Narratives of Social Support and Health in Aboriginal Communities

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ABSTRACT

Objective: Societies that foster high-quality social relationships and social support seemingly produce healthier populations. Existing research identifies social support as a significant dimension and determinant of Canadian Aboriginal health, yet patterns of morbidity and mortality overwhelmingly reflect social causes (e.g., violence, suicide), thereby suggesting that social support may not be widely accessible within this population. This paper seeks to understand how broader societal factors (e.g., colonialism) work to influence access to social support in the everyday social environments of Aboriginal communities.

Method: Narrative analysis of interviews with 26 Aboriginal Community Health Representatives (CHRs) from across Canada.

Results: Sources of social support are institutional (e.g., those employed to provide support) and intimate (e.g., family). In terms of access to social support, CHRs' stories reflected a narrative detailing the post-colonial context. Key elements of this narrative include the child-parent relationship, group-belonging, trust, socio-economic dependence, and the changing nature of help. Findings suggest that features of the broader societal context (e.g., poverty) have manifested as local social conditions (e.g., providing help has come to be seen as a possible source of income), thereby reducing access to social support. Access to this resource is also affected as institutional and intimate supports tend to overlap in Aboriginal communities, many of which are small in terms of size and population.

Conclusion: Research and policy options must recognize the post-colonial influences that affect the everyday realities of Aboriginal communities and study the complex interactions between these influences, and how health determinants – like social support – play out in local places as a result of this legacy.

MeSH terms: Aboriginal health; social support; social environment; colonialism; community health representatives; narrative analysis

La traduction du résumé se trouve à la fin de l'article.

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Societies that foster high-quality social relationships and social support seemingly produce healthier populations.^{1,2} It has been illustrated elsewhere that social support is a key dimension³ and determinant⁴ of health among Aboriginal Canadians, yet patterns of morbidity and mortality overwhelmingly reflect social causes⁵⁻⁸ (e.g., violence, suicide), thereby suggesting that social support may not be widely accessible within the Aboriginal population. Aboriginal health researchers have described the health effects of varied 'upstream' determinants^{5,9,10} (i.e., structural processes, such as those linked to colonialism), yet little is known about how the broader societal context interacts with local social conditions to shape access to health determinants, such as social support. Consistent with a greater movement seeking social explanations for health and disease,¹¹⁻¹³ this paper draws from interviews with Aboriginal Community Health Representatives (CHRs) to address the following objectives: 1) to explore sources of social support in Aboriginal communities, and 2) to identify the mechanisms that determine access to social supports at the community level.

Community health representatives

In Canada, there are approximately 633 First Nation and 45 Inuit communities. These communities vary widely in terms of their population, size and geographic location. There are roughly 1000 Aboriginal Community Health Representatives (CHRs) across Canada, approximately one per First Nation and Inuit community, and of these, 90% are women. The CHR program was conceived in the 1960s by the Medical Services Branch of Health Canada (later renamed the First Nation and Inuit Health Branch) to practice health promotion activities in Aboriginal communities. Other duties of the CHR include assisting health professionals by translating medical instructions to clients, dispensing medication, home visitations and some treatment.¹⁴ However, with the high turnover – and in some cases, non-existence – of health professionals in Aboriginal communities today,¹⁵ the CHR is often the only source of stable health care provided in Aboriginal communities.¹⁴

Population health in the post-colonial context

Post-colonial societies are those which endure the ongoing and continually evolving

ing 'after-effects' of colonial relations.¹⁶ Globally, Indigenous peoples share a common history of oppression. With colonialism came loss of ancestral lands and migration of Indigenous peoples to isolated regions, wherein truncated lands were often insufficient to support a familiar way of life. This loss of land has radically disrupted the socio-cultural and economic activities that tie Indigenous peoples to their physical environments, and significantly shifted patterns of health.^{4,5,10,17} The after-effects of this legacy contribute to the health and social inequalities we witness across Indigenous populations today,¹⁶ including lowered life expectancies, elevated infant mortality, persistence of infectious disease, and increased rates of non-communicable diseases, accidents, violence and suicide.^{5-8,10,18} Indigenous peoples experience the kinds of health problems most closely associated with poverty;¹⁹ levels of education and workforce participation among Indigenous people lag far behind that of their non-Indigenous counterpart.⁵ Current patterns of health and social suffering reflect the combined effects of colonial oppression, systemic racism and discrimination, as well as unequal access to human, social and environmental resources.^{9,15}

Social support: "Upstream" and "downstream" factors

Social support refers to four broad classes of supportive behaviour or acts, including positive interaction, emotional support, tangible support, and affection and intimacy.²⁰ Social support operates on the level of individual and community,²¹ and it is the nature of one's social integration (i.e., the existence or quantity of social ties) that provides opportunity for the development of social support.² Our social relationships can affect health because they regulate human thoughts, feelings and behaviours in ways that shape health.² At the community level, widespread recognition of values and cultural beliefs may translate into normalized understandings about how the resources of our social ties (i.e., social supports) are organized, and expectations regarding what can be derived from them.

Because social support is a property of both individuals and communities,^{21,22} it is crucial to locate the mechanisms that shape opportunities for accessing social support.

Access to social support is determined not only through an individual's support-seeking behaviour, however (e.g., downstream), but also through greater societal conditions that work at the level of the community and beyond (e.g., upstream).²³ For instance, an individual's geographic isolation may reduce his/her access to social support, as the individual is physically unable to reach the help he/she needs. For another individual, their support-seeking behaviour may be limited by a lack of trust in those providing social support. In each example, access to social support may be limited by factors that may be perceived as characteristic of the individual (i.e., because they choose to live in an isolated area, or because they lack trust). In reality, however, such factors may be part of a set of upstream, structural processes that shape local social conditions (e.g., community politics, widespread poverty) and can actually limit an individual's opportunities for support. In examining the nature of and access to social support, it is necessary to critically evaluate how individual actions and behaviours are shaped by the upstream contextual features of their communities.

METHODS

The research was the result of collaboration between the author and the National Indian and Inuit Community Health Representatives Organization (NIICHO), a not-for-profit non-governmental organization with which most CHRs hold active memberships. CHRs were initially approached at NIICHO's annual general meeting and 26 CHRs were interviewed during the summer of 2005. Twenty-five of the CHRs were women. All interviews were conducted over the telephone, except for one that took place face-to-face. All interviews were tape-recorded (with permission), and once transcribed into electronic format, hard copies of the interviews were mailed to all participating CHRs for their input or clarification. In order to protect identities of those interviewed, pseudonyms have been assigned. The interview focused on three key areas: 1) the nature of and factors that determine access to social support; 2) perceptions of individual and community health; 3) how social supports can impact health. The analyses described here relate to the first key area.

Narrative as a means of understanding

Narrative analysis is a form of interpreting a conversation or story in which attention is paid to the embedded meanings and evaluations of the speaker and their context.^{24,25} Through narrative analysis, researchers can understand 'the contingent, the local, and the particular',²⁴ thereby connecting the speaker to varying levels of context at once. In terms of the current analyses, for example, the use of narrative analysis provides a medium for understanding how people feel about their communities, and how access to social support may be implicated in the broader societal contexts underpinning everyday social life and supportive behaviours.

RESULTS

Sources of social support

CHR's described sources of social support as institutional and intimate. Institutional supports reflected those employed to provide support in the community. The main professions mentioned were CHRs, social workers, and members of band council. Intimate supports were defined as family members, friends, and fellow community members. In many of these communities, most of which are small in terms of space and population, there is often significant overlap between institutional and intimate supports. This overlap can lead to tension around the supportive roles community members are expected to fill. This was observed by one CHR, who remarked that she could not escape her occupational role, even outside of work hours:

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).

Access to social support

CHR's' stories about social support emerged around a narrative detailing how various elements of the post-colonial context have manifested in their everyday community contexts to shape access to social support. Elements of this narrative include the child-parent relationship,

socio-economic dependence, social structures, trust, and the changing nature of help. CHRs defined the post-colonial context as the most pervasive issue underpinning access to social support. Respondents described a shared experience of trauma related to forced assimilation, loss of lands, and rapidly changing culture, all of which were defined as root causes of many current-day social problems, including mass unemployment, feelings of apathy, government dependence, and loss of control.

Child-Parent Relationship

The effect of the post-colonial context of Aboriginal communities was described by CHRs as a vicious and continually-evolving cycle, one that perpetuates trauma from one generation to the next, mainly through the child-parent relationship. CHRs linked the residential school experience and various types of abuse endured at residential schools (e.g., mental, physical and sexual abuse) with a lack of current-day parenting skills:

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).

As Martha describes, the effect of the residential school experience stayed with many of her fellow community members from childhood and into adulthood. This is so because children who attended residential schools accepted the abuses suffered there as normal ways of showing love or affection.

Socio-economic Dependence

The government of Canada, under the auspices of the *Indian Act*, is fully responsible for the health and social services of Aboriginal communities. CHRs interpreted this fiduciary responsibility as resulting in widespread dependency, and an expectation that the community will always be 'taken care of' by the federal government. Related to the lacking economic opportunities and high rates of unemployment that characterize many Aboriginal communi-

ties, CHRs described the situation to be worsening, as higher levels of unemployment translate into more widespread dependency. Michelle interprets this dependence to be reflective of a process of internalized colonialism:

...sometimes a lot of the community members are dependent on us, and then they are kind of like disabled, they don't know how to help themselves... for so many years the whole community has been so dependent on the band and the social services, that they will phone here for us to make their doctor's appointments... (Michelle)

Group Belonging

CHR identified group belonging as the most powerful means through which access to social support is determined. Group belonging is formed by means of family, spiritual and cultural beliefs and individual behaviours. As Margaret alludes to, it can be very difficult to access social supports when you do not hold 'group membership':

I think that social support happens more in group settings... You have to belong to the group, and if you don't belong then they are not going to support you (Margaret).

While the group context is important for accessing social support, CHRs expressed concern that not all social groups share equally in the distribution of power and access to material resources. As a result, the factions of a community can actually create barriers to social support, and inequalities in terms of 'who gets what.' CHRs explained that these social groupings can be very exclusive, and that the benefits of such belonging may not be transferable to those outside certain groups or families (e.g., teens, elderly). This marginalization can normalize the exclusion of certain community members, and further restrict them from gaining access to the support they need.

Trust

CHR established links between declining levels of trust and access to social support. CHRs described how community members seek support from those they trust, and avoid those they do not. Precisely because of these issues of trust and confidentiality, there is a tendency for community members to draw upon institutional supports who are sworn to confidentiality.

Despite assumptions around confidentiality, however, Bonnie mentioned that lacking trust, coupled with the shame associated with an illness or social problem (e.g., HIV/AIDS, family violence), can prevent community members from seeking the support they require:

I think there is a lot of that, not trusting, with certain people... You need to be able to earn trust. Say if they [support seekers] are not talking about something – drug abuse, or physical abuse – and you know it's happening, you need to gain their trust and be willing to listen. But a lot of the time, if community members know somebody that works in the place, then they don't want anybody to recognize them. They would just rather go somewhere else where nobody knows them (Bonnie).

Some community members may prefer to seek support from 'outsiders,' or those who do not live in the community. In remote Aboriginal communities where it can be difficult to keep private and public issues separate, community members may fear judgement or stigma from others in the community. Leaving the community for support services may be a more appealing option.

Changing Nature of Help

CHR expressed worry about the changing nature of help in their communities, particularly as community members place more emphasis on providing help as a source of income for themselves. They explained that the need for income is so great in some communities that core beliefs about sharing and reciprocity are no longer heeded as important. When Grace moved with her husband to a new community, for instance, she was very surprised to learn that the selling of traditional foods was a common practice. In her previous community, the sharing of traditional foods was something people did because of moral obligation:

They sell traditional food! Like walleye, or moose. Like a piece of moose will cost \$20, whereas in my community when somebody kills a caribou, they cut it into pieces and go and offer it to elders. I was very surprised when I came here to find that people are selling these parts, when you are supposed to offer them (Margaret).

In this context, we see that the material circumstances of some communities are

Figure 1. Access to social support in the post-colonial context

causing a significant shift in the nature and meaning of help.

DISCUSSION

This paper has explored the nature of and access to social support in Aboriginal communities through narrative analyses of interviews with Aboriginal Community Health Representatives. Two research objectives were addressed: first, to identify sources of social support in Aboriginal communities; and second, to explore access to social support at the community level. Results point to two sources of social support: institutional and intimate. Institutional supports are those paid to provide support, while intimate sources are those who provide support because of the love, commitment and obligation they feel towards their family, friends, and members of their social networks.

In terms of the second objective, CHR's stories about *access* to social support were embedded within a narrative of the post-colonial context. Within this narrative, access to social support is shaped by the interaction of the broader societal context (i.e., poverty, government paternalism) and local social conditions (i.e., cultural norms and behaviours at the local level, such as parenting skills, socio-economic dependence, and trust). Combined, elements of the broader societal context and local social conditions represent the formation of a framework (Figure 1) that outlines the pathways through which post-colonialism manifests in the social environ-

ment, and the subsequent impact for access to social support at the community level.

Social support, then, is characterized as a property not only of individual behaviours, but also as a product of the larger social, political and economic factors that underpin community norms, values and behaviours.²² As in the case of so many health-related behaviours (e.g., overeating, driving too fast), there is a propensity to assume that individual choices are the sole predictor of individual behaviour (e.g., actively choosing not to access social supports).²⁶ Such thinking places responsibility for health exclusively on the individual, thereby masking the broader societal influences that shape health behaviour. Such health behaviours are rarely the result of individual choices alone; rather, these actions are responses to widely-held social norms and values, and the everyday contexts within which individuals live their lives.²⁷ Therefore, while support infrastructures may be in place at the community level (e.g., support groups, social workers), individuals may actively choose not to use the available resources for any number of reasons, including lack of trust in institutional supports, the shame associated with illness, or fear of being judged. Such fears, furthermore, may be exacerbated in communities wherein public and private interests often intersect. In gaining access to social support, we must therefore be cognizant that individual choices and opportunities can be masked by features of the broader societal context, many of which are reinforced in the post-colonial setting.

CONCLUSION

Research into the fundamental causes of poor health among Aboriginal Canadians points to varied upstream determinants of health (e.g., colonialism, poverty), yet few researchers have explored the means through which access to health determinants, such as social support, may be influenced by factors associated with the broader societal context. In this paper, attention has been focused specifically on identifying how the large scale can *interact* with everyday community environments to shape the nature of and access to social support. Related to the contextual factors of Aboriginal communities – namely that they are small places with small populations – the overlap of intimate and institutional types of social support contributes to high levels of social integration. Access to social support is determined not only by being socially integrated, however, but by a number of inter-related issues associated with the post-colonial context of Aboriginal communities, including socio-economic dependence, trust and group belonging – all of which CHRs described as influential for accessing social support.

Opportunities for the development of social support are immeasurably shaped through the interaction of varied upstream processes and the everyday context of local places. The key to building policy that encourages the development of these supports is acknowledgement that individual health behaviours, in and of themselves, are only part of the equation towards

improved health and social conditions for Aboriginal communities. By simply making resources available (i.e., through social welfare programs that allocate money for issues), we fail to address the broader societal factors that fundamentally underpin issues of access to such resources (e.g., dependency, inequality). It is vital that health and social policy options recognize the post-colonial influences that affect Aboriginal peoples,^{5,10,16,17} and study the connections between these influences and how health determinants, like social support, play out in local places as a result of this legacy. In our efforts to improve conditions among Canada's Aboriginal population, the challenge therefore remains to find ways of building on Aboriginal concepts of health^{3,28} – the strength of community ideals, sense of commitment, and maintenance of cultural identity. Such an approach is essential for creating solutions that build upon the positive attributes of Aboriginal communities and work to make Aboriginal communities healthy, supportive places.

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RÉSUMÉ

Objectif : Les sociétés qui encouragent des relations sociales et un soutien social de grande qualité semblent produire des populations plus saines. Les recherches déjà réalisées définissent le soutien social comme une dimension importante et un déterminant de la santé des Autochtones canadiens, mais les modèles de morbidité et de mortalité reflètent essentiellement des causes sociales (p. ex., violence, suicide), ce qui semble indiquer que cette population n'aurait pas suffisamment accès à un soutien social. L'objectif de cet article est donc de comprendre la façon dont les facteurs sociétaux plus larges (p. ex., système colonial) influent sur l'accès au soutien social dans les environnements sociaux quotidiens des communautés autochtones.

Méthodologie : Analyse narrative d'entrevues réalisées auprès de 26 représentants autochtones en santé communautaire (RSC) de partout au Canada.

Résultats : Les sources de soutien social sont institutionnelles (p. ex., les personnes embauchées pour fournir un soutien) et intimes (p. ex., la famille). En matière d'accès au soutien social, les propos des RSC prenaient la forme d'un exposé des faits dans un contexte postcolonial. Les éléments clés de ce récit comprenaient la relation parent-enfant, le sentiment d'appartenance au groupe, la confiance, la dépendance socio-économique et la nature changeante de l'aide. Les observations laissent supposer que les caractéristiques du contexte sociétal plus large (p. ex., la pauvreté) se sont manifestées en tant que conditions sociales locales (p. ex., l'offre d'aide est désormais perçue comme une source possible de revenus), réduisant ainsi l'accès au soutien social. L'accès à cette ressource est également touché puisque les soutiens institutionnels et intimes ont tendance à se chevaucher dans les communautés autochtones, dont bon nombre sont petites sur les plans de la superficie et de la population.

Conclusion : Les options en matière de recherche et de politique doivent tenir compte des influences postcoloniales qui ont des répercussions sur les réalités quotidiennes des communautés autochtones et des interactions complexes entre ces influences ainsi que du rôle joué par les déterminants de la santé – comme le soutien social – dans les communautés locales en conséquence de cet héritage.