Religiosity, Coping, and Psychological Well-Being Among Latter-Day Saint Polynesian in the U.S.

Kawika Allen  
*Brigham Young University, gekawika_allen@byu.edu*

P. Paul Heppner  
*University of Missouri*

Follow this and additional works at: [https://scholarsarchive.byu.edu/facpub](https://scholarsarchive.byu.edu/facpub)

Part of the [Mental and Social Health Commons](https://scholarsarchive.byu.edu/facpub)

**Original Publication Citation**

**BYU ScholarsArchive Citation**
[https://scholarsarchive.byu.edu/facpub/3183](https://scholarsarchive.byu.edu/facpub/3183)
Religiosity, Coping, and Psychological Well-Being Among Latter-Day Saint Polynesians in the U.S.

G. E. Kawika Allen and P. Paul Heppner
University of Missouri

There is limited knowledge about coping and psychological adjustment in Latter-Day Saint (LDS) Polynesians. This study examined religiosity, collectivistic coping, and psychological well-being among 94 LDS Polynesians residing in the Midwest. As hypothesized, religiously committed LDS Polynesians were more likely to have a healthy psychological well-being and were also likely to use collectivistic coping styles, such that high helpfulness ratings on family support and religion-spirituality coping styles were significantly correlated with a positive psychological well-being. Family support also moderated the relationship between LDS Polynesians’ religious commitment and psychological well-being. Implications are discussed in terms of religiosity, culture, coping, and psychological well-being.

Keywords: religiosity, coping, psychological well-being and distress, Polynesians

As the American society becomes increasingly diverse, further attention to and research on multicultural groups across a variety of settings is needed. Numerous scholars (e.g., Heppner et al., 2006; Heppner, 2008; Marsella & Yamada, 2000; Pedersen, Draguns, Lonner, & Trimble, 2008) maintained that both multicultural and cross-cultural research can expand and greatly enhance the knowledge bases in psychology, particularly in the field of counseling psychology. Multicultural research will not only increase counseling effectiveness, but also enhance the ability of those in the helping field to address the mental health needs across different populations (Sue & Sue, 2008). It is essential that more research be conducted and attention given to underrepresented groups to clarify presenting concerns and best practices to enable professionals to provide state-of-the-art services with specific groups in mind.

Historically the multicultural psychology literature primarily focused on Latinos/as, Asian Americans, African Americans, and Native Americans. South Pacific Islanders, also known as Polynesians, have been substantially underrepresented in social and psychological research. Although studies have examined Native Hawaiians and Pacific Islanders in general (McCubbin, Ishikawa & McCubbin, 2007; McCubbin & Dang, 2010), there is still a lack of empirical investigation specifically related to Polynesians and their psychological well-being in the mainland U.S. (Allen, 2005). Historically for many years, Polynesians were clustered under the Asian American census category, but they represented a group that was very unique culturally, historically, linguistically, and religiously. Currently, the U.S. Census separates Asians and Pacific Islanders (U.S. Census, 2010). Research about Polynesians can aid not only in recognizing and describing group differences and similarities that stem from their unique culture and history, but also in facilitating a greater understanding of specific psychological processes within the Polynesian cultural context. Such research will not only better serve this population, but also may have implications for other populations and cultures.

Of particular interest in the current study is a specific group of Polynesians who belong to The Church of Jesus Christ of Latter-Day Saints (LDS), also known as Mormons. The LDS Church has had a significant influence in the South Pacific Islands, specifically through missionary service. Many Polynesians converted to the LDS Church due to specific doctrines and teachings of the church related to them as one of the Lord’s chosen; these teachings also share
some similarities to their cultural and family values as well as collectivistic principles. Some LDS Polynesians have since relocated to the mainland because of these strong religious beliefs. One of the main locations where LDS Polynesians have relocated is Independence, Missouri, which is considered a very sacred location in LDS Church history and doctrine. Historically, due to persecution and physical violence by mobs, many early LDS members journeyed from the east and settled in Jackson County, specifically in and around Independence. This region, at that time, was promised to be a place of refuge, beauty, and peace for the members. To this day, many believe it will still be a refuge from the world in the last days, and many LDS will prepare for a pilgrimage journey to this area (Barrett, 1973). Little is known, however, about how these Polynesians have adjusted psychologically to a different cultural context, or how their religious commitment impacts their coping strategies and psychological well-being.

Studies on religiosity, religious and collectivistic coping, and their impact on psychological well-being among racial/ethnic minorities have increased in recent years (e.g., Cervantes & Parham, 2005; Fukuyama & Sevig, 1999; Khalili, Murken, Reich, Shah, & Vahabzadeh, 2002; Sue & Sue, 2003; Yeh, Arora & Wu, 2006; Yeh, Inman, Kim, & Okubo, 2006). Studies have shown that racial/ethnic minorities tend to be religious, and when faced with psychological distress, are likely to exhibit religious coping strategies (i.e., attend church services/activities, read scriptures, regular prayer, and engage in effective thoughts like “God will provide and help”) (Ghorpade, Lackritz, & Singh, 2006).

Furthermore, the research indicates that religiosity impacts psychological well-being among some people of color (e.g., Cervantes & Parham, 2005; Fukuyama & Sevig, 1999; Ghorpade, Lackritz, & Singh, 2006; Khalili, Murken, Reich, Shah, & Vahabzadeh, 2002; Yeh et al., 2006). For instance, among African Americans, Korean Americans, Jewish Israeli students, and Latinos, studies found positive mental health benefits accrued from religious practices (Yoon, 2004). In short, the role of religiosity in racial/ethnic minority groups is quite salient and in many cases is closely associated with their healthy psychological state.

However, some studies that examined a wide range of populations have also found that being religious was associated with greater depression and suicidality, regardless of religiosity levels or the degree of comfort found in religion. Depression and suicidality were associated with feelings of alienation from God, fear, and guilt, particularly with the belief in having committed an unforgivable sin (Exline, Yali & Sanderson, 2000). Religiosity can also negatively impact educational attainment through establishing boundaries around what is considered appropriate and good education (Darnell & Sherkat, 2000). Religiosity can also negatively impact psychological adjustment with understudied populations.

The multicultural movement in counseling psychology has been mostly associated with race/culture/ethnicity, gender, sexual orientation, and disability (Cervantes & Parham, 2005); unfortunately, there are few guidelines concerning how to assist clients with integrating their religion into their lives. Richards and Bergin (1997) maintained that there is a spiritual energy in our nation and “it has created a powerful cultural demand for psychotherapists to be more aware of and sensitive to religious and spiritual issues” (p. 6). Moreover, they and others also purport that unfortunately relatively few psychotherapists are adequately trained or prepared to deal effectively with such issues and furthermore, that the religious faith and spiritual concerns of clients have long been neglected in the psychotherapy profession (Bergin, 1991; Cervantes & Parham, 2005; Richards & Bergin, 1997). Indeed, a few studies such as Yeh, Inman, et al. (2006) reported that Asian Americans who had lost family members to 9/11 found that counselors who were not attentive to religious issues contributed to these Asian Americans not utilizing available mental health services. In short, it is essential that therapists have the capacity to understand client’s spirituality and effectively assist the human family.

One cultural value of Polynesians that is similar to and usually associated with non-Western cultures, such as those in Asia, Africa, South America, and other Pacific Islands, is collectivism. Collectivism is an interdependent self-orientation which stresses connectedness to others, social context, and the importance and maintenance of relationships (Singelis, 1994; Yeh, Aurora et al., 2006). One dimension of collectivistic coping is family support (Heppner
et al., 2006; Yeh, Inman et al., 2006), which consists of families resolving the stresses of life together in a collective effort to ensure that all members of the family are psychologically stable and healthy. For example, Yeh, Inman et al. (2006) qualitatively examined the use of individualistic and collectivistic coping strategies among Asian American family members who experienced the loss of loved ones in the 9/11 tragedy. The results indicated that Asian Americans utilized spiritual collectivistic coping to deal with their loss by believing in a higher power. Also, some participants indicated that they increased their religious or spiritual activity by way of prayer, going to church, speaking with a pastor, and attending religious functions. Similarly, Heppner et al. (2006) found strong empirical support in a large quantitative study for both family support and religious/spiritual coping factors in East Asian coping. Moreover, Heppner et al. (2006) also found that higher levels of acceptance and reframing of the stressful life problems as well as striving were found to be very useful coping strategies among Taiwanese college students. Conversely, they also found that higher levels of utilizing coping strategies such as avoidance and detachment as well as private emotional outlets were associated with more psychological distress. Thus, the research suggests that some collectivistic coping activities, namely family support and religious/spiritual coping, were very useful coping strategies for some Asian groups, but other collectivistic coping strategies may sometimes be associated with more distress. In short, Asian Americans as well as others of Asian descent more broadly tend to use family support as well as religious coping to deal with psychological distress, and such coping strategies appear to be associated with a positive psychological adjustment. However, some literature (Heppner et al., 2006) suggests that some collectivistic coping activities may not be associated with a positive psychological adjustment (e.g., avoiding the problem and emotional detachment). Additional research is clearly needed on the role of different collectivistic coping activities in Asian American as well as Asian/Pacific Islander populations.

In sum, currently there is a dearth of research on religiosity, collectivistic coping, and psychological well-being with Polynesians. Given the existing conceptual suggestions and models on spirituality in counseling, religiosity, and collectivistic coping styles (e.g., Cervantes & Parham, 2005; Heppner et al., 2006; Yeh, Aurora, et al., 2006), it is likely that there are specific religious and collectivistic coping strategies that LDS Polynesians use to buffer the daily psychological stresses of life. Therefore, the primary purpose of this study was to empirically examine the impact of religiosity of LDS Polynesians on collectivistic coping, psychological well-being, and distress. The target population was LDS Polynesians living in the Independence, Missouri area.

Specifically, it was first hypothesized that a stronger religious commitment among LDS Polynesians would be associated with a healthy psychological well-being as well as lower levels of anxiety and depression. Moreover, Polynesian family units are built on and operate from a collectivistic orientation. Polynesians also cope collectively among members of the family. Family support tends to be highly valued in the Polynesian culture and there is a feeling of “togetherness” among members of the family that is very unique to this population. Thus, the second hypothesis predicted that a stronger religious commitment among LDS Polynesians would be associated with more helpful collectivistic coping styles, specifically family support and religion-spirituality. Third, it was predicted that these two collectivistic coping styles would also be associated with a healthy psychological well-being among LDS Polynesians. Fourth, it was also hypothesized that the collectivistic coping styles of family support and religion-spirituality would moderate the relationship between LDS Polynesians’ religious commitment and psychological well-being and distress. Finally, we also explored the association between other collectivistic coping styles (e.g., acceptance, reframing, and striving) and psychological well-being and distress with LDS Polynesians.

Method

Participants and Procedure

A total of 110 participants were initially recruited for this study. Ten surveys were excluded due to excessive missing values, and 4 other surveys were also removed as they were either not Polynesian or LDS. Two surveys were removed as they had extreme scores (315LDS POLYNESIANS)...
standard deviations above or below the mean), which could compromise the validity of the study (Tabachnick & Fidell, 2007; Cohen, Cohen, West & Aiken, 2003). The final sample consisted of 94 adults (55 women, 37 men, 2 did not report gender; $M_{age} = 31.5$, age range: 18–75 years) from Polynesian racial backgrounds (i.e., Native Hawaiians, Tongans, and Samoans) residing in Independence, Missouri participated in the study. Most participants were of Samoan heritage ($79\%, n = 75$) while $17\%$ ($n = 16$) reported being Multiracial Polynesian, $3\%$ reported being Native Hawaiian ($n = 3$), and $1\%$ ($n = 1$) of Tongan descent. Ninety-one (96%) participants reported being LDS and 3 (3%) reported that they were “no longer LDS.” Of the 91 participants, $64\%$ ($n = 61$) indicated that they were “Fully Active” in the LDS church, $16\%$ ($n = 15$) reported “Somewhat Regularly Active,” $13\%$ ($n = 12$) indicated “Minimally Active,” and $7\%$ ($n = 7$) reported being “Not At All Active” in the LDS church.

Examination of statistical power analysis for multiple regression in behavioral sciences outlined by Cohen (1988), assuming a medium effect size of .33, the minimum number of participants required for this study was 84 to achieve statistical power of .80. Sample size for this study met these requirements for statistical power.

Two separate data collection methods were used in this study; each was designed to fit into major religious events in the LDS Polynesian culture in Independence. Participants were recruited through personal visits to Polynesian cultural clubs and community associations/organizations, festivals, Polynesian events, and LDS family gatherings. For instance, during June to August, 2009, there were Polynesian festivals called “Island Friday” and the “Heritage Festival” that occurred once in each month. The first author received approval to host booths at these family gatherings. In the Samoan culture, these family gatherings are called To’ana’i (or Kona’i) where immediate and extended family members (oftentimes friends and nonrelatives) gather at one home to have a support group or family meeting and to update everyone on family and community events and activities. Consequent with the local cultural context, the first author made personal visits to these gatherings where an invitation to participate in the study had been granted by the elders of the families. Following the elders’ approval, the first author introduced the reason for the visit and briefly talked about the study. The first author then distributed the survey packet to individuals who fit the criteria and who were willing to participate.

Upon completion of the survey packets, participants dropped them through a slit opening into a large secured and nontransparent box, and were thanked by the first author. This method assured that the first author had no way of knowing who completed the packet and to also secure anonymity of the participants. In this setting, University of Missouri souvenirs were also offered to those who participated in the study.

**Instruments**

Religious Commitment Inventory–10 (RCI–10: Worthington et al., 2003), which consists of 10 items was used to assess religious commitment. Worthington (1988) defined religious commitment as the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living. Two factors accounted for 72.0% of the total item variance: Intrapersonal Religious Commitment (cognitive focus) and Interpersonal Religious Commitment (behavior focus). Participants rated each item on a five-point Likert scale: 1 = not at all true of me, 2 = somewhat true of me,
3 = moderately true of me, 4 = mostly true of me, or 5 = totally true of me. Higher scores indicate higher commitment to religious beliefs. Intrapersonal Religious Commitment was highly correlated with Interpersonal Religious Commitment (.72). The alpha coefficient for the RCI–10 was .95 (.94 in this study) and the test-retest reliability was .91 (across a 5-month interval).

Collectivistic Coping Styles (CCS; Heppner et al., 2006) were developed and validated in 3 studies among Taiwanese college students. 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 Likert-type scale; 0 = Never used this strategy/Not applicable, 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 higher the score is, the more helpful the coping strategy. The coefficient alphas for the total CCS and all 5 factors were as follows: Total CCS (.87; .80 in this study), ARS (.85; .76 in this study), FS (.86; .85 in this study), RS (.90; .85 in this study), AD (.77; .79 in this study), and PEO (.76; .72 in this study). In addition, the CCS factors were significantly intercorrelated on 7 out of 10 correlations; these results suggest that the CCS factors are more highly intercorrelated in this sample than reported by Heppner et al. (2006) but are still independent coping factors.

Because the CCS is a situation-specific coping inventory, the participants were first asked to select a stressful problem from a list of potential stressful problems that participants might have experienced in their lives. Twenty-seven (27%) participants reported “Death or illness of a loved one” as the most common stressful event, while 19 (20%) reported multiple stressful events. Eighteen (19%) participants indicated “other” rather than selecting a stressful event provided from the list, 9 (11%) reported a “Break up with a significant other,” and 6 (6%) reported “Unemployment or job loss.” All other stressful events reported were fairly equally distributed across the other stressful events. Regarding the level of severity of the stressful event, 41 (44%) participants indicated that the stressful 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 occurred, the majority of the participants indicated that the stressful event happened in more recent years. Twenty (22%) participants reported that their stressful event happened “less than 3 months ago,” 18 (19%) indicated “between 1 and 3 years,” 14 (15%) reported “between 7 and 12 months,” and 13 (14%) reported “between 4 and 6 years.” When participants reported how often the stressful event happened, 43 (46%) reported once, while 23 (24%) indicated twice, and 15 (16%) indicated “more than five times.” The participants were also asked how much the stressor affected various domains of their lives (e.g., work, home) both at the time the stressor first happened (Traumatic Interference Index—TII Then) as well as at the time the participants completed the inventory (Traumatic Interference Index—TII Now).

Psychological Well-being Scale (PWS; Ryff & Keyes, 1995) was developed to assess psychological well-being. The authors found six main dimensions of psychological well-being: Self-Acceptance, Environmental Mastery, Positive Relations, Purpose in Life, Personal Growth, and Autonomy. Each item is rated on a six-point Likert-type scale, 1 = strongly disagree, 2 = moderately disagree, 3 = slightly disagree, 4 = slightly agree, 5 = moderately agree, 6 = strongly agree. For this study, only two dimensions of the PWS were used to measure psychological well-being among LDS Polynesians: Self-Acceptance (SA) and Purpose in Life (PL), as religiosity is intuitively related to how one thinks/feels about him or herself (self-concept) and the meaning (or purpose) to their lives. The authors wanted to examine if LDS Polynesians reported higher levels of self-acceptance and purpose in life based on their religious commitment. High scorers on the SA dimension are described as persons having a positive attitude toward self, meaning that they acknowledge and accept multiple aspects of self including good and bad qualities. Low scorers are described as persons who feel dissatisfied with self, are troubled about certain personal qualities, and wish to be different. The SA has 14 items; the internal consistency is .91. The alpha coefficient for this study was .86. The
test–retest reliability coefficient for SA was .85 over a six-week period. PL consists of 14 items and assesses the extent to which individuals have goals in life, a sense of direction, and feel there is meaning to their present and past life (high scorers). Low scorers are described as having a lack of meaning in life, few future goals, and a lack of beliefs that give life meaning. Internal consistency has been reported to be .88 (α = .85 for this study). An estimate of test–retest reliability alpha coefficient for PL was .82 over a six-week period (Ryff & Keyes, 1995).

Brief Symptom Inventory–18 (BSI–18) assesses psychological distress. The BSI–18 (Derogatis, 2000) is a 5-point Likert scale (1 = not at all to 5 = extremely). The higher the score is, the more extreme the psychological distress. The 18 statements are divided equally among three dimensions: somatization, anxiety, and depression. For this study, only anxiety and depression were used. Based on the principal investigator’s history of understanding the cultural context of Polynesians, his personal interactions, and his observations during the data collection phase, it seemed that Polynesians were more likely to experience symptoms of anxiety and depression rather than struggle with somatization features. In addition, since most of the current literature is on anxiety and depression as they relate to religiosity among other persons of color, we concluded that it was important to examine anxiety and depression rather than somatization among LDS Polynesians. The internal consistency estimate for anxiety was .79 and .84 for depression (α = .77 for anxiety and α = .82 for depression in this study).

Results

Preliminary analyses involved performing frequency tests to examine descriptive statistics (e.g., means, standard deviations, skewness, kurtosis, missing values). The normality of the distributions as well as the range of scores and outliers for each inventory was also tested. Following the preliminary data analysis and cleaning, a total of 94 surveys were used for the subsequent statistical analyses.

Means and standard deviations of the study’s variables are included in Table 1. The mean on the Religious Commitment Inventory for this sample was higher (M = 4.1) than those reported on the development of the RCI and statistically significant when compared the difference between means (Worthington et al., 2003; M = 3.4, p < .001 for European Americans, M = 3.7, p < .001 for African Americans, and M = 2.3, p < .001 for Asian Americans); these results reflect the overall Religious Commitment (RC) of this sample. Similarly, it is also important to note that means on two of the Collectivistic Coping Styles (CCS) subscales, Family Support (FS; M = 3.6) and Religion-Spirituality (RS; M = 4.0) were noticeably higher than those reported on the initial development of the CCS (Heppner et al., 2006; FS, M = 2.4, p < .001; RS, M = 2.2); these results underscore the utility of FS coping as well as RS coping for this sample. In addition, means on the two subscales of the Psychological Well-

<table>
<thead>
<tr>
<th>Measure</th>
<th>M</th>
<th>SD</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCI</td>
<td>4.10**</td>
<td>.94</td>
<td>−1.20</td>
<td>.84</td>
</tr>
<tr>
<td>CCS</td>
<td>ARS</td>
<td>3.30</td>
<td>.80</td>
<td>−.30</td>
</tr>
<tr>
<td></td>
<td>FS</td>
<td>3.60**</td>
<td>1.11</td>
<td>−.97</td>
</tr>
<tr>
<td></td>
<td>RS</td>
<td>4.04**</td>
<td>1.16</td>
<td>−1.60</td>
</tr>
<tr>
<td></td>
<td>AD</td>
<td>2.32</td>
<td>1.21</td>
<td>−.055</td>
</tr>
<tr>
<td></td>
<td>PEO</td>
<td>1.70</td>
<td>1.31</td>
<td>.50</td>
</tr>
<tr>
<td></td>
<td>PWS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SA</td>
<td>4.60**</td>
<td>.84</td>
<td>−.30</td>
</tr>
<tr>
<td></td>
<td>PL</td>
<td>4.56**</td>
<td>.86</td>
<td>−.27</td>
</tr>
<tr>
<td></td>
<td>BSI-18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DEP</td>
<td>1.50**</td>
<td>.72</td>
<td>2.30</td>
</tr>
<tr>
<td></td>
<td>ANX</td>
<td>1.65</td>
<td>.79</td>
<td>1.49</td>
</tr>
<tr>
<td></td>
<td>Combined Scores</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SAPL</td>
<td>5.34</td>
<td>.91</td>
<td>−.28</td>
</tr>
<tr>
<td></td>
<td>DEPANX</td>
<td>1.60</td>
<td>.70</td>
<td>1.88</td>
</tr>
</tbody>
</table>

Note. RCI = Religious Commitment Inventory; CCS = Collectivistic Coping Scale; ARS = Acceptance, Reframing, and Striving; FS = Family Support; RS = Religion-Spirituality; AD = Avoidance and Detachment; PEO = Private Emotional Outlets; PWS = Psychological Well-being Scale; SA = Self-Acceptance (PWS); PL = Purpose in Life (PWS); BSI–18 = Brief Symptom Inventory–18; DEP = Depression Dimension (BSI–18); ANX = Anxiety Dimension (BSI–18); SA + PL = Combined Scores for SA and PL; DEP + ANX = Combined Scores for Depression and Anxiety. For the CCS, the M and SD indicate the helpfulness ratings for the specific coping strategy and were calculated from only those who used the strategy. Significant mean difference compared to normative samples. **p < .01.
being Scale were also higher for this sample (Self-Acceptance (SA), M = 4.6; Purpose in Life (PL), M = 4.6) compared to the normative means initially reported by Ryff and Keyes (SA, M = 2.4, p < .001; PL, M = 2.4, p < .001); these results also suggest that the sample had a relatively high level of psychological well-being (SA and PL). Means on the Brief Symptom Inventory - 18 (BSI–18) (Derogatis, 2000; Shacham, Basta & Reece, 2008) were lower on the two subscales Depression (DEP) and Anxiety (ANX) in this sample (DEP, M = 1.50; ANX, M = 1.65) compared to the normative means, but only means on depression for this sample and the normative sample were statistically different (DEP, M = 1.78, p < .001; ANX, M = 1.67).

Table 2 summarizes the bivariate correlations between the variables. Our first hypothesis predicted that the Religious Commitment would be significantly correlated with Self-Acceptance and Purpose in Life as well as Depression and Anxiety. The results partially supported the hypothesis. That is, the results indicated that RC was significantly correlated with SA and PL (r = .33, p < .01). However, RC scores were not predictive of DEP and ANX. Thus, the first hypothesis found that Religious Commitment was positively associated with their Self-Acceptance as well as their Purpose in Life but not Depression and Anxiety. The second hypothesis predicted that Religious Commitment would be significantly correlated with Family Support and Religion-Spirituality. The results supported this hypothesis (rs = .24, p < .05). In addition, it is important to note that participants’ RC scores were also positively related to their Acceptance, Reframing, and Striving scores. These results suggest that higher levels of Religious Commitment were related to participants’ perceived helpfulness of Family Support and Religion-Spirituality coping, as well as Acceptance, Reframing, and Striving coping. The third hypothesis predicted that participants’ scores on two forms of coping, Family Support and Religion-Spirituality, would be correlated with Self-Acceptance and Purpose in Life. The results supported this hypothesis in that FS and RS were both significantly correlated with SA and PL (rs = .21 and .24, respectively, ps < .05). Moreover, it is important to note that although not predicted, the other three CCS coping factors were also significantly correlated with SA and PL; that is, ARS was positively correlated with SA and PL (p =

Table 2
Bivariate Correlations of the Study's Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RCI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ARS</td>
<td>.30**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. FS</td>
<td>.46**</td>
<td>.46**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. RS</td>
<td>.70**</td>
<td>.28**</td>
<td>.53**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. AD</td>
<td>-.04</td>
<td>.36**</td>
<td>.15</td>
<td>-.08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. PEO</td>
<td>.05</td>
<td>.29**</td>
<td>.31**</td>
<td>.06</td>
<td>.45**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. SA</td>
<td>.23*</td>
<td>.25*</td>
<td>.16*</td>
<td>-.13</td>
<td>-.21*</td>
<td>-.30**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. PL</td>
<td>.38**</td>
<td>.26*</td>
<td>.24*</td>
<td>-.24*</td>
<td>-.20*</td>
<td>-.33**</td>
<td>.70**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. DEP</td>
<td>-.11</td>
<td>-.03</td>
<td>-.01</td>
<td>-.08</td>
<td>.26**</td>
<td>.20</td>
<td>-.41**</td>
<td>-.43**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. ANX</td>
<td>-.08</td>
<td>-.00</td>
<td>-.03</td>
<td>-.07</td>
<td>.21*</td>
<td>.20</td>
<td>-.22*</td>
<td>-.32**</td>
<td>.72**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. SAPL</td>
<td>.33**</td>
<td>.27**</td>
<td>.21*</td>
<td>.24*</td>
<td>-.22*</td>
<td>-.34**</td>
<td>.92**</td>
<td>.92**</td>
<td>-.46**</td>
<td>-.29**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. DEPANX</td>
<td>-.10</td>
<td>-.01</td>
<td>-.02</td>
<td>-.08</td>
<td>.25*</td>
<td>.21*</td>
<td>-.34**</td>
<td>-.40**</td>
<td>.92**</td>
<td>.93**</td>
<td>-.40**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. TII</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Then</td>
<td>-.26*</td>
<td>-.11</td>
<td>-.36**</td>
<td>-.12</td>
<td>-.18</td>
<td>-.16</td>
<td>.01</td>
<td>.06</td>
<td>.08</td>
<td>.09</td>
<td>.04</td>
<td>.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Now</td>
<td>-.20*</td>
<td>-.04</td>
<td>-.08</td>
<td>-.14</td>
<td>.14</td>
<td>.13</td>
<td>-.14</td>
<td>-.08</td>
<td>.21*</td>
<td>.22*</td>
<td>-.12</td>
<td>.23*</td>
<td>.42**</td>
<td></td>
</tr>
</tbody>
</table>

Note. Correlations above represent participants’ reported scores on RCI = Religious Commitment Inventory; ARS = Acceptance, Reframing, and Striving; FS = Family Support; RS = Religion/Spirituality; AD = Avoidance and Detachment; PEO = Private Emotional Outlets; SA = Self-Acceptance (PWS); PL = Purpose in Life (PWS); DEP = Depression Dimension (BSI–18); ANX = Anxiety Dimension (BSI–18); SA + PL = Combined Scores for SA and PL; DEP + ANX = Combined Scores for Depression and Anxiety; TII Then = interference in general at the time the event happened; TII Now = interference in general at the present time. α = Alpha coefficients.

*p < .05. **p < .01.
.27, p < .05) and negatively correlated with Avoidance and Detachment and Private Emotional Outlets (rs = −.22 and −.34, ps < .05, .01, respectively). In short, the results suggest that all the CCS factors were all significantly correlated with positive well-being (SA and PL) in this study.

The correlations also show the negative association between Religious Commitment, Family Support, and Traumatic Interference Index–Then (TII–Then) and TII–Now. Similarly, correlations also reveal the relationship between lower levels of current (TII–Now) stressful traumatic interference with less Depression and Anxiety symptoms. Also, Acceptance, Reframing, and Striving (ARS) was positively associated with a strong Self-Acceptance (SA) and Purpose in Life (PL), and Private Emotional Outlets (PEO) was negatively associated with SA and PL. It is also important to mention that of all the CCS factors, Avoidance and Detachment (AD) coping factor was most consistently associated with SA and PL and Depression (DEP) and Anxiety (ANX). Specifically, AD was negatively associated with SA and PL and positively associated with higher levels of DEP and ANX. Moreover, SA and PL was also negatively correlated with DEP and ANX, and the intercorrelation between SA and PL was higher (r = .70) in this sample than what was reported (r = .22) by Ryff and Keyes (1995).

The fourth hypothesis postulated that Family Support (FS), Acceptance, Reframing, and Striving (ARS), and Religion-Spirituality (RS) would moderate the relationship between Religious Commitment (RC; predictor) and psychological well-being (SAPL; criterion) would be changed, strengthened, or altered when Family Support (FS), Acceptance, Reframing, and Striving (ARS), and Religion-Spirituality (RS; moderators) were entered into the equation. Frazier et al. (2004) defined this moderation model as an interaction between the predictor and criterion variables. Given that this sample revealed significant correlations with FS, ARS, as well as RS, it was decided to analyze which of these variables strengthened or altered the relationship between RC and SAPL.

Because these moderator variables were continuous as outlined by Frazier et al. (2004), the choice of using regression analysis was appropriate to test for moderation (Baron & Kenny, 1986; Frazier et al., 2004). In the first step of the regression, both the predictor (RC) and moderator variables (FS, ARS, and RS) were independently entered into the regression equation predicting the criterion variable (SAPL). In the second step of the regression, the interaction (predictor × moderator) between RC and each moderator variable was entered into the regression equation. The difference between the $R^2$ obtained in the first step of the regression and the $R^2$ obtained in the second step is the amount of variance in the criterion variable that is predicted by the interaction of the moderator. If the difference between the $R^2$ values from the first and second steps of the regression is significant, then there is a moderation effect (Frazier et al., 2004).

Table 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$ Change</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FS Moderator</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 1</td>
<td>.11</td>
<td></td>
</tr>
<tr>
<td>Religious Commitment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Support</td>
<td>.349</td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious Commitment × Family Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*p &lt; .05.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To test for moderation, the authors sought to examine if the relationship between Religious Commitment and Psychological Well-Being (Self-Acceptance and Purpose in Life) was stronger when Family Support, Acceptance, Reframing, and Striving, and Religion-Spirituality were entered into the regression equation as moderator variables. Results showed that ARS
and RS were not statistically significant as moderating the relationship between religious commitment and psychological well-being (ARS: $R^2_{adj} = .206$, $F(1, 93) = 1.19, p = .33$; RS: $R^2_{adj} = .197$, $F(1, 93) = 1.38, p = .196$), but FS was significant in strengthening or enhancing the relationship between religious commitment and psychological well-being ($R^2_{adj} = .349$, $F(1, 93) = 1.98, p = .004$).

Discussion

The results of this study provide important information about relations among LDS Polynesian religious beliefs, coping, and psychological adjustment. In essence, the results not only underscore a strong association between LDS Polynesian religious beliefs and psychological adjustment, but also highlight connections between their religious beliefs and subsequent helpfulness ratings of their coping strategies. These results confirm and extend previous research with other racial/ethnic minority groups in the U.S.

First, it is important to note that the mean religious commitment score obtained from this LDS Polynesian sample was much higher ($M = 4.1$) than those reported on the development of the Religious Commitment Inventory–10 (Worthington et al., 2003; $M = 3.4$ for European Americans, $M = 3.7$ for African Americans, and $M = 2.3$ for Asian Americans). This finding is very consistent with the cultural context of the LDS Polynesians; generally speaking, the cultural context of LDS Polynesians is heavily focused on spiritual beliefs and practices as a way to understand the world, particularly problems and trials that arise on a daily basis. LDS Polynesians typically define a life trial (e.g., loss of a loved one or a significant financial burden) as an opportunity to learn what God wants to teach them or as a test to see if they are sufficiently faithful and resilient to overcome that particular trial.

Moreover, the results also suggest that LDS Polynesians who were highly committed to their religious beliefs were also likely to have a healthy psychological well-being, specifically positive self-acceptance and a meaningful purpose in life. This finding is consistent with previous research among persons of color in the U.S. (e.g., Cervantes & Parham, 2005; Fukuyama & Sevig, 1999; Ghorpade, Lackritz, & Singh, 2006; Khalili et al., 2002; Yeh, Aurora, et al., 2006). In sum, our study suggests that LDS Polynesians’ strong religious beliefs are independently and directly associated with their well-being and desire to live a meaningful life. It is important to note that the same relationships were not found with depression and anxiety; additional research is needed to determine the associations with the range of indices of psychological adjustment with LDS Polynesians.

The LDS Polynesians’ strong religious beliefs, as predicted, were associated with collectivistic coping strategies, specifically more helpful ratings of family support coping as well as religious/spiritual coping. These relationships also support previous research conducted on Asian/Asian Americans who reported that family support coping as well as religious and spiritual coping strategies were helpful in resolving traumatic stressors (Heppner et al., 2006; Yeh, Inman, et al., 2006). Moreover, our results suggest that LDS Polynesians who are highly religious, when confronted with stressful situations not only use religious/spiritual coping frequently, but find it to be very helpful in resolving their problems. In fact, the mean perceived helpfulness rating of religion/spirituality coping ($M = 4.0$) was noticeably higher than the mean reported in the initial development of the CCS (Heppner et al., 2006; $M = 2.2$).

Moreover, consistent with the collectivistic cultural perspective within LDS Polynesians, our results found that LDS Polynesians’ high religious commitment scores were also associated with higher helpfulness ratings of family support coping. Again, relatively speaking, the mean of the LDS Polynesian family support coping in this study was 3.6 (as compared to 2.4 in the original Taiwan sample of college students reported by Heppner et al., 2006). Clearly, family support coping as a way to respond to daily problems appears to be a very helpful coping activity for LDS Polynesians.

The results of this study also consistently linked collectivistic coping to psychological well-being and partially to psychological distress. More specifically, family support and religious/spirituality coping were also associated with psychological well-being, specifically self-acceptance and purpose in life as well as acceptance, reframing, and striving coping. However, coping associated with personal emotional outlets was negatively associated with psychological well-being.
ical well-being, and avoidance and detachment coping was negatively associated with well-being and positively correlated with depression and anxiety. Thus, collectivistic coping styles as measured by the Collectivistic Coping Styles (Heppner et al., 2006) were clearly associated with indices of psychological well-being within LDS Polynesians and to some extent psychological distress. The moderation analysis revealed that family support coping moderated (strengthened/enhanced) the relationship between religious commitment and psychological well-being. Thus, greater perceived helpfulness ratings of family support coping strengthened the relationship between religious commitment and psychological well-being (specifically, self-acceptance and purpose in life); additional research is needed with other LDS samples to examine the stability of this relationship, perhaps with larger Polynesian samples.

In terms of limitations of the study, although 94 participants were adequate for data analysis, a larger sample would make the findings more robust. Moreover, 79% (N = 75) of the sample were of Samoan ethnicity, which does not accurately represent Polynesians as a whole. Additional research with other Polynesian groups such as Native Hawaiians, Tongans, Fijians, and Maori are needed to more fully represent these subgroups in future research. Further research might also consider preparing the inventories in the native language of the participants; for example, the primary investigator noticed on a few occasions an older Samoan asking a younger Samoan to explain some of the English words on the inventories. In addition, this is the first study to report a sample size of over 90 LDS Polynesians; the culturally sensitive data collection strategies at festivals and Polynesian culture events in people’s homes may be in part responsible for collecting such a sample. Nonetheless, additional data collection strategies may be needed to sample a broader array of LDS Polynesians. Given that this sample included more female than male participants, research on Polynesian gender-specific studies related to psychological processes could provide additional information within this group. Also a comparison study of Polynesians who are not religious or LDS could add to information about this subgroup. In addition, research on LDS Polynesians using longitudinal data may provide a greater opportunity on making causal conclusions than cross-sectional data.

The results of this study highlights the necessity for therapists working with this population to attend to clients’ religious commitment and beliefs, collectivistic coping styles, associations between these two sets of variables; additionally, they must be sensitive to probable associations with psychological well-being and distress. If counselors are not appropriately sensitive, competent, and prepared to engage in psychotherapy with highly religious clients within collectivistic cultural contexts, they may not be attentive enough to religious issues, relevant coping strategies, and cognizant of clients’ psychological well-being and distress; the lack of counselor understanding can contribute to clients of color not utilizing available mental health services (Cervantes & Parham, 2005; Yeh, Inman, et al., 2006).

Research on LDS Polynesians, particularly regarding religiosity, collectivistic coping, and psychological well-being, is not only critical for the purpose of expanding our understanding of this understudied population, but also essential for individuals working in the helping fields to more effectively engage and assist LDS Polynesians in psychotherapy. Multiculturalism in counseling psychology should not only be associated with Latino/as, Asian Americans, African Americans, and Native Americans related to race/culture/ethnicity, gender, sexual orientation, and disability, but also with education about and acquiring competence in psychotherapy with persons of color who are highly religious, more specifically with LDS Polynesian clients (Bergin, 1991; Cervantes & Parham, 2005; Richards & Bergin, 1997; Yeh et al., 2006). Research on well-being, identity, trauma, and resilience of Native Hawaiians has been studied in recent years (McCubbin, 2006; McCubbin, Ishikawa & McCubbin, 2007; McCubbin & Dang, 2010). However, additional research on other Polynesian groups (Tongan, Samoan, Fijian, Maori) in the U.S. is strongly encouraged to add to the knowledge of cultural context, identity, acculturation, and psychological well-being and adjustment of these cultural groups.

References

Polynesian/Caucasian individuals (Unpublished master’s thesis). University of Utah, Salt Lake City, UT.


Received November 11, 2010
Revision received February 14, 2011
Accepted February 18, 2011

Showcase your work in APA’s newest database.

PsycTESTS

Make your tests available to other researchers and students; get wider recognition for your work.

“PsycTESTS is going to be an outstanding resource for psychology,” said Ronald F. Levant, PhD. “I was among the first to provide some of my tests and was happy to do so. They will be available for others to use—and will relieve me of the administrative tasks of providing them to individuals.”

Visit http://www.apa.org/pubs/databases/psyctests/call-for-tests.aspx to learn more about PsycTESTS and how you can participate.

Questions? Call 1-800-374-2722 or write to tests@apa.org.

Not since PsycARTICLES has a database been so eagerly anticipated!