal Investigator)

IRB ID# IRB2022-174

This form is to be filled out by parents of male Pacific Islander adolescents. Parents, your child must sign an assent form to participate in this study. Please go over the assent form before having them sign.

Introduction

My name is Melia Fonoimoana Garrett, and I am a student at Brigham Young University. I am conducting a research study about Pacific Islander male adolescents and their attitudes and perceptions about mental health services. I am inviting your child to take part in the research because as a male Pacific Islander adolescent, his input will be very helpful in understanding the barriers that male Pacific Islanders feel in receiving mental health services.

Procedures

We are asking for your child's participation in a focus group. If you agree to have your child participate in this research study, the following will occur:

The focus group will meet for a total of 90 minutes. Your child will be asked various questions about mental health services, they will then have a break, then we will resume with the focus groups. They will receive a ten-minute break in the middle. The focus group will be audio-recorded for the purpose of data analysis only.

Risks/Discomforts

There are minimal risks associated with this study. Participants might feel some discomfort if they recall or share difficult experiences. This is dependent on what the participant's prior experiences, but if it does occur it should be brief. There's a possibility of information being disclosed if participants know each other outside the focus group or share information about what was discussed during the focus group. There is a possibility that some of the questions in the focus group may motivate them to provide personal information. Participants also face the risk of loss of data privacy as the recordings will be transcribed and uploaded. The risk of loss of confidentiality will be minimized by password protection, restricting data accessibility to the research team, and removing identifiers subsequent to data collection. The facilitator has been trained to provide a comfortable environment where opposing ideas are valued. Information regarding mental health resources will be provided after the focus groups. Focus group questions have been intentionally designed to understand what participants think about mental health services, not about the participant's mental health experiences. Before each focus group, participants will be informed of the need for confidentiality and privacy; so participants are aware to respect other participants' privacy. Participants may terminate their participation at any moment and will be given the option to opt out of any question. Participants will not be forced to answer questions or penalized for answering a certain way. We will provide mental health resources for students who need them. All information will be password protected, de-identified, and original audio files will be deleted. The risk of loss of confidentiality will be minimized by password protection, restricting data accessibility to the research team, and removing identifiers subsequent to data collection.

Data Sharing

We will keep the information we collect about your child during this research study for analysis and for potential use in future research projects. If the study data contain information that directly identifies your child: Their name and other information that can directly identify them will be stored securely and separately from the rest of the research information we collect from them. All data will be uploaded to the cloud on BYU's account of Box, a secure cloud storage company. Only members of the research team will have access to the folders holding data collected for this study.

De-identified data from this study may be shared with the research community, with journals in which study results are published, and with databases and data repositories used for research. We will remove or code any

personal information that could directly identify your child before the study data are shared. Despite these measures, we cannot guarantee anonymity of your child's personal data.
The results of this study could be shared in articles and presentations, but will not include any information that identifies your child unless you give permission for use of information that identifies them in articles and presentations.

Benefits

There will be no direct benefits to you or your child. However, a greater understanding of the mental health and well-being of male Pacific Islanders adolescents can be achieved, who are historically underrepresented in psychological research, despite being among the fastest growing populations in the US. What's equally beneficial, is that this research will help mental health professionals (e.g., psychologists, counselors, social workers) better assist Pacific Islanders struggling with psychological difficulties through improved mental health treatment options and appropriate culture-specific therapy models.

Compensation

There will be no compensation for your child

Questions about the Research

Please direct any further questions about the study to Melia Fonoimoana Garrett at melia.fonoimoana@gmail.com (801)-604-6167. You may also contact Elizabeth Cutrer-Parraga at elizabethcutrer@byu.edu.
Questions about your child's rights as a study participant or to submit comment or complaints about the study should be directed to the Human Research Protection Program, Brigham Young University, at (801) 422-1461 or send emails to BYU.HRPP@byu.edu.
You will be emailed a copy of this consent form to keep.

Participation

Participation in this research study is voluntary. You are free to decline to have your child participate in this research study. You may withdraw you child's participation at any point.

Statement of Consent

I have read and understood the above consent and desire of my own free will to have my child participate in this study. If you sign on this survey, this will be your consent to have your child participate in this study.

Assent Form

"Barriers to Mental Health Services for Male Pacific Islander Adolescents"
Elizabeth Cutrer-Parraga (Principal Investigator)
IRB ID# IRB2022-174
This form is to be filled out by male Pacific Islander adolescents under the age of 18. Your parents should explain this form to you before you sign.

What is this study about?

My name is Melia Fonoimoana Garrett, and I am a student at Brigham Young University. I would like to invite you to take part in a research study. Your parent(s)/guardian know we are talking with you about this study. This form will tell you about the study to help you decide whether you want to participate. In this study, we want to learn more about how Pacific Islander male adolescents feel about mental health services.

What am I being asked to do?

If you decide to be in the study, you will be asked various questions in a group with other Pacific Islander teenagers about mental health for approximately 90 minutes. Audio devices will be recording so we can study the questions and answers of group members.

How will being in this study affect me?

Taking part in this research study may not help you in any way, but it might help us learn how to help Pacific Islander teenagers struggling with mental health problems. We think there are a few risks to you by being in the study, and it is possible you might become worried or sad because of some of the questions we ask regarding mental health services. You don't have to answer any of the questions you don't want to answer. If you become upset, let us know and we can discontinue the focus group, or you can leave if you would prefer. At the end of the focus group, we will provide a list of resources to seek more help.

Who will see the information collected about me?

We won't tell anybody that you are in this study and everything you tell us will be kept private. Your parent may know that you took part in the study, but we won't tell them anything you said or did, either. When we tell other people or write articles about what we learned in the study, we won't include your name or that of anyone else who took part in the study.

The information collected about you during this study will be kept safely locked up. Nobody will know it except the people doing the research. The study information about you will not be given to your parents. The researchers will not tell your friends.

What if I have questions?

You can also take more time to think about being in the study and also talk some more with your parents about being in the study.

If you want to be in this study, please sign your name.

Standard Consent Form

This form is to be filled out by male Pacific Islander adolescents age 18 and older.

"Barriers to Mental Health Services for Male Pacific Islander Adolescents"

Elizabeth Cutrer-Parraga (Principal Investigator)

IRB ID# IRB2022-174

Introduction

My name is Melia Fonoimoana Garrett, and I am a student at Brigham Young University. I am conducting a research study about Pacific Islander male adolescents and their attitudes and perceptions about mental health services. I am inviting you to take part in the research because as a male Pacific Islander adolescent, your input will be very helpful in understanding the barriers that male Pacific Islanders feel in receiving mental health services.

Procedures

We are asking for your participation in a focus group. If you agree to participate in this research study, the following will occur:
You will be asked various questions about mental health services for a total of 90 minutes (with a break in the middle). The focus group will be audio-recorded for the purpose of data analysis only.

How will being in this study affect me?

Taking part in this research study may not help you in any way, but it might help us learn how to help Pacific Islander teenagers struggling with mental health problems. We think there are a few risks to you by being in the study, and it is possible you might become worried or sad because of some of the questions we ask regarding mental health services. You don't have to answer any of the questions you don't want to answer. If you become upset, let us know and we can discontinue the focus group, or you can leave if you would prefer. At the end of the focus group, we will provide a list of resources to seek more help.

Risks/Discomforts

There are minimal risks associated with this study. Participants might feel some discomfort if they recall or share difficult experiences. This is dependent on what the participant's prior experiences, but if it does occur it should be brief. There's a possibility of information being disclosed if participants know each other outside the focus group or share information about what was discussed during the focus group. There is a possibility that some of the questions in the focus group may motivate participants to provide personal information. Participants also face the risk of loss of data privacy as the recordings will be transcribed and uploaded. The risk of loss of confidentiality will be minimized by password protection, restricting data accessibility to the research team, and removing identifiers subsequent to data collection. The facilitator has been trained to provide a comfortable environment where opposing ideas are valued. Information regarding mental health resources will be provided after the focus groups. Focus group questions have been intentionally designed to understand what participants think about mental health services, not about the participant's mental health experiences. Before each focus group, participants will be informed of the need for confidentiality and privacy; so participants are aware to respect other participants' privacy. Participants may terminate their participation at any moment and will be given the option to opt out of any question. Participants will not be forced to answer questions or penalized for answering a certain way. We will provide mental health resources for students who need them. All information will be password protected, de-identified, and original audio files will be deleted. The risk of loss of confidentiality will be minimized by password protection, restricting data accessibility to the research team, and removing identifiers subsequent to data collection.

Data Sharing
We will keep the information we collect about you during this research study for analysis and for potential use in future research projects. If the study data contain information that directly identifies you: Your name and other information that can directly identify you will be stored securely and separately from the rest of the research information we collect from you. All data will be uploaded to the cloud on BYU's account of Box, a secure cloud storage company. Only members of the research team will have access to the folders holding data collected for this study.
De-identified data from this study may be shared with the research community, with journals in which study results are published, and with databases and data repositories used for research. We will remove or code any personal information that could directly identify you before the study data are shared. Despite these measures, we cannot guarantee anonymity of your personal data.
The results of this study could be shared in articles and presentations, but will not include any information that identifies you unless you give permission for use of information that identifies you in articles and presentations.

Benefits

There will be no direct benefits to you. However, a greater understanding of the mental health and well-being of male Pacific Islanders adolescents can be achieved, who are historically underrepresented in psychological research, despite being among the fastest growing populations in the US. What's equally beneficial, is that this research will help mental health professionals (e.g., psychologists, counselors, social workers) better assist Pacific Islanders struggling with psychological difficulties through improved mental health treatment options and appropriate culture-specific therapy models.

Compensation
There will be no compensation for participation in this focus group.

Questions about the Research
Please direct any further questions about the study to Melia Fonoimoana Garrett at melia.fonoimoana@gmail.com (801)-604-6167. You may also contact Elizabeth Cutrer-Parraga at elizabethcutrer@byu.edu.
Questions about your rights as a study participant or to submit comment or complaints about the study should be

directed to the Human Research Protection Program, Brigham Young University, at (801) 422-1461 or send emails to BYU.HRPP@byu.edu.
You will be emailed a copy of this consent form to keep.

Participation
Participation in this research study is voluntary. You are free to decline to participate in this research study. You may withdraw at any point.

Statement of Consent

I have read and understood the above consent and desire of my own free will to participate in this study. If you sign on the survey, this will be your consent to participate in this study.

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APPENDIX C

Instruments

Interview Protocol

Distribute name tags for focus groups (first names only).

*Before the interview begins double and triple check recording devices. Have at least 2 zoom recording devices dedicated to capturing audio for each focus group (two separate computers or phones with zoom pulled up should be used to make sure no audio is lost.

Introductory comments:

"Welcome and thank you for being willing to participate."

***If focus group is being held at a public park, please state

I first want to ask if you feel comfortable and safe meeting here in this public place. We have chosen a spot in the park that is away from others, but I want to make sure that you are comfortable in this location. If someone comes closer to us, we can stop the conversation and proceed once they are outside of earshot. However, because this is a public space, we cannot guarantee complete privacy. If you have any concerns at this time, please share them.

*** If focus group is being held over zoom, make sure that participants know that they can use the notepads and pencils to take notes during the focus group. If on zoom, let the participants know that they can take notes during the focus group on a paper or they communicate on the chat function of zoom to help them remember what they would like to say if someone else is speaking or simply to write down their thoughts during the focus group.

Introduce yourself.

Introduction:

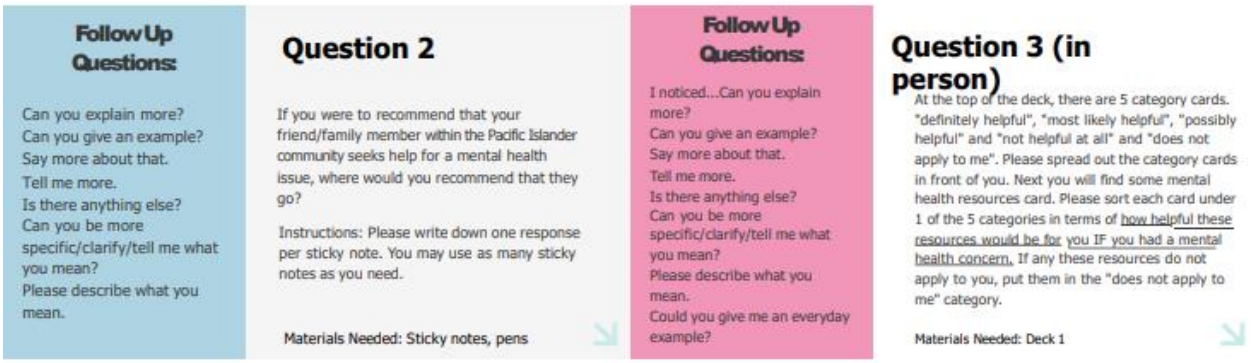
“Hey guys thanks for being here today! I’m looking forward to talking with you all. Today we are talking to you to find out about mental health services that exist for male Pacific Islander adolescents in the State of Utah. We would like to find out what works and what does not work, and how you feel these services could be more useful or improve (if at all). A little bit about how today will go. The focus group is meant to last 90 minutes. First, we will go over all what to expect for the focus group and leave room for questions. Then, we will talk for about 30 minutes. You will then have a break for 10 minutes. After the break we will visit for about 30 more minutes. If you need the bathroom at any point, feel free to get up and go. Before we get started, I’m going to go over some guidelines for the group discussion: a. Everything you say will be kept confidential. The research team will not share any information that will identify you. In order to help with the transcription process, before you share something, please say out loud your first name. That will help us later on as we transcribe this group discussion recording. b. In the same way, remember to keep personal stories “in the room”; do not share the identity of the other participants or what anybody else said outside of the meeting. We really encourage everyone in this room to keep what you hear confidential. c. There are some limits to confidentiality, we don’t anticipate any of these topics to come up, we just have to let you know. First, if you report intent to cause serious harm to yourself. Second, if you report intent to cause harm to another person. Third, if you report any abuse (including child abuse, abuse of the elderly, or abuse of the disabled), we must make a report to a governing body. d. If you feel uncomfortable during our discussion, you have the right to leave or to pass on any question. e. What questions do you have?”

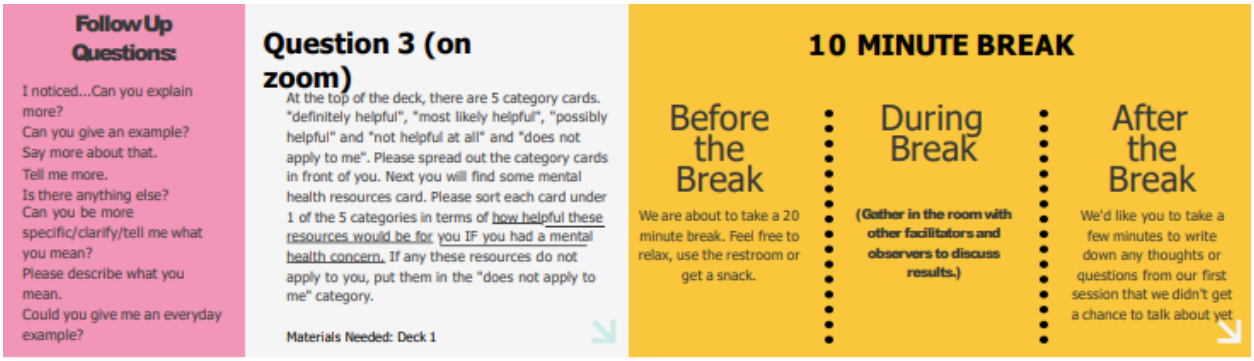
Distribute sticky notes/notebooks, pens and water

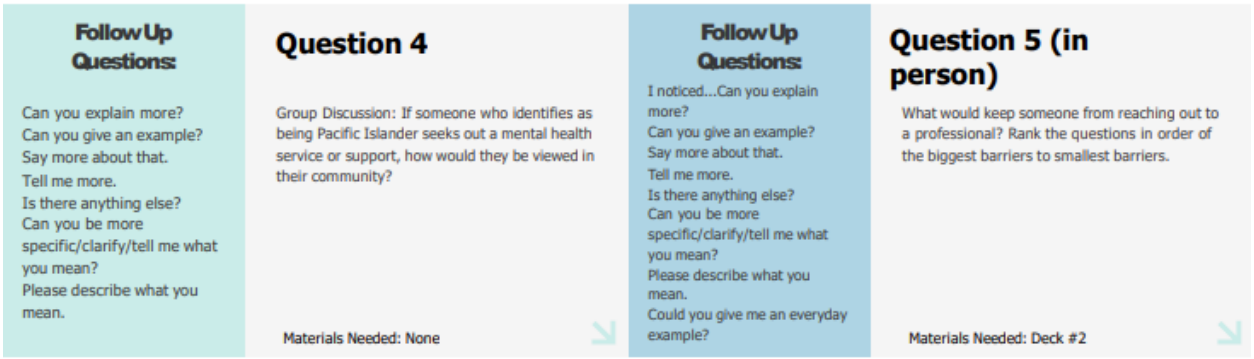
“You’re welcome to use the notebook or stick notes to take notes or record your thoughts if you’d like to. It will also be yours to keep at the end.”

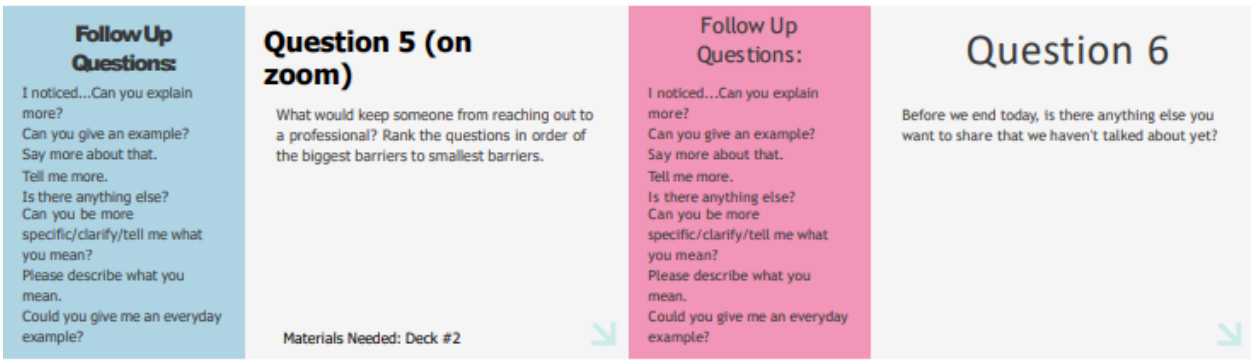
“Before we begin, does anybody have any questions?”

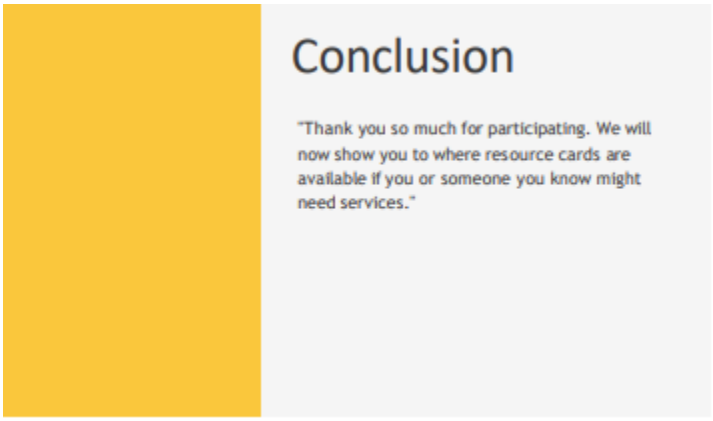
Focus Group Questions




Follow Up Questions:
I noticed...Can you explain more?
Can you give an example?
Say more about that.
Tell me more.
Is there anything else?
Can you be more specific/clarify/tell me what you mean?
Please describe what you mean.
Could you give me an everyday example?
Question 3 (on zoom)
At the top of the deck, there are 5 category cards. "definitely helpful", "most likely helpful", "possibly helpful" and "not helpful at all" and "does not apply to me". Please spread out the category cards in front of you. Next you will find some mental health resources card. Please sort each card under 1 of the 5 categories in terms of how helpful these resources would be for you IF you had a mental health concern. If any these resources do not apply to you, put them in the "does not apply to me" category.
Materials Needed: Deck 1
10 MINUTE BREAK
Before the Break
We are about to take a 20 minute break. Feel free to relax, use the restroom or get a snack.
During Break
(Gather in the room with other facilitators and observers to discuss results.)
After the Break
We'd like you to take a few minutes to write down any thoughts or questions from our first session that we didn't get a chance to talk about yet


Follow Up Questions:
Can you explain more?
Can you give an example?
Say more about that.
Tell me more.
Is there anything else?
Can you be more specific/clarify/tell me what you mean?
Please describe what you mean.
Question 4
Group Discussion: If someone who identifies as being Pacific Islander seeks out a mental health service or support, how would they be viewed in their community?
Materials Needed: None
Follow Up Questions:
I noticed...Can you explain more?
Can you give an example?
Say more about that.
Tell me more.
Is there anything else?
Can you be more specific/clarify/tell me what you mean?
Please describe what you mean.
Could you give me an everyday example?
Question 5 (in person)
What would keep someone from reaching out to a professional? Rank the questions in order of the biggest barriers to smallest barriers.
Materials Needed: Deck #2


Follow Up Questions:
I noticed...Can you explain more?
Can you give an example?
Say more about that.
Tell me more.
Is there anything else?
Can you be more specific/clarify/tell me what you mean?
Please describe what you mean.
Could you give me an everyday example?
Question 5 (on zoom)
What would keep someone from reaching out to a professional? Rank the questions in order of the biggest barriers to smallest barriers.
Materials Needed: Deck #2
Follow Up Questions:
I noticed...Can you explain more?
Can you give an example?
Say more about that.
Tell me more.
Is there anything else?
Can you be more specific/clarify/tell me what you mean?
Please describe what you mean.
Could you give me an everyday example?
Question 6
Before we end today, is there anything else you want to share that we haven't talked about yet?


Conclusion
"Thank you so much for participating. We will now show you to where resource cards are available if you or someone you know might need services."

Card Sort 1

Professional therapist/ counselor	Immediate family member
Relative	Co-worker/ colleague
Roommate/ housemate	Supervisor/ boss
Church member	Church official (bishop, pastor, minister etc.)
Doctor/ physician	Friend

Neighbor	Teacher/ instructor
School counselor	Tribal elder
Spiritual healer	Acquaintance
Coach	Someone who doesn't know me/ anonymous
Mentor/ advisor	Role model

Card Sort 2

Unneccesary/ Not-needed

I don't know think I need treatment.
I don't think my concerns are severe enough to require treatment.
I think I can handle my mental health concerns without treatment.
I would prefer to address my mental health concerns with a family member, friend, religious leader.
I would prefer to address mental health concerns through my own cultural/spiritual practice.

Cultural Fit

I don't think a mental health professional would understand my culture or beliefs.
There are no mental health resources available in my preferred language.
There are no Pacific Islander counselors/therapists in my area.

Cost/Insurance

I can't afford the cost, it's too expensive.
I don't have health insurance.
My health insurance does not pay enough for or cover mental health treatment/counseling.

Trust

I don't think my information will be kept confidential.
I don't trust the medical system.
If I seek treatment, I might be committed to a psychiatric hospital or have to take medicine.
I don't believe mental health resources are effective.

Stigma/Perception

I would be embarrassed to get mental health treatment/counseling.
Getting mental health treatment would bring shame to my family.
Getting mental health treatment might cause my family/friends to have a negative opinion of me.
Getting mental health treatment might have a negative effect on my job.
I don't want others to find out that I need counseling or treatment.