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Community Perspectives on Mental Health Stigma in American Samoa

by

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Abstract

Despite reports of mental health concerns among adolescents in American Samoa, little is known about the current mental health burden. Furthermore, previous literature has identified mental illness-related stigma as a significant barrier to mental health care access and treatment. By gathering various perspectives of adult stakeholders and adolescent participants, this community-partnered qualitative study aimed to describe the perceived stigmatization of mental health in American Samoa.

This study stems from a larger qualitative project on adolescent mental health in American Samoa. Employing the *Fa'afaletui* research framework, 28 adult informants of differing professions, ages, and gender participated in semi-structured, in-depth virtual interviews from October 2020 to February 2021. During June 2022, adolescent stakeholders were split into five focus groups on Zoom to validate themes gathered from the adult interviews. After duplicate coding of transcripts, the research team adopted a deductive approach to identify themes and levels of mental health stigmatization before mapping them on to a socio-ecological model.

Participants described multiple levels of mental health stigma that an adolescent struggling with mental health challenges may encounter. Although there has been progress in mobilizing services and educational resources to address various mental health needs, the perceived structural, social, interpersonal, and self-stigma of mental illness may prevent an adolescent in American Samoa from seeking social support and utilizing mental health services. Current and future interventions promoting adolescent mental wellness in American Samoa should also focus on addressing the multi-level aspects of mental health stigma in the community.

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Chapter 1: Introduction

The maintenance of mental health and wellness remains a growing problem for both adolescents and adults worldwide. Since more than half of mental health problems start during childhood and adolescence [1], building mental health literacy and promoting mental health is crucial during this period. In the United States, the rate of depression in American adolescents (aged 12-17) increased nearly 8% from 2009 to 2019 [2].

American Samoa, an unincorporated United States territory slightly larger than the size of Washington D.C., is in the South Pacific with a population of nearly 50,000 people [3]. While previous studies have found that rates of suicide and suicide attempts are alarmingly higher in Pacific Islander youth compared to the Western Pacific region and European regions [4-5], less is known about the status of mental health among American Samoan adolescents.

Emerging evidence, however, underscores the need to conduct a thorough and culturally appropriate qualitative- and quantitative-needs-based assessment of the mental health burden on the island. In the 2013 iteration of the Youth Risk Behavior Survey (YRBS) conducted in American Samoa, 38% of students in grades 9-12 felt so sad or hopeless every day during the past two weeks that they stopped doing their usual activities. In the same survey, 23% of students reported that they contemplated attempting suicide during the past twelve months [6]. More recently, a cluster of adolescent suicides shows a mounting public health challenge among American Samoan youth [7]. With a limited mental health workforce (two trained psychologists, three psychiatrists, and two licensed clinical social workers) [8], current mental health service provision in American Samoa may be severely limited in serving a population with growing mental health concerns and needs.

In addition to limited infrastructure, mental illness-related stigma may pose an obstacle to the utilization of existing behavioral health services. The stigmatization of mental illness includes negative perceptions and prejudicial attitudes, labeling, and discriminatory behaviors from the public toward individuals living with a mental disorder [9-11]. Mental illness stigma can manifest at multiple levels of society and can be embedded within social institutions and health systems [12]. Individuals experiencing mental health challenges may experience negative adverse psychological and psychosocial outcomes due to stigma, including loss of self-esteem, poor mental health, and social exclusion [13-15]. A recent study found that compared to the general U.S. public, Native Hawaiians and other Pacific Islanders (NHPI) reported greater mental illness stigma [16]; it Is not clear whether this extends to the American Samoan context.

Coming from a larger qualitative project on adolescent mental health in American Samoa [17], this study sought to understand how adult and adolescent stakeholders perceive the stigmatization of mental health among adolescents, and how multiple components of stigma might negatively affect an adolescent's relationships with others, conception of self, and accessibility and utilization of behavioral health services or mental health treatment.

Chapter 2: Research Design

Methods

Semi-structured in-depth interviews with adult (>18 years) key informants (KIs) living in American Samoa were conducted over Zoom between October 2020 and February 2021. Between June 2022 and May 2022, adolescent (aged 13-18 years) participants were placed in one of five different focus groups on Zoom. Ethical approval was obtained from the Yale University (#2000028354) and the American Samoa Department of Health (#00001249) Institutional Review Boards.

The semi-structured interviews and focus group discussions used open, non-directive questions that focused on broad topics around common mental health problems, barriers and facilitators to mental health care, and potential interventions to improve the current mental health systems. Further information regarding the semi-structured interviews and focus groups, interview guides, and coding categories have been reported previously [17].

Adult Stakeholder Interviews. Speaking English was a requirement for participation in the adult interviews (which likely contributed little bias, since 80% of the population speak English [3]). While identifying as Samoan was not an inclusion criterion for adult participants, the research team aimed to recruit people of Samoan ethnicity when possible. Adult participants were identified through nominations from our partners at the Department of Health, Division of Behavioral Health Services, and additional participants were identified using snowball sampling.

To sample for diversity in community perspectives, the *Fa'afaletui* methodological framework, developed for research in Samoan communities [18-19] was used. The *Fa'afaletui* methodological framework allowed for the active recruitment and weaving together varying views on adolescent mental health, from the broader outlook 'the top of the mountain' (e.g., mental health

providers, policymakers, and those working in non-governmental organizations), the mid-distance lens 'from the top of the tree' offered by individuals who work directly with adolescents like teachers, and the finer observations 'from the person in the canoe fishing' that young adults and adolescents could provide [18-19]. The MacDonald et al framework on pathways to mental health services for young people was also followed to maximize diversity when recruiting participants and to ensure that various professions with different degrees of involvement along the mental health services pathways–from mental health professionals to school staff and religious leaders–were included [20]. Aligning the MacDonald et al framework with the *Fa'afaletui* framework resulted in a sampling frame that aimed for diversity by age, gender, region, residence, and education level.

For the recruitment of adult participants, 56 individuals and four organizations were invited to participate; 36 KIs (64%) expressed interest in participating. Of these, 8 KIs were unable to participate because of scheduling problems or due to the sample reaching saturation. 28 KIs were in the final adult sample.

Adolescent Focus Groups. Semi-structured focus groups between May 2022 and June 2022 with English-speaking school-age adolescents were conducted to validate the results gathered from the adult interviews. To participate in the focus group meetings, selected adolescent participants were required to identify as ethnically Samoan and have lived in American Samoa for at least one year. Adolescents were identified through snowball sampling, and participants were recruited by primarily using a Facebook ad, supplemented with snowball sampling using email, texts, and Facebook messenger leveraging our collaborator's and participant's social networks.

Thirty-five adolescent participants were in the final sample, with each participant being placed in one of five different focus groups on Zoom, with one group consisting of all boys, two

comprising all girls, and two being mixed gender. Each focus group session was led by two moderators from American Samoa who are Samoan, speak Samoan, and have expertise in Samoan culture. Although interview prompts were mostly read in English, the moderators used English and Samoan languages based on the adolescent participants' preferences.

Analysis. Interviews and focus groups were transcribed verbatim with the assistance of Temi software [21]. Deductive thematic analysis was primarily used to identify explicit meanings of the data [17]. Most frameworks on health-related stigma focus on the individual experiencing stigma and/or those who stigmatize an individual [22], but more researchers in high-income countries (HIC) and low- and middle-income countries (LMIC) are now addressing the individual, social, and structural pathways in which stigma manifests through a socio-ecological framework [22-24]. Therefore, a socio-ecological model was used to guide the assessment of mental health stigma into different forms or manifestations: structural stigma, public (or social) stigma, interpersonal stigma, and internalized (or self) stigma. Employing this framework allows for the visualization of the effects of stigma across multiple domains and different populations, particularly adolescents; evaluating the different levels of mental health stigma may help organizations, community leaders, and advocates devise interventions that target stigma at certain or multiple levels. Illustrative quotes are included to demonstrate depth and breadth corresponding to each level of mental health stigma.

Chapter 3: Presentation and Analysis of Findings

Results: Overview

Among the 28 adult KIs, 13 were mental health professionals–specifically, 4 licensed mental health professionals and 9 lay counselors–while the remaining 15 were community members [17]. Each KI brought diversity in perspectives from 'the top of the mountain' (n=15), 'the top of the tree' (n=9), and 'the person in the canoe fishing' (n=4). The 35 adolescent participants (with an age range of 13-18 years, the average age being 15.8 years) provided additional perspectives from the 'person in the canoe fishing' and largely validated the themes brought about during the adult interviews. Adolescent participants also validated that their conceptions of mental health and mental illness are valid and aligned with current medical standards and interpretations.

To identify the characteristics of the 28 adults and 35 adolescents who participated in our interviews, the following labeling system was developed. Adults are referred to as "A" and adolescents–or youth–are referred to as "Y". For the adult participants, a superscript was included to identify whether they represent perspective from the top of the mountain ("M"), top of the tree ("T"), or person in the canoe fishing ("C"); for adolescents, a superscript was included to identify their gender as male ("M") or female ("F").

All adolescent and young adult participants were of Samoan ethnicity while most of the adult stakeholders were of Samoan ethnicity. Other demographic characteristics are not described, as this information could be used to identify participants.

Adult and adolescent KIs explicitly and implicitly described the multiple forms in which mental health stigma manifests in American Samoa. Based on their accounts, each level of stigma is influenced by and interacts with each other, potentially resulting in negative

psychosocial outcomes for a stigmatized adolescent and/or hindering an adolescent from seeking social support and utilizing any mental health services on the island (Figure 1).

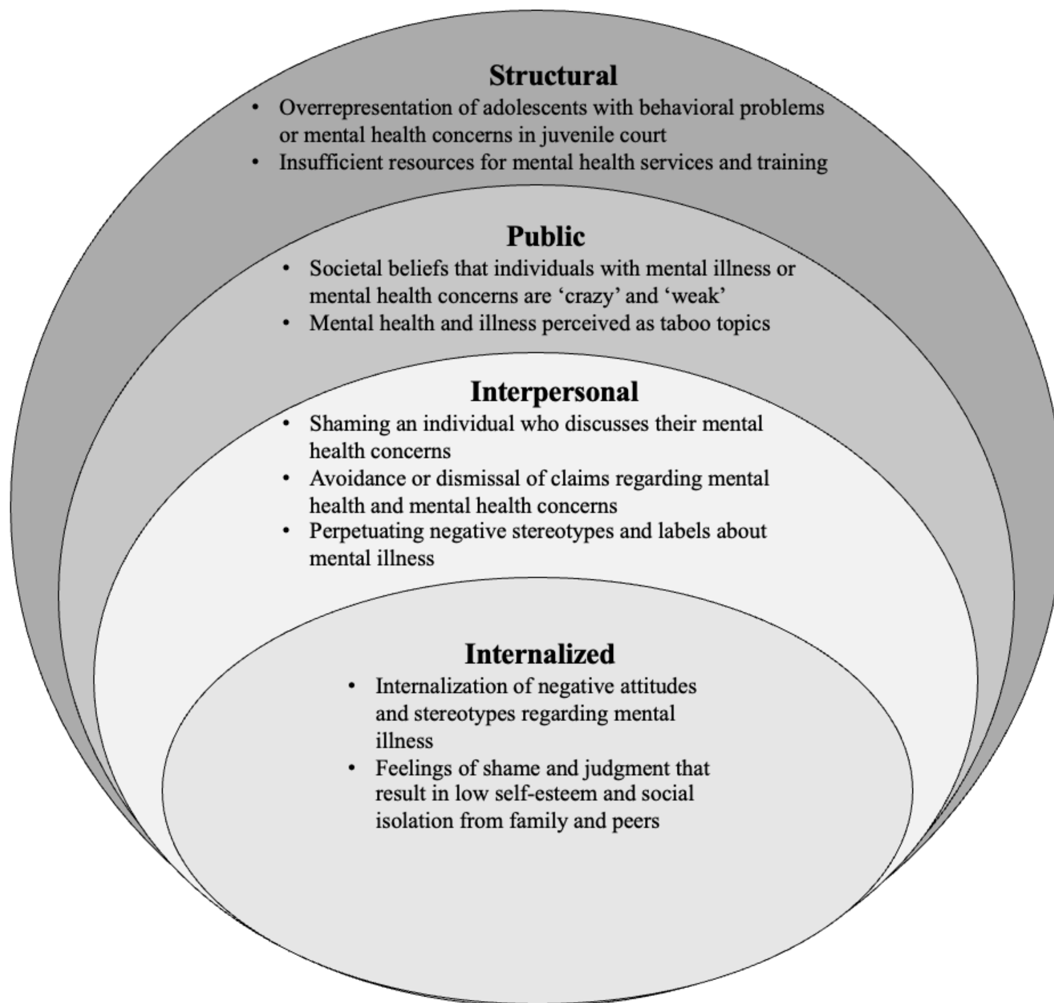

Figure 1. Based on the qualitative interviews, perceived manifestations of mental health stigma at the individual, interpersonal, public, public, and structural levels were mapped on a socio-ecological model

Structural Stigma: "human capital is really limited" (A-ID#10[M])

Structural stigma refers to institutional policies and societal-level conditions that result in unfair treatment of the individual experiencing stigma. Multiple KIs cited a lack of investment by policymakers in mental health infrastructure, reflected in insufficient funding and resource allocation toward mental health services, especially in the school system:

> "*Unfortunately, it has been years since we have had adequate training to actually empower [school] counselors...And so what has happened over time is that we have school counselors who are school counselors, on paper, but they do not have the skills nor do they possess the abilities from the Department of Education to actually deal with some of the mental health issues that they are starting to see in the schools*." (A-ID#07[M])

KIs often commented on the limited number of mental health professionals in American Samoa, believing the current number is, "*not enough to really be able to do assessments for all the kids…that need it…I think that there's a lot [mental health conditions] that's out there that's just not been identified or diagnosed"* (A-ID#04[M]).

Many KIs additionally mentioned the lack of a clear mental health referral system for adults to follow if they were concerned about an adolescent struggling with a mental health challenge: "*The way the system works now, it's only those who…have severe behavioral problems who end up having to mental health services for children and adolescents"* (A-ID#01[M]).

KIs also explained the roles of legal authorities and the court system when attempting to find mental health resources for an adolescent that may be struggling with behavioral and/or mental health issues: *"...Instead of possibly going into the hospital, look for help, it's more of*

arresting the person and seeing them stay in prison rather than seeking a…mental health professional to see maybe possibly they have a mental health condition" (A-ID#21[M]).

One KI described a negative experience with police involvement after the KI had expressed concern about a student's signs of self-harm to the school administrators:

> *"I'm just going to take [the student] with me. Go straight to the office, went to the principal's office. He called the police. The police came in and then started questioning her…I'm like, 'Oh my goodness, she's the victim here? Why are you treating her like she is the abuser?'…Where are the social workers? Is there a psychiatrist? And I was just going down the list and I'm like, why did the police come in?"* (A-ID#11[M])

Further elaborating on the relationship between the legal system and mental health resources on the island, another KI commented on the need to incorporate and strengthen mental health screenings at schools because "*Those [adolescents] who have been…have had a long history of school disciplinary problems…these kids are generally not picked up by the school system and…reach mental health services until they are involved in the legal system"* (A-ID#01[M]).

The lack of sufficient funding for mental health care in American Samoa also limits the availability of educational resources on mental health. This form of structural stigma further drives the stigmatization of mental health and illness at the public, interpersonal, and individual levels, ultimately shaping the way mental health is perceived among the community and communicated between adolescents and their families. Many KIs frequently cited a lack of mental health literacy and education among the community, schools, and families in areas such as:

1) how to healthily express one's emotions "*It's because [adolescents are] depressed and they don't really know how to…explain it…to express themselves or not having that trust, you know, to talk to someone*" (A-ID#23[M])
2) knowing whom to go to for mental health support: *"...when someone falls down at school and breaks their leg, who do you call?', and you're like, 'the ambulance', they know. 'But if you have something that's bothering you emotionally, who do you call?' Everybody just kind of looks around, and 'I don't know'"* (A-ID#13[M]).

Several KIs listed recent efforts to combat mental health stigma by increasing mental health awareness among the American Samoan population and encouraging community input. For instance, these two cases show efforts from the government and church community, respectively:

> *"...a Task Force for Suicide Prevention just started…headed by the Department of Health, with mental health services…the public awareness is really good on island…two presentations in school and [going] to groups in villages and talk to parents and children, so the kids, the adolescents would get information from that public awareness."* (A-ID#16[M]; note, minor edits were made to remove potentially identifying information)
>
> *"There's just been this huge outpouring of community involvement in that program, being spearheaded by this particular Christian pastor [talking about depression and anxiety]. And we've seen positive feedback from the kids who are telling their school principals and their school teachers, that there needs to be more of these kinds of opportunities for them to speak and to feel heard and safe spaces…"* (A-ID#07[M]).

Additionally, some KIs listed the church community as a positive source of social support to an adolescent who may be struggling with their mental health: "*I think a lot of kids turn to the church because they feel like the church won't judge them"* (A-ID#02[C]).

Public Stigma: "we just don't have enough discussions about it" (A-ID#15[M])

Defined as the cultural norms and negative attitudes that the general public may hold toward individuals living with mental illness, most adult and adolescent KIs described the effects of public mental health stigma in American Samoa, in terms of mental health not being "*openly talk[ed] about. We don't talk about depression and anxiety and stress. It's just kind of…wrapped up tightly, put in a box and left for later*" (A-ID#13[M]).

Many KIs outlined two potential ways the broader American Samoan community may respond to topics revolving mental health and illness: 1) believing and being "*taught that [mental health problems] doesn't exist"* (A-ID#14[T]) or 2) ignoring the existence of mental illness and having it *"swept under the rug"* (A-ID#03[T]).

There was consensus among KIs that mental health in American Samoa is seen as "*such a taboo topic*" (A-ID#02[C]). Multiple KIs believed this negative perception of mental health meant that "*there's not really a culture of…open dialogue, especially when it comes to emotional issues*" (A-ID#14[T]). Several informants also stated that the topic of mental health was seen as "*Palagi [foreign], not Samoan*" (A-ID#10[M], A-ID#14[T]) and "*a white person thing*" (A-ID#05[C]).

Some topics in mental health that the public might find *"disrespectful to talk about"* (A-ID#15[M]) include depression and suicide, though some community leaders are trying to increase opportunities for mental health education: "*We're trying to…create a space to talk about suicide. It's such a taboo thing in our culture*" (A-ID#12[T]).

When mental health is discussed in the community, most KIs stated that it was often done in a negative light: "*in Samoa we have this stigma… that mental health, anything pertaining to mental health means that someone's crazy*" (A-ID#21[M]). Anyone who might show signs of struggling or living with *"a mental health problem, is just labeled as crazy*" (A-ID#22[C]).

Most KIs commented that the stigmatizing nature of mental illness in the community appears to be linked with individuals being "*…not informed… we don't know about mental health from a very young age. We grew up not learning about it and then having to deal with these mental health issues…it builds up, and we don't know how to cope*" (A-ID#12[T]).

Several KIs noted that the broader community's "*lack of education on the island about mental health issues*" (A-ID#07[M]) also means that the population is "*missing the plain language…And we're asking people to try to measure, their feelings…but not giving them all the tools to be able to do that*" (A-ID#11[M]).

Increasing opportunities for mental health education would require policymakers and community leaders in American Samoa to address structural stigma and increase cross-sectoral collaboration, funding, and resource allocation for mental health programs, a need that one KI stressed:

> "*I would like to see some kind of organized, consolidated collaboration…by both churches, NGOs, and the government…because there's just a lot of fragmentation right now…and no one wants to share…because they fear that those people are going to take their federal funding*." (A-ID#07[M])

Additionally, many KIs described a "social pressure" that prevents many individuals from discussing with others on how they may be feeling, especially among men and boys, as "*it's not masculine to talk about your feelings*" (A-ID#05[C]). Several KIs stated that many boys in the community are "*taught to be strong for their families and we need to suck it up and move on*" (A-ID#18[C]).

Other KIs explained how gender roles may shape perceptions of mental health and emotional well-being among adolescent boys: "*…those traditional male roles, they're supposed to be stronger than this... the male Samoan male archetype is tough exterior…it's like whatever comes along, just grin and bear it, whatever it is, wrap it up tight, put it in a box, put it away, deal with it some other time*" (A-ID#13[M]).

The majority of KIs perceived that gender-related differences in emotional expression are influenced by cultural norms, and these differences may affect an individual's ability to find social support when facing a significant stressor or when needing to address a mental health-related need:

> *"Men aren't supposed to show feelings...more so here in a Pacific culture where everything is [a] patriarchal hierarchy. And so young men don't feel comfortable sharing their feelings with other men or other peers. And so they just seem to bottle up a lot of that aggression or a lot of those negative feelings that they have until they burst…I feel like for young women, they're able to reach out, they have the capacity to reach out to their peers, to other young women. And for young men, there's always this, stigma, oh 'I'm a guy, I'm a man I'm not supposed to share show or share any feelings.' And so that becomes an obstacle for them to seek the kind of help that they need."* (A-ID#07[M])

Multiple KIs also discussed the role of religion in affecting the community's perception of mental health: "*There's a lot of people on [the] island who think that if you say you're depressed or that you're going through depression, there's a lot of people who think that that's all like the devil's work"* (A-ID#10[M]).

While several KIs stated that the church community can be an additional source of support for an adolescent struggling with their mental health, others also noted that "*the role that the church plays ...could be another one of those areas where discussion of themes such as mental health is discouraged"* (A-ID#13[M]).

Similarly, some KIs expressed concern over *"this minimizing attitude towards [mental health] as if, 'Okay, let's not talk about it, let's pray about it'"* (A-ID#25[T]) and that "*Everybody tells you to turn to God like everything...I think that we're already doing enough to make them feel like they should pray instead of talking to somebody*" (A-ID#05[C]).

Most KIs believed that the negative public perception of mental illness may affect an adolescent's interactions with friends and families–described as interpersonal stigma–while also preventing them from seeking help for any issues related to mental health: "*[Adolescents] don't feel safer at home and now there's nobody else to talk to at the school level. They don't feel comfortable talking to adults in their village. So the question becomes, who are they talking to, who [are] they sharing their concerns, and all of the things they must be going through on a daily basis?*" (A-ID#07[M]).

KIs also observed that some of the public's most recent response to the cluster of suicides in the community may further stigmatize mental illness: *"The public was responding to the recent suicides here on [the] island there was a lot of victim shaming and victim blaming going on social*

media. So [adolescents who had attempted suicide] were feeling defeated or they were feeling like they were back in that place because the stigmas are still alive and well here" (A-ID#03[T]).

The perceived stigma around mental health is why many KIs stressed the importance of increasing mental health literacy among the adult and adolescent population in American Samoa:

> "*Yes, everyone is aware of suicide and mental health but they're not understanding the perspective or view from a person who has thoughts of committing suicide.... I feel that people should be educated on what depression is and how we can help with it, instead of saying 'I wish I can help' or 'You'll get through this'. Our youth just needs someone to listen to, and when I mean to listen, I mean actually listening"* (Y-ID#21[F]).

Interpersonal Stigma: "people see mental health as a weakness" (A-ID#25[T])

Interpersonal stigma refers to interactions that occur between a non-stigmatized individual and a stigmatized person. KIs described a myriad of outcomes that may occur if an adolescent struggling with their mental health chooses to confide in their parents about how they are feeling. The first three were most frequently mentioned by KIs, but references to physical punishment were also common:

> 1) Shaming: "*It's frowned upon…If the parents perceive [their children], they're not in their place. Um, they'll say that, you know, like* fiapoko *[smart aleck, know it all]…The parent is always the parent. The parent is higher authority…Regardless if…the child has more information or is more knowledgeable about something*" (A-ID#15[M]).

2) Parental dismission of claims: "*And I think I, what I have noticed is when they do turn to their parents, it's not a very pretty outcome…they kind of just push it aside…And yeah, yet again, it's kind of like that thing where it's like, 'If you're an abled body person, then why are you depressed?'*" (A-ID#05[C]).

3) The usage of negative stereotypes associated with mental illness: *"…My students had been sharing that they know a lot of youth who don't speak up because they're either shamed for it or, you know, it's not acceptable in the family…Their parents would tell them, you know, they're just being lazy or cowardice"* (A-ID#03[T]).

4) Physical punishment: *"We, all Samoans, we spank our kids, so they would, be obedient. They'll learn to listen and obey…. It [spanking] was, um, it was like our way of discipline here on Island"* (A-ID#18[C]).

KIs commonly listed the importance of family and fulfilling responsibilities and expectations as reasons why an adolescent may not feel comfortable discussing their emotions and mental well-being with parents:

"Our culture is brought up in such a way that you're supposed to be mentally fit and strong to overcome anything. I've also come across some parents who will not acknowledge the fact that their child has mental health problems, that they're actually going through depression and suicidal tendencies. They won't see it, or they won't acknowledge it..." (A-ID#07[M])

Several KIs said that families may also be influenced by the public stigma around mental health to the point that they *"would rather brush the behavior [of the adolescent] under or hide it under the rug rather than, bring it up to light and asking for help from professionals or from the Department of Social Services"* (A-ID#21[M]).

Additionally, some KIs described the importance of maintaining a positive image in a small, tight community where everybody knows everyone: *"and a lot of times families will... they don't want that attention, the negative attention, if something like"* a family member having a mental illness *"would reach the public"* (A-ID#12[T]).

Most KIs stated that the negative interactions between parents or peers and a stigmatized adolescent may make the adolescent less likely to ask for help in dealing with a mental health issue:

> *"Kids are taught, you know, to toughen it out…when you're struggling and especially if you're crying about something, there's not really the process, 'Let me help you organize your thoughts and help you feel and calm you down'... A lot of it is…someone's crying, it's invalidating, like, 'Why are you crying? That's not even a big deal. It's not anything you should be crying about'."* (A-ID#14[T])

KIs have also described instances of adolescents being shunned or bullied on social media after showing signs of suicide ideation or self-harm:

> "*Someone who was already feeling weak for having suicidal thoughts and then going on Facebook and seeing people write things about other youth who have committed suicide,*

'They took the easy way out' or, 'They were cowards,' like, 'Why weren't they thinking about their families or parents'...It discouraged [adolescents] to even speak out about it because, they were seeing how people were shaming, others who have committed suicide." (A-ID#03[T])

"Because [self-harm] is a taboo thing here and a lot of kids are made fun of for self-harm, instead of comforted. I know there are kids here who post self-harm and a lot of other kids, they screenshot that and share it amongst friends and make fun of them calling them weak." (A-ID#02[C])

In addition to negative experiences with family members, some KIs noted similar experiences with school counselors, as written by an adolescent participant: "*My counselor likes to yell at me every time when I try to come to her for help!"*(Y-ID#17[M]).

Another KI also remarked on a similar moment: *"And one of our counselors is saying, 'Why are you crying like a baby?'... just 'Suck it up'... They're not very sensitive to what the adolescent is going through"* (A-ID#13[M]).

These potential instances of interpersonal stigma that an individual with a mental health concern may experience can influence whom they chose to confide in and whether they seek a mental health professional. For example, some KIs believed that adolescents' concern over confidentiality may prevent them from utilizing mental health services in American Samoa:

"*...because of the issue of confidentiality, the children might [be] reluctant to go and talk to them [counselors]..."* (A-ID#16[M])

"I think that there's different barriers to different things. And I think a lot of it may have to do with just lack of awareness and also the concern about what happens with their information…nowhere have I had more questions about confidentiality than here in Samoa. And it makes sense because, you know, it's a small place…so that question of where does my information or material, where does it go? Who do you know, who are you going to tell?" (A-ID#10[M])

Interpersonal stigma may also negatively influence the self-image and self-esteem of a stigmatized individual, potentially resulting in the manifestation of self-stigma.

Self-Stigma: "we're just holding everything in" (A-ID#05[C])

Internalized stigma, or self-stigma, occurs when an individual living with a mental illness holds negative attitudes about their self and shames themselves for their mental health condition or struggles. KIs frequently described how adolescents may be struggling with addressing their emotional needs while juggling the social pressures they feel from their families, peers, church members, and the broader community:

"…everybody belongs in the making of these children growing up, children of the church, children of the family, children of the village. So it's shaped their line of thinking and their mental health, because they don't want to disturb anything to embarrass the church, family, and his village. And those were taught to us as our responsibility growing up." (A-ID#16[M])

Numerous KIs mentioned that an adolescent's sense of responsibility to uphold a family image may come at the expense of their mental health: "*…expectations that may be had by family*

members…not wanting to disappoint their family members, feeling a huge sense of responsibility…but this feeling that they're taking on a lot…they can't really express themselves to others…[and] needing to kind of create this façade” (A-ID#10[M]).

Aside from adolescents potentially hiding their mental health struggles to preserve a positive image for themselves and their families, one KI also explained that the social pressure by the community to be perfect may be associated with poor mental health among adolescents:

> “*For every young person, their desire is to please their families, you know? And so they try to do the best...they try to strive to be the perfect kid, the perfect daughter, the perfect son, you know? And so when those expectations are not met, they become depressed… It's the family's expectations as well… they expect certain things from the children…so there's that struggle of wanting to please the parent at the same time, [but] what about what [adolescents] want...”* (A-ID#19[T])

An adolescent KI echoed this sentiment and the effect of internalizing negative attitudes on an adolescent’s mental health:

> “*You gotta always watch what you're doing, make sure you don't take the wrong path or…well, you're gonna get a whole lecture about all that. And all you're gonna think is, am I even good enough for this family? Why am I even doing this when all I'm gonna get back is scolding? Like thinking of those that's why it's very typical saying pressure to make your family proud, cause we all can feel that one mistake, a whole lecture from the past can come running through your brain all over again it's the same lecture over and over. And*

all you can feel is like, I'm not even good enough for this family, that's why they keep lecturing me. And that's where this bad mental health comes in.” (Y-ID#33[F])

Numerous KIs also commented that adolescents may fear being judged if they choose to tell family members how they are feeling, resulting in a ‘bottling up’ and internalization of emotions that can have negative effects for their mental health:

“*We're just holding everything in…if we were able to talk to somebody or if we were, if we have the knowledge that we could talk to somebody that it's okay to talk to somebody judgment free, then I think it would be better. But I think the only reason would be because we can't turn to people here.*" (A-ID#05[C])

“*In some cases [adolescents] really see it as the only option to turn to suicide. Instead of opening up to people because opening up would mean admitting one's vulnerability and, possibly being subjected to criticism due to their quote unquote lack of strength.*” (Y-ID#13[F])

Additionally, several adolescent KIs believed that the current actions adolescents take to keep emotions to themselves may prevent the utilization of current mental health services:

“It’s because of the mindset that many of our youth have, that they can do it. Like they can just keep all their emotions to themselves instead of expressing it or instead of sharing how they feel and how they're hurt about some certain situations. I'm guessing that's why most

of the youths don't really want to dial the [crisis hotline] numbers because even at our school, like a lot of presentations are presented at our school and the people are really nice. They give out the numbers and then they give out the pamphlets and they make promises and they make sure that they will be able to help. But it's just that some of the students, some of the youth just think that they can do it themselves." (Y-ID#14[F])

Discussion

To our knowledge, this study is the first to document the multiple forms of the perceived stigma associated with mental health in American Samoa and its potential effects on adolescents who may be struggling with their mental well-being. These findings provide further evidence that any programs or interventions focused on adolescent mental health concerns in American Samoa must also address the stigmatization of mental illness.

Research has shown that high mental health stigma has been associated with low mental health literacy [25-27], bolstering the need to increase mental health campaigning and the inclusion of activities and resources on health literacy in future mental health interventions. Increasing mental health literacy and awareness may be particularly useful to address the mental health challenges and concerns among Pacific Islanders, particularly American Samoan adolescents. A qualitative community-based research study in Southern California found that a low level of mental health awareness contributed to mental health stigma among Samoan Americans in Southern California, posing a significant barrier to formal help-seeking [28]. Focus group sessions among Samoan mental health providers and consumers in New Zealand similarly found that mental health stigma may prevent Samoan youth from utilizing formal mental health services, with participants highlighting the need to identify de-stigmatization strategies that educate families, churches, and

communities about mental health through appropriate Pacific specific language [29]. A more recent qualitative study applied the *Fa'afaletui* framework to investigate Samoan families' experience with mental health services in Aotearoa, New Zealand; they also found that mental illness stigma posed a significant issue for engagement with mental health services and recommended building capacity for holistic Pacific models of care [30]. Although most research on mental health literacy has been conducted in HIC, literature on the subject is increasing in LMIC due to active collaborations between HIC and LMIC [31].

Several organizations in Pacific Island countries have also underscored the need to increase mental health literacy to promote mental wellness and facilitate ways for youth to access behavioral services. Starting in 2003, the Samoa Nurses Association, New Zealand International Aid and Development (NZAID), and the Foundation of the Peoples of the South Pacific International collaborated on the Youth and Mental Health (YMH) Project, which sought to increase mental health education and awareness through advocacy programs and focus group discussions among Pacific youth in Samoa, Papua New Guinea, Vanuatu, Solomon Islands, Kiribati, Tonga, Fiji, and Tuvalu. Youth participants for the YMH project in Apia, Samoa acknowledged the importance of social networks in providing social support and shaping their self-perception [32]. YMH project researchers recommended that interventions focused on mental health promotion must consider how Samoan cultural beliefs and values of religion and family may provide avenues of resilience and strength among youth as well as additional stressors for individuals whose actions and self-perception are strongly influenced by their peers and family members [32]. Expanding mental health literacy also involves the development of culturally validated

terminology that allows members in a community to discuss topics on mental health and illness. The Samoa Nurses Association explained the importance of using Samoan cultural philosophy to create an essential understanding of mental health in a Samoan context; approaching mental health as "*soifua maloloina o le mafaufau*", or a holistic state of well-being, can help Samoan families recognize the ways an adolescence's wellness can be affected by a myriad of social factors [32].

Similarly, many KIs in our study believed that expanding mental health literacy in American Samoa would require the improvement of the current mental health infrastructure as well as the development of culturally validated terminology to discuss topics related to mental health. Since confidentiality was a frequently cited concern among KIs, it may be beneficial to increase trainings among mental health professionals while informing the public which available mental health services and resources in American Samoa are confidential; however, this could be challenging to address in a small setting where many individuals know one another [33].

Many participants also described several programs led by community leaders, youth, and school faculty that are aimed at increasing mental health awareness on the island. Skill-training and evidenced-based suicide prevention programs that were reported by KIs to be used in schools include *SOS: Signs of Suicide* and *Youth Mental Health First Aid* [17, 34-36]. Additionally, several nonprofit organizations like Pacific Roots Open Mic (PROM) and Empowering Pacific Islander Communities (EPIC) are focused on empowering adolescents through community outreach efforts and activities that promote self-confidence among youth [37-38]. Similar school interventions and programs are being implemented in Samoa by NGO Fa'ataua Le Ola (Samoa Lifeline), which also offers free 24/7 confidential phone

counseling to Samoans [39]. Another mental health promotion initiative in Apia, Samoa was the launch of a 12-month-long series of health-oriented art workshops that provided materials and resources for community members to exercise creative expression. The pilot study reported enhanced self-esteem, levels of confidence, and communication skills among participants, particularly among young women and child victims of domestic violence and sexual abuse, suggesting that a combined health and art initiative like art therapy may allow for higher public engagement with mental health promotion campaigns [40]. However, future work evaluating the effectiveness of all these programs in a Samoan context is needed. Future interventions that aim to increase mental health literacy not only among adolescents in American Samoa, but families and adults as well may further reduce mental health stigma in the community and ultimately promote an environment where adolescents feel safe to seek social support with their mental health needs.

Chapter 4: Conclusions

The current study shares a diverse range of community viewpoints on the experiences and stigmatization of mental health stigma among adolescents in American Samoa. Adult and adolescent participants implicitly and explicitly described various dimensions of mental health stigma that an adolescent struggling with a mental health concern may experience. Structural stigma includes insufficient funding and resource allocation for formal mental health services and educational programs related to mental health, resulting in the lack of open dialogue around mental health that contributes to the negative perception of mental illness that is observed at the public or societal level. Such public stigma drives interpersonal stigma and may negatively influence the manner an individual interacts with an adolescent who is struggling with their mental health, including shaming and labeling with negative stereotypes. These harmful interactions may lead to self-stigma, where an adolescent with a mental health concern internalizes negative attitudes toward themselves, thereby potentially hindering help-seeking behavior and increasing the risk of social isolation and low self-esteem.

Despite the recent mobilization of services and educational resources to address various mental health needs in American Samoa, the perceived structural, social, interpersonal, and self-stigma of mental illness may prevent an American Samoan adolescent from seeking social support and utilizing mental health services. These findings may inform local community leaders, the Department of Health, the Department of Education, and community-based organizations on the need to address and reduce mental health stigma when designing mental health interventions and services for adolescents.

This qualitative study has many strengths and limitations. One notable limitation is that participants were recruited and interviewed during the COVID-19 pandemic and

recently after a cluster of suicides had occurred on the island, two factors that may have resulted in a higher awareness about mental health. issues. However, the sample size (which was large, especially given the size of the setting) included a diverse set of both adolescent and adult Samoan voices, and the community-partnered approach to this work allowed the involvement of many Samoan voices in the design and analysis phases of this study. The semi-structured interviews and focus groups from a variety of participants offered detailed insight into the barriers to mental health care and the perceived stigmatization of mental health in American Samoa.

DECLARATIONS

Do you need mental health support?

If you are struggling with your mental health, please call the 988 Suicide and Mental Health Helpline to connect with a mental health counselor in American Samoa or call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

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