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Collectivistic Coping Strategies for Distress among Polynesian Americans

Abstract

Previous research has shown that psychological services designed to assist clients in coping with stressful or traumatic events are more effective when aligned with clients' cultural values, practices, and worldviews. However, limited research is available regarding the preferred coping strategies of Polynesian Americans. In examining collectivistic coping styles and their association with previous distress among 94 Polynesian Americans, we found that participants were highly likely to use family support and religion/spirituality to buffer the initial and residual effects of distress, using private emotional outlets, such as psychotherapy, very infrequently. The use of private emotional outlets was associated with decreased impairment from distress, although family support was much more predictive of decreased impairment and positive psychological well-being. Mental health professionals can align their services with the cultural values of Polynesian Americans by accounting for collectivistic coping styles and family dynamics.

Keywords: coping, distress, Polynesian Americans

Collectivistic Coping Strategies for Distress among Polynesian Americans

Research of specific client populations, particularly historically oppressed cultures and ethnicities, can enhance the effectiveness of mental health services with clients otherwise overlooked by the profession (e.g., Heppner, 2006; Marsella & Yamada, 2000; Pedersen, Draguns, & Trimble, 2008). Population-specific research informs practitioners about particular mental health needs, conceptualizations, and resources across different populations (Bernal & Sáez-Santiago, 2006; Smith, Domenech Rodríguez, & Bernal, 2011). More research must be conducted and attention given to underrepresented groups in order to clarify presenting concerns and best practices to enable professionals to provide state-of-the-art services for specific groups.

Historically, the literature on multicultural psychology has focused primarily on Latinos/as, Asian Americans, African Americans, and Native American Indians—groups also represented in general psychology research (Case & Smith, 2000). Polynesian Americans have been conspicuously underrepresented in all aspects of psychological research. A few studies have examined Native Hawaiians and/or Pacific Islanders in general (McCubbin, 2006; McCubbin & Dang, 2010; McCubbin, Ishikawa & McCubbin, 2007), but very little empirical investigation has specifically focused on Polynesian Americans, particularly on their psychological well-being in the mainland U.S. (Allen, Garriott, Reyes & Hsieh, 2013; Allen & Heppner, 2011).

For decades Polynesian Americans have been lumped under the Asian American/Pacific Islander census category, although they represent a group that is distinct culturally, historically, linguistically, and religiously. Research focused on Polynesian Americans not only provides necessary descriptions of unique cultural characteristics, but also facilitates understanding of specific psychological processes in the Polynesian American cultural context (e.g., McCubbin,

2006). Such research is essential to informing culture-specific adaptations to psychotherapy

(Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Bernal & Sáez-Santiago, 2006), which

have been shown to improve client outcomes in treatment (Benish, Quintana, & Wampold, 2011;

Griner & Smith, 2006; Smith et al., 2011; Smith & Trimble, in press).

Collectivistic Coping

A value of Polynesian Americans that must be considered in psychotherapy is cultural

collectivism. Cultural collectivism, distinguished from the individualism characteristic of

Western societies, is an interdependent orientation empahsizing connectedness to others,

importance of social contexts, and significance and maintenance of relationships (Marcus &

Kitayama, 1991; Singelis, 1994; Yeh, Inman et al., 2006). An important dimension of

collectivistic coping is family support (Heppner et al., 2006; Yeh, Inman et al., 2006), which

involves families resolving the stresses of life together to ensure that all members are

psychologically stable and healthy. A second dimension of collectivism is holistic worldviews,

often explicitly including spirituality. Although insufficient research has investigated coping

with distress among Polynesian Americans (McCubbin et al., 2007), these two aspects of

collectivism have been commonly identified in research with other non-Western populations. A

qualitative research study of Asian American family members who experienced the loss of loved

ones in the 9/11 tragedy (Yeh, Inman et al., 2006) found that the participants utilized spiritual

collectivistic coping, which included interpreting the tragedy through the lens of religious

teachings and increasing their religious or spiritual activity by praying, speaking with religious

leaders, and attending religious services. Similarly, a large quantitative study (Heppner et al.,

2006) found strong empirical evidence for both family support and religious/spiritual coping

among East Asians; in contrast, coping strategies not culturally congruent with a collectivistic

worldview, such as detachment, were associated with greater levels of distress. Psychotherapists

should attend to the coping methods used by their clients from collectivistic cultures.

Cultural Disconnections with Mental Health Services

Notwithstanding the need to attend to clients' cultural worldviews, psychotherapy

typically does not address or facilitate collectivistic coping methods (Hall, 2003; Tummala-

Narra, 2007), such as extensive family discussions or spiritual methods for healing and finding

meaning. Hence there is a disconnect between common forms of therapy, which tend to

emphasize individualistic methods of coping (Kirmayer, 2007; Smith & Draper, 2004), and the

collectivistic strategies preferred among many non-Western cultures (Hall, 2003), including

Polynesian Americans.

The problematic disconnect between individualistic mental health services and

collectivistic cultural preferences becomes easily apparent in cases involving distress or trauma

(Tummala-Narra, 2007). Individuals respond to distress or trauma with acquired, familiar

coping strategies (Aldwin, 2007). So if a client has acquired collectivistic coping strategies but

the therapist advocates individualistic methods, such as cognitive therapy, the client may not

successfully implement the cognitive therapy or may feel invalidated and thus remain

traumatized.

Moreover, individualistic approaches to treatment "are designed to help with single

trauma and ignore the cumulative trauma dynamics as well as the collective identity and culture-

specific traumas" (Kira, 2010, p. 137). Racial and ethnic minorities experience cumulative

collective distress, and they report relatively high levels of trauma (Perilla, Norris, & Lavizzo,

2002; Switzer et al., 1999; Weems et al., 2010). For example, ethnic minority youth exposed to

Hurricane Katrina had higher than expected PTSD symptom rates that did not significantly

decline over time (Weems et al., 2010). Similarly, among Florida residents exposed to Hurricane

Andrew, Latinos/as had the highest rate of PTSD (38%), followed by African Americans (23%),

with Whites having by far the lowest rate (15%) (Perilla, Norris & Lavizzo, 2002). In another

study, 94% of urban African Americans had experienced trauma, with 42% reporting having

PTSD during the previous year (Switzer et al., 1999). These researchers also found relative

dissatisfaction with mental health services among the African American clients with PTSD.

Thus, it is possible that cultural differences may not only result in increased risk of distress, but

also in decreased satisfaction with the treatment provided.

Research Questions

Although limited research has examined strategies for coping with distress among racial

ethnic minorities, virtually none has addressed these issues among Polynesian Americans.

Research specific to that population is clearly needed, particularly accounting for collectivistic

coping strategies. Therefore, this study was focused to answer the following questions:

1. Which collectivistic coping strategies do Polynesian Americans find most helpful
   when coping with a distressing event?

2. To what degree are collectivistic coping strategies associated with ameliorating life
   interference from a distressing event?

3. Which specific collectivistic coping strategies are most strongly associated with
   experiences of family life among Polynesian Americans?

4. Which specific collectivistic coping strategies are most strongly associated with
   psychological well-being among Polynesian Americans?

Method

Participants and Procedure

As part of a larger study (Allen & Heppner, 2011), 110 participants were recruited from a

suburban city with a high concentration of Polynesian Americans. Participants were asked to

complete a survey containing several measures of psychological well-being; data for the present

study consisted of the measures of collectivistic coping strategies, distressing event severity, and

family home environment that had not been analyzed or reported previously. Ten surveys were

excluded due to excessive missing values, and four surveys were removed because the

respondents indicated an ethnicity other than Polynesian American. Two surveys were removed

because they had extreme scores (three standard deviations above or below the mean), which

could compromise the validity of the study (Cohen, Cohen, West, & Aiken, 2003; Tabachnick &

Fidell, 2007). The final sample consisted of 94 adults (55 women, 37 men, and 2 who did not

report gender); the mean age was 31.5, with a range of 18 to 75 years. Of these participants 79%

were of Samoan heritage ($n = 75$), 17% reported being multiethnic Polynesian ($n = 16$), 3%

reported being Native Hawaiian ($n = 3$), and 1% was of Tongan descent ($n = 1$).

We had previously conducted a statistical power analysis for multiple regression in using

procedures outlined by Cohen (1988). Assuming an effect size of $d = .33$, the minimum number

of participants required for this study was 84 to achieve statistical power of .80. The obtained

sample exceeded that requirement.

Instruments

Collectivistic Coping Styles (CCS; Heppner et al., 2006). This instrument was

developed and validated in three studies among Taiwanese college students. This instrument

was chosen due to the prevalence of collectivistic coping in both Taiwanese and Polynesian

American individuals and communities. Five factors were confirmed through exploratory and

confirmatory factor analyses: (a) acceptance, reframing, and striving (ARS), (b) family support

(FS), (c) religion-spirituality (RS), (d) avoidance and detachment (AD), and (e) private

emotional outlets (PEO). The CCS is rated on a 6-point Likert-type scale: 0 (*never used this*

strategy), 1 (*used but of no help at all*), 2 (*a little help*), 3 (*a moderate amount of help*), 4 (*a*

great deal of help), 5 (*a tremendous amount of help*). The reliability coefficient (Chronbach's

alpha) for the total CCS and all five subscales for both the normed and current sample were as

follows: total CCS (.87; .80 in this study), acceptance, reframing, and striving (.85; .76 in this

study), family support (.86; .85 in this study), religion-spirituality (.90; .85 in this study),

avoidance and detachment (.77; .79 in this study), and private emotional outlets (.76; .72 in this

study).

Because the CCS is a situation-specific coping inventory, the participants were first asked

to select a stressful problem from the following list of distressing events that they might have

experienced in their lives: a major accident, violence at home, natural disaster (e.g., earthquake),

death or illness of a loved one, personal illness, academic pressure, relationship termination with

significant others (e.g., divorce, breakup of romantic relationship), social isolation and peer

group ostracism, poverty, unemployment or job loss (including self or family), racial or cultural

discrimination, and other (with a space for participants to describe the event).

Results showed the most common stressful event reported by participants was death or

illness of a loved, selected from the list by 27 (27%), followed by multiple stressful events

reported by 19 (20%). Of the remaining participants, 18 (19%) described an event in the self-

report category of "other" rather than selecting a stressful event provided from the list, 9 (11%)

reported the termination of a relationship with a significant other, and 6 (6%) reported

unemployment or job loss. All other stressful events reported were fairly equally distributed

across the listed items. Regarding the level of severity of the stressful event, 41 (44%) indicated

that the selected event(s) were *extremely stressful*, while 21 (22%) reported *moderately stressful*, 16 (17%) reported *mildly stressful*, 6 (6%) indicated *somewhat stressful*, and 10 (11%) reported *not stressful at all*. Regarding when the stressful event had occurred, the majority of the participants indicated in recent years. The largest number, 20 (22%), reported that their stressful event had happened *less than 3 months ago*, 14 (15%) reported *between 7 and 12 months*, 18 (19%) indicated *between 1 and 3 years*, and 13 (14%) marked *between 4 and 6 years.* When participants reported how often the stressful event had happened, 43 (46%) reported *once*, while 23 (24%) indicated *twice*, and 15 (16%) indicated *more than five times*.

Traumatic Interference Index (TII). The participants were also asked how much the stressor affected four domains of their lives (mood, school/work, interpersonal relationships, and thinking and judgment) at the time it first happened. The following scale was used to rate the degree of interference: 1 (*no interference at all*), 2 (*a little interference*), 3 (*a moderate amount of interference),* 4 (*a lot of interference*), 5 (*a major interference*). The Chronbach's alpha coefficient for this scale in this study was .85.

Positive Attitudes Toward Living at Home (PALH; Glezer, 1984). Because family cohesion is an important aspect of collectivistic coping, we assessed participants' perceptions of family life using the PALH. This instrument focuses mainly on evaluations of one's family of origin and the environment in which the individual was raised. A Likert-type scale is used:1 (*strongly disagree*) to 5 (*strongly agree*). Six items evaluate family climate: pleasantness living at home (PLH; whether participants felt like the home environment had been pleasant during their youth) and openness to discussing issues at home (ODH; whether participants had felt comfortable discussing problems or important matters openly with family members during their youth). Several items evaluating negative aspects of environment (discomfort, arguments, etc.)

were reverse scored, such that overall high scores represented positive views of family life. The

alpha coefficient reported by the developer of the PALH was .83, and for this study it was .70.

Psychological Well-being scale, Self-Acceptance and Purpose in Life subscales. Ryff

and Keyes (1995) developed and validated the Psychological Well-being Scale (PWS) to assess

the nature and meaning of people's well-being. Following the exploratory and confirmatory

analyses and an analysis of fit, the developers found six main dimensions of psychological well-

being, which became the subscales of the instrument: Self-Acceptance, Environmental Mastery,

Positive Relations, Purpose in Life, Personal Growth, and Autonomy. All were reported to have

had evidence of reliability and validity.

In the present study two PWS subscales were used to measure and assess psychological

well-being among Polynesian Americans: Self-Acceptance (SA) and Purpose in Life (PL). High

scorers on the SA dimension are described as persons who have a positive attitude toward self;

acknowledge and accept multiple aspects of self, including positive and negative qualities; and

feel positive about past life. Low scorers are described as persons who feel dissatisfied with self,

are disappointed with what has occurred in past life, are troubled about certain personal qualities,

and wish to be different than they are. The SA is a 14-item subscale with an internal consistency

coefficient of .91 in this study. It is rated on a six-point Likert-type scale: 1 (*strongly disagree*) to

6 (*strongly agree*). Sample SA items include "I like most aspects of my personality" and "For the

most part, I am proud of who I am and the life I lead."

The Purpose in Life (PL) subscale evaluates individuals' sense of directedness and

meaning in life. Low scores reflect a lack of meaning in life, limited future goals, and absence of

direction. The PL has 14 items, with an internal consistency coefficient of .88 in this study. It is

rated on the same six-point Likert-type scale as the SA. Some of the PL items are "I have a sense

of direction and purpose in life" and "Some people wander aimlessly through life, but I am not one of them."

Results

Preliminary analyses using descriptive statistics confirmed the normality of the data distributions and range of scores (see Table 1).

Prevalence of Helpful Coping Strategies

In addressing our research questions, we first sought to identify which of the coping methods had been most helpful for the participants when experiencing distressing events. Means on two of the CCS subscales, Family Support (FS; $M = 3.6$) and Religion-Spirituality (RS; $M = 4.0$) were statistically much higher than those reported in the initial development of the CCS (Heppner et al., 2006): FS, $M = 2.4$, $p < .001$; RS, $M = 2.2$, $p < .001$. Thus participants in this sample were much more likely to use and benefit from those two collectivistic coping strategies than the participants involved in the original CCS research. Strong family support and religious and spiritual coping were highly characteristic of this sample of Polynesian Americans.

Bivariate Associations of Coping Strategies with Distress

We next evaluated the relationship between collectivistic coping and the level of distress experienced at the time of the stressful event, as measured by the TII. Table 2 summarizes the bivariate correlations among study variables. Distress at the time of the event was apparently buffered to some degree by family support and also by avoidance and detachment. Specifically, family support was inversely correlated with all four of the TII subscales, work ($r = -.21$, $p < .01$), interpersonal relationships ($r = -.21$, $p < .01$), thinking and judgment ($r = -.33$, $p < .001$), and mood ($r = -.28$, $.001$). Similarly, avoidance and detachment were inversely correlated with three of the TII subscales: school and work ($r = -.24$, $p < .01$), thinking and judgment ($r = -.27$, p

< .001), and mood ($r = -.24$, $p < .01$). The other methods of coping were not consistently

associated with impairment experienced at the time of the distress.

Multivariate Associations of Coping Strategies with Distress

Notwithstanding the straightforward pattern of bivariate correlations, the association

between sets of variables is better explained by multivariate analyses, so we examined the

overall association between the constructs of collectivistic coping (CCS subscales) and

impairment due to distressing events (TII subscales) through canonical correlation (Brown,

Hendrix, Hedges, & Smith, 2011), the appropriate method when comparing sets of variables.

This analysis yielded four canonical variates for the two sets of measures because the smaller set

consisted of four measures (the four TII subscales). The overall multivariate test for

dimensionality reached statistical significance (Wilk's lambda = .68, $p < .001$), with the first

canonical function being the only one to reach statistical significance ($p < .05$). This step of the

analysis could be considered similar to the extraction of factors in an exploratory factor analysis

(Brown et al., 2011), with only one factor predominating. In other words, the relationship

between the collectivistic coping measures and the measures of distress could be explained

parsimoniously. The canonical correlation between collectivistic coping (CCS) and distress (TII)

was .45; the two constructs shared 20% of their variance.

The associated canonical loadings are presented in Table 3. These data can be interpreted

similar to factor loadings; they represent the degree to which each variable contributes to the

canonical function, with values above .30 indicating a meaningful contribution. All four

subscales of the TII loaded on the first canonical function. Specifically, distress in thinking and

judgment loaded the most highly (-.91), followed by mood (-.82), school and work (-.67),

interpersonal relationships (-.44). Thus the first canonical function was a latent variable that

represented general distress across all four aspects measured, although cognitive and emotional

distress (the first two variables) were more prominent than distress in life circumstances (the

second two variables), meaning that the reported distress (TII) that was relevant to collectivistic

coping (CSS) was more of an internal/personal nature than external/situational, as would be

expected of psychological reactions to stressful events.

As can be seen in Table 3, the two subscales of the CCS with the highest canonical

loadings were family support (.75) and avoidance and detachment (.73). Those two measures

contributed most to the latent variable representing collectivistic coping; however, personal

emotional outlets also loaded strongly (.58), with avoidance, reframing, and striving contributing

to some degree (.38), but with religion/spirituality contributing less (.23). Thus the multivariate

analysis indicated that several aspects of collectivistic coping helped to explain the association

with impairment from distress.

Collectivistic Coping Strategies and Family Life

We next examined the degree to which the collectivistic coping strategies were associated

with the family life of the Polynesian American participants. As would be expected, individuals

who benefitted from family support when coping with distress also reported discussing matters

with members of their family of origin ($r = .33, p < .01$) and having pleasant experiences while

living at home ($r = .31, p < .01$). However, it was noteworthy that coping using acceptance,

reframing, and striving and also using religion/spirituality were similarly positively associated

with discussing matters with family members and having pleasant experiences while living at

home, with correlations ranging from .21 to .33 (see Table 2).

These findings suggested that the type of coping strategies used and perceived to be

helpful do vary as a function of family dynamics. In fact, they were associated with family

dynamics to nearly the same degree that using family support was associated with family

dynamics. Nevertheless, when simultaneously entering all five types of collectivistic coping into

a regression model that explained 16% ($p < .01$) of the variance in family dynamics (combined

PLH and ODH, which were correlated at .49), the only one that remained statistically significant

at the univariate level was family support ($b = .26$; $p < .05$). Religious/spiritual coping and

acceptance, reframing, and striving were associated with family dynamics, but due to a high

degree of multicollinearity they were partialed out of the relationship after accounting for family

support.

Collectivistic Coping and Psychological Well-being

The collectivistic coping strategies used by this sample of Polynesian Americans were

significantly associated with their psychological well-being, as measured by self-acceptance

(SA) and purpose in life (PL).

1. Acceptance, reframing, and striving were positively correlated with both SA and PL (r

= .25 and .26, respectively; see Table 2).

2. Family support and religion/spirituality were positively associated with PL ($r = .24$).

3. Both avoidance/detachment and private emotional outlets were negatively associated

with both SA and PL (correlations ranged from -.20 to -.33; see Table 2).

Participants' coping styles were clearly associated with their core personal beliefs and

outlook on life. However, the key distinction is that acceptance, reframing, and striving, along

with family support and religion/spirituality, were more likely to be used by individuals with

stronger self-acceptance and purpose in life, whereas avoidance/disengagement and private

emotional outlets were more likely to be used by individuals with less self-acceptance and

purpose in life. Entering all five types of collectivistic coping in a regression model explained

34% ($p < .001$) of the variance in psychological well-being (combined PL and SA, which were

correlated at .70). The two coping methods that remained statistically significant at the

univariate level were acceptance, reframing, and striving ($b = .38$; $p = .001$) and private

emotional outlets ($b = -.43$; $p < .001$). The addition of family dynamics (PLH and ODH) to the

regression model did not increase the amount of explained variance, which remained at 34%.

Thus collectivistic coping strategies accounted for positive well-being independent of family

dynamics.

Discussion

Psychologists work with individuals in distress. Those individuals vary in their coping

methods and in their level of impairment from the distress; both types of variation may be due to

contextual factors such as cultural background. Different cultures emphasize different methods

for coping (e.g., Heppner et al., 2006). Psychologists should therefore be informed about

culture-relevant coping methods. The results of this study provide important information about

coping strategies among Polynesian Americans that can and should influence adaptation of

treatments to better align with client cultural worldviews (Benish et al., 2011; Smith et al., 2011;

Smith & Trimble, in press).

Family and Religious Support vs. Avoidance/Detachment and Private Outlets

Specifically, the data indicated that Polynesian American participants most frequently

reported that when confronted with stressful situations they benefit from religious and spiritual

coping (e.g., praying, meditating, fasting, actively participating in religious services, reading

religious texts) and from the support of their family members (e.g., openly discussing problems

with them). In fact, the mean perceived helpfulness ratings of religious/spiritual coping and

family support coping were much higher ($p < .001$) than the corresponding means reported in the

initial development of the CCS (Heppner at al. 2006).

The participants in this study reported that using private emotional outlets was the least

helpful coping method. Perhaps, participants were less likely to seek opportunities to share their

problems in private with others. When considered together, these findings could suggest that

Polynesian Americans are also unlikely to spontaneously seek professional mental health

services (Allen et al., 2013; Allen & Heppner, 2011) due to perhaps stigma and cultural

difference in seeking help, but would be much more likely to address their problems within their

family and their religious/spiritual community. Therapists who aim to enhance the cultural

compatibility of the services they provide should seek ways to reduce reported barriers to

receiving professional treatment (Smith & Trimble, in press). And therapists working with

Polynesian American clients can appropriately inquire about communal supports and integrate

those into treatment (Bernal & Sáez-Santiago, 2006). Such cultural adaptations should improve

client retention and outcome (Bernal et al., 2009; Smith & Trimble, in press).

An important finding is that collectivistic coping strategies were moderately associated

with decreased levels of reported impairment from distress. In particular, family support and

avoidance and detachment explained much of that association, with private emotional outlets

also contributing. This finding qualifies the previously reported finding of self-reported benefits

from using each coping strategy. Even though the Polynesian American clients reported (a)

somewhat infrequent benefits from avoidance and detachment and (b) very infrequent benefits

from private emotional outlets, these coping strategies were associated with decreased

impairment from distress.

Avoidance and detachment may have a negative stigma in contemporary society, making Polynesian Americans reluctant to rate this strategy as helpful even though it appears to have actually helped them. Alternatively, avoidance and detachment may have been strategies used in more serious distress, so that the apparent benefits were exaggerated in the correlational data since individuals with mild to moderate distress could be less likely to use avoidance and detachment. Future research is needed to sort out the plausible causal pathways. The same could be said about the use of private emotional outlets like psychotherapy. Those outlets appeared to be associated with decreased impairment from distress, even though participants infrequently rated them as being helpful. It is possible that the individuals who availed themselves of private emotional outlets were indeed benefitted, but because the majority did not use them, the overall rating for the strategy was low.

Overall, family support was perceived to be a very helpful coping strategy; it was associated with lower levels of impairment from distress and with a greater sense of purpose in life. As would be expected, Polynesian Americans who reported pleasant experiences living at home (e.g., fewer arguments, more relationship-building moments) were the most likely to report benefitting from family support during times of distress. They were also more likely to benefit from spiritual and religious coping methods. In contrast, individuals who reported less positive home environments were more likely to report using and benefiting from avoidance, detachment, and a tendency to be private about emotions. Thus the degree of family cohesion is associated with type of coping preferred. Therapists should therefore evaluate the degree of family cohesion before assuming that a particular Polynesian American client has strong family bonds just because Polynesian Americans typically do. Furthermore, the coping methods of family support and religious/spiritual strategies also increased the likelihood of greater well-being,

particularly for those experiencing self-acceptance and purpose in life. In particular, these

findings underscore the association between Polynesian Americans' coping strategies and family

life. In that regard, these results are similar to those found with other racial and ethnic minority

groups in the U.S. (Yeh, Inman et al., 2006; Yeh, Arora et al., 2006). Additional research is

needed with other Polynesian American samples to confirm these findings.

Limitations

Several limitations of this study deserve consideration. First of all, the cross-sectional

research design that was used cannot establish causality, so interpretations of the correlational

data remain tentative. Future research should seek to confirm the causal direction of the

associations observed. Second, study participants were predominantly of Samoan ancestry and

did not represent Polynesian Americans as a whole. Additional research is needed with other

Polynesian groups, including Native Hawaiians, Tongans, Fijians, and Maoris. Third, several of

the older participants in this study spoke English as a second language, so a few of the

participants asked a younger Samoan to explain some of the English words on the survey.

Future research would benefit from preparing copies of the inventories in the native languages of

the participants. Fourth, even though 94 participants were adequate for data analysis, a larger

sample would have helped to make the findings more robust. Nevertheless, to our knowledge

this is one of very few studies in the psychology literature to involve more than 90 Polynesian

Americans.

Implications for Practice

The results of this study highlight the necessity for therapists working with Polynesian

Americans to explicitly attend to collectivistic coping strategies (particularly family support and

religion/spirituality) and to account for probable associations with family dynamics,

psychological well-being, and distress. If therapists are not appropriately sensitive to clients'

cultural contexts when they engage in psychotherapy with Polynesian Americans who hold

collectivistic worldviews and who act in close coordination with their families and religious

communities, those therapists may decrease the likelihood that Polynesian clients will participate

in professional mental health services (Cervantes & Parham, 2005; Smith & Trimble, in press).

Results are more beneficial if therapists consider clients' preferred methods for handling distress

and maintaining psychological well-being as they attend to cultural considerations (Bernal et al.,

2009).

Although mental health practices are being effectively adapted to better meet the needs of

many ethnic minority groups, the benefits of multicultural and cross-cultural research need to be

extended to Native American Indians, Alaska Natives, Polynesian Americans, and other groups

unrepresented in the literature (e.g., Duran & Duran, 1995; Richards & Bergin, 2014). This

research on Polynesian Americans' experiences with collectivistic coping, distress, and

psychological well-being was conducted to facilitate appropriate cultural adaptations to mental

health services for this underserved population (Benish et al., 2011; Smith et al., 2011; Smith &

Trimble, in press).

Currently the field of psychology understands very little about the experiences of

Polynesian Americans. In recent years a few studies have investigated the well-being, identity,

trauma, and resilience of Native Hawaiians (McCubbin, 2006; McCubbin & Dang, 2010;

McCubbin, Ishikawa & McCubbin, 2007). However, additional research on other Polynesian

American groups (e.g., Tongan, Samoan, Fijian, Maori) living in the U.S. is strongly encouraged

to add to our knowledge of the cultural contexts, identities, acculturation, and psychological

well-being of these cultural groups.

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Table 1

Means and Standard Deviations of the CCS and PALH.

Measure	*M*	*SD*	Skewness	Kurtosis

CCS

ARS	3.30	.80	-.30	-.07
FS	3.60*	1.11	-.97	.85
RS	4.04*	1.16	-1.60	2.23
AD	2.32	1.21	-.06	-.58
PEO	1.70	1.31	.50	-.50
PALH	3.1	.39	1.60	5.90

Note. CCS = Collectivistic Coping Scale; ARS = Acceptance, Reframing, and Striving; FS = Family Support; RS = Religion/Spirituality; AD = Avoidance and Detachment; PEO = Private Emotional Outlets. For the CCS, the *M* and *SD* indicate the helpfulness ratings for the specific coping strategy which was calculated from only those who used the strategy. PALH = Positive Attitudes about Living at Home. The significant mean difference compared to normative samples was *p* < .001.

Table 2
Bivariate Correlations of Study Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. ARS	1												
2. FS	.46**	1											
3. RS	.28**	.53**	1										
4. AD	.36**	.15	-.08	1									
5. PEO	.29**	.31**	.06	.44**	1								
6. TII–Then: M	-.07	-.28**	-.13	-.24*	-.21*	1							
7. TII–Then: S/W	-.18	-.21*	.08	-.24*	-.17	.49**	1						
8. TII–Then: TJ	-.11	-.33**	-.14	-.27**	-.20	.64**	.44**	1					
9. TII–Then: IR	.06	-.21*	-.04	-.04	-.08	.48**	.51**	.49**	1				
10. SA	.25*	.16	.13	-.21*	-.30**	.07	.15	-.13	.13	1			
11. PL	.26*	.24*	.24*	-.20*	-.33**	.07	.16	-.05	.12	.70**	1		
12. PLH	.16	.31**	.27**	.08	.12	-.18	-.18	-.08	-.04	-.04	-.07	1	
13. ODH	.30**	.33**	.21*	.07	.07	-.14	-.09	-.16	-.09	.10	.08	.49**	1

Note. Correlations above represent participants' reported scores on ARS = Acceptance, Reframing, and Striving; FS = Family Support; RS = Religion/Spirituality; AD = Avoidance and Detachment; PEO = Private Emotional Outlets; TII Then = interference in general at the time the event happened; TII Now = interference in general at the present time (M = Mood, S/W = School and Work, TJ = Thinking and Judgment, R = Interpersonal Relationships); SA = Self-Acceptance; PL = Purpose in Life; PLH = Pleasant Living at Home; ODH; Openness to Discussing Important Matters at Home. *$p < .05$. **$p < .01$.

Table 3
Canonical Correlation Data for Measures of Collectivistic Coping and Impairment from Distress.

Variable	Canonical Loading
Impairment from Distress	
Mood	-.82
School & Work	-.67
Thinking & Judgment	-.91
Interpersonal Relationships	-.44
Collectivistic Coping	
Acceptance, Reframing, & Striving	.38
Family Support	.75
Religion/Spirituality	.23
Avoidance & Detachment	.73
Private Emotional Outlets	.54
Canonical Correlation	.45, $p = .03$