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Journal

Asian American Journal of Psychology, 10(3)

ISSN

1948-1985

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Publication Date

2019-09-01

DOI

10.1037/aap0000140

Peer reviewed

HHS Public Access

Author manuscript

Asian Am J Psychol. Author manuscript; available in PMC 2021 March 25.

Published in final edited form as:

Asian Am J Psychol. 2019 September ; 10(3): 227–238. doi:10.1037/aap0000140.

Addressing Mental Health Challenges of Samoan Americans in Southern California: Perspectives of Samoan Community Providers

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Abstract

While a variety of health concerns have been documented, little is presently known about the mental health challenges facing Samoan Americans in Southern California. This community-based research study investigated the perspectives of Samoan healthcare providers affiliated with two Los Angeles County agencies regarding: 1) mental health challenges; 2) obstacles to use of formal services to address mental health concerns, and 3) recommendations and needed resources for development of culturally responsive interventions to address mental health challenges. Eleven healthcare advocates affiliated with two agencies specializing in health and social services for Samoans participated in a 90-minute group discussion and/or an individual interview. Qualitative data were analyzed using a thematic data analytic approach based on grounded theory. Participants strongly self-identified as Samoan or mixed-race Samoan and were primarily female (73%). Key themes from these discussions are presented to highlight this seminal discussion. Despite concerns regarding substance use, depression, and suicide, significant cultural resources were noted as sources of resilience that could be incorporated into prevention and intervention for Samoan Americans coping with mental health problems. The perspectives of these community advocates for the Samoan community reflect a low level of mental health awareness and identify urgent unmet mental health needs among Samoan Americans in Southern California. Findings support prioritization of mental health awareness interventions and education regarding available services. Systemic efforts to integrate physical and mental health care services may be aligned with traditional Pacific Islander concepts of mental health and facilitate addressing the unmet mental health needs of underserved Samoan Americans.

Keywords

Native Hawaiian; Pacific Islander health; qualitative methods; health disparities; stigma; integrated care

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Native Hawaiians and other Pacific Islanders (NHOPI) are people with origins in Hawaii and other Pacific Islands such as Fiji, Guam, and Samoa. There are slightly more than one million people (0.4% of the total population) of NHOPI background in the United States with the largest subgroups being Native Hawaiians and Samoans according to the most recent census data (US Census, 2010).

While high rates of cancer, diabetes, obesity and heart disease are well-documented among NHOPIs in the United States, particularly in Hawai'i (Bitton, Zaslavsky & Ayanian, 2010; Beckham et al., 2008; Juarez, Samoa, Chung, & Seto, 2010), little is known about the health and healthcare disparities of specific NHOPI populations living in the United States. Even less is known about the mental health challenges facing various NHOPI communities (Braun, Kim, Ka'opua, Mokuau, & Browne, 2014; Subica & Wu, 2018). The lack of research is concerning as NHOPIs as a pan-ethnic group represent the second fastest growing racial population in the United States (U.S. Census, 2010).

There are several factors contributing to the lack of research on the health of NHOPIs. The relatively small population of NHOPIs in the United States often results in sample sizes too small to disaggregate data across the NHOPI groups for analysis in comparative subgroup epidemiological studies (Institute of Medicine, 2009; Stafford, 2010). In addition, because people of NHOPI origin were aggregated with Asian Americans as a single racial category in the US Census until 2000, some data purporting to reflect the state of NHOPI health actually reports aggregated Asian American and NHOPI data that misrepresents the health status of the heterogeneous NHOPI population (Miller, Chu, Hankey, & Ries, 2008; Panapasa, Mau, Williams, & McNally, 2010).

As the second largest NHOPI group in the United States, the most recent census data indicates that more than 184,440 individuals claimed Samoan or part-Samoan heritage (U.S. Census, 2010). Given limited, yet alarming findings suggesting that Samoans exhibit greater health problems than their NHOPI counterparts in Hawai'i (Bitton et al. 2010; Goggins & Wong, 2007; Park, Braun, Horiuchi, Tottori, & Onaka, 2009) and Los Angeles, California (Asian Americans Advancing Justice, 2013), and there are documented high rates of mental health risk factors among Samoan migrants in the state of Hawai'i, the entire United States, and in New Zealand (e.g. Foliaki et al 2006), the current study sought to address the need for increased NHOPI mental health research by exploring provider perspectives on mental health challenges among Samoan Americans.

Samoan Americans

The total number of Samoans in the United States (207,003 people) exceeds the population of the Independent State of Samoa (also known as Western Samoa) at 195,843 people (US Census 2016 Estimates). The majority of Samoan Americans reside in Hawai'i and California. Thirty-three percent of all Samoan Americans in the United States reside in California, with large populations concentrated in the Southern California counties of Los Angeles, Orange County, and San Diego (U.S. Census, 2010); the 2016 US Census estimate of Samoans living in California is 67,217. The largest NHPI population in the continental

United States is located in Los Angeles County with over 54,000 NHOPIs (Asian American Advancing Justice Los Angeles, 2013).

Despite a strong sense of community, Samoans have historically faced a number of sociocultural challenges associated with transitioning from a communal, agrarian lifestyle in Samoa to individualistic, urban, industrial societies in the US, placing them at increased risk for mental and physical health problems (Tamasese, Peteru, Waldegrave, & Bush, 2005). These challenges include segregation, language barriers, unemployment, and low socioeconomic status (Stafford, 2010) that place Samoans at increased risk for mental and physical health problems (Galanis, McGarvey, Quested, Sio, & Afele-Faamuli, 1999; McGarvey, & Seiden, 2010; Young & Galea'i, 1995).

Samoan Conceptualization of Mental Heath

Within the Samoan culture, mental health is expressed as "soifua maloloina o le mafaufau", which is conceptualized as a holistic state of well-being stemming from an integrated mental, physical, spiritual, and social self (Hope & Enoka, 2009). This wellness-based perspective towards mental health is evident in the Samoan philosophy of mental health representing a positive balance between the atua (God), tagata (people), and laufanua (land) (Lui, 2003).

The Fonofale Model (Pulotu-Endemann, 2009) uses the metaphor of a Samoan house to represent the holistic Samoan concept of health and wellness. The model portrays the foundation of the house as family; the roof (shelter) represents cultural values and beliefs. The four posts connecting the roof to the floor represent the four dimensions of health: spiritual, physical, mental, and contributing factors; such as gender, age, and SES. The entire model is placed within a circle that represents the environment, the specific time in history, and the context (e.g., country of residence, politics, and socioeconomics).

Mental Health Status of Samoans

While there is little data documenting the prevalence of mental health problems in Samoa there is likewise little recent evidence that there are large unmet mental health needs (Mulder et al., 2016). Overall, there is a lack of information, in part, as stigma and limited resources have tended to result in the prioritization of public health needs (e.g. life-threatening physical symptoms of illness) over emotional or mental health symptoms (Szmedra, & Sharma, 2011).

In 2007, the National University of Samoa created one of the only psychiatric nursing programs in the Pacific region and produced data estimating that emotional stress such as depression affected nearly 20% of the Samoan population (National University of Samoa, 2009 as cited in Szmedra, & Sharma). Substance abuse among Samoans has also been reported to be common (Samoan Ministry of Health, 2006) and suicide has been identified as another mental health concern, particularly among youth (Bourke, 2001; Odden, 2012). Consistent with the limited available research, the Samoan National Youth Policy 2001–2010 (as cited in Hope & Enoka, 2009) identified alcohol and substance abuse, suicide, and juvenile delinquency as some of the priority issues facing youth.

Misalignment between the Samoan wellness-based perspective of mental health as healthy living and the Western medical deficit-based perspective of mental health as freedom from mental illness may contribute to low use of formal mental health services in Samoa (Mulder et al., 2016), where providers have historically have been educated to treat mental illness as a clinical disease (Allen & Laycock, 1997). According to the Samoa Nurses Association (as cited in Hope and Enoka, 2009) community based care services are preferred over institutionalization. Accordingly, the limited mental health services that have been developed build on strengths such as holistic models of illness (Mulder et al.), are centered on community and family, and are typically provided by nurses rather than by mental health professionals (Samoa Ministry of Health, 2006). Licensed Samoan rmental health professionals, such as social workers, are scarce and much more attention to educating and training of professionals who understand Pacific models of health and wellness is considered critical to increasing attention to mental health issues (Mafile'o & Vakalahi, 2016).

Mental Health Status of the Samoan Diaspora

Australia, New Zealand, and the United States are home to approximately 300,000 Samoans who migrate for many reasons, including employment, education and family reunification (McGarvey, & Seiden, 2010). Despite the high rate of migration of Samoans throughout the Pacific, cultural ties to Samoa are maintained through relatively affordable options for travel and the financial remittances sent home by those living abroad (Mafile'o, & Vakalahi, 2016). While kinship ties and spirituality have been recognized as protective factors, Samoan migrants have been identified as an at-risk population for poor health related to cultural, social, and economic factors (McGarvey & Seiden). Limited population-based research is available to document the mental health issues of this population, with the majority of research occurring in New Zealand and to a much lesser extent in the United States.

Samoans in New Zealand.

Pacific people in New Zealand comprise nearly seven percent of the population with Samoans making up almost half of this group; nearly two-thirds of the Samoan population was bom in New Zealand (New Zealand Census, 2014). According to data from the *2006 New Zealand Mental Health Survey*, the 12 month prevalence of any mental disorder among the aggregated Pacific Islander population was higher than that of the non-indigenous (non-Maori, non-Pacific) composite population at 24.4% and 19.3% respectively, with the lowest rate of use of mental health services use (Baxter, Kokaua, Wells, McGee, & Oakley Browne, 2006). Overall, based on a community sample, Pacific Islander adults reported experiencing higher levels of anxiety and depression than their European counterparts (Statistics New Zealand, 2015). Based on the 10-item Kessler Psychological Distress Scale, nearly 30% of Pacific Islanders reported a medium or greater level of psychological distress compared to 17% of their European counterparts (Hudson, Russell, & Holland, 2017). Data specific to Samoans is needed to fully portray the current status of this population residing in New Zealand.

Samoans in the United States.

Mental health data for Samoan Americans may appear outdated, yet offers a historical perspective on the long-term existence of adjustment difficulties and psychological distress among Samoans in the United States (see Nishimura, Goebert, Ramisetty-Mikler, & Caetano, 2005; Shu, 1985; Yamamoto, Satele, Fairbanks & Samuelu, 1981). More recent efforts to oversample NHOPI adults for the population-based *Native Hawaiian and Pacific Islander National Health Interview Survey* are laudable, yet available data on Samoan rates of serious psychological distress are described by the authors as unreliable, in part due to small numbers of Samoans sampled (Galinsky, Zelaya, Simile, & Barnes, 2014).

Even when mental health issues were identified through aggregated data on NHOPIs, Samoan Americans have had documented low rates of formal service use. For instance, from 1995–1996, only 36 (0.006%) of approximately 60,000 Samoans living in Los Angeles were admitted for substance abuse treatment (Young & Galea'i, 1995). This low use of services appears to continue based on outcomes of a small pilot project targeting enrollment of Samoan Americans in mental health, health, and substance use treatment services; despite dedicated funds and efforts, only four people were enrolled in services (Los Angeles County Department of Mental Health, 2014).

More recently, small studies have documented stressors that increase the risk of mental health problems among Samoan American youth. Davies-Mercier and colleagues (2017) interviewed Asian American and Samoan American middle school students in Northern Calufornia and reported that in comparison with their Asian American peers, Samoan youth experienced more potentially traumatic events, with nearly three-quarters of Samoan students having reported experiencing a potentially traumatic event involving a loved one. Family and cultural obligations (e.g. attending funerals) of Samoan high school students may result in stress and limited access to educational and career preparation opportunities because of missed school days (Yeh & Borrero, 2012). Samoan youth also report stress related to experiencing racism and negative stereotypes such as being perceived as "lazy" or "dangerous" (Borrero, Yeh, Tito, & Luavasa, 2010).

Yet, despite the presence of pronounced mental health risk factors in the sparse research literature, mental health issues among Samoan Americans have been largely ignored and services have been underfunded (Szmedra & Sharma, 2011). This may be in part due to the alarmingly high incidents of chronic illnesses with elevated mortality rates (Goggins & Wong, 2007; Institute of Medicine, 2009), leading to most funding, resources, and research to be dedicated toward the physical rather than mental health concerns of Samoan Americans. Even if adequate attention were allocated to mental health issues and services, potential barriers still exist. For instance, members of immigrant groups may view mental health challenges as a normal aspect of transitioning to a new culture, which can discourage them from seeking appropriate and timely care (Clough, Lee, & Chae, 2013). A lack of Samoan heritage mental health professionals (e.g. social workers) has been identified as another potential barrier to use of mental health services by this population (Mafile'o & Vakalahi, 2016). While research on mental health issues of Pacific Islanders in New Zealand reveals a further barrier in the form of hesitation among some Samoans to seek out mental health treatment, the specific challenges that may limit Samoan Americans from receiving

care have not been adequately explored. The current study addresses this problematic gap by exploring the perspectives of Samoan American community providers regarding mental health challenges, obstacles to receipt of mental health services and recommended approaches to meet the mental health needs of Samoan Americans.

Methods

Participants

Eleven individuals (72.72% women) of Samoan or part-Samoan heritage aged between 39 and 70 years old (M= 52.67; SD = 9.54) participated in this community-based participatory research study. The majority of participants were bilingual (i.e., Samoan and English speaking) with seven (63.6%) providers indicating that Samoan was their primary language. Participants were affiliated with one of two Samoan-serving non-profit agencies in various positions such as administrator, clinical staff (e.g., case manager, mental health advocate), outreach worker (e.g., health educator), or consultant. As illustrated in Table 1, none of the participants were licensed mental health practitioners such as social workers or psychologists.

Procedure

All study protocols were approved by the Institutional Review Board of the University of Southern California. This study was conducted in partnership with two agencies operating in Los Angeles County that provide diverse outreach, education, and health services to our targeted Samoan American communities in Southern California.

Inclusion criteria were age 18 years or older, Samoan or part-Samoan heritage and formal affiliation with one of our Samoan community partners. Exclusion criteria were lack of English fluency sufficient to participate and not residing in the targeted Southern California Samoan American communities. After being identified by the executive directors of our community partner agencies, potential participants were provided with an information sheet briefly describing the study. They were also provided with a recruitment sheet documenting their willingness to be contacted by the research team to determine eligibility and discuss study participation.

A focus group was chosen as the best method for obtaining the data because the group format is aligned with traditional Samoan values placing emphasis on an interdependent (communal) sense of self (Mulder et al., 2016; Nelson, 2015). Although the topic of mental health may be taboo to some Samoan Americans, the group format allowed for sharing of thoughts and was designed to offer learning opportunities, and prevent shaming participants with limited knowledge of mental health who may be uncomfortable if directly called upon. Our partners did not believe gender to be a concern so we did not separate male and female participants.

The focus group (n= 10) was conducted at one of our community partner sites and was facilitated by a European American community mental health nurse experienced in leading community-based focus groups and a Samoan heritage bilingual research assistant graduate student. Although the focus group was conducted in English, participants were encouraged

to speak Samoan if easier to express an opinion and the co-facilitator was available to interact in either English or Samoan and translate if called upon. Immediately prior to the focus group, participants were offered refreshments and asked to complete a 15-minute demographic survey developed for this study to assess acculturation to Samoan and American cultures. The 90-minute focus group was recorded and written notes were taken by two members of the research team.

The focus group covered five domains of open-ended questions designed by the research team and Samoan partners to solicit participants' perceptions of the: 1) biggest mental health problems within the Samoan community; 2) obstacles preventing Samoans from receiving mental health services; 3) mental health resources Samoans used to address their mental health problems; 4) services needed to promote mental health within the Samoan community; and 5) solutions to the identified mental health problems. Upon conclusion of the focus group, participants were thanked and given fifty dollars in appreciation for their time.

Given the broad age range of the participants, the sensitive nature of the research topic, and the cultural tendency for younger Samoans to defer to Samoan elders in group settings (Nelson, 2015), we conducted four follow up individual interviews with a diverse cross-section of focus group participants who were willing to share their opinions in greater depth. A fifth interview was held with an interested individual who was unable to attend the focus group session.

The interviews ranged from 45–120 minutes and participants were asked more detailed questions adhering to our five research domains in order to obtain greater detail than was possible during the focus groups. After the interviews, participants were again thanked and given fifty dollars in appreciation of their time.

Data Analysis

Qualitative data were analyzed using a thematic data analytic approach based on grounded theory (Willms et al., 1992). First, the research team convened to establish *a priori* codes and categories based on the five domains of questions. Next, the qualitative data were transcribed by a trained medical transcriber. A Samoan, bilingual member of the research team assisted with preliminary thematic analysis of the transcripts. Then, two team members, the health professional who facilitated the focus group and a clinical psychology postdoctoral fellow, independently coded the data. The research team then met again to review the codes and resolve disagreements in the coding through team discussion. Finally, the research team evaluated the coded data and identified core themes through investigator consensus. To increase the trustworthiness of the data we provided our community partners with the preliminary themes aligned with segments of the transcripts and encouraged reading and commenting on the drafted manuscript. No content or discussion points required modification.

Results

Three salient themes were extracted from the focus group and interview transcripts: Perceived Mental Health Challenges, Identified Barriers to Mental Health Service Utilization, and Recommended Strategies. Table 2 presents each theme with succinct quotes to illustrate subthemes. The themes, subthemes and categories of responses with representative quotes follow.

Theme 1: Perceived Mental Health Challenges

This theme reflects the views of participants regarding mental health struggles of the Samoan American community. Two subthemes emerged from participants' responses: 1) priority mental health problems; and 2) factors contributing to mental health problems.

Priority mental health problems.—Substance abuse, depression, and suicide were identified as the most concerning mental health issues. Providers reported that many Samoan Americans experience issues with "alcoholism" and "drug abuse," and that it was a growing problem among the Samoan American youth. For example, one male provider stated, "I think the biggest [problem] is the drugs… being a person under drugs, everything changes" and another provider indicated that some Samoans were self-medicating with controlled substances as a means to "get rid of [mental illness]." Depression was also acknowledged as a major mental health problem by many participants. One provider struggled to describe depression in her community,

> A lot of depression because we are a very close knit community and if there 's a death of a loved one in the community, we don't talk about depression, but we have people in the community that have taken depression for a long time.

Suicide was another frequently cited concern. One nurse reported that during a mental health workshop with Samoan American youth, she was surprised when half of the youth acknowledged having suicidal thoughts. Similarly, another provider stated, "I did not realize how many 10-year olds and 16-year olds have contemplated suicidex…it's like, 'Wow, you're only 10! What is a 10-year old doing thinking about suicide?'"

Factors contributing to mental health problems.—In discussing major mental health challenges participants shared their thoughts on factors that could increase the risk of mental illness or exacerbate problems they had identified. Four factors that were raised were: 1) stress stemming from cultural obligations, 2) mental illness perceived as a violation of sacred principles or "sin," 3) youth gang involvement and 4) generation differences.

The most commonly reported cause was "stress," a vague construct that appeared to encapsulate distress caused by failure to meet one's cultural obligations. Participants revealed that a number of Samoan Americans experienced chronic stress due to *fa 'alavelave*, the custom where family and friends are expected to donate or contribute money or other gifts for significant occasions such as funerals and weddings (Bergey, Steele, Bereiter, Viali, & Mcgarvey, 2011). Family members were reported to have to sell valuable items or borrow money to meet their *fa 'alavelave* obligations with one administrator stating, "If one of my siblings cannot afford $300…that's stress on the family. And then what, he got

to pay that back and not pay his car payment, not pay his rent, now he's behind on everything else. Stress."

Violating sacred doctrine such as Christian morals was also noted by some providers as a cause of mental illness. Grounded in the Samoan conceptualization of health as the integration of the mental, physical, and spiritual well-being, mental illness was seen as caused by amoral "sin" or going "against God's ruling…His divine standard…His word." For many of these providers, the concept of mental health recovery requires accepting responsibility for wrongdoing and committing to moral behavior through spirituality or spiritual practices.

Gang involvement was also noted as contributing to mental health challenges. Providers perceived gang membership as leading to negative peer interactions, violent behavior, substance use, and suicidal ideation. The lure of gangs was explained by one provider who suggested that gangs provided Samoan youth with a sense of family and comfort in response to a turbulent home environment.

The final stressor linked to mental health challenges was generation differences among family members. Generation differences were discussed in terms of differences in awareness and views of mental illness. A participant stated,

> I'm born and raised here so I consider I was American, even though I went to Samoan church. But there really needs to be like some kind of intergenerational discussion amongst, like, our older generations, American born, even the college students now. And …bring a Samoan who 's just moved here like 10–20… 10–15 years ago. There 's all different perspectives on how they view mental health… Cuz my perspective would be totally different from say my parents since they were born and raised in Samoa.

Theme 2: Identified Barriers to Mental Health Service Utilization

Providers offered perspectives on the greatest obstacles to Samoan Americans receiving quality mental health care. The most common obstacles reported were culturally sanctioned stigma and shame associated with mental illness. Other barriers included a lack of awareness and knowledge of mental health problems and a perceived lack of culturally responsive providers.

Many participants mentioned "stigma" as the primary barrier to mental health care utilization: "[mental illness], it's not a subject that you would bring up and be acceptable in the culture…it's sort of a hush-hush kind of thing." Another provider added:

> The fact that you don't see our people in your system speaks volumes to what 's happening to us; we're falling through the cracks. Uh, stigma, what I'm talking about is that we do not let it be known. It 's not an issue that is discussed, you know, like a conversational thing.

Other providers indicated that admitting to mental health problems would bring "shame" to either: a) the individual who is often labeled "crazy," "kookoo," "cursed," or "dumb;" or b)

the "family name" described as "your family is going to be branded as being crazy." Another participant added, "When you have a crazy person in your family, that family is cursed."

Stigma and shame were most often linked to Samoan Americans' limited knowledge of the signs and symptoms of mental illness. Participants provided insight such as "[Samoan] people are not aware of what mental health, mental illness is." Despite working in community agencies that addressed a wide range of physical health concerns, some participants indicated needing additional education about mental illness. For example, the male youth minister expressed frustration with his own lack of mental health knowledge, stating, **"I** would like to have more information about mental problems, mental illness…1 don't have the knowledge…I would love to have more knowledge of mental illness, how to deal with it, how to help." Another provider echoed that sentiment reporting, **"I** never knew the definition of mental health…1 never knew that eating disorder, thinking about committing suicide was mental health…all we thought about mental health was, you're crazy."

Lastly, the perceived lack of Samoan-speaking and/or culturally responsive mental health providers was cited as a significant barrier to seeking and receiving care. As one participant offered, "if [you're] targeting the majority of the Samoan community, you gotta know how to speak Samoan." Other participants described the negative impact of "the language barrier" and how it prevented Samoan individuals from feeling comfortable disclosing mental health issues with non-Samoan speaking providers. The formal mental health system was viewed as an organizational barrier that limits the ability of providers to work effectively with Samoan Americans. "When you speak to the Samoan community specific, if you want to get them to enroll, talking to a client, you have to first get to know them, get their trust, and then it's more than eight visits."

Theme 3: Recommended Strategies

Participants discussed the needs of their communities for prevention, early intervention, and treatment of mental health concerns and serious forms of mental illness. Two subthemes were identified, one that reflects recommendations for capitalizing on cultural sources of resilience and identified (pre-existing) resources to address mental health challenges, and a second that offered potential approaches corresponding to unmet needs.

Capitalizing on existing resources.—Using available resources and strengthening these existing resources were recommended as culturally appropriate strategies to address mental health challenges. Participants primarily identified religion/spirituality and family and community support as cultural sources of resilience that could be leveraged to address mental health problems.

According to participants, religion/spirituality is the most prominent resource for addressing mental health needs. Many providers shared that spirituality was essential for Samoan mental health, defining mental illness as "a sickness of mind, body, and soul…because it affects your mind and it'll affect your body and then it affects your soul, your spirit." As a result, religion/spirituality was seen as the primary mental health coping tool: "Samoan people are known to be religious, and in times of disaster, they run to God…prayer is the

first defense that they have." Multiple providers also reported that religious institutions were the core of the Samoan community. As one provider stated, "churches are the Samoan village…because that's where the community comes together at every village, is the church." Samoan Americans often turn to religious leaders for mental health support, as described by one provider: "Ministers, they deal with so many things like anger…with depression, stress…Samoans, they think the minister will be the best person to help… they think the [minister] is always the best person to go to with those problems." Yet, this reliance on religious leaders for treatment was seen by some providers as problematic due to ministers' potential lack of mental health education. The youth minister said:

> I don't know why [Samoans] think a minister can help everybody, but I don't believe the minister can. If a minister was trained in school for theology and for preaching, where is he going to get [mental health] information from to help all those people?…being a minister I can't help everybody with those problems. I can preach a good sermon on the pulpit but I cannot deal with somebody with mental problems.

After religion/spirituality, the other discussed resources were mentioned much less frequently. Family support was the next most frequently discussed source of strength and coping. Not all participants viewed family as helpful. One provider expressed caution with offering family and community support as a resource for those experiencing mental illness because she believed that the support was hindered by the limited mental health awareness of the Samoan American public.

Recommendations for using existing community resources to address mental health needs included using programs offered by community agencies not affiliated with mental health centers. For instance, one provider spoke about workshops she offered through a community-based Samoan health organization. "Some of them are coming, you know, that are attending our workshops, they beginning to realize and understand what depression is… what anxiety is. You know. And we brought out a lot of issues like attempted suicide and all that." An administrator reported awareness of an integrated health care program offered by the county department of mental health and the local chapter of the National Alliance for Mental Illness, a peer-run organization for families of individuals with mental illness, as a potential avenue to address mental health needs of the Samoan American community.

The final existing community resource mentioned by participants was existing Samoan American media (e.g., radio stations, newspapers, newsletters). Participants reported that no mental health information was currently being disseminated by the Samoan American media in their communities. However, based on their prior experiences broadcasting education sessions, they believed that Samoan media outlets would be ideal for increasing the mental health awareness of the Samoan community.

Advocating for germane resources.—Participants offered three recommendations to solve identified problems and improve mental health services to the Samoan American community: increasing awareness of mental health challenges, identifying culturally responsive providers to deliver services, and creating educational tools and resources appropriate for their community.

To raise awareness of the impact of mental health problems on members of their community, participants overwhelmingly cited mental health education as critical. One participant stated, “The important thing is to educate our people to identify what mental health is and then we go from there.” A second participant said, “Education is number one because you can’t go any other way unless the people understand what it is…just simple education, the basics of mental health, of mental illness.” Another participant echoed these sentiments, “We don’t even have a sense of, understanding what mental health is. So, education is very important, but it has to be cultural education.”

Participants also discussed the importance of having more culturally responsive providers to establish “trust” with Samoan clients. For some, this meant having mental health professionals who speak Samoan. One participant shared how difficult it was for her mother with schizophrenia to trust her providers due to a language barrier which increased her mother’s suspiciousness of the provider and her, as she was serving as primary translator. For other participants, non-bilingual mental health professionals who were aware of and responsive to Samoan cultural approaches were sufficient.

Recommended culturally responsive approaches to care also included spending multiple sessions building rapport before directly addressing mental health topics, conducting follow-up phone calls during the week to demonstrate caring, and adhering to cultural norms (e.g., treating elderly patients with deference). Providers were aware that provision of culturally responsive services may require that public mental health systems relax service caps to accommodate the lengthened time required to build sufficient rapport with Samoan patients.

A final strategy centered on the need to develop culturally responsive mental health educational materials for the Samoan public. Suggestions included brochures and informational brochures to post at churches and health fairs, brief audio presentations for radio stations, and video and in-person presentations to church congregations.

Discussion

The current study fills a gap in the literature by exploring the perspectives of community healthcare advocates affiliated with two agencies serving Samoan Americans, with the aim of identifying and recommending approaches to address mental health challenges in their Samoan communities in Southern California. This purpose was met through organizing participant narratives into three themes: Perceived Mental Health Challenges, Identified Barriers to Mental Health Service Utilization, and Recommended Strategies. While Theme 1 lays the foundation, our 2nd and 3rd themes directly relate to the development of interventions so will be discussed in this context.

The lack of recent large-scale research attention to the mental health problems of Samoan Americans has led to a lack of public attention, resulting in a tragically overlooked population given few public mental health resources responsive to their needs, and little voice in the mental health care dialogue (Strafford, 2010). The first theme addressed this gap by focusing on participants’ perception of major mental health challenges affecting Samoans Americans. Substance use, depression, and suicide were the most frequently mentioned

problems. These issues are nearly identical to those identified for Samoan youth a decade ago in Samoan government policy reports (see Hope & Enoka, 2009).

Despite their own self-disclosed limited knowledge of mental health problems, these providers offered stories of personal, familial, and communal suffering and stress contributing to and resultant from these issues. Stress related to cultural obligations was most frequently mentioned as a contributor. This finding is consistent with a prior qualitative research study that presented the views of Samoans residing in New Zealand regarding financial burdens imposed from obligatory communal sharing of resources (Tamasese et al., 2005). Similarly, participants in our sample echoed responses of those in prior research studies (e.g., Malo, 2000; Tamsese et. al.) regarding different experiences and stressors of the second generation youth in comparison to the hardships of older and migrant Samoans.

Implications for Education and Interventions

Interventions aimed to provide mental health education and treatment to Samoan Americans must be responsive to preferences such as those reported by our participants as detailed in themes 2 and 3. Participants noted that cultural responsivity of services could be enhanced by integrating cultural values such as the importance of Christian faith and spirituality, and strengthening family and community connections. Vakalahi and Godinet (2014) note that culturally responsive services must also incorporate key Pacific Island values that de-emphasize self-identiy in favor of group centric views associated with collective obligations, reciprocity, and respect of others. Recognizing the value of promoting this collective world view, a strength-based intervention designed to promote resilience and increase social support for Samoan American youth in San Francisco was developed and subsequently demonstrated the effectiveness of targeting vulnerable segments of the Samoan population (Yeh et al., 2015). Simultaneously, increasing mental health service use among Samoans would involve addressing formidable barriers to service use such as stigma and shame and the challlenge of increasing the availability of linguistically and culturally responsive providers and services for Samoans and other NHOPI groups (Mafile'o & Vakalahi, 2016).

Research on Samoans in other countries offers further insights into culturally responsive service delivery approaches that might inform the development of mental health services in the United States. Services developed in New Zealand for their migrant Samoan population appear to be particularly suited to adapting intervention approaches reflecting the cultural beliefs and practices of Samoan Americans (see Agnew et al 2004; Enoka et al., 2013; Samu & Suaalii-Sauni, 2009; Suaalii-Sauni et al., 2009; Tamasese et al., 2005). We next highlight five intervention approaches that capitalize on existing resources and Samoan cultural values based on the needs and associated strategies elicitated from our participants.

Spirituality infused approaches.—Spirituality is considered the essence of wellness for Samoans, particularly among older adults (Ihara & Vakalahi, 2011). Some Samoan Americans may rely on the church because they do not always have supportive families in times of crises (Samu, Suaalii-Sauni 2009). Interventions based on the significance of faith and spirituality, especially those presenting a holistic model in which spirituality is viewed in relation to body, mind and environment (Ihara and Vakalahi), offer one possible approach

to providing mental health support. Our participants tended to describe mental illness as sin; Lui (2007) has described another treatment approach designed to foster forgiveness and coping strategies for perceived moral faults.

To illustrate, the county mental health system of Los Angeles encourages the infusion of spirituality into mental health wellness centers (Yamada et al., 2014; Subica & Yamada, 2017) and offers training for clergy who may not have the knowledge and skills to support people experiencing mental health problems. Likewise, mental health services in New Zealand infuse spirituality into mental health services in several ways. Traditional healers and Christian ministers work collaboratively to restore harmony that is necessary for well-being by using a combination of techniques including massage, herbs and Christian prayers (Samu, Suaalii-Sauni 2009). Tamasese and colleagues (2005) go further in advocating for the necessity of addressing spiritual beliefs when providing Western-based psychiatric care to Samoans.

Strengthening family and community connections.—While participants did not uniformly view their families as prepared or willing to support family members' mental health needs, the overall value of family was portrayed as a source of resilience. Increasing familial support for people with mental health problems could capitalize on the notion that many Samoan Americans perceive their church or community as "one big family." This is reflected in a broad definition of family that includes extended and honorary family members, including those without blood relations (Borrero et al., 2010). In addition, psychoeducation and supportive family-based services could be offered to address the challenge of stigma and negative perceptions of family members. Training family members to increase their skills in offering empathie, supportive care has been proposed by Samoan family members dealing with caregiving responsibilities (Agnew et al., 2004).

Anti-stigma approaches.—Similar to other racial/ethnic populations with low use of mental health services, such as Asian Americans (Leong & Lau, 2001), stigma and shame emerged as a major barrier to formal help-seeking. Participants cited lack of mental health awareness/knowledge in the Samoan community as the underlying cause for this stigma and shame, leading to misperceptions and negative judgments that prevent help-seeking. The negative impact of stigma has been identified as particularly problematic for Samoan youth in New Zealand (Agnew et al., 2004) and in consideration of our findings and the work spearheaded by Christine Yeh (e.g., Yeh et al., 2015), is an area of great need for further exploration and intervention.

Therefore, to address this underlying barrier and enhance Samoan help-seeking, public-sector providers and systems could culturally adapt and implement existing anti-stigma interventions focused on mental health education (Corrigan, Morris, Michaels, Rafacz & Rüsch, 2012). These interventions could be used to 1) increase mental health awareness in Samoan American communities and 2) shift Samoan conceptions of mental illness away from traditional/cultural attributions that place blame on the individual or family (e.g., mental illness is caused by sin or violation of sacred principles) toward less stigmatizing neurobiological attributions (e.g., mental illness as a neurobiological disease).

Integrated care approaches.—Participants were aware of the value of services that offer integrated physical and mental health, and substance use/abuse services. Providing mental health and substance use services in healthcare setting has been shown to reduce stigma (Yamada, Wenzel, DeBonis, Fenwick, & Holguin, in press) and may offer a more appealing help-seeking option for Samoan Americans. Integrated care efforts have been recognized as being aligned with Samoan traditional health models that conceptualize well-being as a balance of mental, physical, and spiritual health (Ida, SooHoo, & Chapo, 2012; Ihara & Vakalahi, 2011). Likewise, successful alcohol and other drugs services for Samoans in New Zealand use a holistic approach that incorporates beliefs such as described in the Samoan Fonofale model of wellness (Robinson et al., 2006).

Kokua Kalihi Valley Comprehensive Family Services, a Federally Qualified Health Center (Patient-Centered Medical Home) in Hawai'i, is another example of an integrated, comprehensive, and holistic healthcare program offering culturally relevant services for NHOPI immigrants. Spirituality is incorporated into programs targeting Samoan immigrant elders through music, dance, prayer and opportunities to connect with the land through communal gardening. This type of interdisciplinary, culturally grounded provision of services has been shown to be effective in reducing health risks such as hypertension and obesity among NHOPIs in Hawai'i (Kaholokula et al., 2014; Kaholokula, Ing, Look, Delafield, & Sinclair, 2018) and could inform behavioral health prevention and intervention development for Samoan Americans in Southern California.

Physical health intervention approaches.—Mental health interventions can be informed by literature that features intervention development and testing focused on management of chronic illnesses such as diabetes or on increasing cancer screening behaviors among Samoans in the United States and in American Samoa. These interventions feature cultural adaptations such as collaboration on study design between Samoan community agencies and academic institutions (Mishra, Luce & Baquet, 2009), involvement of Christian ministers and recruitment via churches (Mishra, Bastani, Huang, Luce, & Baquet, 2007), and use of community health workers to teach desired health behaviors (Beckham, Bradley Washburn,& Taumua, 2008).

Limitations

Our study has several limitations. First, although acceptable for an exploratory study using qualitative methods, our findings are based on a small sample and are not generalizable to the broader Samoan American community. Future work conducting individual interviews and collecting quantitative survey data with a larger sample of providers is needed. Second, although the focus group approach was chosen by our Samoan American research partners as the most culturally appropriate way to collect the data, some participants may have felt inhibited from sharing their stories with a facilitator not of Samoan heritage or had less opportunity to share comments than in individual interviews. However, these limitations were offset by offering participants the opportunity to be interviewed individually. Furthermore, most participants referenced the comments of fellow group members as they shared and several participants began to cry while sharing personal stories, suggesting comfort with group members and facilitators. Finally, there are limitations related to the

selection of the participants. Given that none of the participants were licensed mental health professionals, they were also unsure about the precise mental health issues within their Samoan communities. Although this could have limited the credibility of their views, the sampling strategy was meant to target individuals who were advocates for their community, passionate about serving their community, knowledgeable of a variety of community needs, and comfortable sharing their experiences.

Future Directions

Further funding must be allocated to determine how best to direct resources to overcome the barriers related to the underutilization of mental health services in this high risk population. Providing culturally responsive care requires first being able to assess the needs and preferences of community members, including those experiencing mental health problems, their families, providers and community support. Additionally, quantitative research with greater external validity is needed to ascertain the degree of similarity in the experiencing and coping with mental health issues among Samoans and NHOPI's in other locales.

Our group of providers was aware that there is limited data to support the need for specialized services and funding earmarked for a rather small community. Thus, while data collection is needed and data that disaggregates the NHOPI population remains a priority, there are also opportunities for developing mental health interventions and programs applicable across many Pacific Islander groups. Agnew and colleagues (2004) conducted an international literature review and note the similar experiences of immigrant and underrepresented group members who would likely benefit from similar interventions. Although linguistic barriers remain formidable when targeting such a heterogeneous population, NHOPI appropriate services could be modeled after successful programs operated for pan-ethnic Asian American groups (e.g. Chen, Kramer, & Chen, 2003). Existing psychoeducational training materials could be made available in various NHOPI languages. Finally, spiritually infused approaches to educating Samoans and other NHOPI groups about mental health issues might also be well-received, as many of these groups traditionally have turned to Christian churches with strong Pacific Island cultural influences (Godinet & Vakalahi, 2008) for a broad array of supportive services.

Conclusion

The lack of research attention to the mental health problems of Samoan Americans has led to limited awareness of the need for public mental health resources that are culturally responsive. Many traditional Pacific Islander models conceptualize recovery from mental illness as necessitating an integrative approach combining rectification of breaches of sacred relationships, reconciliation in the disrupted family, and healing of the spiritual self (Suaalii-Sauni et al., 2009; Tamasese et al., 2005). Yet, the degree to which this traditional conceptualization of health and well-being affects help-seeking and service use of Samoans who have immigrated to the United States as well as those bom here, is presently unknown. Samoans, like other NHOPIs, have had little voice in the mental health care dialogue (Strafford, 2010). This study offers an initial step forward by using community-based

research methods to offer insights into perceived mental health needs and strategies to support the large Samoan American communities in Southern California.

Acknowledgments:

In-kind staffing support for this project was provided by staff funded through *SC CTSI (NIH/NCATS) Grant #* ***UL1 TR000130.*** The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health, or the National Center for Advancing Translational Sciences. We gratefully acknowledge research support provided from Tania F. Reza and the Suzanne Dworak-Peck School of Social Work, University of Southern California.

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Public Significance

This study engaged community advocates in discussion to address mental health challenges among Samoan Americans in Southern California. Study participants noted limited awareness of mental health problems and stigma as barriers, and spirituality and family support as cultural protective factors to bear in mind when developing mental health interventions for Samoan Americans

Table 1

Characteristics of Samoan Healthcare Provider Participants

Sex[a]	Age	Nativity[b]	Education	Position Title[c] (Specialty)
F	39	U.S.-born	High School	Project Coordinator
F	--	Samoa-born	Master's	Health Educator Consultant (RN)
F	44	U.S.-born	High School	Mental Health Advocate
F	59	Samoa-born	Associate	Case Manager (RN)
F	62	Samoa-born	Master's	Administrator (Education)
F	70	Samoa-born	--	Consultant; Retired
M	48	U.S.-born	High School	Elementary School (Food Services)
F	49	Samoa-born	Bachelor's	Executive Director
M	51	U.S.-born	High School	--
F	52	Samoa-born	Bachelor's	Program Specialist
M	50+	Samoa-born	Bachelor's	Health Educator (Youth Minister)

Note.

[a] For Sex, F = female, M = male.

[b] Persons born in Western Samoa and American Samoan were aggregated as not all participants specified.

[c] Participants were all affiliated (paid or volunteer) with one of two organizations providing a variety of health education and advocacy services to Samoan Americans in Southern California.

Table 2

Themes, Subthemes and Illustrations of the Perspectives of Samoan American Community Health Providers Addressing The Mental Health Challenges of Their Communities in Southern California

Themes, *Subthemes*, Illustrations	**Provider Excerpts**
Theme 1: Perceived Mental Health Challenges	
Priority Mental Health Problems	
Substance abuse	"The things that we've seen in the outreach that we've done here with our group is alcoholism is one of the top [issues]…drug abuse."
Depression	"We do have a lot of mental health issues…problems with depression. A lot of depression."
Suicide	"Unfortunately, in this state that we're living, there are 10-year olds and teenagers that are thinking [about] suicide."
Factors Contributing to Mental Health Problems	
Stress of cultural obligations	"It's the stress…all the fa'avalaves[a]…it's a lot of stress."
Conceptualization of mental illness as sin	"Mental illness…I believe it's more of a moral issue. Mental irregularities for lack of a better word…I believe that at the crux of it is sin."
Youth gang involvement	"You got kids that are in gangs…dying from getting shot at…the gang violence…how can you cope..?"
Generation differences	"…the way I was brought up versus the way I'm bringing up my kids, it's a whole big issue.… And those are the generation gap because I, I fail as a mom to see that, in Samoa we don't have things in Samoa that are here. There is a lot of stuff here that my children are exposed to that I wasn't exposed to."
Theme 2: Identified Barriers to Mental Health Service Utilization	
Stigma of mental illness	"[Mental illness] has not been brought forward because of the stigma that your family's going to be branded as crazy."
Shame	"If you do know about it and if you admit it, you're only going to…bring shame to the family. …there's lots of branding within the family. So, because 'so and so' is crazy that means you're crazy, and then your whole family is crazy."
Lack of knowledge of mental illness	"When it comes to mental health issues, mental health problems, there's no discussion. …identifying them and knowing what they are, that's a problem."
Perceived lack of culturally responsive providers	"The [Mental health organization] does not have any Samoan social worker or Samoan therapist…it's kinda scary especially for people like my community that are not used to non-speaking Samoan people and just the word 'mental health' is a scary thing."
Theme 3: Recommended Strategies	
Capitalizing on Existing Resources	
Religion/spirituality	"Samoan people are known to be religious…their first thing is prayer…so if there's a death in the family, there's anything…that causes harm or anything like that, they'll bring it to a prayer."
Family & community support	"My family support, like my brothers and my families being there every time Mom gets sick, that's where I got my strength from."
Community partner agency services	"The only resource that we have right now is the project that we work with [mental health organization], that's the mental health resource we have."
Samoan language media	"We did the radio station, we actually went on the radio about mental health and that was a big hit."
Advocating for Germane Resources	
Community education about mental health	"We do, just like any other community, we do have a lot mental health issues. But identifying them and knowing what they are, that's a problem. Because there's many that not had any training, any prior experience in dealing with mental"

Themes, *Subthemes*, Illustrations	**Provider Excerpts**
Culturally responsive providers	"You need to gain the trust of the [Samoan] people…if the non-Samoan professionals are [culturally] understanding and willing to be patient, they can break through…whether you're Black, White, or Samoan…it's the communication."
Developing culturally responsive mental health education tools	"I think brochures would be good, and maybe a presentation…a video of people that have the illness just to show everybody how this looks, and the danger behind it, that would help."

Note.

[a] obligatory practice of public gift exchange in Samoan communities.