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Psychotherapy utilization and presenting concerns among Polynesian American college students

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Psychotherapy Utilization and Presenting Concerns
among Polynesian American Students in a University Counseling Center

Abstract

This study examined psychotherapy utilization, presenting concerns, reported distress levels, and psychotherapy outcomes among Polynesian American students presenting for services at a counseling center at a large intermountain university on the mainland U.S. We collected data at intake, during therapy sessions, and at termination for 415 Polynesian American students over a 17-year period. Polynesian American students were equally likely to utilize counseling services as European American students but were more likely to drop out earlier. At intake these students shared higher numbers of presenting concerns and greater levels of self-reported emotional and psychological distress than did European American students. Implications for counseling center programs and services are discussed.

Keywords: Polynesian American college students, university counseling centers, college student psychological adjustment, psychotherapy utilization.

Psychotherapy Utilization and Presenting Concerns
among Polynesian American Students in a University Counseling Center

Many college students across the U.S. seek out and attend personal counseling for psychological and emotional assistance. These services are typically offered on campuses at university or college counseling centers. Due to the current demands in a changing and evolving college environment, heightened psychological concerns among students (Kitzrow, 2003) have made campus personal counseling essential. These student needs can include effective brief therapy, group counseling, culturally adapted counseling (Griner & Smith, 2006), outreach and consultation, and other important student mental health services across campus at all institutional levels (Archer & Cooper, 1998; Kitzrow, 2003).

College counseling utilization rates among racial/ethnic minority students have been reported to be lower than among European American college students. This underutilization has been stable over the years among racial/ethnic minority students on campuses and continues to be a concern with university and college counseling centers. Particularly disquieting is that Asian American students, followed by Latino and African American students, though more hesitant to seek help, have been diagnosed with higher distress levels at intake than European American students (Kearney, Draper, & Barón, 2005).

A Neglected Population

One of the underserved populations of racial/ethnic minority students that warrant specific attention by mental health centers in universities and colleges across the U.S. is Polynesian Americans. Virtually no research is documented on the psychological and health

concerns or the treatment of these students. In addition to being underrepresented in clinical services, Polynesian American students have been underrepresented in the literature on counseling and multicultural psychology. Over the years Latinos/as, Asian Americans, African Americans, and Native Americans have been the main racial/ethnic minority subjects for researching and developing psychological issues (Allen & Heppner, 2011). Although the Polynesian American population, including Polynesian American students, has been one of the fastest growing racial and ethnic groups in the U.S. (U.S. Census, 2010), little has been documented on their psychological well-being; more specifically for this study, little is known about the psychological needs of this racial/ethnic student population. Thus the mental health issues and treatment of Polynesian American college students, particularly those who reside in the U.S., need more focused research attention (e.g., Allen & Smith, 2015).

Need for distinct identity. Aside from a lack of psychological research pertaining to Polynesian Americans, this group is also very unique and different from other racial/ethnic populations. People living in the Polynesian islands (e.g., South Pacific, Polynesian Triangle; Allen & Heppner, 2013) share similar cultural and family customs, values, and traditions, and their languages have similarities as well. Despite having similar values and traditions, Polynesians choose to identify specifically with their island of origin, cultural heritage, and racial lineage in a very proud, honorable, and respectful manner, while also respecting Polynesians from other islands within the triangle. Certain distinctions must be made between Asian/Asian Americans and Polynesian Americans (e.g., other Pacific Islanders). Polynesian Americans and Asian Americans are two distinct groups racially and culturally, differentiated by geographical location, languages, customs, traditions, and phenotype characteristics.

Research that should include this group tends to be overshadowed and overlooked due to

the problematic lumping of the larger Asian American Pacific Islander category, thereby inhibiting specific knowledge and understanding related to Polynesian people and cultures. Although research has been conducted on Native Hawaiians, which are part of the Polynesian community (McCubbin, 2006; McCubbin & Dang, 2010; McCubbin, Ishikawa & McCubbin, 2007, 2008), there is still a dearth of empirical investigation related to other Polynesians (e.g., Samoans, Tongans, Fijians, Tahitians, Maoris) and their psychological adjustment/well-being in the mainland U.S., particularly around counseling utilization rates, counseling best practices, and culture-specific counseling interventions in their cultural contexts.

Because of a lack of research focused on adjustment and distress of Polynesians, until this current study little was known about some of the specific psychological concerns, issues, and emotional difficulties among Polynesian American college students. However, recent research has found that collectivistic coping strategies such as family support, religious/spiritual practices, and open family communication are effective methods to buffer against some emotional difficulties in some younger adult Polynesian Americans (Allen & Heppner, 2011). Also a strong racial/ethnic identity among Polynesian Americans can lead to positive mental health (Allen et al., 2013) during college. These positive buffering effects against psychological struggles could possibly remedy some of the concerns among Polynesian American college students across the U.S.

Research Questions

Although some studies have centered on coping and racial identity among Polynesian individuals in the U.S. (Allen & Smith, 2015; Allen et al., 2013), current literature focused on counseling utilization, presenting concerns, distress levels, and counseling service effectiveness

for U.S. Polynesian American college students has been sparse. To help fill this gap in the literature, this study addressed the following research questions:

1. What are the utilization and drop out rates of Polynesian American students in psychotherapy in a university counseling center?
2. What are the common presenting concerns that bring Polynesian American students to counseling centers? What are the differences between concerns of European American and Polynesian American students?
3. How effective is treatment-as-usual for this specific subset of Polynesian American students?
4. Do Polynesian American student-client reports regarding racial discrimination, physical abuse, and family dependence differ from those of European American students?

Methods

Participants

At a large intermountain area university on the mainland U.S., all 415 Polynesian American students who had completed an intake during the academic years 1996-2013 were included in this sample. Intake records were found for 165 men (39.8%) and 250 women (60.2%); their mean age was 22.2, 248 (59.8%) reported that they were single, while 149 (35.9%) reported that they were married and six (1.5%) reported that they were divorced. These individuals were from a variety of Polynesian racial backgrounds (Native Hawaiian, Tongan, Samoan, Fijian, and Maori). Those who had reported that their ethnicity was Hawaiian and/or Pacific Islander (PI) were considered to be of Polynesian descent, except those who reported being PI but also reported a country of birth or country of citizenship that would traditionally be considered Asian (e.g., China, Hong Kong, Indonesia, India, Japan, Malaysia, Mongolia,

Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Thailand, and Vietnam). Using this method, we narrowed the subject pool to those of Polynesian heritage, thereby avoiding the historical problematic issue of ethnic lumping regarding “Pacific Islanders” (Allen & Heppner, 2011).

Generally speaking, counseling centers across the U.S. have adequate methods of collecting data from their student clients. Although many counseling centers have well-intentioned methods of accurate and sound record-keeping, some issues seem to always arise. These record-keeping issues could be clerical and/or research assistant data entry errors, or clients dropping out of treatment prematurely leading to incomplete measures, or transitioning from paper records to electronic records. Although the counseling center where these data of Polynesian Americans were gathered strived to maintain the most accurate and complete records as humanly possible, the above issues unfortunately occurred. Specifically due to clerical and/or research assistant data entry errors and difficulties in transitioning from paper records to electronic records during the years of 1996 to 2008, some students were missing one or more of the questionnaires included in this study. We identified 346 (210 females and 136 males, $M_{age} = 22.2$) students for which we located the Family Concerns Survey (FCS) and Presenting Problem Checklist (PPC), but no Outcome Questionnaire (OQ). We identified 48 students for which we located the FCS, but no OQ or PPC, 27 students for which we located the OQ, but no FCS or PPC, 1 student for which we located the OQ and the FCS, but no PPC, 1 student for which we located the OQ and the PPC, but no FCS, and 2 students for which we located the PPC, but no OQ or FCS. Of the Polynesian students included in this study, complete records of all questionnaires were available for 236 (156 females and 80 males, $M_{age} = 22.6$) students. Due to the relatively small sample size of Polynesian student clients involved in this study and because

there were no conceptually compelling reasons to exclude participants with missing data, we included all data available for each analysis. Thus, the analyses for each questionnaire show different sample size numbers of clients.

Setting

Over the past 17 years, the university counseling center in this study has employed a range of 21-28 full-time, staff psychologists, 3-5 psychology interns, and 16-22 practicum doctoral students in any given year. Counseling sessions involve a wide variety of theoretical orientations (e.g., cognitive-behavioral, acceptance and commitment therapy). Students who requests counseling are assigned to the first available psychologist or doctoral student, and they receive treatment as usual according to that clinician's theoretical orientation. Additionally, students can be referred to one of over 20 psychotherapy groups of different types held each semester, as well as biofeedback services. Unless student clients request a specific type of theoretical orientation, they are assigned according to availability of staff psychologists, interns, and doctoral students with careful attention to severity levels at intake appropriate for the level of competence across clinicians.

Instruments

A variety of instruments were involved in this study: three that gathered intake data, and one that measured outcomes at the conclusion of counseling.

Demographic Questionnaire (DQ). This measure gathers demographic information (e.g., citizenship, religious preference, year in school, and major), as well as previous counseling experience.

Family Concern Survey (FCS). This self-report measure was designed to assess whether students experienced particular problems (e.g., frequent hostile arguing among family

members; a family member diagnosed with a mental disorder) in their family of origin. It includes 18 items to be ranked on a 0-2 scale (0=*no*, 1=*unsure*, 2=*yes*). Table 1 presents the specific items from this measure.

The Presenting Problem Checklist (PPC). This 42-item self-report measure was designed to assess the degree to which students experience distress in several major areas of life functioning; Table 2 presents the specific items. Developed by the Counseling and Mental Health Center at the University of Texas at Austin (Draper, Jennings, & Baron, 2003) this checklist is used by many counseling centers across the country to comprehensively assess students' presenting concerns and difficulties.

The instrument measures five areas: academic stress, college life adjustment, value questions, emotional distress, and body image (Draper et al., 2003). Individual items assess perfectionism, depression, sexual orientation concerns, and self-esteem—among others. The total scale shows a Cronbach alpha of .90, with individual reliabilities ranging from .67 to .84 (Draper et al., 2003). The Cronbach's alpha for this study was .94.

The Outcome Questionnaire-45. This commonly used measure of therapy outcome with college students has been shown to be sensitive to change (Lambert & Finch, 1999). It is a 45-item, self-report measure designed to provide a global assessment of client distress (Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994). Items are rated on a 5-point scale from *never* to *almost always*. For example, Item 2 reads, "I tire quickly," to which students respond with a 0 (*never*), 1 (*rarely*), 2 (*sometimes*), 3 (*frequently*) or 4 (*almost always*). Higher scores indicate greater levels of distress. Typically a score of 63 or lower falls in the subclinical range, whereas scores above 63 represent a clinical population (Kadera, Lambert, & Andrews, 1996). The standard deviation for this measure is 15 points, and 14-point increases or decreases indicate

reliable change. Prior research indicates that the OQ-45 has excellent internal reliability alpha at .93, test-retest reliability at .84, and concurrent validity with other instruments ($r = .58$ to $.84$; Kadera et al., 1996). The Cronbach's alpha for the data in this study was .92

Results

Utilization of Services

During the years 1996 to 2013, roughly 32,496 students on average per year attended this university. In addition, during this same period approximately 7,005 identified as Hawaiian and/or Pacific Islander students at this university, and roughly 292 (.009%) Hawaiian and/or Pacific Islander students were enrolled per year at this university from 1996 to 2013. During this 17-year period, approximately 31,855 students completed intake questionnaires, and 415 (.01%) of these students who completed questionnaires at the counseling center self-identified as Hawaiian and/or Pacific Islander. Between the years 1996 to 2013, of the 31,855 students who completed questionnaires for services at the counseling center, approximately 23,138 (.7%) were European American students. Exact annual student enrollment data and the number of those students seeking services at the counseling center each year from 1996 to 2013 were used to calculate odds ratios of the discrepancies in counseling center utilization between Polynesian and European Americans. The annual data were then aggregated by averaging the natural log of the odds ratios, weighted by standard error, and subsequently converting the value back to the metric of odds ratio for ease of interpretation (an odds ratio of 1.50 would be considered small, and an odds ratio of 1.0 indicates no difference whatsoever). The resulting aggregate odds ratio of 1.02 indicated essentially no difference in utilization rates across race: Polynesian and European American students were almost equally likely to complete an intake at the counseling center, relative to their proportions on campus.

In a subsequent analyses, we examined the number of sessions of counseling completed by Polynesian Americans. A significantly higher proportion of Polynesian American students did not return after intake (13.6%, $n = 36$, crosstabulation z-test, $p < 0.05$), compared to European American students (9.3%, $n = 1794$). To examine trends over time using survival statistics to evaluate differences across race, we conducted two Cox regression models of the data for (1) total number of sessions completed and (2) total duration of treatment in days, controlling for OQ-45 intake score and client gender and age. Both of these models reached statistical significance (for number of sessions, chi square $(df = 3) = 257.7$, $p < .0001$; for treatment duration, chi square $(df = 3) = 153.9$, $p < .0001$), with Polynesian Americans attending fewer overall sessions and remaining in treatment for shorter duration than European Americans.

Family and Student Presenting Problems and Distress

Given the 3-anchor points (i.e., No – Never Happened, Unsure, Yes – This Happened) on the Family Concerns Survey (FCS; see Table 1), the authors conducted chi-square analyses for nominal data to examine significant differences between Polynesian and European Americans. Regarding the Presenting Problems Checklist (PPC; see Table 2), which is a 5-point Likert scale, the authors performed Kruskal-Wallis tests for ordinal data to examine differences between Polynesian and European American students related their presenting problems and distress.

Family Concerns Survey (FCS). On the FCS, significant differences between Polynesian Americans and European Americans were found on 10 of the 18 items, with Polynesian Americans reporting higher rates of family concerns on 8 of those 10 items (see Table ~). Considering the central position of the family unit in Polynesian American culture, little wonder that concerns related to instability in the family or risks to family members would be disturbing enough to cause hesitant college students to seek help through counseling. The

following were of greater concern to Polynesian American students than to European American counterparts: parents divorced or permanently separated before the student reached the age of 18 ($p = .001$), parents unemployed for an extended period of time ($p < .001$), frequent and hostile arguing among family members ($p = .001$), parent(s) with a drinking problem ($p = .001$), parent(s) with a drug problem ($p = 0.004$), parent(s) with a gambling problem ($p = .03$), physical abuse in the family ($p < .001$), and family member prosecuted for criminal activity ($p = .04$). European Americans statistically showed higher rates on 2 of the 10 significantly different items: family member hospitalized for emotional problems ($p < .001$) and family member diagnosed with a mental disorder ($p < .001$).

Presenting Problems Checklist (PPC). There are two dimensions of the PPC that measured presenting problems among students: distress and duration of distress. Regarding distress first, of the 42 questions on the PPC indicating the distress that brought the students to the counseling center, Polynesian and European American students differed significantly on 11 (see Table 2). Out of that 11, Polynesian American students reported higher distress rates on 10 of the 11. The following results show those rates for Polynesian American students: academic or school work or grades ($\chi^2 = 8.0, p = .05$), adjustment to the university ($\chi^2 = 11.2, p = .001$), alcohol and drugs ($\chi^2 = 13.6, p = .000$), concentration ($\chi^2 = 5.9, p = .02$), ethnic/racial discrimination ($\chi^2 = 231.6, p = 2.61E-52$), homesickness ($\chi^2 = 5.3, p = .02$), irritability, anger, or hostility ($\chi^2 = 10.1, p = .001$), reading or study skills problems ($\chi^2 = 9.0, p = .003$), test, speech, or performance anxiety ($\chi^2 = 5.0, p = .03$), and time management ($\chi^2 = 8.9, p = .003$). European Americans statistically showed higher rates of distress on 1 of the 42 items: making friends ($\chi^2 = 6.5, p = .01$).

Regarding the duration of presenting problems, Polynesian and European American students statistically differed on 9 of the 42 and 6 of the 11 distress indicators mentioned above (see Table 2). The following are those 9 related to duration of presenting problems on which Polynesian Americans reported higher: adjustment to the university ($\chi^2 = 7.0, p = .008$), alcohol and drugs ($\chi^2 = 13.4, p = .000$), ethnic/racial discrimination ($\chi^2 = 222.4, p = 2.74E-50$), homesickness ($\chi^2 = 4.0, p = .004$), rape, sexual assault, or unwanted sex ($\chi^2 = 3.8, p = .05$), reading or study skills problems ($\chi^2 = 6.5, p = .01$), relationship with family, parents, or siblings ($\chi^2 = 6.9, p = .01$), and test, speech, or performance anxiety ($\chi^2 = 9.3, p = .002$). European Americans statistically showed higher rates of duration on 1 of the 9 significantly different items: making friends ($\chi^2 = 3.8, p = .05$).

Although the options on this checklist are basically oriented toward the university experience rather than the family, Polynesian American students demonstrated significantly greater distress and duration of presenting problems on almost as many family items as academic items. Many of the academic difficulties may have been related to inadequate preparation for the academic challenges of college, difficulty in adapting to mainland college life, homesickness and worry concerning family members, or combinations of these factors.

The presenting concerns of Polynesian American students are problems needing attention; thus, it is vital that college counseling centers reach out to Polynesian American students across the U.S. who may be struggling with these same issues. The one item on distress and duration of presenting problem that European Americans endorsed more frequently than Polynesian Americans was related to making friends. Perhaps Polynesian American students felt closer and more involved and thus more stressed about family members than friends because of

the family solidarity characteristic of Polynesian cultures. Or perhaps in a collectivistic culture, friends were an assumption not a challenge.

Psychotherapy Outcome

ANCOVA analyses examining intake OQ-45 scores (controlling for first OQ scores) indicated no differences between Polynesian and European American students based on last OQ scores ($F = .69, p = .41$). In addition, a t-test for independent means was conducted to examine differences of change of OQ scores over the course treatment. Results suggested no difference in change ($F = 1.32, p = .25$). Additional ANCOVA analyses controlling for pre-tests and t-tests for independent means were conducted on subscales of the OQ-45: Symptom Distress (SD), Interpersonal Relationships (IR), and Social Role (SR). Results showed no differences between Polynesian and European American students based on last scores of Symptom Distress ($F = .68, p = .40$), Interpersonal Relationships ($F = .41, p = .52$), and Social Role ($F = .01, p = .92$), as well as differences of change of SD ($F = .51, p = .48$), IR ($F = .23, p = .63$), and SR ($F = 1.9, p = .17$) scores over the course treatment.

Discussion

Multicultural psychology lacks research among Polynesian Americans related to overall mental health and well-being, and specifically empirical investigations around psychological difficulties and counseling among the student population (Allen & Heppner, 2011). This study of Polynesian American college students presents new and important findings about presenting personal and family concerns, as well as college counseling utilization among Polynesian American college students.

Differences in Distress and Duration of Presenting Problems Between Polynesian and European Americans

The second and fourth research questions dealt with presenting problems and family concerns of Polynesian American students as contrasted with those European Americans. Question 2 asked, “What are the common presenting concerns that bring Polynesian American students to counseling centers? What are the differences between concerns of European American and Polynesian American students?” Question 4 was more specific: “Do Polynesian American student-client reports regarding racial discrimination, physical abuse, and family dependence differ from those of European American students?”

On both of the instruments measuring stress factors and concerns, all but three of the items with statistically significant differences showed more intense concern and stress among the Polynesian American students. For convenience in discussion, items with significant differences were grouped as family concerns, academic struggles, and emotional challenges.

Family concerns. The family concerns indicated by the students related to divorce and unemployment showed higher levels among Polynesian American students and their families, particularly from this sample. Or the prevalence of such concerns over issues of family instability may lead to more stress for Polynesian American students than for European Americans due to the centrality of the family in their culture. Polynesian American students also indicated more concern with factors such as parents’ difficulties with alcohol, drugs, gambling, and criminal activity—matters perhaps frequently associated and interactive with the instability issues. Furthermore, these family difficulties may be correlated factors in the reported concerns about aspects of the family environment, such as frequent hostile arguments and even physical abuse. The Polynesian American students indicated on their intake form that they worried about their relationships with family members. Again the overrepresentation of these issues among the Polynesian American students may be due to the collectivistic nature and desire for harmony in

the family, as well as an increased sensitivity and concern for the welfare of their families.

Regardless of whether one or both of these possible factors may be involved, these worries and challenges can add to the overall distress and distractibility of the student.

Relative to their family members being either diagnosed with a mental disorder or hospitalized due to it, European Americans endorsed higher rates in these areas. Perhaps a lack of psychoeducation or knowledge about mental health leading to underreporting could be the reason for Polynesian Americans indicating lower scores. Also, stigma around mental illness and emotional problems could also be associated with Polynesian Americans not reporting certain psychological struggles, which may be a type of taboo within the Polynesian culture. The resulting mental state may become sufficient or at least contributing sources to students' academic difficulties.

Academic struggles. Polynesian American students in this sample seeking help at college counseling centers struggle academically. They may worry about their academic work and grades, and may struggle with decisions about their major and the career for which it will be preparing them. On the questionnaires students mentioned difficulties in specific academic areas: reading and study skills as well as anxiety over the tests, speeches, or performances with which they need to demonstrate their learning. These anxieties may be exacerbated by the family worries and stress, as well as by struggles they indicated on the forms including concentrating and managing their time. As mentioned earlier, some consider the difficulties in academic disciplines as perhaps indicating that these students may not be sufficiently prepared for high skill levels and rigorous study habits needed to excel in some college courses. Further assessment could examine potential language barriers, test/performance anxiety, and overall

adjustment to college life. The relationship of academic struggles to family and cultural values might also be explored.

Emotional challenges. Polynesian American college students had significantly higher rates of difficulty adjusting to college life than European American students. They indicated significantly higher rates of irritability, anger, and hostility. The total weight of family, academic, and emotional problems could be associated with sleeping problems and in more extreme cases to alcohol or drugs. Another significant concern reported on duration of the problem that also needs additional attention among Polynesian American college students involves rape, sexual assault, and unwanted sexual activities.

Particularly damaging among the emotional challenges faced by Polynesian American college student is ethnic/racial discrimination. Supposedly causal but offensive racial comments or slights, known as racial microaggressions (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007), although they may seem on the surface to be without malice, can lead to students of color, including those of Polynesian descent, feeling downgraded, unimportant, and even inadequate or incompetent for college, particularly if the campus is predominantly European American. Studies have examined negative effects of racial discrimination among Polynesian Americans (Allen & Heppner, 2011; Allen & Smith, 2014). These damages warrant attention.

The increased distress levels among this sample of college students of color that affect their overall performance at school, their potential to use drugs, or alcohol to self-medicate are alarming. Ethnic/racial discrimination and the fact or possibility of rape, sexual assault, and/or unwanted sexual activities might be particularly influential on self-concept, self-esteem, and self-efficacy. College counseling centers must reach out with appropriate treatment to Polynesian

American students before these distress and duration of presenting and family concerns increase in frequency and ultimately negatively impacts these students' academic experiences.

Cultural Factors in Utilization/Dropout Rates and Treatment Effectiveness

The first of the research questions that guided this study expressed the anticipated finding that motivated it: "What are the utilization and drop out rates of Polynesian American students in psychotherapy?" If utilization rates turned out to be low and drop-out rates were high, many other questions and areas of research would open up. The third research question was a natural development of the answers to the first: "How effective is treatment-as-usual for this specific subset of Polynesian American students?" A logical fifth question, not specifically asked in this study but also treated, would concern things that might be done to make that treatment more effective.

Utilization of professional mental health counseling. Although there were no statistical differences between Polynesian and European American students' counseling utilization rates; however, Polynesian American students may be more hesitant than European Americans to seek help at college counseling centers and less likely to return after intake (13.6% non-returns vs. 9.3%). This cultural group is less likely to consider professional counseling services as a first-line defense when they experience psychological difficulties. Their cultural context may guide them to turn first to their family for guidance and support (Allen & Heppner, 2011; Allen & Smith, in press). Seeking and attending counseling from a qualified professional could be interpreted as personal weakness and bring disgrace and disrespect to their family.

For these students of color to overcome any cultural hesitation and present themselves for counseling sessions may involve reaching a point of emotional exhaustion (their threshold limit) to take the step for psychological relief. Such a conflict may explain why the intensity of their

problems when they finally do present at college counseling centers, and it appears to be elevated significantly more than that of students who are more likely to utilize psychotherapeutic services at an earlier period of distress. Similarly, a cultural stigma against counseling may be a reason so many change their minds and terminate therapy after their initial intake.

Once students had begun the actual treatment, no significant difference was found between the average number of sessions they attended. Despite the higher symptomatic distress levels at intake, no difference was found in outcome factors. The only items on the intake surveys on which European American students showed significantly more anxiety/distress than Polynesian American counterparts was being able to make friends and having a family member with a mental disorder. These findings might be attributable to the same cultural expectation. Because Polynesian individuals turn to family then friends rather than to professional mental health treatment (Allen & Heppner, 2011; Allen & Smith, 2014), they have less expectation of not having friends and more experience in dealing with problems non-professionally. Also since fewer family members seek professional help, fewer would have professional diagnoses.

Need for adapting outreach and services. The number and variety of presenting concerns and the significantly higher levels of distress and duration among this sample of Polynesian American students indicate a need for additional services at counseling centers across the nation, particularly at colleges where there may be a large population of Polynesian American students on campus. A specific way counseling centers could attend to these students of color is through improving their outreach and treatment practices. Initial steps towards reaching out to and serving this community might include the following:

- Learning more about the Polynesian Americans' cultural context and being culturally sensitive to these students (Allen & Heppner, 2011).

- Gaining knowledge of their specific cultural coping strategies (Allen & Smith, 2014; Allen & Heppner, 2011) and applying them in session.
- Understanding Polynesian Americans' strong cultural identity (Allen, Garriott, Reyes, & Hsieh, 2013).

Based on the fact of the low number of Polynesian American students attended psychotherapy sessions at a mainland U.S. college counseling center over the span of 17 years is concerning. This under-utilization may be associated with the culture not necessarily encouraging individuals to use professional counseling services or perhaps counseling centers are not meeting the needs of this ethnic minority group of students. Whatever the reasons, bridges need to be built, outreach efforts need to be more inclusive, and counseling centers across U.S. campuses need to be aware of this increasing population and their psychological struggles.

Study Limitations

A limitation to this study that should be mentioned is the age range of Polynesian American students. Because the age mean was in the early 20s, researchers cannot infer generalizability across all Polynesian American students of all ages. Factors in this age group such as life stage, development level, and context-appropriate family standards could have influenced or overinflated the results found in presenting concerns and distress levels that may not be found in older age groups. This study also had some incomplete measures from clients across samples due to clerical errors and the transition from paper records to electronic records. However, a study of this kind, with this amount of data, has never been done with students of Polynesian background, an underrepresented population. Furthermore, we deemed that the benefit of including as many students' data as possible was more important than analyzing a

smaller subset of subjects based on time or complete data. Thus, we believe that the impact of some of the few missing measures across samples was less important than the potential benefits gained by proceeding with as much data as possible about Polynesian American college students and their psychological well-being.

Implications for Practice

The results of this study highlight the need for therapists working with Polynesian American students, particularly at college counseling centers, to explicitly attend to the various presenting concerns of students seeking services and to learn how these concerns can be both understood and ameliorated through the students' cultural context. Therapists who are appropriately sensitive to cultural contexts when they engage in psychotherapy with Polynesian American students, who attend to collectivistic worldviews, and act in close coordination with their families and religious communities (Allen & Smith, 2014), may decrease the likelihood that these students will participate in campus counseling services and possibly increase the students' likelihood of dropping out of higher education (Allen & Smith, 2014; Cervantes & Parham, 2005; Yeh et al., 2006a). In contrast, counseling center therapists can explicitly attend to cultural considerations such as building on students' preferred methods for handling distress and maintaining psychological well-being (Bernal et al., 2009).

Conclusion

This study of Polynesian American college students' presenting concerns and distress levels at intake was conducted not merely to expand our understanding of this understudied and underserved population, but also to facilitate improved outreach procedures and appropriate cultural adaptations to mental health services (Benish et al., 2011; Smith et al., 2011). Currently the field of psychology, particularly counseling psychology, understands very little about the

experiences of Polynesian American college students. And although mental health practices are being effectively adapted to better meet the needs of many other ethnic minority groups at counseling centers across the U.S., it is past time for the benefits of multicultural and cross-cultural research to be extended to this population (Allen & Smith, 2014).

Although a few studies have investigated the well-being, identity, trauma and resilience of Native Hawaiians in recent years (McCubbin, 2006; McCubbin & Dang, 2010; McCubbin, Ishikawa & McCubbin, 2007), additional research on other Polynesian American student groups (Tongan, Samoan, Fijian, Maori) in the U.S. is strongly encouraged (Allen & Heppner, 2011; Allen et al., 2013; Allen & Smith, 2014) to add to our knowledge of the cultural contexts, family and personal concerns, academic struggles, racial issues, and psychological well-being of these cultural groups while they are pursuing higher education on U.S. college campuses.

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Table 1

Pearson Chi-Square Test for Differences for Family Concern Survey (FCS): Polynesian American Students (n = 227) and European American Students (n = 18117)

Item	Value	df	p	Poly Count %			White Count %		
				No - Never Happened	Unsure	Yes - This Happened	No - Never Happened	Unsure	Yes - This Happened
1. Parents divorced or permanently separated before you were 18 years old.	14.4	2	.001	77%	1%	22%	86%	1%	13%
2. Family frequently moved.				71%	5%	24%	77%	3%	20%
3. Parent(s) unemployed for an extended period of time.	85.7	3	.000	73%	3%	24%	79%	4%	18%
4. Frequent, hostile arguing among family members.	16.3	2	.000	46%	8%	46%	59%	8%	34%
5. Death of parent(s) before you were 18 years old.				94%	1%	5%	97%	2%	3%
6. Parent(s) with a drinking problem.	13.1	2	.001	88%	3%	8%	94%	2%	4%
7. Parent(s) with a drug problem.	10.9	2	.004	93%	1%	6%	96%	1%	3%
8. Parent(s) with a gambling problem.	6.9	2	.032	96%	3%	1%	98%	1%	1%
9. Physical abuse in your family.	128.5	3	.000	73%	4%	23%	85%	5%	9%
10. Sexual abuse in your family.				87%	4%	8%	90%	3%	6%
11. Rape/sexual assault of yourself or family member.				85%	2%	13%	87%	3%	9%
12. Family member hospitalized for emotional problems.	42.4	3	.000	83%	7%	10%	82%	5%	13%
13. Family member diagnosed with a mental disorder.	90.0	4	.000	74%	9%	16%	65%	9%	25%
14. Family member attempted suicide.				77%	7%	15%	81%	7%	11%
15. Family member committed suicide.				96%	1%	3%	96%	1%	3%
16. Family member with a debilitating illness, injury, or handicap.				76%	5%	18%	82%	3%	15%
17. Family member prosecuted for criminal activity.	15.6	4	.004	81%	5%	14%	89%	3%	8%
18. Family member with an eating problem.				74%	10%	15%	74%	10%	17%

42. Weight problems or body image
