Received: 17 May 2023 | Revised: 16 August 2023 | Accepted: 17 August 2023

DOI: 10.1002/hpja.800

RESEARCH ARTICLE

Health Promotion Journal of Australia

Australian Health Promotion Association

WILEY

Health and illness beliefs regarding pain and pain management of New Zealand resident Sāmoan community leaders: A qualitative interpretive study based on Pasifika paradigms

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Handling editor: James Arnold Smith

Abstract

Issue Addressed: Ethnic disparities in chronic pain exist in Aotearoa New Zealand, including a greater impact of pain, less access to chronic pain services and less benefit from treatment for Pasifika people. This study investigated Sāmoan health perceptions and beliefs in relation to pain and how it is managed.

Methods: An interpretive descriptive study was undertaken involving interviews with nine Sāmoan key informants from Aotearoa New Zealand. Interviews explored their beliefs in relation to interpretations of pain and experiences of and preferences for pain management. Interviews were recorded and transcribed. Data were analysed using thematic analysis.

Results: Four main themes were constructed from the data. *Pain is interpreted holistically* described the attribution of pain to many causes, without limitation to physiological explanations. *Stoicism is a character virtue* described the predominant belief that pain should be endured without display or complaint. *Strength in connectivity* described the inherent pain coping strategies that are present within Sāmoan communities. *To improve healthcare is to nurture vā* described the disconnect Sāmoan people feel from healthcare services and the need to foster relationships to improve health delivery.

Conclusions: Sāmoan people have beliefs and perceptions about pain and its management that extend beyond traditional Western interpretations. While pain is often endured using traditional strengths within the ʻāīga (family) and community, the Sāmoan community faces challenges in receiving healthcare from mainstream pain services.

So What? Clinicians need to foster stronger relationships with Sāmoan individuals and their ʻāīga and appreciate the wider psychosocial context of pain, including spirituality.

KEYWORDS
chronic disease, culturally and linguistically diverse people, Pacific Island people

1 | INTRODUCTION

Chronic pain is one of the most prevalent long-term health conditions in Aotearoa New Zealand and internationally.[1,2] It is estimated to affect approximately 20%–25% of adults[1–4] and causes significant impact on individuals and society.[2,5] Chronic pain is a multidimensional experience affecting physical, psychological and social well-being.[2,5] However, it does not affect populations equally. International research has shown that, due to systemic problems with Western healthcare, culturally and linguistically diverse people, including indigenous and immigrant populations, have a greater impact of pain and face more barriers to pain management.[6–9] This is reflected in Aotearoa New Zealand data that has shown Pasifika people have greater pain-related disability and psychological distress,[10] are under-represented in attending chronic pain services,[10] and face inequality in outcomes from pain treatment.[11]

Pasifika people make up approximately 8% of the Aotearoa New Zealand population and are one of the fastest growing groups.[12] While the Pasifika population is diverse, representing a multitude of different cultures with unique languages, traditions and beliefs, Sāmoan people make up almost half of this group.[12] Despite the size of this group, there are currently no known studies that have investigated the unique beliefs and attitudes regarding pain and pain management in any of the Pasifika cultures in Aotearoa New Zealand. Given that Pasifika people disproportionately experience poorer health outcomes across a range of chronic conditions, including pain, it is pertinent to investigate this perspective. Cultural beliefs, values and attitudes are known to influence the interpretation and expression of pain, as well as help-seeking behaviours.[13–15] Having an appreciation of these unique beliefs and attitudes is essential to more effectively tailor service delivery of chronic pain management and help mitigate discrepancies between Western healthcare models and Pasifika orientations to health. Therefore, the overarching objective of this study was to explore the health and illness beliefs about pain and pain management of Sāmoan people resident in Aotearoa New Zealand, and how these beliefs might affect the experience of pain, the way that healthcare is utilised, and the experience of healthcare.

2 | METHODS

This was a Pasifika-centred research project underpinned by interpretive and Pasifika paradigms. A Sāmoan glossary is provided in the supplementary material. Interviews with key informants were informed by principles associated with tālanoa (shared conversation) and vā (relational space), facilitating informants to speak freely and forthrightly about their experiences, thoughts and beliefs, coming to the core or heart (loto) of the ideas being discussed with the researchers.[16] These cultural practices were led by the participants and the Sāmoan author and upheld the informants as experts in their knowledge of the subject matter, as well as facilitating balance and reciprocity within the relationship space. An interpretive approach was adopted, acknowledging that each individual informant's and the researchers' own ideas, values, culture and perspectives worked to co-construct the findings and narrative of this paper.

The first author (Angela Upsdell) is Pālagi/Aotearoa New Zealand European who is a physiotherapist working and residing in the South Auckland community. The second author (Jessee Fia'ali'i) is an Aotearoa New Zealand-born Sāmoan raised in South Auckland who works as a health psychologist. The remaining two authors (Gareth Terry and Gwyn Lewis) are Aotearoa New Zealand Europeans who are experienced health researchers.

2.1 | Key informants

Purposive sampling was used for recruitment of key informants who had expert knowledge of Sāmoan health and pain beliefs and who were familiar with the South Auckland Sāmoan community and healthcare. To promote diversity of perspectives, informants were sought who occupied a range of leading or formal positions of authority within the community, which enabled them to give privileged insights, broad knowledge and rich ideas about the topic. Nine Sāmoan individuals (age 32–65 years) from different positions and roles within the local community and healthcare setting were involved (Table 1). All were trained in a Western setting in Aotearoa New Zealand, except for Informant S, who was a taulāsea (Sāmoan traditional healer). Ethical approval was obtained from the Auckland University of Technology Ethics Committee (#19/262). All informants were provided with both written and verbal information about the study prior to providing written consent to participate. A mea'alofa (gift) was given to each informant to acknowledge their contribution.

2.2 | Data collection

Individual interviews were conducted by two researchers (Angela Upsdell, Jessee Fia'ali'i), with the exception of one that was facilitated by a single researcher (Angela Upsdell) with two informants. The interviews were conducted at the participants' work or home, or at a clinical facility in the South Auckland community. A semi-structured interview guide (provided in the supplementary material) was developed with questions centred on the Sāmoan worldview of chronic pain and the informants'

TABLE 1 Key informant gender and profession.

Pseudonym	Gender	Professional activity
R	Female	Community social worker
S	Female	Taulāsea/Sāmoan traditional healer
T	Male	Physiotherapist
U	Female	Sāmoan interpreter
V	Female	General practice registered nurse
W	Female	Occupational therapist
X	Male	Mental health social worker
Y	Female	City Council social worker
Z	Male	General practitioner

attitudes towards treatments and healthcare utilisation. In the interviews with two researchers, Jessee Fia'ali'i led the elements that helped ensure cultural safety. In the case of the single researcher interview, the two informants were invited to and led these components and ensured the interview remained tied to their expectations of good practice. Each interview lasted approximately 1 h, including time for lotu (prayer) and shared food, and finished when there was a sense of having reached loto.[16] The interviews were audio recorded and transcribed verbatim. Any Sāmoan words used were interpreted by Jessee Fia'ali'i.

2.3 | Data analysis

Thematic analysis followed a six-phase process outlined by Braun and Clarke.[17] Braun and Clarke's[18] 'reflexive' approach to thematic analysis, described by them as a 'Big Q' approach to analysis, was an ideal fit for the interpretive orientation of the project. Big Q approaches value the active role of the researcher in the research process in interpreting and generating meaning,[18] and as such, postpositivist/small q techniques, such as coding reliability and saturation, are not appropriate. Phase 1 involved data familiarisation through careful reading and re-reading of the transcripts, use of note taking, and regular conversations between authors to discuss findings, interpretations and perspectives. Phase 2 involved systematic coding of the data by Angela Upsdell and Jessee Fia'ali'i, with support from Gareth Terry. This was initially done independently and then working together to discuss their codes' similarities and differences, drawing meaning from the interview transcripts and making sense of them through their different lenses. Phase 3 involved the generation of initial themes from the coded and collated data using Miro online software (Miro, 2021). In conversation with all authors, themes were constructed into meaningful clusters that collected the shared understanding of Sāmoan experiences of pain and healthcare found among the participants. In this way, the analysis worked to find the loto, or the 'central organising concepts', within the data. Following the generation of these themes, they were presented in a tālanoa with the informants to enable an opportunity to discuss together the findings and whether they resonated and had reached loto. Phase 4 involved the further development of the themes based on this tālanoa, which were discussed among all authors and ensured they worked to tell the best possible story of the dataset in relation to the research question and the participants. Phase 5 involved defining and naming the themes. The final phase consisted of writing the report, which involved consideration of the data within the context of current literature and weaving together selected extracts that best reflected the themes developed.

2.4 | Quality of research

Braun and Clarke's[19] 15-point checklist was used to enhance the quality of data analysis and the writing process, while other elements informed and supported by Jessee Fia'ali'i's cultural knowledge helped ensure cultural safety and worked to add 'thickness' and depth to our contextualisation and interpretation of the data. Regular conversations between the research team and members of the wider Sāmoan community and working with the informants to find loto during the final tālanoa added richness to the data. Following the lead of Jessee Fia'ali'i was essential in ensuring Sāmoan beliefs, practices and language nuances were not lost in translation or context. Finally, the practice of reflexivity allowed the authors to recognise the ways our own beliefs, values and worldview played a part in the active interpretation of knowledge being constructed.[18] As cultural outsiders (Angela Upsdell, Gwyn Lewis, Gareth Terry), constant reflection of our own cultural values, assumptions and interpretations towards Sāmoan people was explored. Angela Upsdell initially engaged in this process in relation to her prior knowledge and experience as a clinician and as a South Auckland community member. During tālanoa, Angela Upsdell reflected on how her presence may influence the participant's ability to engage in open conversation. Through the analysis, interpretation and discussion phases, the authors critically reflected on the material produced through observations of feelings, concerns, problems, fears and frustrations, and discussed these with each other.

3 | RESULTS AND DISCUSSION

Four overarching themes were constructed from informant interviews: *pain is interpreted holistically*, describing the attribution of pain to many causes; *stoicism is a character virtue*, describing the attitude towards enduring pain; *strength in connectivity*, describing the strengths that relationally occur within this community and *to improve healthcare is to nuture vā*, describing the importance of relationships to bridge the disconnect between the Sāmoan community and Western healthcare. These themes were interpreted through the lens of fa'a Sāmoa—the Sāmoan way—to help bring understanding of Sāmoan pain beliefs, community values and help-seeking for pain. Fa'a Sāmoa is not used as a separate theme, but rather enables the themes to be better understood, adding connection and context to interpretation. The analytic themes are enveloped by the fa'a Sāmoa values of love, respect and humility.[20] Fa'a Samoa helps us to understand how Sāmoan people might interact with the healthcare system and factors that influence the choices and decisions that they make in pain management.

3.1 | Pain is interpreted holistically

Informants discussed pain within a holistic health model. Although pain was often experienced in an embodied way, it could be attributed to many causes, including physical, spiritual or relational. Several informants constructed pain as a form of punishment for personal behaviour or a longer-standing historical event. For example, an informant stated:

> Some people believe that they deserve to be in pain to pay for some sins. Often that has come from familiar lines, family curses, and things like that, so they think they don't deserve to ask for help.
>
> (female, occupational therapist)

Breaking of protocol or relationships was also presented as one of the primary causes of persistent pain, as described by one informant:

> 'I deserve this. I wasn't respectful to my parents', or 'my father married, or married his cousin', or there has been some other curse that is there from some family discord. And so, 'I deserve this, so I don't deserve to have this taken away'.
>
> (male, physiotherapist)

The holistic view of pain matches onto the proposed pan-Pacific Fonofale model of health that encapsulates physical, mental, spiritual and other aspects of well-being.[21] A holistic interpretation of pain is also associated with other indigenous cultures, including Māori, Indian and Chinese, whereby pain can be associated with past discretions (karma), evil spirits, the environment or physical causes.[22–26]

The interpretation of pain was reported to influence if and where treatment was sought. For example, severe pain that could clearly be attributed to an organic, physical pathology (e.g., an injury) was more likely to lead to Western-based treatment. This was described by informant U (female, interpreter) as '*Sāmoans see healthcare as a physical thing as opposed to all the other things, cos they get that from church, or family*'. For minor injuries or pain seen to have originated from other non-biological causes, such as emotional or interrelational issues, traditional Sāmoan healing practices were sought first in most instances. Massage was seen as particularly popular to manage the impacts of pain and 'used for everything'. Seeing a fofō (traditional Sāmoan healer skilled in massage) or a taulāsea (traditional healer) were also options that were often sought before Western healthcare. Informant Y commented:

> We don't go to hospital for pain. There is always someone that you know … someone knows how to do it at home, or they have their own way of dealing with it … Yeah, when I'm in pain with something, I will try and fix it myself, unless it's pain like you're giving birth, then that's different.
>
> (female, social worker)

If there is a belief that their pain was due to a spiritual cause, it may be deemed more appropriate to seek help from a healer with a religious connection. The Christian faith was described as providing a framework through which pain could be understood and acknowledged in a positive sense. Past literature has also reported that chronic pain can be perceived as providing strength and spiritual growth.[27–29] Contemporary Sāmoan people often have a strong trust and faith in a transcendental being that is in control and can be sought for comfort and guidance.[30] The Christian faith was presented by informants as enabling acceptance, solace and hope amid pain, and a lower reliance on medication or interventional treatment. Recent studies suggest that spirituality can impact the pain experience through a psychological influence, giving hope, optimism and a sense of purpose that can serve to promote pain coping and resilience.[31,32] Prayer, in particular, was described as being used at times of personal and community pain and hardship. As one informant commented:

> Prayer is very strong, it is very, very strong in our culture. Even at time of extreme personal pain, like death or at funerals, the common saying is 'Pray, pray. Be strong, pray, pray, pray … Pray into the very painful personal situations'.
>
> (male, general practitioner)

Research suggests prayer provides many people with the capacity to cope, and it can also have a therapeutic effect by reducing pain severity and increasing pain tolerance.[33,34] This has been attributed to prayer being a positive reappraisal technique, in that people are better able to identify things gained from the experience of pain, rather than only negative consequences.[33] This increased positive cognitive reappraisal may enable people to re-establish the sense of meaning in their life and is associated with greater pain tolerance.[33] Informants reasoned that acknowledgement of prayer as a component to the patient's health was greatly appreciated when it was included in their interactions with healthcare professionals, and encouraged this as a way to strengthen the patient–clinician relationship.

3.2 | Stoicism is a character virtue

This theme explored the belief that chronic pain should be endured without display or complaint, which may be viewed as wasting the time and resources of healthcare services. Key informant V described her experiences with Sāmoan patients attending Western healthcare services, who did not disclose their pain issues:

> I have advocated on behalf of many of the Island people that I come across, and you know, like it's the same thing. They do the same thing, they go into the doctors, and the doctor will say, 'Are you in pain?'. 'No, no, yes, yes, I'm fine.' And then they come out and it's a different story. They haven't even told the doctor exactly why they came to the clinic or the hospital. I think they tend to hold back, until it gets to the stage that it's too late.
>
> (female, general practice nurse)

Many of the informants described Sāmoan patients as being shy, reserved and embarrassed of asking for help. Pain seen to be caused by either spiritual or relational discord was, for the most part, to be endured and kept private. It was raised that stoicism may be due to the belief that the ability to endure pain is a character virtue. Tolerating pain, and the suffering that comes with this, was perceived as a sign of strength, particularly for men. This depiction of how a Sāmoan should respond to pain with stoicism and self-reliance was described by informant W:

> You would never let the other person know that you are in pain or you are weak until you are at that point where you can't tolerate it.
>
> (female, occupational therapist)

The virtue of enduring pain is evident in other cultures. Studies involving Māori report pain is rarely discussed openly due to whakamā (shyness, embarrassment, shame)[24,35,36] or is seen as a necessary part of healing that should be tolerated without complaint.[37] Similarly, it is a strength of character to endure pain without complaint and without burdening others in Chinese cultures.[38,39]

Within the Sāmoan worldview, key informants reported that pain was a symptom of something else, and the pain itself did not necessarily warrant attention or help-seeking. Healthcare was seen as acceptable for significant trauma or obvious injuries, but not for pain that did not have an obvious physical precursor. Informant T described the Sāmoan attitude towards pain as being inconsequential to typically self-managed:

> Pain, particularly for Sāmoans, is not something that would send them to the doctors. It will be (sigh), it won't be pain. It will be something that they are not familiar with, like maybe the loss of feeling in their arm, or, you know, maybe a droop on one side. It would have to be something drastic to send them to the GP [general practitioner]. I know so many Sāmoan patients, even family that suffer from gout. But even that, I look at their joints and it looks awful, they still won't go to the GP. Man. 'Nah, I'll deal with it. Take a few Panadol'.
>
> (male, physiotherapist)

Using healthcare services for emergency care and delaying seeking help for more 'minor' symptoms appeared prominent in the interviews. This is a common attitude reported in health service literature, with Pasifika people more likely to present to hospital with preventable conditions[40] and more likely to miss a general practitioner visit due to cost than non-Pasifika.[1] There may be a number of other possibilities for explaining this lack of engagement with health services beyond something inherent to Sāmoan culture, including previous negative experiences of healthcare, the effects of institutional racism and workloads that prohibit attendance at clinics, but the notion of bearing pain with courage is considered a fundamental of Sāmoan identity.[41]

Stoicism related to pain may be influenced by incorporation of pain in traditional Sāmoan rituals. For example, withstanding pain of traditional body tattooing for a young male is part of the overall transition into manhood.[41] Part of the ritual is the ability of the male to manage pain without complaint, showing he is ready for coming of age, and shows mental fortitude to see the completion of the pe'a (traditional male tattoo). Natanielu[42] described the pain from a tattoo as acting like a 'silent teacher' to find meaning and purpose, ultimately connecting a person to their identity. This was evidenced in the interview with informant T:

> Yeah, it's like a male thing. If you can't handle pain, and so the guys will say, 'harden up mate, take it' and you have to just show that strength and resilience … You see it when they play rugby, they just go hard out and hit each other. If they get hurt, they don't show it. They could be broken in six places, but it's a sign of coming of age, of manhood, strength and, hey, 'even though I was broken I still went on' … 'You are the man!'
>
> (male, physiotherapist)

Stoicism in the family and social context allowed people to function despite pain. Informants described the strong commitment Sāmoans make to their 'āiga, church and communities, which may mean that until an individual is unable to fulfil their role within their 'āiga or community, help for pain may not be sought.

Other reasons were also raised why pain was endured, including shame or guilt that revelations would bring to the individual or their family, and the financial implications of seeking healthcare.

> They don't want to say, 'oh, I'm in pain,' because they are scared of what's going to happen afterwards. Like if I tell you, 'oh, I'm in pain,' oh, you are going to say, 'we have to do this, this, this' and then there is the financial side of it as well. Not having enough money. We think like that.
>
> (male, social worker)

The informants suggested that individuals will consider the impact that exposing their pain will have on the people they are connected to, particularly in the context of perceived causal attributions related to spiritual impediments or social transgressions. Members of the 'āiga are often juggling several responsibilities and asking for help may not be practical for the 'āiga or may be considered culturally shameful. Similar cultural beliefs regarding stigma and shame, along with practicality reasons, have been previously cited as barriers to accessing mental health care for Pasifika families, meaning that they only sought Western healthcare in times of crisis as a last resort.[43]

3.3 | Strength in connectivity

The data highlighted that the connections and relationships the Sāmoan community is built around have multiple strengths that can be incorporated alongside Western pain management strategies. This theme brings the community's unique competencies and group practices to the forefront, focusing on the practices that enhance health and wellbeing. The theme speaks to the importance of connectivity with self, 'āiga, community and faith-based activities, and the benefits of this in managing chronic pain. The Sāmoan culture is a collective community, where the importance of role and responsibility within the 'āiga is critical to an individual's identity and value.[41]

Across the data, pain was described as a shared experience felt by the whole ʻāīga. An individual's identity and purpose are intertwined with their position and role within the family. Pain and illness become a collective experience and responsibility for the whole ʻāīga. Informants expressed the importance of seeing a patient from within a wider framework, taking into account their family and social context, and discussed the therapeutic benefit of belonging and sharing of illness. This was described by informant X:

> It's more or less other people in the family will feel, like when you are sick they can sense, they can feel one person, and they affect the whole family … Supporting is very important, and that's why the feeling within the family affecting when you are sick and when you feel pain, they will also feel pain as well.
>
> (male, social worker)

For Sāmoan people, social, emotional and practical support is often found in their ʻāīga. Even in Aotearoa New Zealand, where there is no longer a traditional ʻvillage', informants described the connectedness that ʻāīga make through gatherings, church communities and social media. For example, informant Y stated:

> When you do find someone who is suffering quite a bit you will always find a big extended family network around them, and for them seeing cousins, aunties, uncles, and those sorts of things, is much more therapeutic than taking something specifically for the pain.
>
> (female, social worker)

Informants described the community fostering the sharing of information, supporting a collective knowledge that leads and guides individuals to treatments/remedies or to people and services for their health. The ʻāīga were described as essential for advocacy and support, and to help reinforce treatments given to patients. Evidence shows this collective sharing of health responsibility leads to protective and positive health behaviours[44,45] and increases active participation in health programmes for Pasifika people.[46]

The Sāmoan community have strong social connections that foster organic methods of healing and expressions of coping through the use of story-telling, tālanoa/talking, singing, music and laughter. These practices were presented as naturally occurring within the community, promoting mental health and giving opportunity for those in pain for distraction, and emotional and spiritual support. Informant W described some of the ways Sāmoan people cope with pain as ʻMusic, entertainment, laughing, laughing, laughing'.

Although there appears to be a tension between the previous theme and this one, there seemed to be indications that the ideas within each theme are congruent with one another and co-exist. For instance, informant R described her grandmother and friend's daily activities, a routine of social interactions, spiritual practices, and attending to family roles. This informal support group appeared to act as a buffer to the frustrations of living with pain, enhancing individual coping strategies by sharing and distracting from suffering:

> They could sit around for hours and hours, laugh, backstab and gossip, and make up stories and bring things up in the past. They repeat these stories over and over, and I wonder if it helps them manage their pain. They laugh, and laugh, and mock and laugh, and gossip, and then they sit there and read their bibles and pray, then they go back to gossiping. This is their daily cycle. They get up, they clean their houses, they sit down, talk, laugh, talk, laugh, pray, read their bible, talk, laugh. I wonder if that is a component towards managing all of that, or minimising some of what is physically going on.
>
> (female, social worker)

Finlay et al.[47] found a similar preference to focus on the importance of comradery and congeniality of conversation in support groups, and there is literature reporting the benefits of the use of singing, laughing, chanting and story-telling in the Sāmoan community to help reduce stress and anxiety, bring connectedness and promote relaxation.[48] A significant part of the traditional fofō or taulāsea treatment is the interaction, relationship and time spent with the clinician. Massage is commonly used in other indigenous cultures as a treatment for pain and the interaction component is a well-established motivator for using such practices.[26,29,49,50] Informant S described their interaction as a taulāsea and how much time and empathy they are able to offer their patients:

> We laugh, we cry, we talk about the week. I reason around the table, they come home and talk at the table …. Here, I am the healer, counsellor, psycho-analyst, everything all at once.
>
> (female, traditional healer)

The community living and collectivism is a stark contrast with the Western individualist mindset that dominates among Pālagi New Zealanders. The ʻāīga, which includes extended family, are collectively responsible for the welfare and health of the family unit. The needs of the individual are secondary to the needs of the ʻāīga, with decisions around well-being, seeking healthcare and following treatment being made collectively and in ways that support all the members of the ʻāīga. While this clashes with individual patient autonomy promoted by most Western healthcare systems, it promotes commitment to the ʻāīga and strengthens these connections.

3.4 | To improve healthcare is to nurture vā

This theme describes the disconnect that Sāmoan people feel from the Aotearoa New Zealand health system, the disempowerment experienced from this, and the importance of relationships to bridge the disconnect. For Sāmoan people, vā is a necessary ingredient to support their navigation of the healthcare system, and the absence of vā may contribute to difficulties engaging with healthcare environments, professionals, and treatment provided. Vā is a relational concept that describes a place of mutual respect and regard for one another; it is a place of harmony and willingness to understand and value each other's perspective.[41] Western health systems, and often the clinicians trained within these systems, tend towards operating in ways that do not nurture this relational space. Instead, the overarching expectation is that Sāmoan people must enter into a cultural space not their own with the onus of navigating the healthcare (and Western biomedical cultural) landscape to receive medical care. This lack of connection and lack of space for mutual regard and respect were reported as leading to marginalisation and misunderstandings between patients and clinicians. Health service delivery was framed as depersonalised and positioned in direct conflict with Sāmoan culture, where the core value is of relationships. This is explained by informant X:

> If you build relationship over a period of time, you have long term connection that's far more valuable and that's when you will respect and listen to someone that you have relationship with. Unfortunately, in tertiary care you only see them for a brief period in their whole life and that's why, OK, they will listen and they will take out what they want, but they will go back to that foundation.
>
> (male, social worker)

The lack of Pasifika healthcare workers and language difficulties were identified as barriers to open communication. While a preference for Sāmoan or Sāmoan-speaking health professionals was noted, some informants felt that regardless of ethnicity and language, the ability for a health professional to build rapport and show genuine care and understanding was of higher importance, as concordant ethnicity did not guarantee quality of healthcare. All informants described the importance of seeking information and gaining knowledge for patients to be able to make informed decisions and advocate for themselves and their ʻāiga. However, informants reported that often Sāmoan people would miss this aspect of treatment due to language difficulties, clinicians not spending enough time or attention to clarify understanding, or appointment times being simply transactional rather than relational. This would often lead to fear and mistrust of the healthcare system. This is supported by Aotearoa New Zealand literature indicating that medical jargon and limited consultation time increase miscommunication and give poor satisfaction for Sāmoan people.[51,52]

Distrust in, and disconnection from, the healthcare system was still relevant for Aotearoa New Zealand-born Sāmoan people. Informants indicated they faced the same cultural difficulties as migrant Sāmoans but had the added expectation of representing and advocating for their family in healthcare encounters. Often, this meant leading the decision making when they themselves feel ill equipped or supported. Informant R noted:

> Being New Zealand born, our parents have relied on us heavily from very young ages to kind of represent them and speak on their behalf. The pressure is just enormous.
>
> (female, social worker)

Having family members used as interpreters and health advocates is not always optimal.[53,54] While Aotearoa New Zealand-born Sāmoans may have a language advantage when interacting with healthcare services, they are generally younger and of lower status than the family members they are representing and may not necessarily have any greater health knowledge. Further, as with many interpreter-based situations, the technical or advanced languages of health and biomedicine may be outside of their translation capabilities.[54] Thus, entering into and interacting with a healthcare setting that is not sensitive to these cultural and family nuances may not only increase the chance of miscommunication or misunderstanding in care provision, but it may also serve to inadvertently disempower family members who support patients.

Some informants also felt that non-Sāmoan healthcare workers were unable to understand and appreciate the spiritual aspect of health. Spiritual beliefs were not often shared with clinicians due to the fear of being judged or misunderstood. Informant R commented on this, comparing Westernised health professionals with traditional practitioners:

> …and you think the doctor knows everything, well sometimes they don't understand the spiritual stuff. The wairua stuff. And these ladies [fofō clinicians] know how to calm it.
>
> (female, social worker)

Spiritual aspects of health appear to be often left out of routine medical consultations, even when there is evidence that patients would like this aspect included in their care.[55] Informants argued that fostering vā requires inclusivity and acceptance of traditional alternative healing practices. Non-disclosure of these practices is high within ethnic minority communities internationally, with migrants fearing the disapproval from conventional health professionals.[56]

The informants in this study argued that a power differential is experienced and felt by Sāmoan people as they interact with the physical health settings, health system protocols and health personnel. This Sāmoan—Pālagi interaction is further complicated when, in trying to create a familiar space, Sāmoan people might try to follow appropriate cultural etiquette and protocols in the clinical space that can inadvertently exacerbate the power differential. Informants described doctors to be positioned as all-knowing, all-powerful and to be highly respected for their education and intelligence. The data indicated that Sāmoan people will often not question, show dissatisfaction or challenge health professionals because of wanting to honour and respect the status of the profession. For instance, informant R commented:

> When you are going to the doctors it's like going to visit the queen or king, you [doctors] have this qualification. And they know the hard work to get there, so there's this.
>
> (female, social worker)

Our findings reinforce that, in being deferential to those in authority, Sāmoan people may be restrained in their communication. This barrier to open communication was also identified in informants describing the difficulty patients had in concealing that they did not fully understand what a health professional was telling them, or not disclosing the full medical issue that they attended for. This was described by informant V:

> They will be like, ‘OK, OK, OK’ [when with the clinician], and then they come out and say, ‘oh, I didn't tell him I had this, this, this, this…’ I think it's the fear of, especially now being in a foreign country, it's the fear of saying the wrong words, you know the language barrier, not being able to express clearly what's happening.
>
> (female, general practice nurse)

Similar communication barriers have been found in Māori communities in Aotearoa New Zealand, with patients and whānau recognising judgement or blame-based attitudes from GPs[57,58] that were intensified by medical professionals not picking up subtle, potentially culturally bound communications.[57]

The Aotearoa New Zealand health system was reported as seen as Western and built and governed by Pālagi to respond to and treat Pālagi health needs. Informants discussed how navigating an unfamiliar, complex organisational system appears overwhelming and unwelcoming for many Sāmoan people. This was expressed by informant R:

> ….when we are engaging with the health sector or government departments, for them it's massive, it's a beast, it's a white system, and for them it's the Pālagi man.
>
> (female, social worker)

Previous research has also indicated that Aotearoa New Zealand's public funded health system privileges the dominant individualistic approach and biomedical discourse, and is designed primarily to respond best to acute need.[59] This often does not allow space for the traditional Sāmoan collectivist and holistic views of health and healthcare and is likely to contribute to negative experiences in seeking mainstream healthcare for chronic pain.

3.5 | Limitations

While this was a collaborative research project and embraced Pasifika methodologies of both tālanoa and vā, as well as the involvement of a Sāmoan clinician in the research team, the other authors are Pālagi. The narrative and analysis are therefore shaped by these authors' cultural outsider perspectives.

4 | CONCLUSIONS AND CLINICAL RECOMMENDATIONS

Findings from this study highlight the need for culturally responsive healthcare provision in pain management. Drawing on holistic and culturally informed health models can guide assessment, treatment planning and ongoing engagement with Sāmoan people and their families. Specifically, models such as the Fonofale Model can be used as an assessment guide to overtly acknowledge the physical, social, psychological and spiritual aspects of their pain experience. While the inclusion of prayer/lotu in the clinical setting has been recommended in research past, emergent points in the current study posit the need to expand on this. As such, understanding the role of spirituality in causal explanations of, and coping with, pain among Sāmoan people can bolster the validity of the assessment and treatment of persistent pain. Using holistic assessment tools and models that capture spiritual, historical, environmental and familial aspects of health and wellbeing can help to contextualise the pain assessment process in a manner that is familiar with Sāmoan people and their ‘āiga. As these models make reference to culturally relevant phenomena and structures, these can be used to facilitate non-judgemental conversations while reducing tokenism in the interaction. Patients and their ‘āiga should be supported to utilise their inherent cultural strengths relating to connectivity in the management of pain. Appropriately involving and supporting ‘āiga in all aspects of care and having open discussions about traditional treatments and practices would be beneficial. The acknowledgement and acceptance of such treatments and practices, and how they would fit into a meaningful management plan, would provide a means to empower Sāmoan people to use their own cultural strengths. While ‘āiga represent a reservoir of practical and emotional support, it is important to recognise the limitations of what they are safely able to contribute. In the case of having family members act as interpreters or advocates for patients with pain, supports should be provided in the services to ensure the safety of all ‘āiga involved. For example, Sāmoan cultural navigators could be available to assist ‘āiga through the systems and processes in a way that maintains their cultural values and identity.

Teu le vā, or the act of building and maintaining relationships, is predicated on notions of respect and reciprocity, and is key for establishing an effective clinical relationship. This cannot be created by strict methodology but is rather nuanced and requires a sensitivity across individuals and their ‘āiga. Vā can be fostered through checking appropriate pronunciation of names, the dynamic and appropriate sharing of personal information between the patient and clinician, and allowing sufficient time to do this in a meaningful way, particularly when meeting a new patient and their ‘āiga for the first time. Even the appropriate use of humour can help reduce hierarchical structures and allow Sāmoan patients and their ‘āiga to engage in more collaborative healthcare relationships. Given the importance of relationships, context and connection to effective treatment and care,[41] these recommendations would be valuable for all people, but particularly for those with collectivistic orientations.

Many of the inherent strengths of the Sāmoan community lie in the wider networks that exist beyond the realm of the healthcare system. Health promotion efforts may find benefit in promoting the role of these networks in pain management. Establishing relationships with those already in the Sāmoan community, such as Pacific health workers, community leaders, church groups or sporting organisations, would not only provide avenues of support to refer Sāmoan patients and their ʻāīga, but also a means of delivering healthcare and health information from within the community. Such community-lead and -based support is more likely to deliver healthcare in a way that incorporates both Sāmoan understandings of pain and pain management as well as Western-based principles, empowering people to make informed choices about how they manage their health.

ACKNOWLEDGEMENTS

The authors would like to thank the key informants who participated in the study for sharing their knowledge and expertise.

FUNDING INFORMATION

The study was funded by the Auckland University of Technology.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to report.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Ethical approval was obtained from the Auckland University of Technology Ethics Committee (#19/262).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Upsdell A, Fia'ali'i J, Lewis GN, Terry G. Health and illness beliefs regarding pain and pain management of New Zealand resident Sāmoan community leaders: A qualitative interpretive study based on Pasifika paradigms. Health Promot J Austral. 2024;35(3):724–33. https://doi.org/10.1002/hpja.800