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A Comparative Study of Psychotherapy Utilization and Presenting Concerns Among Pacific Islander and Asian American Students in a University Counseling Center

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ABSTRACT

A Comparative Study of Psychotherapy Utilization and Presenting Concerns Among Pacific Islander and Asian American Students in a University Counseling Center

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The current study examined the psychotherapy experiences of Pacific Islander and Asian American students at a large intermountain university on the continental United States. We used archival data collected over a 17-year span to investigate the psychotherapy utilization, presenting concerns, reported distress levels and psychotherapy outcomes of Pacific Islander students compared to Asian American students. In an effort to address the current and problematic practice of combining Asian Americans and Pacific Islanders into a homogeneous category, subgroup outcomes of Pacific Islander students were compared to Asian American students to highlight any significant differences and similarities. Results indicated significant differences between Pacific Islander and Asian American students in terms of amount of psychotherapy sessions attended and length of treatment in days. Asian American students were more likely to remain in therapy during the first 100 days and eight sessions. We found significant differences between both groups on several items assessed in the Presenting Problem Checklist and the Family Concerns Survey. Pacific Islander students reported significantly more traumatic experiences occurring in their family. We also found significant differences in the presenting concerns of both populations. Additionally, on the OQ-45, Pacific Islander students answered questions regarding risk factors significantly different from Asian American students. Clinicians are encouraged to understand the values and nuances of collectivist groups including Pacific Island and Asian cultures. It is recommended that clinicians and counseling centers reach out to Pacific Islander students on their campuses to inform them about mental health services. Counseling centers are encouraged to gather information on the reasons for therapy termination.

Keywords: Pacific Islander students, Asian American students, university counseling centers, utilization, psychotherapy outcome

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DESCRIPTION OF DISSERTATION FORMAT

Traditionally dissertations have been organized in a five-chapter format. However, this dissertation, *A Comparative Study of Psychotherapy Utilization and Presenting Concerns Among Pacific Islander and Asian American Students in a University Counseling Center*, is organized to be ready for publication in a standard peer-reviewed journal. A full literature review is included in the appendix with other supporting documents after the discussion section.

Introduction

Counseling centers on college and university campuses are at the forefront of providing services to students experiencing different mental health issues with varying levels of severity. These counseling centers face higher demands for services even when they are restricted by economic cutbacks and endure public scrutiny in the occurrence of campus violence or suicides (Much & Swanson, 2010). The services provided by counseling centers on these campuses include individual and group therapy, couples therapy, crisis interventions, biofeedback services, culturally adapted counseling, consultation, outreach activities, and other mental health services for students.

Research related to ethnic minority students' college counseling utilization rates have generated mixed results with some reporting relatively equal rates of utilization (e.g., Hayes, Youn, et al., 2011) and others reporting that ethnic minority students tend to underutilize counseling services (Davidson, Yakushka, & Sanford-Martens, 2004; Kearney, Draper, & Baron, 2003). The needs of Pacific Islander and Asian American students are underrepresented in the literature because they are typically combined into a homogeneous group. The current study investigates the similarities and differences between these populations in terms of utilization rates, presenting concerns, and psychotherapy outcomes in a university counseling center.

Increase in Student Enrollment in College Campuses

Over the past several decades, there has been a steady increase in the student enrollment in American colleges and universities (Smith, Chesin, & Jeglic, 2014; Snyder & Dillow, 2015). Between 1994 and 2014 there was a 21 percent increase in student enrollment in postsecondary institutions. In the fall of 2015, there were 20.2 million students attending American colleges and universities, a 4.9 million increase of students in higher education since 2000 (Snyder &

Dillow, 2015). This has led to more diverse campus populations including students who identify as ethnic and racial minorities, economically disadvantaged, first-generation, disabled, or international (Snyder & Dillow, 2015).

Researchers have subsequently focused on the mental health needs of college and university students. The majority of students seeking higher education are young adults, between 18-25 years old, who are likely experiencing a transitional period in their lives. This particular population is a high-risk age group who are prone to common mental health problems like depression, anxiety, schizophrenia, and substance abuse (Cook, 2007). It is likely that poor mental health among this particular age group may be related to relationship stressors, low social support or being the victim of sexual abuse (Blanco, Okuda, & Wright, 2008).

Increase in Symptom Severity in College Counseling Centers

There are mixed findings regarding the level of mental health symptom severity in college counseling centers. However, research generally shows that the mental health issues of college students are becoming increasingly more severe (Gallagher, 2012; Hunt & Eisenberg, 2010; Kettmann et al., 2007; Watkins, Hunt, & Eisenberg, 2012). Over 90% of college counseling center directors reported an increase in students presenting with serious psychological problems (Gallagher, 2012) and an increase in presenting concerns from the 'typical' developmental challenges (e.g., stress, anxiety) to more severe mental disorders (e.g., major depressive disorder, schizophrenia; Barr, Rando, Krylowicz, & Reetz, 2011). As the level of symptom severity heightens among the general college population seeking mental health services, female and male students face unique stressors.

Gender Differences in Utilization Trends

Women face unique disadvantages on college campuses, including overt and covert sexual harassment and discrimination, lack of role models, and/or underrepresentation in specific fields (Lucas & Berkel, 2005). A number of studies over the last couple of decades have yielded consistent findings in the utilization trends among men and women: females in colleges tend to have more positive attitudes toward psychological counseling and less stigma around seeking mental health services than did their male counterparts (Nam et al., 2010).

For men, the stigma around mental health elicited a sense of fear about what others might think of them for seeking counseling services (Nam et al., 2010). Another study found that women who experienced difficulties at work or school presented with symptom distress, interpersonal problems, and vocational barriers (Lucas & Berkel, 2005). Similar to the different experiences of students in terms of gender, ethnic and racial minority students encounter additional stressors than the general population on college campuses.

Utilization Trends Among College Students of Color

Ethnic and racial minority students typically experience greater distress in regards to depression, family concerns, social anxiety, hostility, and academic issues than White students (Hayes, Chun-Kennedy, Edens, & Locke, 2011). Although they are at greater risk for psychological problems, studies have found that the mental health utilization rates of racial and ethnic minorities are generally lower than their White counterparts (Santiago & Miranda, 2014; Smith, Rodriguez, & Bernal, 2011).

There is inconsistent evidence about the counseling center utilization rates of students of color. One study found that African American and Latino/a college students underutilize counseling centers (Davidson et al., 2004) while another study concluded that the counseling

center utilization rates of ethnic and racial minorities were consistent with the rate of university enrollment for African American, Asian American, European American, Latino/a, and American Indians (Hayes, Chun-Kennedy, et al., 2011). Nevertheless, the underutilization of mental health services among racial and ethnic minorities continues to be a major concern for university and college counseling centers (Ibaraki & Hall, 2014).

Utilization Trends Among Asian Americans and Pacific Islanders

Previous studies that have combined Asian American and Pacific Islander students into a homogeneous group, showed that they experience higher rates of depression and anxiety when compared to White students (Lam, Pepper, & Ryabchenko, 2004), and are the least likely of any ethnic minority groups to utilize mental health services (Abe-Kim et al., 2007; Choi & Miller, 2014; Eisenberg, Golberstein, & Gollust, 2007; Le Meyer, Zane, Cho, & Takeuchi, 2009; Smith & Trimble, 2016). In college counseling centers, Asian American students have the lowest rates of utilization, while White students have the highest rate (Eisenberg, Hunt, Speer, & Zivin, 2011). Furthermore, when Asian American students seek counseling services, it is usually for academic issues (Kim, Park, La, Chang, & Zane, 2016).

There is a myriad of reasons why people of color may choose not to seek mental health services to alleviate their distress. For Asian Americans, strong adherence to their traditional cultural values and cultural stigma contribute to their underutilization rates (Garrett & Portman, 2011; King, Trimble, Morse, & Thomas, 2014). Thus, it is imperative that mental health professionals gain an understanding of multicultural values to bridge the gap of service utilization among racial and ethnic minorities (Smith & Trimble, 2016).

When Asian Americans seek professional mental health services, their approach is congruent with their cultural values. For example, Asian American individuals typically respond

well to theories of mindfulness and acceptance-based interventions, mostly because these therapeutic approaches are rooted strongly in Asian philosophies (Hall, Hong, Zane, & Meyer, 2011). Additionally, when they seek counseling services, Asian Americans tend to approach their counselors with the formality and respect that they would give to an elder within their culture.

Since Pacific Islanders have been historically combined with Asian American populations, research on the utilization rates of Pacific Islanders as an exclusive group is scarce. Recognizing that the current practice of lumping is problematic, recent studies have focused specifically on the psychological health and well-being of Polynesian Americans (Allen, Kim, Smith, Hafoka, 2016). A study on the collectivistic coping strategies of Polynesian Americans found that family support and avoidance/detachment are common mechanisms that Pacific Islanders use to cope with distress (Allen & Smith, 2015). A few studies have further examined the resilience, identity, well-being, and trauma of Native Hawaiians (McCubbin, 2007; McCubbin & Dang, 2010; McCubbin, Ishikawa, & McCubbin, 2008). Allen, Cox, et al. (2016) investigated the utilization rate, presenting concerns, counseling service effectiveness, and distress levels of Polynesian American students seeking help at a university counseling center. In comparison to European Americans, there was no statistical difference in their utilization rates; however, after the intake session, Polynesian Americans were less likely to return. These recent studies on Polynesian Americans show a significant step in introducing a population that is underserved and underrepresented in the current literature.

Rationale for Current Study

The historical aggregation of Asian American Pacific Islander data has trivialized the needs of underserved populations such as Pacific Islanders in America. Because Pacific Islanders

are often subsumed under the "Asian American" label, it is difficult to understand their unique cultural and psychological experiences, mental health issues and utilization, and help-seeking behavior (Allen, Cox, et al., 2016; Mallinckrodt, Shigeoka, & Suzuki, 2005; Sullivan, Ramos-Sánchez, & McIver, 2007).

There are also socioeconomic differences that are masked by the lumping of both cultural groups. Historically, the group labeled Asian Americans and Pacific Islanders (AAPI) has often been viewed as the "model minority." This originates from the common perception that they excel in educational pursuits, secure stable employment, cultivate strong family ties, and experience low rates of health problems (Yee, DeBaryshe, Yuen, Kim, & McCubbin, 2007). AAPI are typically portrayed as high achieving individuals who are successful in society. Unfortunately, one of the consequences of this stereotype leads to researchers overlooking the Pacific Islander population because of the assumption that they are generally successful and healthy. While Asian Americans may be more likely to fit the description of the "model minority" label, this distinction does not account for the unique experiences of Pacific Islanders and overlooks common struggles that they face dealing with racial discrimination, trauma, or family stress (Yee et al., 2007).

The current study contributes to existing literature by exclusively comparing Asian Americans to Pacific Islanders. The current study compares the utilization rates, presenting concerns, and psychotherapy outcome change between Asian Americans and Pacific Islanders at a university counseling center. This study is necessary to provide a platform for continued dialogue advocating for the disaggregation of Asian Americans and Pacific Islanders as unique groups and provide a closer examination of the nuances that students from these populations

experience in university counseling centers. The current study will assist counseling centers in their efforts to provide more culturally appropriate interventions in therapy.

Research Questions

Although previous studies have examined the utilization and outcomes of Asian students in university counseling centers (Kim et al., 2016) and Pacific Islanders (Allen, Cox, et al., 2016), there are virtually no studies comparing Asian Americans to Pacific Islanders in this context. The purpose of this study is to bridge the chasm and provide counseling centers with insight into the treatment utilization and presenting concerns of Asian Americans and Pacific Islander client-student populations. We address the following:

1. What are the utilization rates of Pacific Islander students in comparison to Asian American students at a large intermountain university counseling center?
2. What are the presenting concerns (as measured by the Family Concerns Survey and Presenting Problems Checklist) that lead Asian American and Pacific Islander students to the university counseling center?
3. How do changes in Pacific Islander and Asian American students' outcome scores compare in treatment-as-usual (individual counseling, group therapy, and biofeedback services)?
4. How do these changes differ when controlling for gender, age, and amount of sessions?

Method

Participants

This study examined archival data collected over a 17-year-span from 1996-2013 of 415 Pacific Islander students and 443 Asian American students at a large intermountain area university in the continental United States. Pacific Islander participants included 165 men

(39.8%) and 250 women (60.2%) with a mean age of 22.2. Their marital status included 248 single (59.8%), 149 married (35.9%), six divorced (1.5%), and 12 (2.8%) unreported. These students were from a variety of Pacific Island racial backgrounds (e.g., Native Hawaiian, Tongan, Samoan, Fijian, Tahitian, and Maori). Participants who reported their ethnicity as Hawaiian and Pacific Islander and country of birth or citizenship as United States were regarded to be of Pacific Island descent and included in our study. Participants who reported their ethnicity as Asian and country of birth or citizenship as United States were regarded to be Asian American and included in our study. Asian American participants included 170 men (38.3%) and 273 women (61.7%) with a mean age of 21.9. Their marital status included 269 single (60.7%), 143 married (32.3%), six divorced (1.5%), and 25 (5.5%) unreported. The average number of sessions attended for Asian American and Pacific Islander students at this counseling center was 10.87 and the modal number was 2. The average length of treatment for this sample lasted over a year, while the median was 78 days and the mode was 7 days.

Counseling centers across the United States generally have effective methods of collecting data from their clients and yet some issues unintentionally emerge in which some data may be lost, particularly when data is collected over extended periods of time. These issues could arise due to clerical and/or research assistant data entry errors, premature client dropout before completing all of the required measures, or losses in date when centers transition from paper to electronic records. This center was no exception. During the process of transitioning from paper records to electronic records during the years 1996 to 2008, some clients in our dataset were missing one or more questionnaires. There were 346 (210 females and 136 males) Pacific Islander students who completed one or more of the Family Concerns Survey (FCS), Presenting problems Checklist (PPC), and Outcome Questionnaire (OQ) and 225 (126 females

and 99 males) Pacific Islanders who completed all of the aforementioned measures. There were 403 Asian Americans (249 females and 154 males) who completed one or more of the FCS, PPC, and OQ-45, and 399 Asian Americans (248 females and 151 males) who completed all of the aforementioned measures. Thus, the available data for each analysis yielded differing sample sizes for each measure. Given the paucity of research in the current literature comparing Pacific Island students to Asian American students, we analyzed each measure with the total number of students in each group who completed it. Thus, at times, analyses for each measure had differing sample sizes. The sample sizes for the FCS analysis included 227 Pacific Island students and -403 Asian American students; for the PPC there were 227 Pacific Island students and 403 Asian American students; and for the OQ-45 there were 225 Pacific Island students and 399 Asian American students.

Setting

Archival data were obtained from a counseling center of a large intermountain university on the continental U.S. In addition to offering direct client services, the faculty and staff of this counseling center provide services to the university community through outreach, teaching, and training doctoral students in the Counseling and Clinical Psychology programs. In addition, clerkships and predoctoral internships that are accredited by the American Psychological Association are offered annually.

In addition to the individual counseling that is provided, the counseling center offers more than 25 psychotherapy groups each semester and biofeedback services. The academic calendar at this university holds classes during Fall and Winter semesters (each 16 weeks long) and Spring and Summer terms (each eight weeks long). The counseling center requires that students who seek services be enrolled full-time for Fall and Winter semesters, and at least part-

time for Spring and Summer terms. Students who meet these requirements are not only eligible for services but receive such services free of charge. During the time of the data collection, students did not have a session limit for individual or group therapy.

The counseling center provided demographic information on the clinicians who offered services from 1996-2013. In any given year during the 17-year span in which the data were collected from this university counseling center, clinicians included 21-28 full time psychologists, 3-5 psychology interns, and 16-22 practicum doctoral students. During this time, a total of 320 counselors provided services at this particular counseling center. This included an accumulation of 32 full time psychologists, 259 doctoral students, and 28 individuals who were practicum students when they started meeting with clients and then later were employed as staff members/faculty. Among the 320 counselors, 178 (55.6%) were male and 141 (44.1%) were female.

Counselors employ a range of modalities in their approach to therapy (e.g., acceptance and commitment therapy, existentialism, cognitive-behavioral therapy). As protocol, in this counseling center, when students seek counseling and after they complete the intake forms, they are assigned to the first available psychologist or doctoral student. At times the severity level, as determined from the intake forms, informed the assignment of clients to the appropriate clinician, depending on the clinician's level of competence (staff psychologists, interns, and doctoral students).

Instruments

Demographic questionnaire (DQ). This questionnaire was administered at intake and was used to collect basic demographic information including gender, age, ethnicity, citizenship, birth country, religious affiliation, and previous counseling experience.

Family Concerns Survey (FCS). The purpose of the FCS is to assess the occurrence and frequency of traumatic family history. Students completed this measure at intake and were asked to indicate whether each event had occurred or not during their childhood or adolescence and were given the following instructions: "Below is a list of experiences which may occur in families. Read each experience carefully. Some of these may have been true at one point in your life but not true at another point. Think about your childhood and your adolescence. If the experiences never happened in your family, please fill in the 'bubble' mark for NO. If you are unsure whether or not the experience occurred in your family at some time, please fill in the middle bubble mark for UNSURE. If the experience happened in your family during either of these periods, either during your childhood or adolescence, please fill in the bubble for YES."

The 18-item questionnaire assessed the occurrence of the following experiences within the family: parental divorce or permanent separation, parental unemployment, hostile arguing, death of a parent, parental substance or alcohol use, physical or sexual abuse, family member diagnosed or hospitalized with a mental disorder, sexual assault, mental disorders, attempted or completed suicide, family member with an eating disorder, and family member with criminal activity. The Cronbach's alpha for the FCS in this study was .78.

Presenting Problems Checklist (PPC). This measure is designed to examine the magnitude of distress that students experience in major areas of life functioning. It was developed by the Counseling and Mental Health Center at the University of Texas at Austin (Draper, Jennings, & Baron, 2003), after reviewing 12 presenting concern checklists by other counseling centers to construct a comprehensive list of presenting problems. The PPC was administered at intake at this counseling center. The questionnaire asked that clients to "Indicate the extent to which the problem is currently causing you distress" on a 5-point Likert scale (0 =

not at all; 4 = extremely) and to report "For how long have you had the problem" on a 6-point Likert scale (1 = less than a week old; 6 = over three years).

Issues such as academic stress, emotional distress, adjustment to college life, perfectionism, depression, sexual orientation, and body image were measured (Draper et al., 2003). Items are scored on two subscales, one score indicating how distressed a student is by a particular issue, and the other indicating how long they have experienced that problem. Thus, clinicians can gather information on each item regarding the magnitude of the distress the duration of the experienced distress for each item. The test-retest reliability was reported as .84 and internal reliability alpha as .93 for the PPC. It also has concurrent validity with other measures (*r* = .58 to .84; Kadera, Lambert, & Andrews,1996). The Cronbach's alpha of this measure was .90.

The Outcome Questionnaire-45 (OQ-45). The OQ-45 is designed to evaluate psychological functioning and symptomatic distress. It is a self-report measure consisting of 45 items. This instrument provides an efficient measurement tool to assess the efficacy of clinical interventions of patients in therapy. Items on this questionnaire are rated on a 5-point Likert scale from 0 (never) to 4 (almost always*).* This instrument provides a total score, in addition to three subscales measuring social-role functioning, symptom distress, and interpersonal relationships. The Social Role subscale measures levels of conflict, distress, dissatisfaction, and inadequacy in tasks related to family roles, employment, and leisure life. The Symptom Distress subscale measures anxiety- and depression-based disorders. The Interpersonal Relations subscale identifies problems and satisfaction in friendships, family, and marriage. Higher scores are typically indicative of higher levels of distress. A total score below 63 is classified as subclinical, while scores above 63 are considered in the clinical range (Lambert et al., 1996). A

14-point increase or decrease over the course of treatment can be considered reliable change, and the standard deviation is 15 points. The validity and reliability for this measure have been established across various settings, using clinical and normal populations. The OQ-45 has a high internal reliability alpha at .93, test-retest reliability at .84, and concurrent validity with other instruments (r = .58 to .84; Lambert et al., 1996). The Cronbach's alpha for this study is .92.

Literature Search

Pacific Islanders and Asian Americans have generally been categorized as a homogenous group, which in turn has trivialized their unique cultural values, background, and experiences in the United States. In 2000, the U.S. Census recognized Asian Americans and Native Hawaiian and Pacific Islanders (NHPI) as separate and unique groups. We conducted a literature search to examine how researchers have implemented the recommendation by the U.S. Census to separate Asian Americans from Pacific Islanders. An online search was conducted on the Academic Search Premiere, Ebscohost, ERIC, PsycARTICLES, PsycINFO, and Psychology and Behavioral Services databases for publications in the year 2015 with the following keywords:

("American" or "U.S. citizen*" or "U.S. National*" or "U.S.A." or "United States") and ("Pacific Island*" OR Hawaii* OR Tonga* or "Samoa*" OR "Fiji*" OR "Maori*" OR "Tahiti*" OR "Cook Island*" OR "Niue*" OR "Tokelau*" OR "Tuvalu*" OR "Rotuman*" OR "Uvean*" OR "Polynesia*" OR "Melanesia*" or "Micronesia*" OR "New Caledonia*" OR "Kiribati*" OR "Chamorro*" OR "Solomon Island*" OR "Marquesa*" OR "Marshallese" OR "Carolinian*" OR "Chuuk*" OR "Naurua*" OR "Papua*") and ("Asian*" OR "Chinese" OR "Japanese" OR "Korean*" OR "Mongolian*" OR "Taiwanese" OR "Tibet*" OR "Bangladesh" OR "Bhutan" OR "Indian*" OR "Mongolia*" OR "Nepal*" OR "Pakistan*" OR "Sri Lanka*" OR "Burmese" OR Burma* OR "Cambodia*" OR "Filipino*" OR "Hmong*" OR "Indonesia*" OR "Lao*" OR "Malaysia*" OR "Mien*" OR "Singapore*" OR "Thai" or "Vietnam*") and (DE Treatment* OR DE therapeutic OR DE Psychotherap* OR DE Counseling OR counseling OR intervention* OR Treatment* OR therapeutic OR Psychotherap* OR "symptom reduc*" OR "client improvement" OR "symptom remission" OR "client functioning" OR "client prognosis" OR "behavior change" OR "process outcome*" OR "treatment result*" OR "product of treatment" OR "symptom minimization" OR "symptom improvement" OR "treatment response" OR "symptom change*" OR "response to treatment" OR "behavioral change*" OR "symptom level change" OR "treatment result*" OR "outcome of treatment" OR "outcome of therapy" OR "outcome of psychotherapy" OR*

"counseling outcome" OR "outcome of counseling" OR "therapy efficacy" OR "therapy effectiveness" OR "treatment efficacy" OR "treatment effectiveness" OR "effectiveness of treatment" OR "effectiveness of therapy" OR "effectiveness of counseling" OR "efficacy of treatment" OR "reduc of symptom" OR "Counseling "progress" OR "therapy progress" or "Psychotherapy progress" OR DE "Helping Alliance" OR DE "Working Alliance" OR DE "Therapeutic Alliance" OR "Helping Alliance" OR "Working Alliance" OR "Therapeutic Alliance" OR "Client Satisfaction" OR "Client Attitudes" OR "Client Treatment" OR "Therapist Selection" OR DE "Client Satisfaction" OR DE "Client Attitudes" OR DE "Client Treatment" OR DE "Therapist Selection" OR DE "Patient-therapist" OR DE "Client-therapist" OR clients or "psychological service*" or clinic* or therapy or "mental health treatment*" or "mental health service*" or "mental health program" or "mental health recovery" or "mental health session")*

We calculated the frequency by taking the sum of research studies that examined an aspect of psychotherapy and included Pacific Islander and Asian American participants. Of those studies, we calculated the sum of the studies that distinguished between Pacific Islander and Asian American participants as separate populations in their data collection and report of results.

Procedure

As standard procedure at this particular university counseling center, students were given an informed consent form at intake, granting permission for the center to use their de-identified data in current or future research projects. The informed consent form described the purpose, procedures, terms of confidentiality, and potential benefits and risks of participating. This did not affect their eligibility to receive counseling services and students could decide not to allow their de-identified data to be used in future research. The counseling center collected and kept the data from the DQ, FCS, PPC, and OQ-45. When data were extracted for the purposes of this study, the primary researcher received information void of any identifying information.

Results

Statistical analyses were conducted using the IBM Statistical Package for the Social Sciences (SPSS) to evaluate the data.

Utilization of Services

Odds ratio analyses were used to determine the likelihood that Pacific Islander and Asian American students would attend therapy compared to the proportion of students in each population on campus. We calculated odds ratios as the probability of students who sought counseling services compared to the probability of students who did not. We used the enrollment data provided by the university and attendance data from the counseling center to examine the treatment utilization of Pacific Islander students and Asian American students at this counseling center from 1996 to 2013.

During the 17-year period, about 32,500 students were enrolled each year at the university, of which approximately 292 (0.01%) were Pacific Islander students and approximately 746 (0.02%) were Asian American students. On average, in any given year, approximately 1,300 students completed intake paperwork at this counseling center during the 17-year period, of which about 14 (1%) were Pacific Islanders and about 26 (2%) were Asian Americans.

After odds ratios had been calculated for each of the 17 years, the natural log of the odds ratios was averaged and weighted by standard error, then converted back to the metric of odds ratio for interpretation. An odds ratio of 1.0 indicates no significant difference. The aggregate odds ratio for Pacific Islander students compared to Asian American students was .91 (95% CI = 0.35-1.27), which is a very small difference, indicating that Pacific Islanders were 9% less likely to attend therapy than Asian Americans during this 17-year time period.

Attendance Trends in Treatment

We sought to determine if Asian American and Pacific Islander students differed in terms of their participation in treatment in the counseling center. Preliminary analyses revealed that

clients' initial OQ scores were related to clients' treatment attendance, in terms of both sessions attended and number of days in treatment. As would be expected, individuals with higher OQ scores (higher levels of distress) remained in treatment longer (for both Pacific Islanders and Asian Americans). We therefore needed to statistically control for clients' initial OQ scores when evaluating treatment duration, and we also included client gender and age as covariates.

We conducted Cox regression analyses to examine between group differences in psychotherapy attendance. The median number of days in treatment for both populations in this sample was 78. Given that university counseling centers operate in parallel with a university semester calendar, we analyzed data during the first 100 days in treatment, the approximate length of an academic semester. The Cox regression indicated that Asian American students were 30% more likely to remain in psychotherapy treatment longer than 100 days, when compared to Pacific Islander students (hazards ratio = 1.30; $p < .05$) in the presence of the covariates. Figure 1 portrays the client discontinuation curves for both groups during the first 100 days of treatment.

In our analysis of number of sessions attended, we only included students who had attended at least one therapy session. The average number of sessions attended was 10.9, but the data were positively skewed. The median number of sessions for the clients in our sample was five. We analyzed group differences through eight sessions of therapy because only about one third of clients received more sessions than eight and because previous research has indicated that eight sessions constitute standard treatment exposure (Choi, Buskey, & Johnson, 2010; Haase et al., 2008; Howard, Kopta, Krause, & Orlinsky, 1986). The results of the Cox regression indicate that Asian Americans were 24% more likely than Pacific Islanders to remain in psychotherapy through eight sessions (hazard ratio = 1.24; $p < .05$) after accounting for

covariates. Figure 2 displays the client discontinuation curves for both groups across the first eight sessions of treatment.

Presenting Problems Checklist

When clients seek counseling services, they report a variety of presenting concerns. Previous research suggests that Pacific Islanders and Asian Americans are the least likely of any ethnic minority group to utilize mental health services (Abe-Kim et al., 2007; Choi & Miller, 2014; Eisenberg et al., 2007; Le Meyer et al., 2009; Smith & Trimble, 2016). Thus, identifying the concerns that lead them to the counseling center is essential in understanding their experiences in therapy. Given the rank-ordered nature of the data on the PPC, a Kruskal-Wallis one-way analysis of variance (ANOVA) was used to examine any differences in the presenting concerns at intake between groups. This is a non-parametric method that does not assume a normal distribution of data. Client scores were analyzed on an item-by-item level because clinicians typically use the data from this measure on an item-by-item level.

The PPC examines the individual's reported level and duration of distress at intake. Table 6 provides the mean ranks for differences between Pacific Islanders and Asian Americans that were statistically significant. When compared to Asian American students, Pacific Islander students endorsed higher levels of distress in regard to sexual concerns ($p < .01$). Asian American students reported significantly higher levels of distress related to confusion about beliefs or values, making friends, and relationships with family, parents, or siblings ($p < .05$), in comparison to Pacific Islander students. In regard to the duration of distress, Pacific Islander students reported longer duration of stress related to alcohol or drugs, and relationship with family, parents, or siblings ($p < .05$). Asian American students reported significantly longer duration of distress related to decisions about career or major, and making friends ($p < .05$). The

aforementioned items were the only items that had statistically significant differences on level of endorsement between groups.

Family Concerns Survey

The FCS provides information about the distress clients feel from traumatic family experiences. Given the nature of the nominal data on the FCS, a chi-square test of independence was used to examine any disproportionate representation between groups. Similar to the PPC, the FCS was evaluated on an item-by-item level because clinicians typically use the FCS on an item-by-item level.

Pacific Islander students endorsed the occurrence of the following events at a significantly higher rate than Asian American students: parents divorced or permanently separated before the student was 18 years old ($p < .01$), physical abuse in family, rape/sexual assault of client or family member ($p < .01$), family member with a debilitating illness ($p < .05$), and family member prosecuted for criminal activity ($p < .001$).

Psychotherapy Outcome

We examined the initial distress levels as reported on the OQ-45 at intake. A one-way analysis of variance (ANOVA) found no statistical differences in the initial distress levels between Pacific Islanders and Asian Americans.

We examined the severity of distress levels by conducting a repeated measures analysis of covariance (ANCOVA) controlling for initial symptom severity, participant age and gender. The results of the ANCOVA showed that both groups improved across time (Wilks lambda .987, $F = 7.12$, $p < .01$), indicating a reduction of client symptoms after psychotherapy for both groups. When controlling for gender, age, number of sessions attended, and ethnic group, there were no significant differences in the psychotherapy outcomes between groups.

Exploratory Factor Analysis

The OQ-45 measure yields an overall score and three scores from the following subscales: Symptom Distress (example item: I feel no interest in things), Interpersonal Relationships (example item: I am satisfied with my relationships with others), Social Role (example item: I have too many disagreements at work/school). We used an exploratory factor analysis (EFA) to identify the underlying relationships in the OQ-45 scores of both groups. More specifically, through factor loadings, we examined how the OQ-45 scores for each group would relate to the subscales developed by Lambert et al. (1996).

We conducted a preliminary EFA to remove items that did not have substantial loading onto any factor. To accomplish this, we used a Kaiser-Meyer-Olkin (KMO) Test to measure the proportion of variance among variables that might be common variance. KMO values between 0.8 and 1 indicate that the sample is adequate and KMO values below 0.6 indicate inadequacy. For the Pacific Islander students, the KMO value was 0.86 and for the Asian American students the KMO value was 0.90. We used Bartlett's sphericity was used to measure any redundancy between variables and to determine whether the variables were perfectly correlated or orthogonal. The Bartlett's Test of Sphericity is recommended to be less than 0.05 prior to conducting a factor analysis. The Bartlett's Test of Sphericity was significant for both the Pacific Islander students ($\chi 2$ (225) = 4407.58, $p < .0005$) and Asian American students ($\chi 2$ (399) = 7021.03, $p < .0005$).

Communalities were examined to determine the degree to which an item correlated with all other items. Low communalities (between 0.0-0.3) indicate that a variable may not load significantly on any factor so high communalities closer to 1.0 are ideal. Pacific Islander students and Asian American students had similar items with the lowest communalities

including: item 11 (After heavy drinking, I need a drink the next morning to get going), item 14 (I work/study too much), item 17 (I have an unfulfilling sex life), and item 32 (I have trouble at work/school because of drinking or drug use). In addition, item 17 (I have an unfulfilling sex life) had one of the lowest communalities for Pacific Islander students and item 16 (I feel annoyed by people who criticize my drinking or drug use) had one of the lowest communalities for Asian American students.

To determine the optimal number of components to extract for the scale, we conducted a scree plot, which suggested a four-factor solution for the Pacific Islander students and a three factor-solution for the Asian American students, meaning that the answers of Pacific Islander students could be explained by four factors while the answers of Asian American students could be explained with three factors. We conducted the EFA with principal components extraction using a varimax rotation for orthogonal factors.

In the development of the OQ-45, Lambert et al. (1996) created three subscales: symptom distress, interpersonal relationships, and social role. The results in the Exploratory Factor Analysis for Pacific Islander and Asian American students slightly deviated from the proposed subscales. The factor structure model for Pacific Islanders included the following dimensions: (1) symptom distress, (2) life satisfaction, (3) somatic distress, and (4) risk factors. For Asian American students, the factor structure model included the following dimensions: (1) symptom distress, (2) life satisfaction, and (3) somatic and interpersonal distress.

Interestingly, both groups answered items similarly regarding psychological distress and life satisfaction. The *symptom distress* dimension included items that measured cognitive and emotional distress. Sample items include: I feel hopeless about the future, I feel worthless, I feel no interest in things. The *life satisfaction* dimension included items that were positively related

to well-being, life, and perception of self. Sample items include: I feel loved and wanted, I am satisfied with my life, and I am a happy person.

Pacific Islander students and Asian American students differed significantly on the remaining dimensions. Pacific Islander students had two additional factors. The *somatic distress* factor emphasized concerns related to their physical body and physical health. The *risk factors* dimension was another factor endorsed by Pacific Islanders. Sample items from this dimension include: I have thoughts of ending my life, I have trouble at work/school because of drinking or drug use, I feel annoyed by people who criticize my drinking or drug use. For Asian American students, the *somatic and interpersonal distress* dimension was a conglomerate of items regarding somatic and interpersonal distress. Sample items include: I have headaches, I have sore muscles, and I have trouble getting along with friends and close acquaintances.

Literature Search

Pacific Islanders and Asian Americans have historically been categorized as a homogenous group. This common practice has masked the unique needs and experiences of both groups. In 2000, the U.S. Census officially recognized Asian Americans and Native Hawaiian and Pacific Islanders as separate entities (Srinivasan & Guillermo, 2000). We conducted a literature search on the Academic Search Premiere, Ebscohost, ERIC, PsycARTICLES, PsycINFO, and Psychology and Behavioral Services databases to examine if recent studies combine or separate these groups. The literature search yielded 141 articles that involved Asian Americans and Pacific Islanders (using the keywords reported in the Methods section). Of the 141 articles, 41 articles were related to aspects of psychotherapy. Nine of those 41 studies analyzed Asian Americans and Pacific Islanders as separate population groups. Therefore, unfortunately, it seems that ethnic lumping (Allen, Cox, et al., 2016) or ethnic

glossing, as Trimble and Bhadra (2013) described it, continues to be pervasive in psychological research pertaining to Asian Americans and Pacific Islanders.

Discussion

Asian Americans and Pacific Islanders have historically been aggregated as a combined group in spite of encouragement by the U.S. Census in 2000 to consider these populations as separate groups. There continues to be a paucity of research in the current psychology literature that recognizes each group as a separate entity. To date, there have not been any studies that we know of that have examined and compared the utilization rates and presenting concerns of Pacific Islander students to Asian American students in college counseling centers. The current study compares these groups and provides information about their counseling utilization, presenting concerns, family concerns, and psychotherapy outcome.

Treatment Utilization

When analyzing treatment utilization rates between Pacific Islander and Asian American students, Pacific Islander students were only nine percent less likely to attend therapy than Asian American students. This difference was very small and did not approach statistical significance. This suggests that Pacific Islander and Asian American students utilize therapy at comparable rates at this particular university.

Attendance Trends in Therapy

Our findings indicate that higher levels of initial distress, as reported by the initial OQ-45 score are correlated to longer courses of treatment and more sessions attended for both Asian American and Pacific Island students in our sample. Interestingly, we found differences in attendance trends amongst Asian American and Pacific Islander students. More specifically,

Asian American students were more likely than Pacific Islander students to remain in treatment during the first 100 days of treatment and during the first eight sessions.

Although the reasons for relatively early termination among Pacific Islander students remain unknown, we hypothesize several plausible explanations for why they were less likely than Asian American students to continue therapy. One potential explanation could be that Pacific Islander students felt satisfied with counseling and needed fewer sessions to meet their treatment needs. Another consideration is that although there is a small representation of Pacific Islanders on this particular university campus, there is a large Pacific Island population surrounding the university. It is possible that Pacific Island students had a strong support network extending beyond the services offered on campus to help them deal with their distress. Comparatively, there is a smaller community of Asian Americans surrounding the university, so it is possible that Asian American students rely more on university services as one of their primary support networks.

It is possible that the cultural sensitivity and responsiveness of the clinicians, or lack thereof, may have impacted the client's perception of the clinician's ability to help them and may have contributed to early termination for Pacific Islander students.

Psychotherapy Outcome Rates as Measured by the OQ-45

Based on the psychotherapy outcome results, counseling was equally effective in that levels of distress (as measured by the OQ-45) decreased over time for both Pacific Islander and Asian American students in this study. There were no statistically significant differences between groups after controlling for gender, age, and number of sessions attended.

The results of our exploratory factor analysis of the OQ-45 showed that both populations endorsed items regarding symptom distress and life satisfaction factors. The symptom distress

factor was the only one retained from the subscales created by Lambert et al. (1996). This factor measured the extent to which participants endorsed symptoms related to psychopathology, so both populations experienced and reported these symptoms in a similar way. Both groups endorsed positive items regarding life satisfaction, indicating that Pacific Islander and Asian American students were generally satisfied and endorsed positive emotions about their lives.

For Asian American students, somatic distress was highly correlated with interpersonal relationship distress. Thus, these issues were combined into one factor. The somatic concerns reported by Asian American students were consistent with findings in current literature (Nguyen & Anderson, 2005) that show high rates of physical concerns among Asians who experience distress, specifically interpersonal relationship distress. For the Pacific Islander students, somatic concerns were not highly correlated with other issues, so this factor was independent from the other dimensions.

The last dimension for Pacific Islanders could be explained as risk factors. This dimension was related to questions inquiring about drug/alcohol use and suicidal ideation. This finding showed that Pacific Islanders experienced and reported risk factors separately from other distress. Items on this factor are consistent with our results on the Family Concerns Survey, indicating higher rates of criminal activity, drug use, and incarceration in Pacific Islander families. Thus, clinicians are encouraged to carefully assess the history of drug and alcohol use when meeting with Pacific Islander students.

Family Concerns as Measured by the FCS

The FCS was constructed to assess the occurrence and frequency of traumatic family history. Although previous research has shown that Pacific Islanders tend to turn to their family as the first source of help and guidance when dealing with emotional issues (Allen & Heppner,

2011), family issues actually contributed to the distress that Pacific Island students in this study experienced when they sought counseling.

Pacific Islander students indicated higher rates of physical abuse within their families. From a Western perspective, Pacific Islanders use rather harsh disciplinary actions. When a Pacific Islander child disobeys or defies an authority figure, it is often met with physical discipline, including some form of hitting or being beaten with sticks, brooms, sandals, belts, and/or fists (Meleisea & Schoeffel, 1996; Pereira, 2010). Generally, this form of discipline is acceptable in Pacific cultures because of the common belief that it is an effective way to teach their children correct behavior (Meleisea & Schoeffel, 1996; Pereira, 2010). It is a cultural understanding that children should not argue nor should they disagree with their parents. Doing so would be considered "bad behavior" that would warrant physical discipline. Thus, Pacific Islanders might have difficulties adjusting to child-rearing methods that comply with the U.S. legal system. Furthermore, while higher rates of physical abuse within their families may be seen as problematic from a Western worldview, Pacific Islander students may not perceive physical abuse in the same way that the question for this measure was designed.

Pacific Islanders reported significantly higher rates of family members with debilitating illnesses, which is consistent with their statistics when compared to the general population in America. Pacific Islanders have disproportionately high risks of obesity (35%), cancer (24%), heart disease (20%), stroke (11%), and diabetes (6%), all of which are much higher than the average population (Empowering Pacific Islander Communities & Asian Americans Advancing Justice., 2014). Traditionally, in Pacific cultures, larger stature was an indication of wealth, social standing, beauty, and good health (Hawley & McGarvey, 2015). Migration from their native lands has taken Pacific people away from farming and active lifestyles to become more

sedentary. Migration, modernization, and urbanization have contributed to higher rates of obesity (Hawley & McGarvey, 2015). It is possible that when Pacific Islanders are in college, they may not be making healthy choices. Furthermore, they might carry with them additional stress from thinking and worrying about the health conditions of their family members at home.

Another area of significance on the FCS indicated that Pacific Islanders reported more occurrences of being a victim or having a family member who was a victim of rape or sexual assault, and family members involved in criminal activity. In 2010, around 12,000 Pacific Islanders were in U.S. correctional facilities (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014). Between 2002 and 2010 the number of incarcerated Pacific Islanders increased 144%. Furthermore, Pacific Island women are disproportionately imprisoned. In 2010, females made up 1 in 8 of incarcerated Pacific Islanders. Given the strong family ties that Pacific Island families have and the rate of crime within Pacific communities, by the time they attend university, they may be more likely than Asian American students to have known someone in their family, immediate or extended, involved in criminal activity.

Distress of Presenting Concerns as Measured by the PPC

Asian American students reported higher distress about their relationships with family, parents, and siblings than their Pacific Islander counterparts. Traditionally, Asian American parents have more control over their children (Yee et al., 2007). Even in college, Asian American young adults are still expected and obligated to obey their parents. While they are away at college, the distance from parents may give Asian American students more opportunities to make more of their own decisions. Asian American students are exposed to more Western values that emphasize individualism and autonomy and the cultural chasm may increase (Yee et al., 2007). However, many Asian American parents expect to exercise the same control and

guidance over their children's decisions (Yee et al., 2007). When Asian American adolescents and young adults attempt to seek autonomy and freedom from their parents, it may put a strain on their relationships. Asian American students who grow up with the influence of American values may view their parents as controlling and over protective (Yee et al., 2007).

Our findings indicated that Asian American students reported higher levels of distress due to confusion about their beliefs. One possible explanation for this could be related to findings in a previous study (Boyd, Hunt, Kandell, & Lucas, 2003) that showed that Asian American women typically experienced diffused identity, or in other words, they had not explored nor had they committed to a solid set of life goals and values. Boyd et al. (2003) suggested that Asian American women are faced with conflicting expectations from their culture and family and the society in which they live. Thus, when they experience a diffused identity, they may be struggling to satisfy the expectations of cultural norms and societal norms simultaneously.

Pacific Islanders reported higher levels of distress around sexual concerns. Although Pacific cultures emphasize a strong desire to discuss their problems and issues within the family, there are some topics including sexuality, that remain concealed, out of respect for other members of the family (Taumoefolau, 2013). It is out of this deep respect that Pacific families may not feel comfortable discussing topics such as sexuality in the home. Consequently, when Pacific Islanders reach college, they may have questions and concerns about sexuality that were not addressed by anyone in their social network. It is possible that they may only feel comfortable discussing their sexual concerns with someone outside of the family system. Thus, they might find it more appropriate to have these conversations with a clinician when they seek counseling.

In the current study, Asian American students reported having higher distress and duration of this distress in regards to making friends. Given the tendency for Asian Americans to generally be more reserved and modest (Kawahara, Pal, & Chin, 2013), it is possible that they may have difficulties fitting in or making connections with the majority of people who value extroversion. Another possible explanation is that Asian American students may find themselves so focused on work and academics, due to pressure from their parents to excel in academics, to the point that they do not allocate time to socializing (Hyun, 2005; Leong, 1991; Lucas & Berkel, 2005).

Duration of Presenting Concerns as Measured by the PPC

The sample of Pacific Islanders in this study reported longer duration of involvement with alcohol or drugs. This finding is actually consistent with the aforementioned Risk Factors that Pacific Islanders reported in our Exploratory Factor Analysis of the OQ-45. When compared to other ethnic college students, Asian Americans and Pacific Islanders reported greater use of cigarettes, pipes, and cigars. They also reported being more likely to consume alcohol (Sabato, 2016). It is speculated that our findings involving higher criminal activity, higher rate of sexual abuse victims, and longer duration of involvement with alcohol or drugs may be related. Further research is recommended to investigate these findings among Pacific Islander college students.

The sample of Asian American students in this study experienced longer distress with decisions about their major and/or career when compared to Pacific Islander students, which is consistent with existing research indicating higher levels of academic distress for Asian Americans at intake (Lockard, Hayes, Graceffo, & Locke, 2013). This is also consistent with the findings of previous studies (Leong, 1991; Lucas & Berkel, 2005) that Asian Americans often

take into account the expectations and desires of significant people in their lives when making decisions regarding vocation and career. For many Asian Americans, their attitudes and behaviors are shaped by the collective familial and cultural values and expectations. Thus, their own personal interests may be pushed aside to satisfy the family. Asian American parents may strongly encourage, perhaps even pressure, their children to pursue a better vocation than their own (Lucas & Berkel, 2005). Often times this means parents may set high expectations and hopes for their children to pursue lucrative careers, whether or not they align with their personal interests. Asian American students may feel pressured to major in distinguished fields, namely medicine, science, or business, because these careers may provide prestige, status, and financial security (Yee et al., 2007). The pressure placed on Asian Americans to excel in areas of study combined with the emphasis universities place on individuality and pursuing careers that align with personal interests, may put these students in a unique and uneasy conundrum.

Implications for Practice

With increasing mental health concerns on college and university campuses, along with the increase in diversity of student bodies, there is a need to focus on the use and effectiveness of counseling services for ethnic and racial minority students. We found that Pacific Islander students were less likely to seek counseling services when compared to Asian American students. Clinicians and counseling centers are encouraged to reach out to Pacific Islander students on campus (through multicultural student services, Pacific Island student clubs, etc.) to offer and educate them about mental health services. In addition, counseling centers are encouraged to collect data on termination to better understand why Pacific Islanders tend to discontinue therapy earlier than their peers. It is possible that Pacific Islander students had their needs met in fewer sessions or, perhaps, discontinued treatment prematurely.

Research has shown that culturally adaptive therapy is effective (Griner & Smith, 2006; Smith et al., 2011). Thus, it is essential that clinicians seek to understand the personal cultural and familial experiences of their clients so as to not impose their own stereotypes and assumptions on them. They are encouraged to demonstrate cultural humility and an openness and respect to the cultural differences they have with their clients of color.

Students of color on college campuses often face greater distress, depression, family concerns, social anxiety, and academic issues than their White student counterparts (Hayes, Chun-Kennedy, et al., 2011). Based on our findings, Pacific Islanders reported higher rates of traumatic family experiences. This contradicts previous research that reports the common practice of Pacific Island families to keep their issues, disagreements, and conflicts within the family, also referred to as "saving face" (Weil & Lee, 2004). It would be incumbent on clinicians to understand the complexities of this family dynamic. Validating the strength and importance of family relations for Pacific Island students, while also creating a safe space for them to disclose possible stress stemming from their family, would most likely be beneficial for them in counseling.

Although individuality is valued in Western culture, clinicians are encouraged to understand collectivist cultures and values among Pacific Island and Asian American students. Since Asian American students in this study reported higher rates of distress in regards to deciding on a career, clinicians should explore cultural and familial expectations, values, and perhaps even pressure that they face from their family. Since our findings show that Asian American students have difficulties making friends, clinicians may encourage Asian American students to be involved in student activities to build relationships and strengthen their social networks.

Counseling centers would benefit from holding workshops, groups, or forums specifically for ethnic minority students to connect around their experiences as minorities, especially in universities with a predominantly White student population. Psychoeducation could be offered in these settings to help Asian American and Pacific Islander students identify and understand psychological services that may help them to process and better understand their experiences on campus. We recommended that an ethnic or racial minority faculty member, who would understand the nuances that ethnic minority students face, lead these groups. Since Pacific Islanders reported higher levels of distress related to sexual concerns, it is recommended that clinicians be prepared to provide sexual education either in individual therapy or in a workshop setting. Pacific Islanders also reported more occurrences of rape and sexual assault within their families, so it is recommended that clinicians assist in connecting them with other offices on campus that could advocate for them (e.g., Title IX Office).

Since Pacific Islanders and Asian Americans are typically categorized as a homogeneous group, it is imperative that counseling centers distinguish between both populations. For example, if demographics are gathered in a checklist form on their intake paperwork, clinicians can ensure that these two groups are separated and not categorized as one. It is important for researchers to recognize and understand the cultural differences among Pacific Islanders and Asian Americans and separate them in future studies.

Limitations

In regards to generalizability, since the current study was conducted at a single university counseling center, results are limited to college students who have sought counseling services (i.e., a clinical college population). Furthermore, since the university where this study took place

is a religious institution, where 98% of the student body believes in the same faith, it is possible that the results of this study may be unique to that religious population.

Another limitation was the use of archival data, which restricted the ability to gather more information including level of racial identity development, acculturation, and socioeconomic background. Based on the archival data we gathered, we had no information on whether Pacific Islander or Asian American students were matched with clinicians of the same racial and ethnic background. Information about reasons for client termination had not been collected. Thus, it was unknown whether the clinician and student agreed upon termination or if the student dropped out of treatment prematurely. Further, the data collection was not consistent throughout the years 1996 to 2013 so there were clients who did not complete all three questionnaires who were included for this study.

Since the data in this study was self-reported, there are likely other limitations. Although the Presenting Problems Checklist and the OQ-45 measure the client's level of distress at intake or when they set up the intake appointment for counseling, the Family Concerns Survey required that they remember experiences from early childhood/adolescent years. It is possible that the results of this survey may have not been completely accurate due to embarrassment or hesitancy to reveal certain family traumas, especially among the populations that we examined. It is also possible that the accuracies of older memories may have diminished over time.

Another limitation of the current study is the way that some of the items on the Family Concerns Survey were presented. The wording of several items did not specify whether the question was directed to the respondent's experiences of trauma or a family member's experience of trauma. For example, question 9 states "Physical abuse in your family." Respondents may be unclear if they should report their own experience of physical abuse in the

family, or a family member's experience. Thus, answers may vary according to whether the respondent answered for himself/herself or for other family members. Future revisions of this instrument might clarify the questions to get a clearer answer from respondents.

On the Presenting Problems Checklist, a few items were vague. Although it informs researchers of the general presenting concern that brings clients into the counseling center, it is difficult to draw conclusions about groups of people when the question is vague. For example, one item states "Sexual Concerns." Although clinicians and researchers get a general idea of concerns that clients have at intake, it might be valuable to clarify several items on this questionnaire.

Another limitation is that the measures used in this study were not normed for the Asian American or Pacific Islander populations. Thus, it is possible that these measures may not provide an accurate account of their experiences.

The current study highlighted the differences between Pacific Islanders and Asian Americans in an effort to disaggregate the data for both populations. However, it is imperative to recognize the limitation of utilizing the terms "Pacific Islander" and "Asian Americans", as it also categorized individual unique and diverse cultures within each group.

Conclusion

Historically, the needs and experiences of Asian Americans and Pacific Islanders have been categorized into a homogenous group. This has masked the unique experiences of both groups. There is little research examining the similarities and differences in the psychotherapy experiences of Asian Americans and Pacific Islanders. This research was conducted to better understand the treatment concerns of both populations in a university setting. Using archival data from 1996 to 2013, we examined demographic information, family concerns, presenting

problems and psychotherapy outcomes using the Family Concerns Survey, Presenting Problem Checklist, and Outcome Questionnaire-45.

The findings of this study indicate that Pacific Islanders and Asian Americans utilize psychotherapy at about the same rate. At termination, students from both groups improved according to an outcome measure (OQ-45). Asian American students in this study were more likely to remain in therapy longer than eight sessions and 100 days than Pacific Islander students. The reasons for Pacific Islanders' earlier treatment termination remain unknown.

Pacific Islander students endorsed more traumatic experiences in their family history including more instances of parental divorce, physical abuse, rape and sexual assault, criminal activity, and debilitating illnesses. Pacific Islander students reported greater distress about sexual concerns, alcohol and drug use, and relationship with family. Given these findings, clinicians are encouraged to understand the complexities of familial relationships for Pacific Islanders. Although the family unit can be a strong coping mechanism for Pacific Islanders, it may also be the source of distress that presents in counseling. Asian American students experienced greater distress about making friends, confusion about beliefs, and decisions about career. Clinicians may benefit from understanding the expectations and perhaps the pressure from family, community, and culture when Asian Americans choose a career. Clinicians who work with Asian American or Pacific Island students are encouraged to understand their unique experiences and culturally modify treatment to meet their needs.

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APPENDIX A

Tables and Figures

Table 1

Demographic Information

Racial Group	Mean Age	% Female	% Male	% Married	% Single	% Divorced
Asian American	21.9	61.7	38.3	32.3	60.7	1.5
Pacific Islander	22.2	60.2	39.8	35.9	59.8	1.5

Note. Some participants in the study did not report some of their demographic information, so several categories above do not add up to 100%.

Table 2

Odds Ratios Comparing Therapy Utilization Rates of Pacific Islanders (PI) to Asian Americans (AA)

Year	Comparing PI and AA	
	Odds Ratio	SE
1996	0.47	0.66
1997	-0.76	1.07
1998	-0.28	0.52
1999	1.02	0.42
2000	0.66	0.39
2001	-0.05	0.38
2002	0.13	0.44
2003	-0.04	0.39
2004	-0.09	0.35
2005	0.83	0.45
2006	-0.28	0.34
2007	-0.21	0.38
2008	-0.60	0.34
2009	-0.15	0.34
2010	-0.31	0.34
2011	-0.54	0.28
2012	-0.49	0.27
2013	-0.40	0.33
Total	0.91	-0.09

Note. The odds ratio was calculated by the proportion of student enrollment from each population group compared to the proportion of students who attended therapy from each population each year. Both of these factors varied each year. An odds ratio greater than 1 indicates a greater treatment utilization rate by the second group compared (AA).

Table 3

Cox Regression Analysis Comparing Days in Treatment of Pacific Islander and Asian American Students

Variable	Sig.	Exp(B)	SE
Ethnicity	<.05	1.3	<.05
Initial OQ	<.05	.99	<.05
Gender			
Age			

Note. Cox regression analysis comparing the likelihood of discontinuance of therapy between Pacific Islander and Asian American student when controlling for treatment length (100 days), initial OQ score, gender, and age. Initial OQ-45 score was significantly related to attendance in terms of length of treatment in days. Pacific Islander students spent significantly less time in treatment. Results with statistical significance were reported.

Table 4

Cox Regression Analysis Analyzing Differences in Number of Sessions Attended by Pacific Islander and Asian American Students

Variable	Sig.	Exp(B)	SE
Ethnicity	<.05	1.24	<.05
Initial OQ			
Gender			
Age			

Note. Cox regression analysis comparing the likelihood of discontinuance of therapy between Pacific Islander and Asian American students when controlling for number of sessions (8), initial OQ score, gender, and age. Asian American students attended more sessions than Pacific Islander students. Results with statistical significance were reported.

Table 5

Pearson Chi-Square Test for Differences for Family Concern Survey (FCS): Pacific Islander Students (n = 227) and Asian American Students (n = 403)

Item		Value	*df*	*p*	Pacific Island Count %			Asian 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.	9.5	2	.009	78%	0%	22%	87%	0%	13%
2.	Family frequently moved.				71%	5%	24%	76%	4%	20%
3.	Parent(s) unemployed for an extended period of time.				73%	4%	20%	76%	4%	20%
4.	Frequent, hostile arguing among family members.				46%	8%	46%	49%	7%	44%
5.	Death of parent(s) before you were 18 years old.				94%	0%	6%	97%	0 %	3%
6.	Parent(s) with a drinking problem.				89%	3%	8%	92%	3%	5%
7.	Parent(s) with a drug problem.	4.5	2	.106	93%	1%	6%	96%	1%	3%
8.	Parent(s) with a gambling problem.	5.2	2	.076	96%	3%	1%	95%	1%	4%
9.	Physical abuse in your family.	14.7	3	.002	73%	4%	23%	81%	7%	12%
10.	Sexual abuse in your family.				87%	4%	9%	91%	2%	7%
11.	Rape/sexual assault of yourself or family member.	7.0	2	.030	85%	2%	13%	91%	2%	7%
12.	Family member hospitalized for emotional problems.				83%	7%	10%	85%	5%	10%
13.	Family member diagnosed with a mental disorder.				74%	9%	17%	75%	6%	19%
14.	Family member attempted suicide.				78%	7%	15%	82%	8%	10%
15.	Family member committed suicide.				96%	0%	4%	97%	1%	2%
16.	Family member with a debilitating illness, injury, or handicap.	7.7	2	.022	76 %	5%	19%	84%	3%	13%
17.	Family member prosecuted for criminal activity.	14.5	2	.001	81%	4%	15%	91%	3%	6%
18.	Family member with an eating problem.				74 %	10%	16%	78%	8%	14%

Table 6

Kruskal-Wallis Test for Differences for Presenting Problem Checklist (PPC) Distress and Duration: Pacific Islander Students (n = 227) and Asian American Students (n = 403)

	Distress				Duration			
			Mean Rank				Mean Rank	
Item	χ^2	*p*	PI	AA	χ^2	*p*	PI	AA
1. Academics or school work or grades								
2. Adjustment to the university								
3. Alcohol or drugs	2.9	.089	321.8	312	5.3	.022	322.2	311.7
4. Anxiety, fear, worries, or nervousness								
5. Assertiveness								
6. Breakup/loss of a relationship								
7. Concentration								
8. Confusion about beliefs or values	4.3	.038	298.4	325.1				
9. Dating concerns								
10. Death or impending death of a significant person								
11. Decisions about career or major					5.8	.016	293.8	327.8
12. Depression								
13. Developing independence from family								
14. Ethnic/racial discrimination								
15. Eating: binging, vomiting, dieting, laxatives, etc.								
16. Fasting or avoiding food								
17. Finances								
18. Homesickness								
19. Irritability, anger, or hostility								
20. Making friends	7.0	.008	293.2	328.1	5.8	.016	298.1	325.2
21. Perfectionism								
22. Physical health problems (e.g., headaches, etc.)								
23. Problem pregnancy								
24. Procrastination or getting motivated								
25. Rape, sexual assault, or unwanted sex.								
26. Reading or study skills problems								
27. Relationship with family, parents, or siblings	3.8	.052	298.2	325.2	5.0	.025	331.1	306.7
28. Relationship with friends, roommates, or peers								
29. Relationship with romantic partner or spouse								
30. Religious or spiritual concerns								
31. Self-esteem or self-confidence								
32. Sexual concerns	6.2	.013	333.6	305.3				
33. Sexual identity or orientation issues								
34. Sexually transmitted disease(s)								
35. Shyness, being ill at ease with people								
36. Sleeping problems								
37. Stress management								
38. Suicidal feelings or thoughts								
39. Test, speech, or performance anxiety								
40. Time management								
41. Uncertain about future or life after college								
42. Weight problems or body image								

Table 7

Kaiser-Meyer-Olkin (KMO) Test and Bartlett's Sphericity for Pacific Island Students

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.857
Bartlett's Test of Sphericity	Approx. Chi-Square	4407.581
	df	990
	Sig.	.000

Note. The KMO test was conducted to measure the proportion of variance among variables that might be considered common variance. KMO values between 0.8 and 1 indicate that the sample is adequate and any KMO value below 0.6 means an inadequate sample. Bartlett's sphericity measures any redundancy between variables to determine whether or not the variables are perfectly correlated or orthogonal. It is recommended that the Bartlett's Test of Sphericity value be less than 0.05 prior to conducting a Factor Analysis.

Table 8

KMO Test and Bartlett's Sphericity for Asian American Students

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.898
Bartlett's Test of Sphericity	Approx. Chi-Square	7021.028
	df	990
	Sig.	.000

Note. The KMO test was conducted to measure the proportion of variance among variables that might be considered common variance. KMO values between 0.8 and 1 indicate that the sample is adequate and any KMO value below 0.6 means an inadequate sample. Bartlett's sphericity measures any redundancy between variables to determine whether or not the variables are perfectly correlated or orthogonal. It is recommended that the Bartlett's Test of Sphericity value be less than 0.05 prior to conducting a Factor Analysis.

Table 9

Communalities for Pacific Island Students

	Initial	Extraction
Q13	1.0	.71
Q24	1.0	.66
Q43	1.0	.62
Q9	1.0	.61
Q20	1.0	.61
Q31	1.0	.61
Q21	1.0	.60
Q23	1.0	.57
Q22	1.0	.56
Q45	1.0	.56
Q5	1.0	.55
Q1	1.0	.54
Q15	1.0	.54
Q42	1.0	.53
Q6	1.0	.51
Q4	1.0	.50
Q28	1.0	.50
Q33	1.0	.50
Q12	1.0	.49
Q34	1.0	.48
Q36	1.0	.46
Q3	1.0	.45
Q18	1.0	.45
Q10	1.0	.44
Q37	1.0	.44
Q8	1.0	.43
Q30	1.0	.43
Q2	1.0	.42
Q38	1.0	.40
Q29	1.0	.37
Q27	1.0	.35
Q39	1.0	.35
Q40	1.0	.35
Q19	1.0	.33
Q35	1.0	.32
Q41	1.0	.32
Q7	1.0	.31
Q25	1.0	.30
Q44	1.0	.28
Q26	1.0	.27
Q16	1.0	.24
Q32	1.0	.20
Q17	1.0	.17
Q14	1.0	.13
Q11	1.0	.104

Note. Extraction method: principal component analysis. Communalities were examined to determine how an item correlated with all other items. Low communalities (between 0.0-0.3) indicate that a variable might not load significantly on any factor.

Table 10

Communalities for Asian American Students

	Initial	Extraction
Q31	1.0	.66
Q13	1.0	.63
Q15	1.0	.60
Q20	1.0	.60
Q23	1.0	.59
Q24	1.0	.56
Q9	1.0	.51
Q3	1.0	.50
Q43	1.0	.49
Q40	1.0	.48
Q42	1.0	.47
Q21	1.0	.47
Q22	1.0	.46
Q12	1.0	.45
Q28	1.0	.45
Q11	1.0	.45
Q4	1.0	.44
Q37	1.0	.43
Q7	1.0	.41
Q6	1.0	.41
Q10	1.0	.40
Q36	1.0	.40
Q33	1.0	.39
Q27	1.0	.39
Q2	1.0	.38
Q5	1.0	.37
Q38	1.0	.37
Q18	1.0	.36
Q29	1.0	.36
Q45	1.0	.36
Q8	1.0	.35
Q1	1.0	.34
Q34	1.0	.33
Q30	1.0	.32
Q41	1.0	.29
Q25	1.0	.29
Q39	1.0	.28
Q44	1.0	.27
Q19	1.0	.27
Q35	1.0	.16
Q16	1.0	.16
Q17	1.0	.10
Q14	1.0	.08
Q32	1.0	.07
Q26	1.0	.07
Q11	1.0	.04

Note. Extraction method: principal component analysis. Communalities were examined to determine how an item correlated with all other items. Low communalities (between 0.0-0.3) indicate that a variable might not load significantly on any factor.

Table 11

Rotated Component Matrix for Pacific Island Students

	1	2	3	4
9. I feel weak	.75			
5. I blame myself for things	.73			
22. I have difficulty concentrating	.72			
23. I feel hopeless about the future	.72			
4. I feel stressed at work / school	.69			
28. I am not working / studying as well as I used to	.66			
15. I feel worthless	.65			
10. I feel fearful	.65			
18. I feel lonely	.65			
3. I feel no interest in things	.63			
2. I tire quickly	.62			
6. I feel irritated	.61			
42. I feel blue	.57			
38. I feel that I am not doing well at work / school	.47			
40. I feel something is wrong with my mind	.45			
27. I have an upset stomach	.44			
30. I have trouble getting along with friends and close acquaintances	.44			
25. Disturbing thoughts come into my mind that I cannot get rid of	.39			
16. I am concerned about family troubles	.34*			
13. I am a happy person		.81		
24. I like myself		.80		
21. I enjoy my spare time		.77		
20. I feel loved and wanted		.76		
43. I am satisfied with my relationships with others		.71		
31. I am satisfied with my life		.70		
12. I find my work / school satisfying		.67		
1. I get along well with others		.59		
37. I feel my love relationships are full and complete		.50		
34. I have sore muscles			.67	
45. I have headaches			.65	
33. I feel that something bad is going to happen			.60	
36. I feel nervous			.57	
39. I have too many disagreements at work / school			.52	

35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth	.50	
44. I feel angry enough at work/school to do something I might regret	.45	
29. My heart pounds too much	.43	
27. I have an upset stomach	.39	
26. I feel annoyed by people who criticize my drinking (or drug use)		.51
8. I have thoughts of ending my life		.48
32. I have trouble at work / school because of drinking or drug use		.43
19. I have frequent arguments		.41
7. I feel unhappy in my marriage / significant relationship		.41
17. I have an unfulfilling sex life		.40
11. After heavy drinking, I need a drink the next morning to get going		.30*

Note. Extraction method: principal component analysis; rotation method: Varimax with Kaiser Normalization; a. Rotation converged in 6 iterations. The symbol * indicates did not meet the minimum criteria of primary factor loading of .35 and above.

Table 12

Rotated Component Matrix for Asian American Students

	1	2	3
23. I feel hopeless about the future	.67		
4. I feel stressed at work / school	.66		
22. I have difficulty concentrating	.66		
15. I feel worthless	.65		
9. I feel weak	.65		
28. I am not working / studying as well as I used to	.61		
3. I feel no interest in things	.60		
5. I blame myself for things	.59		
2. I tire quickly	.57		
38. I feel that I am not doing well at work / school	.56		
10. I feel fearful	.54		
40. I feel something is wrong with my mind	.53		
42. I feel blue	.49		
18. I feel lonely	.46		
8. I have thoughts of ending my life	.42		
20. I feel loved and wanted		.76	
13. I am a happy person		.75	
31. I am satisfied with my life		.71	
24. I like myself		.70	
43. I am satisfied with my relationships with others		.68	
21. I enjoy my spare time		.64	
37. I feel my love relationships are full and complete		.61	
12. I find my work / school satisfying		.60	
1. I get along well with others		.50	
45. I have headaches			.56
34. I have sore muscles			.55
27. I have an upset stomach			.55
29. My heart pounds too much			.53
19. I have frequent arguments			.52
33. I feel that something bad is going to happen			.50
44. I feel angry enough at work / school to do something I might regret			.48

39. I have too many disagreements at work / school	.47
30. I have trouble getting along with friends and close acquaintances	.45
36. I feel nervous	.45
6. I feel irritated	.44
41. I have trouble falling asleep or staying asleep	.40
7. I feel unhappy in my marriage / significant relationship	.40
25. Disturbing thoughts come into my mind that I cannot get rid of	.38
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth	.36
16. I am concerned about family troubles	.34*
26. I feel annoyed by people who criticize my drinking (or drug use)	.24*

Note. Extraction method: principal component analysis; rotation method: Varimax with Kaiser Normalization; a. Rotation converged in 6 iterations. The symbol * indicates did not meet the minimum criteria of primary factor loading of .35 and above.

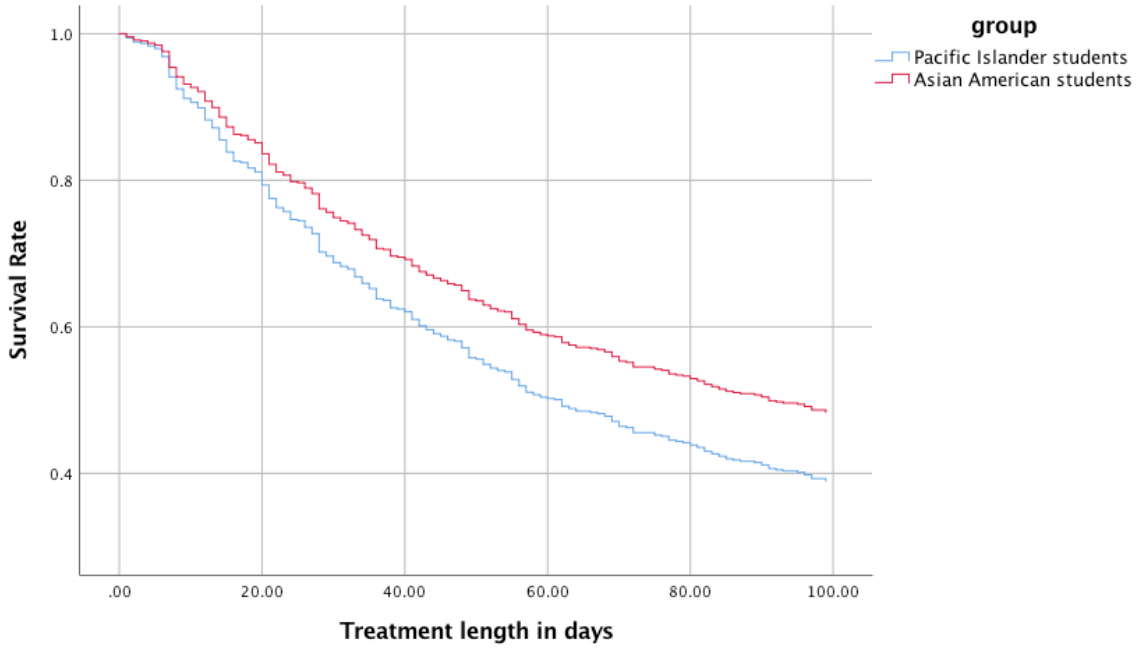

Figure 1. Days in treatment survival curves for Pacific Island and Asian American students.

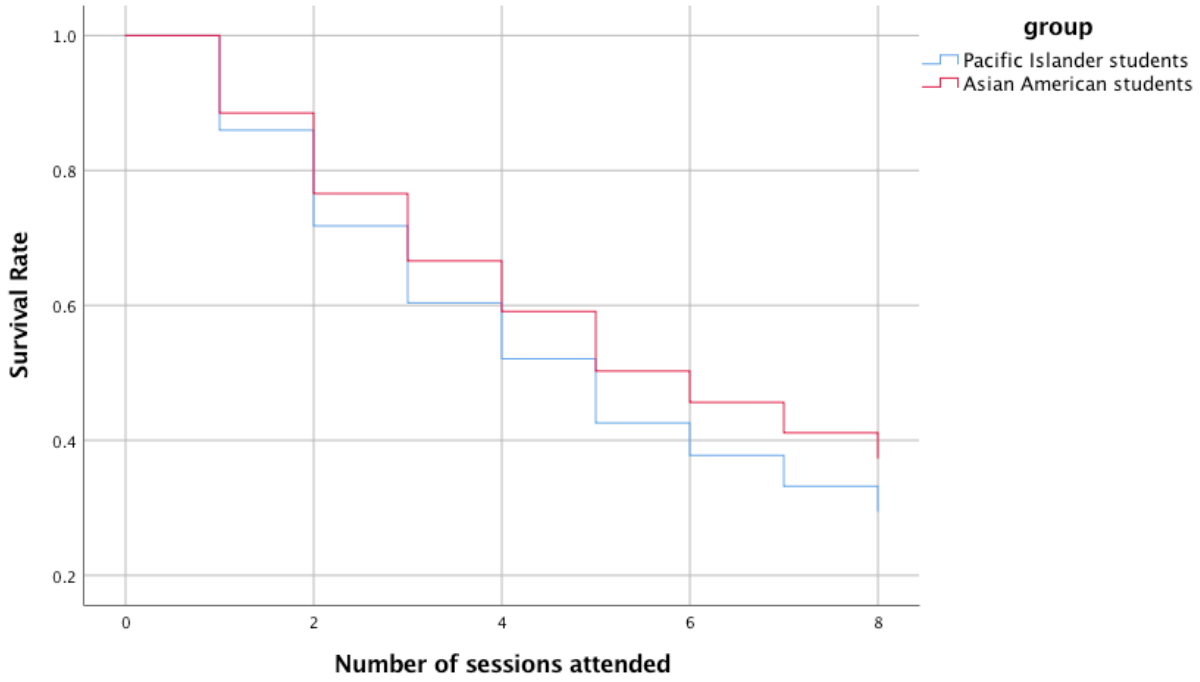

Figure 2. Session number survival curves for Pacific Island and Asian American students.

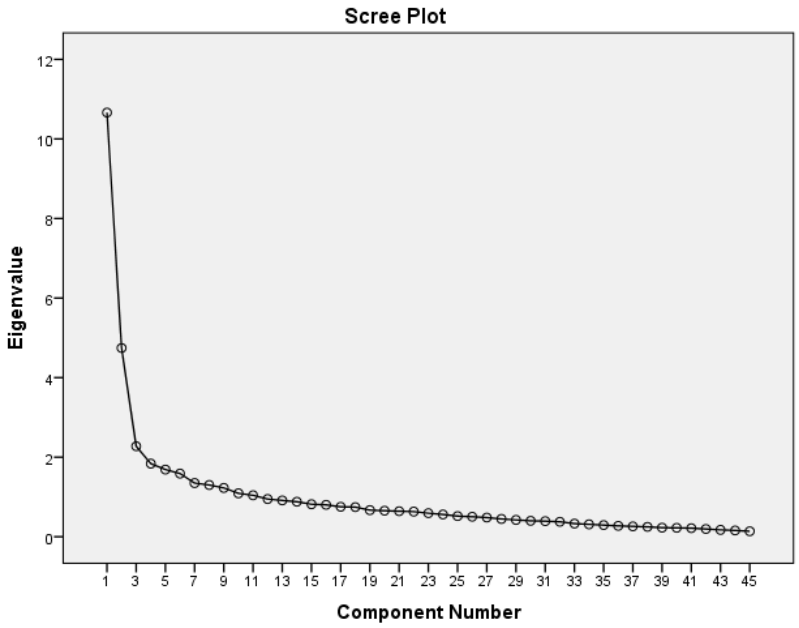

Figure 3. Scree Plot for Pacific Islander students. The scree plot indicates how many factors account for the most variability in the data (given by eigenvalues) indicated by the curve in the graph. The eigenvalues for the first four are above 2. The remaining factors account for a very small portion of the variability and are likely insignificant.

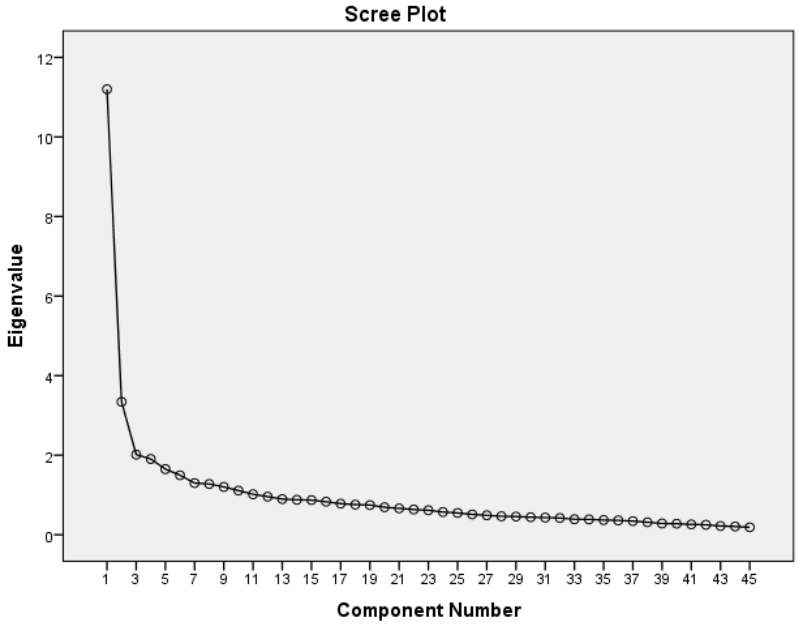

Figure 4. Scree Plot for Asian American students. The scree plot indicates how many factors account for the most variability in the data (given by eigenvalues) indicated by the curve in the graph. The eigenvalues for the first four are above 2. The remaining factors account for a very small portion of the variability and are likely insignificant.

APPENDIX B

Review of the Literature

Increase in Enrollment and Utilization of University Counseling centers

Over the past few decades, there has been a steady increase in the enrollment of students in American universities (Smith, Chesin, & Jeglic, 2014; Snyder & Dillow, 2015). Between 1994 and 2014 there was a 21 percent increase in student enrollment in postsecondary institutions. In the fall of 2015, there were 20.2 million students attending American colleges and universities, a 4.9 million increase of students in higher education since 2000 (Snyder & Dillow, 2015). Higher student enrollment in postsecondary institutions allows for more diversity and multiculturalism on these campuses, considering those who are ethnic and racial minorities, economically disadvantaged, first-generation, disabled, or international students. Not only are there more individuals pursuing higher education than in recent decades, but there is also an increase in the amount of students who are not necessarily prepared or equipped to deal with the stressors of college life (Mowbray et al., 2006). A more diverse student population presents complexities that differ from the student body made up of mostly Caucasian and socioeconomically privileged a few decades ago (Much & Swanson, 2010). It is not uncommon today for universities and colleges to admit students with disabilities, nontraditional students, and racial/ethnic minority and international students. However, these student populations are more likely to have experienced trauma, acculturation, or family stress in their lives (Mowbray et al., 2006).

A great responsibility is placed on institutions of higher education to meet the needs, namely the mental health needs, of the student population so they could succeed in their educational pursuits. This can be accomplished through the student services provided in and the accessibility of the students to those services. Thus, specific changes and outreach efforts should

be considered to better serve students pursuing higher education. Eisenberg, Goldberstein, and Gollust (2007) identified several help-seeking related factors and access to care in university settings, which were associated with help-seeking behaviors. For example, many students were unaware of mental health services offered on campus, including counseling centers. Some of their findings revealed that students who should have sought services reported that they felt like therapy and medication would not be helpful for people their age with depression and the majority of students were unsure whether their health insurance policies covered mental health services (Eisenberg et al., 2007). Although many were covered on their parents' insurance, most of those students were concerned that their parents might find out that they sought help. In addition, a link was found with students who came from financially disadvantaged families and lower mental health service use. Lastly, the most common reasons why students did not seek services felt like the stress they experienced was just a part of college life so they did not have time to seek help (Eisenberg et al., 2007).

Unfortunately, even if institutions provide services to mitigate the issues that students face, there are several barriers that still might prevent students from seeking and receiving adequate mental health care. Some of these barriers may include not knowing what services are offered, feeling like therapy or medication would not be helpful, now knowing what their health insurance covers in terms of mental health services, or possible language barriers (August, Nguyen, Ngo-Metzger, & Sorkin, 2011; Eisenberg et al., 2007).

Increase in Symptom Severity in University Settings

Over the years, mental health issues have become more prevalent and complex among college or university students. There are various factors that contribute to the stress that college students experience. For example, prior to attending college, the majority of students deal with

pressure to meet the qualifications and gain acceptance into post-secondary institutions. This culture of competition starts as early as junior high (Hoff, 2002) and continues on to college. In addition, the role that parents play in the lives of their college-aged children has changed over the years. Parents today are more involved in the lives of their children, as compared to previous generations (Watkins, Hunt, & Eisenberg, 2012). Thus, by the time children come to college, they lack the skills they need to be independent. When students arrive in college, they face hardships of adjustment that can also induce stress. Living away from home for the first time, pressure to meet the expectations of their parents, family problems, financial issues, racism and discrimination, sexual assault, peer pressure, sleeping problems, social anxiety, and worrying about future plans like graduation or job placements are among the stressors that college students experience (Allen, Kim, Smith, & Hafoka, 2016; Cook, 2007). The transition from high school to college could be overwhelming and may contribute to severe mental illness issues in college.

Managing the Increase in Numbers

Counseling centers play an integral role in assisting and addressing mental health issues of students through counseling interventions. University counseling centers are typically staffed by psychologists, professional counselors, and mental health practitioners. Although university counseling centers are expected to fulfill numerous responsibilities, including training workshops, consultation meetings, and outreach, their first priority is to provide direct counseling services to students (Minami, et al., 2009; Murphy & Martin, 2004). The services offered to students may be slightly different in each university or college but typically are made available through individual psychotherapy, group psychotherapy, biofeedback, and outreach, (Minami et al., 2009).

The higher need for mental health services in college campuses has led to challenges that institutions face to meet these demands. To ameliorate this, administrators have reported that ideally, additional staff and expanded physical space would allow them to provide more resources. Other recommendations that would help counseling centers to meet their increasing demands include managing waiting lists in new ways, increasing group therapy options, and establishing emergency and referral procedures (Murphy & Martin, 2004). However, realistically speaking, every institution is unable to meet those requests for various reasons including limited funding (Watkins et al., 2012). In addition, it is important to recognize that university centers are typically restricted in the number of counselors and staff they are allowed to employ. Consequently, administrators have reported that their staff often felt overwhelmed and ill equipped to handle the growing demand for their services (Watkins et al., 2012).

There are various ways in which serious mental illnesses can pose a barrier for the academic success of students in university and college settings. Students dealing with mental illnesses during college often have difficulties with concentration, completing assignments under pressure, executive functioning, mental health stigma, participating in groups, making presentation in front of others, receiving and offering feedback, low self-esteem and maintaining good attendance (Mowbray et al., 2006). Overprotective parents who micromanage their college student's performance might add more pressure for them, on top of managing academics, employment, and extracurricular activities independently for the first time (Young, 2003). In these cases, students turn to services in their universities and college campuses for help.

Some institutions have attempted to address mental health issues on their campuses by providing special introductory college freshman courses to assist them in the adjustment to college and university life. These courses may include topics such as time management,

academic skills, career exploration, and stress management. As universities and college move in this direction to better help their student body, it is imperative that they provide appropriate and specific services for diverse students, namely ethnic minority students.

Utilization Trends Among Racial Ethnic Minority College Students

While college students commonly face difficult transitions into adulthood, financial difficulties, and academic stress, there are added complexities for ethnic minority college students who may experience racial and ethnic discrimination, under-representation on campus and in their programs, and prejudice (Broughman, Zail, Mendoza, & Miller, 2009). Stressors that are unique to ethnic minorities, such as racism and feelings of isolation, have been associated with psychological distress and depression among Latino and African American students (Wei, et al., 2010).

Academic issues are a major concern for Latino/a college students. In one study (Kim, Park, La, Chang, & Zane, 2016), the majority of Mexican students reported they were the first in their immediate family to attend college. The pressures and stressors of being a first-generation student navigating an unfamiliar educational system with limited social and financial resources may be one of the key factors contributing to psychological symptoms (Castillo, Zahn, & Cano, 2012). Underrepresentation in higher education settings is another contributor to stress among Latino/a students. For example, Latino/a students in a diverse public university reported high levels of depressive symptoms, specifically stress related to ethnic minority status (Arbona & Jimenez, 2014). However, high levels of pressure and stress are placed upon them even before they start college. A study on Latino/a youth found that those who were aspiring to attend college reported greater symptoms of depression and distress than their non-college-aspiring counterparts (Turcios-Cotto & Milan, 2013).

One reason that might prevent minorities from seeking mental health services is the perception that those services would be unrelated or irrelevant to their needs. Counselors without training or knowledge in culturally sensitive therapy approaches, limited bilingual counselors, and a lack of cultural sensitivity may contribute to some of the reasons ethnic minorities are uncomfortable or feel misunderstood in counseling services.

Utilization Among Asian Americans and Pacific Islanders

When examining specific Asian subpopulations, Asian Indian, Korean, and Vietnamese American clients were more likely to terminate treatment after one session compared to White clients (Kim et al., 2016). In some Asian cultures, only chronic/violent distress may warrant seeking professional mental health services.

Asian Americans and Pacific Islanders. "Asian American" is used to describe people with ethnic origin from East Asia (i.e., China, Japan), Southeast Asia (i.e., Cambodia, Philippines), and South Asia (i.e., Afghanistan, Pakistan). The term "Pacific Islander" is used to describe people with heritage originally from Melanesia (i.e., Papua New Guinea), Micronesia (i.e., Guam), and Polynesia (i.e., Native Hawaiian, Samoan).

Asian Americans and Pacific Islanders (AAPI) are among the fastest growing ethnic minority groups in the U.S., representing an extremely diverse and multi-racial group of over 100 different languages and dialects. Pacific Islanders are the most recent immigrants of ethnic minorities to the U.S. Many Asian Americans and Pacific Islanders are first or second generation in the U.S. (Vakalahi & Godinet, 2014).

Although the AAPI population represents a heterogeneous group with differences in language, sociopolitical histories, customs, and social norms, there are a number of cultural values that are prominent among these populations (Miville & Constantine, 2007). For example,

collectivism, emotional restraint, conformity to norms, deference to authority, and humility are practices that are evident within AAPI subpopulations (Choi & Miller, 2014; Kim, 2007). Four cultural themes that Yee, DeBaryshe, Yuen, Kim, and McCubbin (2007) found include:

Collectivism: the tendency for individuals to place the needs of the group above their own personal goals and needs.

Relational orientation: the self is identified and defined in terms of the interdependence with others.

Familism/Filial Piety: The family system is hierarchical and includes extended family members as the basic social unit. Each member of the family fulfills a specific role.

Family obligation: Children have the responsibility to care for and respect older family members; seek their advice and respect their decisions; maintain close relationships with parents across the life span.

Overall, the overarching theme that unites these cultural values is family interdependence. Having a stable family system grounded in mutual respect and obligation provides family members with a strong network for assistance when necessary.

Asian values. Asian cultural values place an emphasis on bringing honor to the family name (Leong, Kim, & Gupta, 2011). The common practice of self-concealment, or the tendency for individuals to keep personal and potentially embarrassing information hidden from others, was found to be common among Asian American students (Kim, 2007; Leong et al., 2011; Masuda et al., 2009). Self-concealment is common among Asian American communities because of the desire they have to adhere to the cultural value of maintaining individual and family reputations. Excessive self-disclosure often attracts negative attention and poses a threat to their personal and family honor (Masuda & Boone, 2011). The issue of self-concealment and loss of

face is prevalent among Asian American college students who often feel the pressure of family expectations and bringing honor to the family (Leong et al., 2011). Asian American college students demonstrate greater self-concealment than White college students and that self-concealment is negatively related to their attitudes toward seeking professional psychological services (Masuda et al., 2009). Asians value humility, modesty, conformity, and obedience.

Expectations of Psychotherapy. Asian cultures typically believe in a strong mind-body connection, which leads to more common reports of physiological symptoms of distress when compared with White (Chin, 2007; Smith & Khawaja, 2011). Somatic or physiological symptoms are more acceptable among Asian cultures and could serve as the outlet to express and let go of their distress (U.S. Department of Health & Human Services, 2001). Therefore, Asians might first seek medical services or traditional services before seeking mental health treatment (Nguyen & Anderson, 2005).

Cultural values and worldviews play a vital role in the way that Asian Americans approach therapy. Collectively, they hold a high regard for respecting authority figures. Thus, in therapy, Asian American clients often hold a higher respect for the counselor than do their European American counterparts (Leong, Lee, & Kalibatseva, 2016). Asian Americans often prefer more directive approaches to therapy, often expecting their counselors to problem solve and make immediate decisions for them (Leong et al., 2016).

Pacific Islander values. Common values across Pacific Island subcultures emphasize a deep reverence for spirituality, harmony, and cohesion within the family, and the needs of the collective supersede the needs of an individual (Braun, Yee, Browne, & Mokuau, 2004; Vakalahi & Godinet, 2014). These cultural values play an integral role in their health-seeking behaviors.

Family and culture are fundamental core values of a Pacific Islander's life (Autagavaia, 2001; Culbertson, Agee, & Makasiale, 2007; Vakalahi & Godinet, 2014). Pacific Islanders typically have larger families than most Asian American families and American families (Braun et al., 2004). Pacific children are raised and highly influenced by large extended families in which each generation holds great responsibility to nurture and teach the subsequent generation (Vakalahi & Godinet, 2014). Like many Asian cultures, collectivism and inclusivity are fundamental values that perpetuate the survival of Pacific Island cultures from generation to generation. Pacific families include more than just their immediate family, extending to grandparents, aunts, uncles, cousins, and often times close familial friendships are considered family. In the US, Pacific Islander households are larger than the average size because of their cultural practice of intergenerational living, often resulting in overcrowded and unaffordable housing (Hernandez, Denton, & Blanchard, 2011; Vakalahi, Hafoka, & Fong, 2016). A sense of pride, loyalty, and responsibility to care for the well being of their family have been cultivated through generations, even from life in the Pacific Islands to their migration and settlement in the U.S. (Mokuau, 1990). Consequently, Pacific Islanders turn to their family as the primary source of help and guidance when dealing with emotional issues (Allen & Heppner, 2011). Similar to many Asian Americans, Pacific Islanders typically frown upon seeking help for emotional problems outside of the family because doing so would bring shame to the family name and expose personal weaknesses. Their desire to uphold the family name with respect often serves as a barrier for any family members who may want or need to seek mental health services. These strong family ties can provide Pacific children with a strong support network. However, it may also compound issues of mental health in Pacific Island children.

Expectations of psychotherapy. For Pacific people, mental and spiritual health are intertwined. They view and understand mental health from a spiritual framework.
Since the introduction of Christianity to the Pacific islands, it has had a large impact on how Pacific people view development, growth, and healing (Culbertson et al., 2007). The following guidelines illustrate the fundamental beliefs that Pacific Islanders hold on spirituality:

1. Harmony with someone beyond this known reality (God) is possible.
2. The human person can choose to relate or not to relate, to act or not act, that is, has free will.
3. There are laws which we should week out in order to live in peace.
4. There are paths that lead to personal and social peace, growth, and happiness.
5. Material prosperity is a sign of God's approval.
6. Physical death is not the end, only a transition into life with or without God.
7. Through grace God offers an unfailing and steadfast love to each human person and faithfully upholds the uniqueness and wellbeing of each one to the end. (Richards & Bergin, 1997, pp.76-78)

For the Pacific Islander, spiritual aspects permeate every part of life. Traditional Pacific healers believe that any conflict or discord within family relations may contribute to illness.

Disaggregation of AAPI. In 2000, the U.S. Census officially made a distinction between the Asian American and Pacific Island populations (Srinivasan & Guillermo, 2000). After this movement, studies regarding unique issues that are pertinent to the Pacific Island population have emerged to shed light on diabetes, cancer, and other health related problems (Frisbie, Cho, & Hummer, 2001; Karter et al., 2013; Miller, Chu, Hankey, & Ries, 2008; Srinivasan, & Guillermo, 2000). Although research on Pacific Islanders is emerging, they have continued to be

combined with Asian Americans in the majority of the current psychological literature. Several studies that focused on acculturation, etiology beliefs, and predicting the utilization in university counseling centers combined the Asian Americans and Pacific Islanders into one category (Mallinckrodt, Shigeoka, & Suzuki, 2005; Sullivan, Ramos-Sánchez, & McIver, 2007). This may be problematic for clinicians who might struggle knowing how to approach and address the needs of one population.

Although they share similar values, the differences of Asian Americans and Pacific Islanders are reflected in their cultures, economic conditions, education, and religious practices. Immigrants to the U.S. from Asian and Pacific countries have contrasting experiences. The majority (80%) of Asian American immigrants between 2000 to 2009 were of working age. Employed immigrants were likely to have occupations in fields like technology, management, engineering, and science. Furthermore, 58 percent of immigrant physicians and surgeons, and 52 percent of immigrant registered nurses were Asian. More than half of Asian immigrants were fluent in English. As a group, Asian immigrants were less likely to live in poverty, and more likely to have received postsecondary training or education in their home countries before immigrating to the U.S. (Vakalahi et al., 2016). Immigrants from the Pacific had greater disadvantages related to economics, health, and education (Vakalahi et al., 2016). The impetus for many Pacific Island families to migrate to America is for educational and employment opportunities. Once they settle in America, they face difficulties with acculturation, navigating through the Western value system while holding on to their cultural practices, poverty, and lack of employment opportunities (Vakalahi & Godinet, 2014).

The U.S. Census provides data on the demographic characteristics of Asian Americans and Pacific Islanders each year. The notable differences in the 2017 Asian/Pacific American

heritage month include the following: the Asian Americans who obtained a Bachelor's degree account for 51.5 percent, while Pacific Islanders have 21.5 percent; Asian Americans with a graduate or professional degree account for 21.7 percent, while Pacific Islanders have 6.5 percent. The poverty rate for Asian Americans is 12 percent, and for Pacific Islanders 17.3 percent. The median income for Asian Americans is $76,260 and for Pacific Islanders $60,133. Although Asian Americans and Pacific Islanders have different experiences in the United States, these statistics are often overlooked when these two populations are combined.

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