EXPLAINING THE PARADOX OF HEALTH AND SOCIAL SUPPORT AMONG ABORIGINAL CANADIANS

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ABSTRACT / RÉSUMÉ

Societies that foster high quality social environments and integration produce healthier populations. The mechanisms underlying the protective effect of social integration appear to be through various forms of social support. Despite reportedly high rates of social support within the Aboriginal population, however, current patterns of health are overrepresented by social ills such as family violence, alcoholism and suicide. This paper explores this paradox through qualitative interviews with Aboriginal Community Health Representatives (CHR's). CHR's narratives point to two key explanations for the health-support paradox: (i) social support is not a widely accessible resource; and (ii) the negative health effects of social support can sometimes outweigh the positive ones. The formation of health behaviours and cultural norms that underpin social support is inextricably tied to the colonial legacy and poor material circumstances that characterize Canada's Aboriginal communities. The pathways through which the physical, material and social environments interact to influence the health of Aboriginal Canadians are complex; and, more qualitative research is needed to understand what these interactions mean for health and social support in the every day lives of Aboriginal Canadians. Policy efforts to initiate healthy behaviours cannot succeed without coinciding material investments.

Les sociétés qui favorisent les environnements sociaux de haute qualité et l'intégration produisent des populations en meilleure santé. Les mécanismes qui sous-tendent l'effet protecteur de l'intégration sociale semblent le faire par diverses formes de soutien social. Malgré des taux de soutien social qui seraient élevés au sein de la population autochtone, les tendances actuelles en matière de santé sont surreprésentées par des maux sociaux comme la violence familiale, l'alcoolisme et le suicide. Cet article explore ce paradoxe au moyen d'entrevues qualitatives de représentants autochtones en santé communautaire dont les récits soulignent la pertinence de deux raisons principales expliquant le paradoxe du soutien de santé : i) le soutien social n'est pas une ressource largement accessible, et ii) les effets négatifs du soutien social sur la santé peuvent parfois l'emporter sur les effets positifs. La formation de comportements et de normes culturelles en matière de santé qui sous-tendent le soutien social est inextricablement liée à l'héritage colonial et aux piètres circonstances matérielles qui caractérisent les communautés autochtones du Canada. Les voies par lesquelles les milieux physique, matériel et social interagissent pour influer sur la santé des Canadiens autochtones sont complexes, et il faut plus de recherche qualitative pour comprendre ce que signifient ces interactions pour le soutien en matière de santé et le soutien social dans la vie quotidienne des Canadiens autochtones. Les efforts visant à élaborer des politiques pour favoriser les comportements sains ne peuvent réussir sans investissements matériels coïncidents.

"Despite reportedly high rates of social support within the Aboriginal population, current patterns of health suggest that these social relationships are not working to promote Aboriginal health as the social support literature suggests it should. How do we explain these differences? Potential explanations relate explicitly to Aboriginal people's experience of colonialism as well as the socio-cultural disruption and material deprivation that have ensued in so many Aboriginal communities following years of environmental dispossession (Waldram *et al.* 2006; Adelson 2005; Kirmayer, *et al*. 2000)."

INTRODUCTION

Throughout the world, people who are vulnerable and socially disadvantaged have less access to health resources, they tend to get sick more often and they often die earlier than people in more privileged social positions (Evans *et al.* 2001). Poverty, social exclusion, poor housing and poor health systems are among the main social causes of ill health - those to which Rose (1992) refers to as the "cause of the causes". These causes of ill health refer to the *social conditions* that give rise to high risk of non-communicable disease, whether acting through unhealthy behaviours (e.g., smoking, drug use) or as a response to living under stressful life conditions (e.g., crowding, violence) (Marmot 2004). Compared with the general population of Canada, Aboriginal people experience a significantly higher burden of morbidity and mortality (Frohlich *et al.* 2006; Codon 2005; Adelson 2005; MacMillan *et al.* 1996), the roots of which lie in a legacy of colonial relations, dispossession from traditional lands and territories, rapid cultural change and dependency (Waldram *et al.* 2006; Bartlett 2003).

Over the past few decades, researchers have attempted to explain the roots of these disparities through the study of the larger societal conditions that influence health outcomes among the Aboriginal population. Particular focus has been on issues related to material disadvantage, urbanization, and political and environmental marginalization (Frohlich *et al.* 2006; Richmond *et al.* 2005; Waldram *et al.* 2006). Amidst this flurry of academic pursuit into the determinants of Aboriginal health, however, few researchers have examined how Aboriginal health may be influenced when features of the broader societal context (e.g., colonial legacy, poverty) interact with more proximal health determinants, such as social support. Societies that foster high quality social environments, trusting relationships and social support produce healthier populations (Berkman and Syme 1979). The health benefits of social affiliation have been widely recognized (House *et al.* 1988). The mechanisms underlying the protective effect of social integration appear to be through access to various forms of social support (Kawachi 1999), such as affection and intimacy, emotional support and positive social interaction (House 1981).

In the context of Aboriginal Canadians, recent statistical analyses suggest that social support is both a solid dimension of Aboriginal health (Richmond *et al.* 2007a) and a significant determinant of self-rated health among Aboriginal peoples (Richmond *et al.* 2007b). An interesting paradox emerges: Despite reportedly high rates of social support within the Aboriginal population, current patterns of health suggest that these social relationships are not working to promote Aboriginal health as the social support literature suggests it should. How do we explain these differences? Potential explanations relate explicitly to Aboriginal people's experience of colonialism as well as the socio-cultural disruption and material deprivation that have ensued in so many Aboriginal communities following years of environmental dispossession (Waldram *et al.* 2006; Adelson 2005; Kirmayer, *et al,* 2000). As evidenced in the social epidemiological literature, lower social position reduces access to kinds of interpersonal resources embodied in the concepts of social support and social networks (Link and Phelan 1995). This can negatively impact on adult behaviour and psychosocial characteristics (Lynch *et al.* 1995). The current paper explores this paradox of health and social support within the Aboriginal population and addresses two specific objectives: 1) to describe the types and sources of social support in Aboriginal communities and explore the mechanisms that determine access to these sources of support; and, 2) to explore the health-enhancing and health damaging effects of social support.

METHODS AND ANALYSES

As described elsewhere (Richmond 2007; Richmond and Ross 2008a, 2008b), this paper draws from narrative analyses of in-depth interviews with a national group of First Nation and Inuit Community Health Representatives (CHRs). At the community level, CHRs are front-line health workers who perform a broad range of in-house, health-related functions including environmental health, health

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delivery, medical administration, counseling and home visits, education and community development as well as mental health. Such health services are necessary in communities who do not have a permanent doctor (e.g., doctors are regularly flown into some isolated communities). The breadth of the CHRs duties makes her a common fixture in the everyday community landscape. The cross-over between private and public spaces can make it very difficult for the CHR to maintain privacy in her own life; it also means that she is acutely aware of her social surroundings and the health needs of her fellow community members (many of whom may be family members, friends or neighbours). As a result, the CHR plays a vitally supportive, yet often devalued, role within her community. Even so, 23 of 26 respondents contributing to this study reported that they do the job because they want to help their communities. It was precisely because of the wide occupational context of CHRs and their dedicated passion to their communities, both which link so explicitly to provision of social support that CHRs were selected as the group ideally positioned to provide detailed information about the social support-health connection in their local communities.

In May 2005, CHRs were invited to participate in this research at the annual meeting of the National Indian and Inuit Community Health Representatives Organization (NIICHRO). In the months following the NIICHRO conference, telephone interviews were undertaken with 26 CHRs[1] in rural and remotely located First Nation and Inuit communities. The interviews focused on three key areas: (1) perceptions of community health and changes over time; (2) the nature of, and access to, social support; and, (3) how social supports can impact health. Depth interviews with CHRs provide a source of well-grounded, rich descriptions and explanations of the social, economic, political, cultural and environmental processes that affect health at the community level. Specifically, the CHR's narratives were examined to formulate explanations about the paradox around which this paper is theoretically centered; that is, in spite of reportedly high levels of social support among Aboriginal Canadians, current patterns of health and social indicators point overwhelmingly to social causes, thereby suggesting that social support is not working to improve and/or buffer health as it should. Based on narrative analyses of the interviews with CHRs, two key explanations emerged: (1) social support is not a widely accessible resource (Richmond 2007); and, (2) negative health effects of social support can sometimes outweigh the positive ones (Richmond and Ross 2008). These explanations are described below.

RESULTS

REDUCED ACCESS TO SOCIAL SUPPORT

CHRs pointed to two types of social support: institutional and intimate. Institutional supports were defined as those employed to provide support to their community members (e.g., Nurse, Social Worker). Intimate supports were defined as family, friends, and fellow community members. CHRs noted that in many of their communities, there exists significant overlap between these sources of social support, which can sometimes reduce *access* to social support. That is, the overlap in types of support (i.e., as one person fulfills the role of intimate support and institutional support) may lead to high levels of social integration in the community, but it can also lead to tension around the supportive *roles* community members are expected to fill. This can have negative consequences for those providing support as well as those on the receiving end. For example, the ease at which the types and sources of social supports can become muddied in the context of these small, often remotely located, communities was observed by "Dolly" who remarked that she could not escape her role as a CHR, even while not working:

> When you work in your community you can get called any time. I can be in the grocery store getting my groceries, and a person will come over and talk to me about their problem. It can be very hard because sometimes when you leave your job you like to go home and forget about your job, but you live here, you face it (Dolly).

Indeed, such tensions around the types and sources of support can significantly complicate one's access to social supports, as they intensify issues such as trust, confidentiality, community divisions and perceptions around social hierarchies, all of which may be exacerbated in small communities where privacy can be hard to come by.

Beyond these tensions around the types and sources of social support, CHRs described the post-colonial context of their communities as the most pervasive issue underpinning access to social support (Richmond 2007). The negative effects of environmental dispossession extend from historical times and well into the contemporary social fabric of communities. They shape the way people make a living; the community's access to educational and cultural opportunities; and, the means through which families and community members relate to one another socially. Among their fellow community members, CHRs described a shared experience of trauma related to forced assimilation (i.e., through attendance at residential schools), loss of lands and rapidly changing culture - all of which CHR's described to be at the root of many current-day social problems in their communities, including parenting skills, socioeconomic dependence, trust, group belonging and the nature of help. These findings are illustrated as a framework (*Figure 1*), which conceptualizes how features of the broader societal context of post-colonial communities can manifest in the local social conditions of places, thereby reducing access to social support. For example, widespread poverty is causing a shift in the meaning of help, meaning that less community members are willing to help "for free":

> The great voluntary base that we had before… Well, you don't really see that anymore. I think this community has come to a point where you can do something to help others, but then there are always dollars attached to it. Money talks (laughs). Today, I see that my kids expect to be paid in return for their help (*Margaret*).

CHRs identified the need for extra income to be so great in some communities that core beliefs about sharing and reciprocation are no longer heeded as important values. Another example relates to parenting skills, which have been affected by the residential school experience:

> This community had a residential school, and it was here for many years. A lot of them [students] were pretty young when they went in there…They had a really traumatic experience. *And so a lot of children that attended these residential schools now have children themselves?* Yes they have children, and it depends on the cycle, you know? If they themselves have been abused, then the abuse will keep going on and on, so that makes it very sad (*Martha*).

Health and social policy options must make efforts to recognize the post-colonial influences that affect Aboriginal peoples (Frohlich 2006; Waldram 2006; Adelson 2005; Browne and Smye 2004) as well as study the connections between these influences and how health determinants, like social support, play out in local places as a result of this legacy.

SOCIAL SUPPORT CAN HAVE HEALTH-DAMAGING CONSEQUENCES

Results of the CHRs interview data reveal that there are health-enhancing and health-damaging properties of social support. Furthermore, the negative properties of support can significantly outweigh the positive ones, particularly when they operate in response to conditions of poverty (Richmond and Ross 2008). CHRs identified social support to operate at varying structural levels, beginning with the individual and extending outward to family and community. CHRs identified the supportive behaviours associated with these varying levels of social structure as important for health, as they embed individuals within a social context, thereby reinforcing sense of identity, belonging and cultural norms.

CHRs stated, however, that these forms of belonging are not uniformly health-enhancing at the individual level. The social norms and health behaviours to which one subscribes in the identity-building process can sometimes harm health, for example, as a battered wife in the case of intimate partner violence or a drinking partner in the case of alcoholism. CHRs described these activities as occurring frequently in their communities; and, they identified that conformity pressure and loyalties associated with these ties, in conjunction with the small, isolated nature of First Nation and Inuit communities, can make it impossible to disobey the social rules associated with these relationships:

> Let's say you and 5 friends smoke cigarettes and 1 of you decides to quit and the others don't, so then what happens? You're abandoned. You are really kind of alienated and isolated because you lose your friendships. You hear them [community members] talking about that, not just with cigarettes but with drugs or drinking, they lose their friends (*Laura*).

CHR's recognized that one's loyalties to their social ties can actually 'trap' them within a normalized cycle of damaging health behaviours and, as such, healthy lifestyle changes (e.g., losing weight, becoming sober) may require an individual to physically remove himself/herself from the social environment or social relationship wherein such behaviours were enabled. In the following example, Nora explains how her husband had to do just that as he conquered his alcoholism:

> He has had to change his lifestyle, his friends, and he found friends on the outside [off the reserve] who support him. He had to find friends that are sober like him… In his program he learned that if he wants to change his lifestyle, he has got to change his friends as well. He couldn't continue with the same friends. He misses them and he will tell them 'if you want to join me you will just have to abstain from alcohol and not be a bad influence,' so he's really been helping his friends too, to try and abstain (*Nora*).

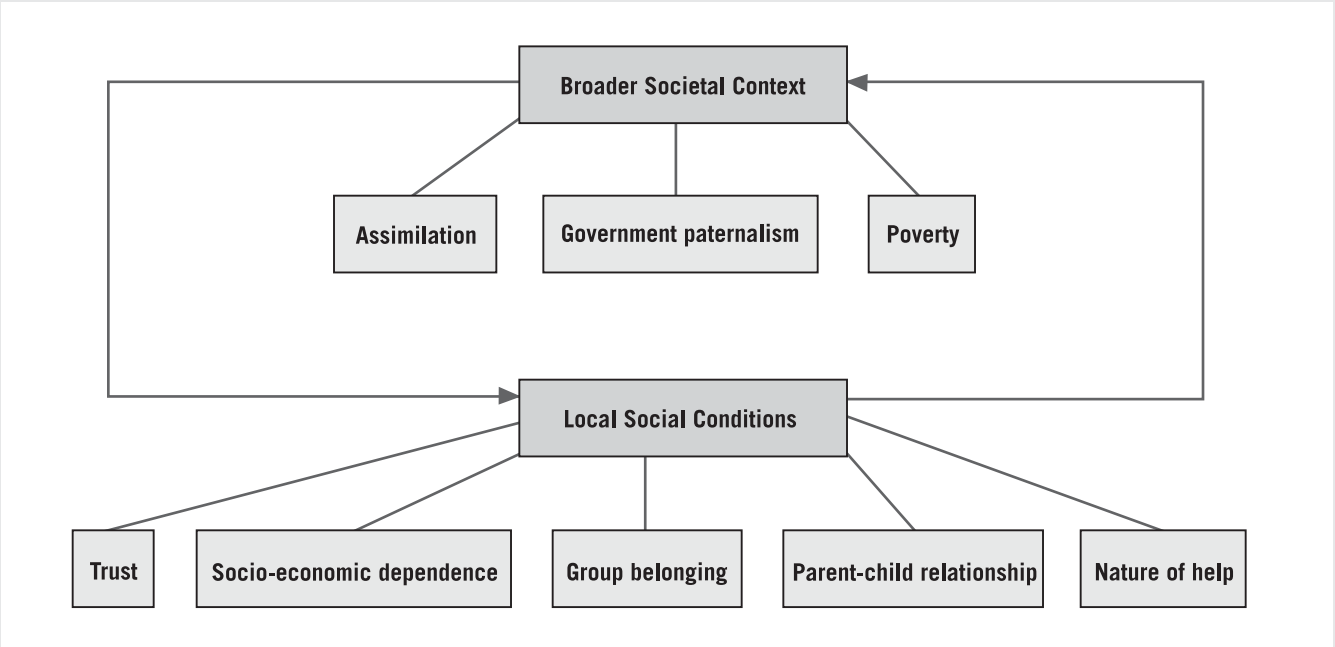
While these lifestyle changes may have positive consequences for physical health, they can be detrimental to one's emotional status, as they may lead to feelings of loneliness and isolation. CHR's reported that these feelings often occur when youth leave their communities for the first time (e.g., for post-secondary education).

The CHR's narratives therefore emphasize that it is negative health behaviours shared within the context of socially supportive ties that be harmful for health. In the context of the overwhelming poverty that exists in so many First Nation and Inuit communities, these negative behaviours can be understood as basic coping mechanisms for those suffering the effects of living under stressful lifeconditions. CHR's indicated that such behaviours (e.g., smoking, excessive alcohol consumption, poor dietary practices) are invariably reflective of the social norms, values and expectations held at the family and community levels: As conditions related to poverty continue to prevail in the these communities, we may expect these behaviours to persist as well.

CONCLUSIONS AND DIRECTIONS FOR POLICY

Within the Aboriginal health literature, there has been little research directed at identifying or understanding the role of social support for health; however, recent analyses have identified social support as a strong dimension and determinant of Aboriginal health (Richmond *et al.* 2007a, 2007b). Still, the persistence of socially caused disease and mortality remains a common trend in the Aboriginal population (Adelson 2005). This phenomenon therefore begs the paradox around which this paper is theoretically centered: given what we know about the health protective properties of social support, how and why it is that patterns of social dysfunction continue to ravage indicators of population health?

FIGURE 1: Access to social support in the post colonial context



Source: Reproduced from: Richmond, 2007

"Environmental dispossession and the impending poverty it has inflicted on First Nation and Inuit communities is most starkly represented in patterns of morbidity and mortality. As Adelson (2005; S45) notes, health disparities are directly and indirectly associated with social, economic, cultural and political inequities. The end result of this is a disproportionate burden of ill health and social suffering upon Aboriginal populations of Canada."

The CHRs interviewed for this research were able to articulate the role of the post-colonial context, in particular that of poverty, as a fundamental cause (Link and Phelan 1995) of the current day social problems that plague their communities. The post-colonial context manifests in powerful ways to shape access and health benefit achieved from social support. However, increased access to social support does not necessarily translate into improved health. The CHRs discussed how the supportive behaviours of one's social ties can operate in both negative and positive ways. Strong connection to family and community provides sense of identity and sense of belonging, which is important for health; but the health behaviours shared within these social contexts can also harm health, for instance, when these behaviours operate in response to poverty and other forms of social disadvantage (Marmot 2002; Lynch *et al.* 1997).

As witnessed in health studies with other vulnerable populations (Krieger 2001; Navarro 1990), factors such as poverty and a low social position strongly influence patterns of Aboriginal health. Environmental dispossession and the impending poverty it has inflicted on First Nation and Inuit communities is most starkly represented in patterns of morbidity and mortality. As Adelson (2005; S45) notes, health disparities are directly and indirectly associated with social, economic, cultural and political inequities. The end result of this is a disproportionate burden of ill health and social suffering upon Aboriginal populations of Canada. Poverty cascades from the community level and down to that of the individual, wherein psychological responses to inequality with the greater Canadian population manifest, mainly through health behaviours, as widespread social dysfunction. These behaviours result as powerful responses to stress, anxiety and coping with the circumstances of living in poverty (Evans *et al.* 2001; Marmot 2004).

Two directions for policy emerge from these findings. First and foremost, changes in the health and wellness of Aboriginal peoples must be rooted in policy attempts focusing on eliminating poverty and improving the social environments of First Nation and Inuit communities. Health education is important for improving health behaviours at the individual and family levels. However, interventions designed to initiate healthy behaviours cannot succeed without coinciding material investments such as job creation, meaningful opportunities for training and safe social environments in which children, youth and adults can live, work and socialize (Marmot 2005; Rose 1992). Interventions that focus on issues related to poverty, social exclusion, poor housing and poor health systems are fundamental for improving the quality of Aboriginal social environments and for providing brighter futures among Aboriginal youth. Along these same lines, policy attempts to improve health and health behaviours must take into consideration the significant cultural value associated with connection to the physical environment.

Second, policy interventions must target not only individuals but families and communities as well (Richmond *et al.* 2007a; Browne and Smye 2004). Social support has been identified as a concrete health dimension and has been associated with thriving health. Improving quality of life among Canada's Aboriginal peoples, therefore, requires health policy and programs that address the social determinants of health in an inclusive and community-based way. Such holistic models are important for unifying communities and building on the innate resources of our First Nation and Inuit communities – the spirit of its people.

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