Samoan and psychiatrists' perspectives on the self: qualitative comparison

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Objectives: To compare psychiatrists' perspectives on the meaning of self, in general adult public practice psychiatry in the Wellington region of New Zealand, with a Samoan view of self and to discuss the implications for the practice of psychiatry with Samoan people in New Zealand.
Method: A focus group of psychiatrists was convened for three sessions. A Samoan view of self was presented to the participants. Transcripts of the focus groups were analysed using inductive content analysis and a process of cultural accountability was included in the research design.
Results: Individual and secular notions of self dominated the psychiatrists' perspectives and contrasted with the primacy of relational and spiritual notions of self in Samoan culture. Psychiatrists experienced a sense of cultural 'dissonance' on first exposure to the Samoan views. The Samoan notion of self was considered to challenge the universalist assumptions of Western psychiatric theories as understood by the participants. The Samoan relational notion of self had implications for clinical interviewing, understanding of phenomenology, formulation and treatment planning with Samoan patients and their families.
Conclusions: Dedicated Samoan or Pacific Island mental health services would allow culture-specific concepts central to an understanding of mental health to be embedded in service delivery. The process used in this study and the notion of dialectical tension could be used in the cultural education of mental health clinicians. The cultural accountability process models an important aspect of such training.
Key words: cross-cultural, cultural accountability, Samoan, self.

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> Human identity is at the heart and soul of our endeavours. Our task is not to negate cultural identity or to squeeze others into straitjackets of cultural neutrality. The challenge is to understand cultural identity as a keystone for healing, for living and eventually for dying.
> Mason Durie, College address RANZCP Congress 1996 [1]

Differences between Western and non-Western views of self have been highlighted by many writers [2–5]. In Western philosophy there is a tradition of debate about whether the self is a unitary phenomenon [6]. However, most psychiatrists do not engage daily with philosophical debates, rather they bring to their practice a 'working

model' of self which is likely to be based on a combination of personal and professional cultural inheritance, knowledge of theory, spiritual belief and individual experience of their own psychological world. If common elements can be identified among the working models of self that psychiatrists bring to their work, and if there is a difference between these and the notion of self shared by an identified cultural group, there are implications for the provision of culture-specific mental health services for the group in question [7,8].

Pacific Island people form about 6% of the New Zealand population and over half of them are of Samoan descent [9]. Mainstream New Zealand mental health services do not serve Pacific Island communities well [10,11] and improving mental health services for these groups has recently become a focus of research and government policy [12,13].

Understanding the Samoan concept of self is considered by Samoan people to be crucial to understanding mental wellbeing. The Samoan self is a relational self, having meaning only in relationship to others [14]. It is 'a total being comprising spiritual, mental and physical elements which cannot be separated', deriving its 'sense of wholeness, sacredness and uniqueness from its place of belonging in family and village, genealogy, language, land environment and culture'. The Samoan concept of self is considered an appropriate theoretical foundation for the development of mental health services for Samoan people in New Zealand [14]. This can only be achieved if those providing the services are aware of the centrality of the Samoan notion of self to Samoan mental health and are able to use the construct in their formulations of the mental health problems presented by Samoan people.

This study was designed as part of an ongoing discourse between local service providers and the Wellington region's Samoan community.

Method

The enquiry was informed by a social constructionist perspective. In this epistemological framework the values, beliefs and customs making up social reality are considered to be constructed by members of a culture as they interact over generations [15]. This perspective acknowledges the importance of power relationships and social forces in determining which values gain dominance in a society.

Research questions

In a New Zealand setting:

1. What are common views of self as understood in everyday adult psychiatric practice?
2. What are the main domains of contrast to the sense of self as understood by the Samoan people?
3. What are the implications for psychiatric practice with Samoan patients?

Sample and recruitment

Using a purposive sampling strategy we approached psychiatrists with over 5 years experience of public practice in the lower North Island of New Zealand, who had exposure to Pacific cultural issues in clinical settings. The psychiatrists were chosen on the basis of their relative homogeneity of training and experience. Following the ethics committee approval, eight participants were recruited by telephone, followed by a letter. All the participants were of Western European descent, either New Zealand or UK born. Most completed specialist psychiatry training locally and occupied senior non-academic positions in adult community psychiatric practice. Two psychiatrists worked part time in a specialist Maori mental health service. There was an even gender mix and we planned for a minimum of six participants attending all three focus group sessions, allowing for unforeseen absences.

Procedure

A series of three focus groups was held at two weekly intervals. They were moderated by Allister Bush (AB) and observed by Sunny Collings (SC) and addressed the research questions in sequence. Focus group questions were developed in draft form before the first session and revised in light of new material as sessions progressed.

In the first session participants explored their personal perspectives on the self, ideas about self dominant in psychiatry and the relevance of these to their clinical work. The Samoan mental health study *Ole Taeao Afua: The new morning* [16] was given to them to read before the next session. The second session was preceded by a presentation of this study by its principal researchers. This included a detailed account of the Samoan view of self. Participants discussed contrasts with their personal views of self and between the Samoan view and what they considered as the dominant views in psychiatry. The final session focused on the implications of these differences for their clinical work with Samoan patients. The focus group questions are available from AB.

Sessions were audiotaped and transcribed and the transcripts were sent to participants within 1 week for verification and to remind participants of the issues discussed.

Cultural accountability

In cultural research there is an ethical obligation to ensure that no harm is done to the communities being studied and to minimize further stereotyping of and prejudice against these communities [17]. In order to maintain cultural accountability, a Samoan member of the *Ole Taeao Afua* research team was involved in each stage of the development of this project including analysis, interpretation and report writing.

Analysis

An iterative inductive content analysis process was used. The unit of analysis was segments of text pertaining to identifiable themes in the participants' talk. The process was one of constant comparison, iteratively classifying and grouping the material to identify preliminary

themes and subthemes [18]. Two researchers (AB and SC) independently analysed each transcript and then met to compare and confirm findings. Attention was paid to corroboration and divergence within the data. Coded text segments were entered into a Microsoft Access database. This facilitated refinement of the domains of broad themes and subthemes which was done jointly by AB and SC. A draft report was reviewed by the other members of the research team. This was then reviewed by the participants to verify the authenticity of the findings.

Results

In the interests of space, we have conflated the description of the key themes in the participants' views of self with the four major contrasts identified between participants' and the Samoan perspective on the self. We considered these distinctions as *dialectics* as this term captures the potential for change that can occur through the dynamic interplay of opposing viewpoints.

1. Individual versus collective notions of self

This was the most prominent dialectic. From a personal perspective, the majority of the participants identified their core self as individual. For example:

> Participant: 'I would see the self as the middle of the wheel, as the hub. And the spokes I wouldn't include in self'
> Moderator: 'So what would you exclude from self?'
> Participant: 'Everything beyond here' (gesture indicated outside of his head and body).

Some participants considered collective identity and family history as aspects of self, while still describing their core self as individual, for example:

> I suppose there is me, however I just see myself sometimes within this whole context of all my forefathers, forebears and it is very kind of diffuse . . .

With reference to dominant ideas in psychiatry there was a consensus among participants that the idea of self as individual was dominant, for example:

> It is based on the idea that I am an isolated alone being and what is me is kind of inside my head or inside somewhere in me.

It was agreed that these influences came from Western European and North American schools of thought. The following two examples contrast participants' views with the Samoan relational self:

> It is a different sort of relatedness to my sort of relatedness. I define myself in terms of my relationship with you or with her or whatever. I don't define it in terms of my family with your family which is much more what I thought (the Samoan presenter) was trying to put across.

> I still think that I tend to start from myself when I'm thinking about my sense of self. I still tend to start with myself and then work out whereas I think from what I've heard today in the Samoan view there is much more of a sense of starting from relatedness to other people and then working away from that.

A number of participants reported feeling confused by the Samoan concept of a relational self as it was described.

> I realised how little I understood. I was confused after I read the document and I just got more and more confused and the more I listened the more I realised that this was cognitively dissonant.

The idea of the 'individual' self dominant in psychiatry was considered quite different from the Samoan view and it was suggested that the Samoan idea of relational self had implications for a number of aspects of psychiatric practice.

2. Spiritual versus secular notions of self

The issue of spirituality was not raised by the participants until the second session. Although some felt uncomfortable discussing religion and spiritual issues, a number of the participants considered spirituality personally important. The fact that they had chosen not to discuss it earlier may reflect a tacit assumption that in psychiatric settings such conversations have little place.

Participants perceived a major difference between the dominant psychiatric view and the Samoan perspectives on religion and spirituality. Here is an example:

> I think predominantly psychiatric thought is secular and it does not have notions of spirituality and sacredness well knitted in . . .

They noted that religion was commonly examined in psychiatry from a non-spriritual perspective, for example:

> even when we talk about religion, we begin to talk about it in secular . . . kinds of ways.

It was felt that mainstream services could benefit from an acknowledgement that spirituality is an important part of mental health for many non-Samoan people. However, to adequately meet the spiritual needs of Samoan patients and their families, a dedicated Samoan or Pacific Island mental health service was considered necessary.

3. Reductionist versus holistic notions of self

This was discussed in response to the Samoan idea of self as holistic in nature. A number of participants described aspiring to a holistic approach in their work. However, this was constrained by characteristics of the health system such as large caseloads, under-resourcing and the climate of legalistic accountability.

> I still think that one of the tensions is that as individual psychiatrists we may want to use a holistic approach, but the pressure of 'the system' and the funding is to perform quite reductionist psychiatry.

4. Universalist versus relativist notions of self

Participants believed that universalist views were dominant ideas in psychiatry. The following exchange illustrates this universalist view:

> A: 'so (the Jungian model) would be a construct that I would use in my everyday work, or have it in the back of my mind, whether I use it or not'.
>
> B: 'If you are seeing a traditional Maori patient how do you modify that?'
>
> A: 'I don't. I would see the psyche as being the same no matter what the race or the cultural background of the person. The same structures would still be there. The cultural heritage of the person would be one of the mediating mechanisms for manifestation of those structures so I would need to take that into account if I could'.

In a different part of the same session, 'A' described his experience of being perplexed by the concept of 'we-ness' in Maori culture.

> . . . this discussion reminds me of practising in an area with a large Maori population, where the 'I/we' dichotomy and the focus on the individual was almost a polar opposite to how it is for European psychiatry where the focus is on 'I'. And to experience patients who had less of a concept of 'I-ness' and more of 'we-ness' was incredibly difficult and even after ten years there I still hadn't got my head around it, and being away from it now I know that I haven't got my head around it.

In light of the confusion this participant experienced when faced with a very different cultural view of self, doubt is cast on the universal applicability of the European model referred to. The opposing relativist view would be that different models of self may be required to understand and work with patients from disparate cultures.

This illustrates an essential dilemma in the practice of psychiatry in specific cultural settings.

Implications for psychiatric theory

Participants had several suggestions about how psychiatric theory might be influenced by the Samoan notion of self.

The dominance of secular and reductionist ways of thinking in psychiatric models in general did not fit well with Samoan views of mental health. In particular, Samoan ideas of self were seen as challenging the universalist assumptions underlying Western developmental theories, especially those where states of individuation and separation are considered more important or more healthy than interdependence. In the light of the Samoan perspectives, Western normative views of family structure and the nature of intrafamilial roles and relationships were also viewed as culture specific.

It was suggested that the analysis of culturally specific power issues was an important part of the process of new knowledge being accepted into the body of psychiatric thought. Otherwise, even if non-dominant ideas were incorporated into psychiatry, they could still be distorted by tacit Western ethnocentric assumptions:

> we only incorporate components of their ideas that are attractive to us.

It was noted that these ideas came from a Palagi (European) perspective. Samoan or Pacific Island mental health clinicians were considered the most appropriate group to assess the implications of these ideas of self for the theory and practice of psychiatry with Samoan patients.

Implications for psychiatric practice with Samoan patients and families

Participants stated that the Samoan concept of a relational self raised issues that should be addressed in clinical interviews. These included appropriate greeting rituals, family involvement at all stages and consideration of the culture-specific roles and relationships in the lives of Samoan patients. They suggested that history-taking practices might require review, in that questions which emphasized individual development might be less relevant and questions which focused on roles and responsibilities in family relationships may be more relevant in a Samoan context. Similarly, spirituality was seen as an important area to address with Samoan patients. The need for sensitivity and an inclusive attitude on the part of psychiatrists and other non-Samoan clinicians was noted.

Participants viewed phenomenology as the same across cultures, but noted that in practice some phenomena were difficult to interpret because of differing notions of self. An example given was that of 'hearing voices' in the context of the spiritual dimension described as part of the Samoan self:

> For us, we're going to have schizophrenia fairly high on the list. But for a Samoan patient hearing voices, there may be other explanations for it, just as there are with Maori patients.

Participants felt that consultation with other family members and appropriate cultural workers in these circumstances would be necessary.

In treatment planning, they stressed the necessity of working with the wider family and community and speculated that some individual therapies might be less relevant for and less acceptable to patients from the Samoan culture because of the relational nature of the Samoan self:

> Another fascinating thing for me is that I've been in New Zealand now for 12 years and I'm yet to be referred a patient, or see a patient from any non-Caucasian culture for individual psychotherapy.

The problem of coping with unfamiliarity with another culture's concepts and norms of communication was a common theme. It was agreed that Samoan cultural workers had an important role in guiding Palagi (European) clinicians in their work with Samoan families. The need for a dedicated Samoan or Pacific Island mental health service to meet adequately the needs of Pacific Island communities was highlighted.

Implications for mental health service development and delivery

Participants suggested that Palagi (European) mental health clinicians in mainstream services needed training on the Samoan concept of self and the relevance of this in clinical work in order to improve mental health care for Samoan patients and their families. They also suggested that sensitivity to spiritual issues, while essential in a Samoan context, was often relevant with Palagi patients as well.

At least two services dedicated to the mental health of Pacific Island people in New Zealand were in early stages of development at the time of this study. Participants made a number of comments about the need of such services. They emphasized the need for resourcing and planning to allow time for the development of culturally relevant ways of working and to address challenges that might arise in a service attempting to meet the needs of a range of different Pacific Island communities.

They supported the view that such a service would be ideally staffed solely with personnel from the relevant Pacific Island communities, with Palagi staff such as psychiatrists employed only if appropriate staff from those cultures were unavailable.

Culturally acceptable processes would be required for appointing staff. Such a service would require an appropriate blend of cultural knowledge and clinical skills and need strong links with local Pacific Island communities. Participants suggested that the Samoan concept of the relational self had implications for design of clinic space to cater more for family groups and budgets for food and time for appropriate greeting rituals. Multiple staff and home visits would be more frequently required for assessment and follow-up interviews. Boundary issues such as the appropriateness of sharing a meal with a patient and their family might be viewed differently in such a service. Such practices might not fit with Palagi values and funding practices, but participants suggested that the Samoan relational self helped to illuminate the need for such differences from a conceptual point of view.

Discussion

To our knowledge this is the first study to examine the response of psychiatrists to the mental health perspectives of Samoan people. In continuing the dialogue that began with *Ole Taeao Afua: The new morning* [16] these findings will contribute to improvements in psychiatric practice and mental health service delivery for Samoan and other Pacific Island communities.

Historically, Western researchers have felt justified in evaluating the values and perspectives of other cultures with some authority, an approach we did not consider appropriate for our study. Throughout the design, execution and reporting of this study the choice of a social constructionist framework legitimized our reflection on the relevant power relationships and the primacy of the views of the Samoan researcher on the team.

The use of a cultural accountability process to address issues of cultural safety is a key strength of this study. The use of the focus group method yielded a rich dataset, encouraged the participants' exploration of ideas and was considered a positive learning experience by them. The parallel analysis of the data, corroboration of findings by participants and the cultural validation process support the credibility of our findings.

The study was limited to a relatively homogeneous professional group in one location. Although this relative homogeneity is a strength in allowing the data to be placed in context, other mental health professional groups would have brought other perspectives to the issues and enhanced this study.

Our findings highlight distinct cultural differences between the Samoan world view and the dominant ideas in psychiatry as practised by our participants. The idea of the dialectic is a useful way of raising awareness among Palagi (European) mental health professionals of divergent underlying cultural values. Responses from participants in this study indicated that the process of the research was a valuable cultural learning experience. The dialectics raised by our study and the process we used could serve as a model for cultural education of Palagi psychiatrists and other mental health professionals.

Quantitative research has highlighted the individualist–collectivist distinction in cross-cultural ideas of self [19,20]. Participants in the present study described their core sense of self as individual. They considered this to be a dominant theme in Western psychiatry, distinctly different from the Samoan relational view of self. Although we cannot claim that our participants are representative of psychiatrists in New Zealand or further afield, our results indicate the likely importance of the individualism–collectivism dialectic for the practice of psychiatry in Samoan communities, with possible implications for other Pacific Island cultures.

Participants experienced confusion and cultural 'dissonance' in trying to understand the Samoan relational self. We have not found reference to this concept in the literature. Understanding that this phenomenon may be an expected part of the learning experience may enhance cross-cultural communication. It may be an essential step in reaching a greater understanding of another culture's perspective. However, whether Palagi mental health professionals are able to learn to truly understand the relational view of self through a process of training is still an open question. Similarly, the universalist view of self was described by participants as dominant in Western psychiatry in contrast to cultural relativist views. Theoretical models based on European and American values may not fit the experiences of people from other cultures. However, they offer clinicians a way of making sense of the experiences of those they work with and may offer a sense of security analogous to a map in difficult terrain. To abandon such a map may leave clinicians with a loss of this security, but attempting to adjust such models to fit another culture risks invoking a form of colonialism. From the social constructionist perspective the best judges of whether a model fits for a different culture are members of that different culture.

There was a major difference between the dominant views in psychiatry on spirituality and religion and the Samoan perspectives. In general, the psychiatrists felt ill-equipped to address these issues with their Samoan patients, yet a recent survey in New Zealand has found spirituality to be an important issue for patients from a variety of cultures attending mainstream mental health services [21].

This study also emphasizes practical constraints which limit psychiatrists from achieving a holistic approach in their work. Holistic practices are highly valued in many

non-Western cultures including Samoan, Maori and other Pacific cultures [1,5,14]. However, when resources are limited these holistic values may not receive priority.

Conclusions

Our findings support the call from Samoan and other Pacific Island communities for the further development of dedicated Pacific Island mental health services in New Zealand. Ongoing cross-cultural dialogue will allow an exchange of ideas and incorporation of more culturally based practices into mainstream services. These findings also demonstrate the need for the development of education programs to assist Palagi (European) psychiatrists and other mental health professionals who work with Samoan patients and their families to gain an understanding of the Samoan concept of self and its relevance to mental health and ill-health.

To further the cross-cultural dialogue in our local services, a Samoan response to this study will be sought. Further research should include other mental health professional groups. A quantitative study could establish whether the psychiatrists' perspectives on self outlined here can be generalized to the wider group of psychiatrists in New Zealand. Exploration of the implications of the Samoan concept of self for understanding of processes of grief, response to trauma and the clinical presentation of depressive, anxiety and psychotic symptoms and the involvement of consumer participants are further avenues for enquiry. There is also scope for further study into effective ways of educating Palagi mental health professionals about the Samoan concept of self and its relevance to the mental health care of Samoan patients and their families.

The importance of further research to improve our understanding of the issues raised by this study is perhaps best expressed in the words of one of our study participants:

> So if we don't have an idea about self in psychiatry, and identity and difference, then there is a risk of kind of mindless or soulless psychiatry, practising to people who have had one of the biggest traumas to their souls that they may ever have encountered, making it very meaningless or empty, or false . . . for the patient.

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