

Disaggregating Mental Health Outcomes: Counseling Service Utilization and Presenting Concerns Among Native Hawaiian/Pacific Islanders and Asian American Students

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This study investigates disparities in mental health service utilization, presenting concerns, and treatment outcomes between Asian American (AA) and Native Hawaiian/Pacific Islander (NHPI) university students. Archival data from 7,715 university students (AA: 7,402; NHPI: 313) provided by the Center for Collegiate Mental Health (CCMH) was used to examine how “ethnic glossing”—the practice of grouping diverse racial/ethnic populations under broad labels—can obscure unique cultural and socioeconomic challenges. Multivariate analysis of variance (MANOVA) compared the number of therapy sessions scheduled and attended, along with initial distress levels, while independent samples *t* tests addressed variables with unequal variances, and multivariate analysis of covariance (MANCOVA) controlled for session attendance and initial symptom severity to evaluate treatment progress. Key findings reveal similar mental health service utilization rates between AA and NHPI students, challenging assumptions of NHPI underutilization. However, AA students reported higher initial distress in depression and social anxiety, whereas NHPI students showed elevated alcohol-related concerns. Treatment outcomes were generally comparable, though NHPI students were more likely to terminate therapy early, indicating additional systemic and family-related stressors. The study underscores the need for culturally tailored mental health interventions in university settings to effectively support these distinct populations.

What is the public significance of this article?

This study reveals that Asian American (AA) and Native Hawaiian/Pacific Islander (NHPI) university students experience different mental health challenges, with AA students facing higher distress in depression and social anxiety and NHPI students reporting greater alcohol-related distress. These findings highlight the need for culturally specific mental health services that address the distinct experiences of these groups, helping advance the psychological well-being of AA communities by informing research, practice, and teaching in mental health care.

Keywords: Native Hawaiian/Pacific Islander, Asian American, university counseling center, treatment utilization

The increasing prevalence of mental health concerns among college students has shed light on the disparities in mental health outcomes across different racial and ethnic groups. Research shows that approximately one in three students meet the criteria for a mental health disorder such as depression or anxiety (Eisenberg et

al., 2013). However, the aggregation of diverse racial and ethnic groups under broad labels—such as “Asian American and Pacific Islander” (AAPI)—obscures crucial distinctions in mental health needs, particularly between Asian Americans (AA) and Native Hawaiian/Pacific Islanders (NHPI). This practice of ethnic glossing—

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using broad, generalized terms to group diverse ethnic populations—masks the unique cultural, socioeconomic, and historical experiences of these populations, making it difficult to develop effective, tailored mental health interventions (Subica & Wu, 2018; Trimble & Bhadra, 2013).

The cultural competence framework (Sue et al., 2009) provides a relevant theoretical lens highlighting the importance of adapting mental health services to the cultural backgrounds of diverse populations. Cultural competence involves an awareness of cultural differences, an understanding of how these differences influence behavior and treatment, and the ability to tailor mental health services to meet the specific needs of various cultural groups. This framework emphasizes the need for disaggregating data between AA and NHPI populations to identify and address their distinct mental health challenges.

Both AA and NHPI populations underutilize mental health services, largely due to cultural stigmas surrounding mental illness. In both groups, mental health problems are often perceived as personal or familial failures, which leads to reluctance to seek professional help (Han & Pong, 2015; Subica et al., 2019). Furthermore, they face barriers such as language difficulties, a shortage of culturally competent providers, and fears of bringing shame or losing face in their communities (Kwan et al., 2020; Sue et al., 2009). These combined cultural and systemic barriers often result in delayed help-seeking behaviors, with many AA and NHPI people only engaging with mental health services once their symptoms have become severe (Brice et al., 2015; Subica et al., 2019).

While AA and NHPI students share obstacles related to stigma and underutilization of mental health services, these populations have different mental health challenges and needs. For instance, NHPI individuals often face compounded systemic barriers such as geographic isolation, socioeconomic disadvantages, and a lack of culturally competent services that are not as prevalent for AA (Pokhrel & Herzog, 2014). These systemic barriers contribute to the disproportionately low rates of mental health service utilization among NHPI populations.

Native Hawaiians face greater mental health challenges compared to Asians, both in Hawai'i and across the United States. For example, the depression rate among Native Hawaiian adults in Hawai'i (13%) is higher than that of Filipinos (9%), Whites (9%), Japanese (6%), Chinese (5%), and the state's overall population (8%) (Salvail & Smith, 2007). Nationally, Native Hawaiians and Pacific Islanders report serious psychological distress within the last 30 days at a higher rate (4%) than Asians (2%) and the general U.S. population (3%) (Galinsky et al., 2017).

This disparity is also present among younger and older populations. The 2009 Youth Risk Behavior Survey found that 33% of Native Hawaiian and Pacific Islander high school students reported feeling sad or hopeless in the past year, at a higher rate than American Indian/Alaska Native (31%), Asian (24%), Black (28%), and White (24%) students (Eaton et al., 2010). Furthermore, the rate of youth who had attempted suicide in the past 12 months was 11.8% of NHPI, 9.5% of AA, and 8% of White (Eaton et al., 2010). Among those aged 65 and older, severe or moderately severe depression affects 4.8% of Native Hawaiians and Pacific Islanders, compared to 1.5% of Asians and 2.7% of Hawai'i's overall population (Aczon-Armstrong et al., 2013).

Depression in Native Hawaiians and Pacific Islanders is often linked to substance use, anxiety, aggression, and suicide (Wu &

Blazer, 2015), illustrating the complex nature of their mental health challenges. In contrast, East Asian American students often face pressure from perfectionism, academic success, and family expectations, contributing to higher levels of social anxiety and depression (Yoon & Lau, 2008).

NHPI populations are disproportionately affected by substance use, particularly alcohol. Between 1991 and 2015, NHPI youth reported the highest rates of early alcohol use and heavy drinking compared to other racial/ethnic groups in the United States (Subica & Wu, 2018). The National Institute on Alcohol Abuse and Alcoholism revealed that NHPI adults experienced alcohol use disorders at rates 4 times greater than 5% of the U.S. population rate in 2019 (U.S. Department of Health & Human Services, n.d.). NHPI college students have also been shown to experience higher alcohol-related distress compared to students from other ethnic groups, while AA students generally show lower alcohol use due to cultural norms discouraging substance abuse (Lefrandt, 2021; Lum et al., 2009). Furthermore, cultural practices, such as the consumption of kava, as well as factors such as trauma, family conflict, and adjustment challenges, heighten alcohol-related distress among NHPI students (Pokhrel & Herzog, 2014). Thus, disaggregating the data for NHPI and AA populations is crucial to developing culturally appropriate interventions tailored to the unique challenges each group faces.

Hafoka Kanuch et al. (2019) began disaggregating and dismantling ethnic glossing between AA and NHPI populations by examining similarities and differences in mental health treatment utilization and outcomes for students from these groups at one university. Their findings showed that AA and NHPI students utilized therapy at similar rates and had comparable levels of psychological distress at intake. However, NHPI students were more likely to terminate therapy earlier and reported higher rates of family-related challenges such as divorce, physical abuse, sexual assault, and family involvement in criminal activities compared to AA students.

The Present Study

No studies to date have expanded on Hafoka Kanuch et al. (2019) recommendation to explore the similarities and differences between AA and NHPI university students using a broader sample. This study aims to disaggregate AA and NHPI data to better understand their distinct mental health service utilization, presenting concerns, and treatment outcomes. By using a nationwide data set, this study seeks to identify these unique needs and support the development of culturally appropriate interventions.

We hypothesize that

1. NHPI students will show lower rates of mental health service utilization, or fewer therapy sessions, compared to AA students due to systemic barriers such as geographic isolation, socioeconomic challenges, and stronger cultural stigma around mental illness (Pokhrel & Herzog, 2014; Subica et al., 2019).
2. NHPI students will present with higher levels of distress at intake due to elevated rates of depression, substance use, and co-occurring mental health challenges compared to other racial and ethnic groups (Galinsky et al., 2017; Salvail & Smith, 2007; Subica & Wu, 2018).

- NHPI students will have comparable or delayed treatment outcomes relative to AA students, as they are more likely to terminate therapy early due to systemic and family stressors, despite similar levels of psychological distress (Hafoka Kanuch et al., 2019; Yoon & Lau, 2008).

Alaskan Native (AIAN), and 0.1% as Native Hawaiian or Pacific Islander (NHPI), with 36.7% missing data. Participants identified as 53.2% non-International Student and 3.4% International Student, with 43.4% missing data. The average age was 22.3 ($SD = 4.8$) with 3.6% missing data.

Method

Procedure

Data for the study were obtained from the Center for Collegiate Mental Health (CCMH), which is a multidisciplinary practice-research network of over 400 college counseling centers and other organizations that provides current information about the mental health of college students. The data were collected between the years 2015 and 2017 from 163 college counseling centers across the United States. Data collected more recently than 2017 were not obtained due to CCMH researcher access restriction policies.

Clients of CCMH-affiliated counseling centers signed consent forms and completed demographic and psychological distress measures, which are described later. The information from these tools was de-identified in order to protect the confidentiality of the students, and the institutions involved in providing data were de-identified as well. Both Institutional Review Board approval and informed consent were obtained from each institution contributing to the data. Institutional Review Board approval for this study was deemed exempt due to the archival nature of the data used.

Data Set

The initial data set ($N = 364,025$) contained demographic and outcome variables for 309,438 unique students. At the time participants presented for their first course of therapy, 39.5% of students identified as White, 5.7% as Hispanic, 5.5% as Black/African American, 5.2% as Asian American/Asian, 3.1% as multiracial, 1% as self-identify, 0.3% as American Indian or

Participants

For the present study, participants were included only if they identified as Asian American/Asian or Native Hawaiian/Pacific Islander through the Standardized Data Set (SDS). Although “self-identify” was an option for reporting racial and ethnic identity, no free-response descriptions were provided in the data received from CCMH; thus, participants who marked “self-identify” were not included in the analysis. Participants were also included only if they identified as either an undergraduate or graduate student, if they identified as a noninternational student, and if they had attended at least two individual session and had complete mental health outcome data (both first and last session) through the Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34). Additionally, as students may have been included in the initial data set more than once (owing to multiple courses of therapy being reported), only instances of first course of therapy, and only those who engaged exclusively in individual therapy, were included. The resultant data set included 7715 unique participants. For detailed demographic information, see Table 1.

Measures

SDS

The SDS is a comprehensive set of exclusively demographic questions developed by CCMH and used by participating counselor centers, typically upon intake. The SDS includes questions about items such as gender, age, ethnicity, religion, and sexual identity.

Table 1
Demographics ($N = 7,715$)

Demographic category	Asian American ($N = 7,402$)	Native Hawaiian/Pacific islander ($N = 313$)
	<i>n</i> (%)	<i>n</i> (%)
Gender identity		
Woman	4,847 (65.5)	195 (62.3)
Man	2,411 (32.6)	107 (34.2)
Transgender	38 (0.5)	1 (0.3)
Other/missing	106 (1.4)	10 (3.2)
Sexual orientation		
Heterosexual/straight	6,041 (81.6)	248 (79.2)
Lesbian	100 (1.4)	3 (0.9)
Gay	139 (1.9)	9 (2.9)
Bisexual	455 (6.1)	18 (5.8)
Questioning	224 (3.0)	6 (1.9)
Other/missing	443 (6.0)	29 (9.3)
Academic status		
Freshman	1,549 (20.9)	84 (26.8)
Sophomore	1,572 (21.2)	67 (21.4)
Junior	1,683 (22.7)	68 (21.7)
Senior	1,551 (21.0)	73 (23.3)
Graduate student	1,047 (14.1)	21 (6.7)

The SDS includes separate versions of the measure for clients, therapists, and counseling center.

CCAPS-34

The CCAPS-34 is a multidimensional assessment of psychological symptoms intended for routine use in college populations (Locke et al., 2012) and is an abbreviated version of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62; Locke et al., 2011). The CCAPS-34 provides scores for seven factors (depression, generalized anxiety, social anxiety, academic distress, eating concerns, hostility, and alcohol use) and an overall distress index. It shows strong convergent validity, with strong and significant Pearson product-moment correlations between subscales with the same referent measures ($r = .52-.78$). In addition, it has acceptable reliability, with internal consistency alphas ranging from .76 to .89 across subscales, and test-retest reliability ranging from .79 to .87 and .74 to .86 between 1-week and 2-week test-retest correlations, respectively.

Results

Mental Health Services Utilization Rates

We hypothesized that NHPI students would attend fewer sessions of mental health services than AA students. We utilized multivariate analysis of variance (MANOVA) to compare the mean number of sessions scheduled, number of sessions attended, and proportion of sessions attended. Box's test of equality of covariance matrices ($M = 9.95$, $F = 1.65$, $p = .13$) indicated that the covariance matrices between the two groups did not differ significantly. However, Levene's test for equality of variances was significant for the proportion of sessions attended. As such, we verified the results for that variable utilizing an independent samples t test which provides an option for unequal variances. We found that the results did not change. Based on the analyses (Table 2), we concluded that attendance rates for AA and NHPI were statistically the same and that the hypothesis was not confirmed.

Symptom Severity and Level of Distress at Intake

We also hypothesized that NHPI students would show a higher severity of initial presenting concerns and overall distress at intake than their AA counterparts. Box's test was insignificant ($M = 42.97$, $F = 1.18$, $p = .21$). However, Levene's test was significant for alcohol concerns ($p < .001$, based on the mean). Thus, we verified the results for that variable utilizing an independent samples t test and found similar results. The analyses indicated that our hypothesis was not confirmed. Rather, NHPI students showed significantly

higher initial distress only in terms of alcohol concerns, while AA students showed significantly higher initial distress in terms of depression, social anxiety, and the overall distress index (see Table 3).

Treatment Progress

We hypothesized NHPI students would demonstrate similar or slower treatment improvement rates compared to AA students. To evaluate this hypothesis, we first filtered the data set to include only those participants who attended at least two sessions and had a viable change score. This reduced our sample from 7,715 to 5,045 participants. We then conducted a multivariate analysis of covariance (MANCOVA), controlling for the number of sessions attended and the initial CCAPS scores. Box's test indicated that covariance matrices were not equal ($M = 138.53$, $F = 3.79$, $p < .001$), and Levene's test was significant for the eating ($p = .03$) and alcohol ($p = .001$) subscales. MANCOVA is generally robust enough to manage these differences; however, the findings should be considered within this context.

The MANCOVA results indicated that race/ethnicity did not significantly impact the combined set of dependent variables, Pillai's trace = .003, $F(8, 5,027) = 1.878$, $p = .059$. This suggests that, when controlling for the covariates, the groups did not significantly vary on the dependent variables collectively. The univariate tests showed no significant effects of race/ethnicity on the change scores across individual dependent variables, with p values ranging from 0.027 to 0.870. The only near-significant result was an F test of 3.390 ($p = .066$) for the academic subscale (Table 4).

Discussion

This study sought to explore differences in mental health service utilization, presenting concerns, and treatment outcomes between NHPI and AA university students. Our hypotheses, informed by previous research, predicted that NHPI students would attend fewer sessions, present with higher distress levels, and experience comparable or delayed treatment outcomes relative to AA students. The results provide important insights into the mental health patterns of these two populations, while also highlighting areas where our hypotheses were not confirmed.

Mental Health Service Utilization

We hypothesized that NHPI students would utilize mental health services at lower rates compared to AA students, based on literature suggesting that NHPI populations face greater systemic barriers, such as geographic isolation, socioeconomic disadvantages, and

Table 2

Asian American (AA, $n = 7,402$) and Native Hawaiian/Pacific Islander (NHPI, $n = 313$) Attendance Rates and Total Sessions (MANOVA)

Category	AA M (SD)	NHPI M (SD)	Mean difference	F statistic	Partial η^2
No. of sessions scheduled	5.25 (5.35)	5.09 (5.24)	0.16	0.27	0.00
No. of sessions attended	4.05 (4.21)	3.86 (4.22)	0.19	0.58	0.00
Attended/scheduled	0.81 (0.21)	0.80 (0.22)	0.01	0.46	0.00

Note. MANOVA = multivariate analysis of variance.

Table 3

Asian American (AA, n = 7,402) and Native Hawaiian/Pacific Islander (NHPI, n = 313) Severity of Initial Concerns (MANOVA)

CCAPS index	AA <i>M</i> (<i>SD</i>)	NHPI <i>M</i> (<i>SD</i>)	Mean difference	<i>F</i> statistic	Partial η^2
Depression	1.96 (1.01)	1.76 (1.02)	0.20*	12.42***	0.002
Anxiety	1.97 (0.99)	2.01 (0.99)	-0.04	0.565	0.000
Social anxiety	2.11 (0.99)	1.80 (1.01)	0.31*	29.22***	0.004
Academics	2.20 (1.07)	2.13 (1.05)	0.07	1.25	0.000
Hostility	0.99 (0.85)	1.03 (0.89)	-0.03	0.43	0.000
Eating	1.06 (1.14)	1.02 (1.15)	0.04	0.46	0.000
Alcohol	0.52 (0.81)	0.68 (0.94)	-0.15*	10.56**	0.001
Distress index	1.93 (0.80)	1.84 (0.81)	0.09*	3.93*	0.001

Note. MANOVA = multivariate analysis of variance; CCAPS = Counseling Center Assessment of Psychological Symptoms.

* $p < .05$. ** $p < .01$. *** $p < .001$.

strong cultural stigma surrounding mental health (Pokhrel & Herzog, 2014; Subica & Wu, 2018). However, our findings did not support this hypothesis. MANOVA results indicated no significant difference in the number of scheduled or attended sessions or the proportion of sessions attended between NHPI and AA students. This aligns with previous findings by Hafoka Kanuch et al. (2019), who also found comparable rates of mental health service utilization between the two groups in a university setting. These results suggest that, at least within the context of university counseling centers, NHPI students may be accessing services at similar rates to AA students, perhaps due to the increasing availability of culturally competent care or outreach efforts aimed at underserved populations.

Symptom Severity and Distress at Intake

We also hypothesized that NHPI students would present with higher symptom severity and overall distress at intake than AA students, particularly due to previous findings highlighting NHPI populations' exposure to higher rates of trauma and substance use (Subica & Wu, 2018). While the hypothesis was partially supported, the results revealed a more nuanced pattern. NHPI students showed significantly higher distress only in terms of alcohol concerns, whereas AA students reported higher initial distress related to

depression, social anxiety, and overall distress. This finding aligns with research indicating that AA students experience heightened academic and familial pressures, contributing to elevated levels of depression and anxiety (Yoon & Lau, 2008). In contrast, NHPI students' elevated alcohol concerns may reflect cultural practices involving alcohol and kava use, as well as the greater exposure to trauma identified in previous studies (Pokhrel & Herzog, 2014; Subica et al., 2019). These results emphasize the importance of disaggregating AAPI data to better capture the distinct mental health patterns in AA and NHPI students.

Treatment Progress

Our final hypothesis predicted that NHPI students would experience comparable or slower treatment progress than AA students, based on findings that NHPI populations are more likely to terminate therapy prematurely and experience greater family-related stressors (Hafoka Kanuch et al., 2019). While MANCOVA results showed no significant differences in overall treatment outcomes between the two groups, it is important to note that NHPI students were more likely to terminate therapy earlier, and this may have affected their treatment outcomes. Despite the lack of statistically significant differences, the near-significant result for the academic subscale ($p = .066$) suggests that further research

Table 4

Asian American (AA, n = 4,850) and Native Hawaiian/Pacific Islander (NHPI, n = 195) CCAPS Change Scores, With Number of Sessions and Initial Scale Scores as Covariates (MANCOVA)

CCAPS index	AA <i>M</i> (<i>SD</i>)	NHPI <i>M</i> (<i>SD</i>)	Mean difference	<i>F</i> statistic	Partial η^2
Depression	0.36 (0.74)	0.36 (0.70)	-0.05	0.81	0.000
Anxiety	0.24 (0.65)	0.23 (0.65)	0.04	0.75	0.000
Social anxiety	0.17 (.54)	0.17 (0.53)	-0.05	1.91	0.000
Academics	0.21 (0.70)	0.10 (0.62)	0.09*	3.39	0.001
Hostility	0.20 (0.52)	0.17 (0.56)	0.03	0.59	0.000
Eating	0.10 (0.63)	0.07 (0.48)	0.03	0.44	0.000
Alcohol	0.07 (0.44)	0.10 (0.56)	0.01	0.03	0.000
Distress index	0.28 (0.56)	0.26 (0.54)	0.01	0.06	0.000

Note. CCAPS = Counseling Center Assessment of Psychological Symptoms; MANCOVA = multivariate analysis of covariance.

* $p < .05$.

could explore whether NHPI students face unique academic challenges that impact their mental health and treatment outcomes. These findings highlight the need for continued efforts to reduce systemic barriers and ensure that NHPI students remain engaged in treatment long enough to see meaningful progress.

Study Limitations

We used national archival data from the CCMH, which provided broader generalizability than the previous single-university study by Hafoka Kanuch et al. (2019). However, the CCMH data do not represent all universities and colleges, limiting the generalizability of the findings across different types of institutions. Additionally, there were significant differences in sample sizes between Asian American (AA = 7,402) and Native Hawaiian/Pacific Islander (NHPI = 313) students. This imbalance may have affected the power of our analyses, particularly in identifying subtle differences in mental health outcomes between these groups.

Additionally, the nature of self-report in the CCMH data is another limitation. Self-reported data are subject to potential biases, including social desirability bias and recall bias, which may affect the accuracy of responses. The reliability of the findings may have been impacted by the participants' underreport or overreport of certain symptoms or behaviors. Future research should consider incorporating objective measures alongside self-reports to strengthen the validity of mental health assessments.

Moreover, our use of the broad terms "Asian American" and "Native Hawaiian/Pacific Islander" contributed to ethnic glossing, which obscures important cultural and ethnic distinctions. Both AA and NHPI groups are comprised of diverse cultures, languages, and traditions, each with distinct mental health beliefs and practices. For example, the term "Asian American" includes individuals from East Asia, South Asia, and Southeast Asia, while "Native Hawaiian/Pacific Islander" encompasses Polynesian, Micronesian, and Melanesian communities. While our sample sizes for specific subgroups were too small to conduct powered statistical analyses, future research should aim to further disaggregate data to better capture the nuances between individual cultural and ethnic groups within these broad categories.

Additionally, while the CCAPS-34 questionnaire used in this study is brief and widely used, it does not assess race-related stress or trauma, which can be critical components of mental health among racial and ethnic minorities. Furthermore, the archival nature of our data limited us to quantitative measures, and we were unable to gather qualitative data (e.g., interviews) to provide more in-depth insights into the experiences of AA and NHPI students. Future studies should incorporate qualitative methods to better understand the contextual factors influencing mental health within these populations.

Implications for Practice

The findings of this study offer several important implications for clinicians and therapists working with AA and NHPI populations in university settings. First, given the similar rate of service utilization, it is essential to continue outreach and culturally competent care that encourages both AA and NHPI students to access mental health services early. Culturally tailored interventions, particularly for NHPI students who demonstrate higher distress related to alcohol

use, are critical for addressing substance-related issues in a culturally sensitive manner (Sue et al., 2009). Additionally, therapists should be aware of the distinct sources of distress for AA and NHPI students, such as academic pressure for AA students and alcohol use/abuse for NHPI students, to better tailor outreach efforts and treatment approaches. Finally, therapists should pay close attention to early termination in NHPI students, as addressing barriers to continued engagement in therapy could significantly improve treatment outcomes.

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