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Social support, material circumstance and health behaviour: Influences on health in First Nation and Inuit communities of Canada[☆]

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A B S T R A C T

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An expansive literature describes the links between social support and health. Though the bulk of this evidence emphasizes the health-enhancing effect of social support, certain aspects can have negative consequences for health (e.g., social obligations). In the Canadian context, the geographically small and socially interconnected nature of First Nation and Inuit communities provides a unique example through which to explore this relationship. Despite reportedly high levels of social support, many First Nation and Inuit communities endure broad social problems, thereby leading us to question the assumption that social support is primarily health protective. We draw from narrative analysis of interviews with 26 First Nation and Inuit Community Health Representatives to critically examine the health and social support relationship, and the social structures through which social support influences health. Findings indicate that there are health-enhancing and health-damaging properties of the health–social support relationship, and that the negative dimensions can significantly outweigh the positive ones. Social support operates at different structural levels, beginning with the individual and extending toward family and community. These social structures are important as they reinforce an individual's sense of belonging, however, these high-density networks can also exert conformity pressures and social obligations that promote health-damaging behaviours such as domestic violence and smoking. The poor material circumstances that characterize so many First Nation and Inuit communities add another layer of complexity as limited resources can trap individuals within the confines of their immediate social contexts. Research and policy interventions must pay close attention to the social context within which social support, health behaviours and material circumstances interact to influence health outcomes among First Nation and Inuit communities.

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Since the late 1970s an expansive literature has grown to describe the connection between social support and health, the basic argument being that the care, respect and resulting sense of satisfaction and well-being related to

our social ties can buffer against health problems (Berkman, Glass, Brisette, & Seeman, 2000; Cohen & Syme, 1985). Some researchers suggest the health effects of our social relationships may be as important as established disease

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risk factors such as smoking, obesity and high blood pressure (Berkman & Syme, 1979; House, Landis, & Umberson, 1988). Though the bulk of the empirical evidence emphasizes the positive, health-enhancing effect of social support, certain aspects can also have negative consequences for health (Rook, 1992; Schuster, Kessler, & Aseltine, 1990; Uchino, Holt-Lunstad, Uno, & Flinders, 2001). That one's social ties may cause harm forms a significantly under-emphasized dimension of the social support and health relationship (Barrera, 1986; Rook, 1984; Thoits, 1995). Some suggest that the assumption that tight-knit social structures lead primarily to improved health is misleading (Gottlieb, 1985; Kawachi & Berkman, 2001).

In the Canadian context, the geographically small and socially integrated nature of First Nation and Inuit communities provides a unique example through which to explore the health effect of social support. Despite reportedly high levels of social support (Richmond, Ross, & Egeland, 2007), many Aboriginal communities in Canada continue to endure patterns of mortality and morbidity that are influenced strongly by social pathologies, including family violence, sexual abuse, widespread poverty, and suicide (Adelson, 2005). These social problems have manifested into potent predictors of morbidity and mortality among this population, thereby leading us to question the role of social support in these processes.

Consistent with other authors in the field of Aboriginal health (Anand et al., 2007; Browne, 1995; Kenny, 2007), we suggest that the current health and social patterns of First Nation and Inuit communities may be better understood if we draw from holistic frameworks of health, those which connect the health of individuals to the health status and behaviours of their families and communities. In the following paper, we draw from narrative analysis of qualitative interviews with Community Health Representatives (CHRs) from 26 First Nation and Inuit communities to critically examine the health and social support relationship, and the social structures through which social support influences health.

Connecting individual to community: Indigenous concepts

On a global scale, Indigenous models of health and healing place distinct emphasis on the larger social system within which the individual lives. Concepts such as balance, holism, and interconnectedness are regarded as keys for healthy living among Indigenous communities around the world (Australia, 2004; Bird, 1993; Casken, 2001; Durie, 1994). Indigenous conceptualizations recognize that individual health is shaped by features of the larger social context, including family, community, nature and Creator. An individual must therefore consider the results of his/her actions and behaviours within a greater scope of life and being (Casken, 2001), and at the same time, an individual's health and well-being depend on the wellness of those surrounding him or her (Durie, 1994).

Canada's Indigenous communities have historically been highly integrated places, and the role of the family has been critically important for personal and community well-being (Barsh, 1994; Royal Commission on Aboriginal Peoples,

1996). Family signifies the biological unit of parents and children living together in a household, but it also encompasses an extended network of grandparents, aunts, uncles, cousins and adopted kin. In many First Nation communities, members of the same clan are considered family, linked through kinship ties that may stretch back to a common ancestor in mythical time (RCAP, 1996). Under the rules of clan membership, individuals are required to marry outside the clan to which they belong. Over generations, this resulted in every family in a community being related by descent or marriage to every other family in the community (RCAP, 1996), thereby securing economical and social resources for these families, and underscoring the need to maintain good relations within communities. These tight-knit social structures are therefore mediated in important ways by the responsibility of Aboriginal peoples to their immediate social and physical environments, those which contribute to the balance of good health (Burch, 1986; Kirmayer, Simpson, & Cargo, 2003).

Contextualizing social support

Social support refers to the supportive behaviours and resources of our social ties, including emotional support, intimacy, positive interaction, and tangible support (House, 1981). These supportive behaviours operate at the levels of individual and community (Felton & Shinn, 1992; Thoits, 1995). Social embeddedness refers to the connectedness of individuals to others in their social environments (Barrera, 1986). This embeddedness provides an individual the opportunity to draw from the resources of their social ties. One's social ties are also embedded within broader social exchanges. At the community level, for instance, increased interconnectedness leads to greater network density and a greater propensity for sharing of information and social feedback which can 'correct' individuals as they deviate from course (Gottlieb, 1985). These high-density networks can also exert more conformity pressures and social obligations than can low density networks (Gottlieb, 1985).

In measuring the health-related functions of an individual's social embeddedness, Gottlieb (1985) defines three units of analysis: the micro-level, the mezzo-level, and the macro-level. The micro-level refers to an individual's most intimate relationships (e.g., intimate partner, spouse, confidant, and family), those who provide deep and nurturing emotional ties. The mezzo-level refers to those with whom the individual shares regular interaction and exchange of support, including advice, material aid, companionship, emotional nurturance and esteem. Gottlieb (1985) defines the macro-level as an individual's most distant social ties – these ties refer to one's social integration or participation at the community level (e.g., participation in volunteer organizations). The presence of varying levels of social structure is an important feature of the community context; the interconnected nature of these social institutions embeds individuals within the social context of their families and communities.

In the greater literature on health and social support, there are two fundamental assumptions regarding the health impact of one's social ties. The first assumption is

that social embeddedness is naturally health-promoting, and the second is that tight-knit social networks such as family and close friends lead primarily to improved health (Gottlieb, 1985; Rook, 1984). As Rook (1984, p 1106) points to, however, negative social interaction can actually have more potent effects on well-being than can positive social interactions. In her seminal study on the relationship between problematic social ties and health among elderly women, Rook (1984) found that 38% of those who caused problems for the respondent were identified as friends and an additional 36% were identified as kin. Similarly, Uchino et al. (2001) have found that network members who are sources of positive and negative feelings (i.e., ambivalent ties) may have detrimental physiological consequences for health. Thus, we cannot assume that friends and family are uniformly supportive or that one's increased social embeddedness will always improve health. Nor can we make assumptions about the quality of a social tie merely from knowledge of role relation (e.g., that micro-level ties (i.e., family) will be more helpful than macro-level ties (i.e., work colleague)).

Recalling the Indigenous concepts of health reviewed earlier, we witness some important conceptual similarities from the epidemiological literature regarding the pathways through which individuals and their well-being may be influenced by their embeddedness within their social contexts. Indigenous frameworks hold that health and well-being are shaped in significant ways by the larger social networks to which an individual belongs (Bird, 1993). The social roles and obligations associated with this embeddedness can powerfully affect one's health behaviours and life choices, therefore influencing the development of self-esteem, competence and sense of self or identity (Styrker & Burke, 2000). Sense of identity is formed within the context of meaningful social ties, for instance in one's role as friend, employee or mentor (Styrker & Burke, 2000). Our social ties influence health as they provide feelings of love and empathy, and as they enforce social pressure to engage in health behaviours (e.g., selecting food, exercise). Much of the prior research on social relationships and health has assessed only this single positive dimension of health (Uchino et al., 2001). However, these ties can affect health in negative ways as well, for instance by exerting conformity pressures that normalize health-damaging behaviours (e.g., smoking, risky sexual behaviour) (Burg & Seeman, 1994). The potential for social support to negatively influence health becomes increasingly apparent in populations that exhibit high levels of social support, but the effect of such embeddedness is not health-protective on its members (e.g., domestic violence).

In terms of epidemiological research specific to Indigenous populations, some studies have been instructive. Drawing from Canada's 2001 Aboriginal People's Survey, Richmond, Ross and Bernier (2007) found social support to be a consistent dimension of health among Métis and Inuit populations of Canada, and in a related analysis, Richmond, Ross, and Egeland (2007) identified social support as a strong determinant of Indigenous health, in particular among women. Cummins, Ireland, Resnick and Blum (1999) identified connection to family as a consistently powerful dimension of physical and emotional health

among Native American youth. In examining the factors that promote sobriety among Alaska Natives, Mohatt, Rasmus, Thomas, Allen, Hazel, and Hensel (2004) identify *ellangneq* – an interdependent, constitutive, or expanded sense of self found among many Alaska Natives – which links the individual to a collective context and protects health. That individuals of 'collectivist cultures' organize their sense of self and well-being according to practices that promote connectedness with others was also demonstrated by Hofboll, Jackson, Hofboll, Pierce and Young (2002) who compared the impact of sense of self-mastery ("I am the key to my success") to that of communal-mastery ("I am successful by virtue of my social attachments") among Native American women residing on Indian Reservations in Montana. Women high in communal-mastery experienced less increase in depressive mood and anger than women who were low in communal-mastery, particularly when faced with high stress circumstances. In another study, Marra, Marra, Cox, Palepu and Fitzgerald (2004) identified social support and functioning as a key factor influencing quality of life among patients with active tuberculosis. TB patients' social functioning was affected through isolation, variable social support by family and friends, and the ability to continue with social and leisure activities. In the following paper, we build on this small base of literature specific to Indigenous populations to examine the ways in which individual health may be influenced by virtue of their social embeddedness.

Methods

The research described in this manuscript contributes to a larger mixed-methods study seeking to understand how Canadian Aboriginal peoples' health is influenced by varying aspects of their social environments. Earlier quantitative findings identified social support as a strong dimension and determinant of Aboriginal health (Richmond, Ross, & Bernier, 2007; Richmond, Ross, & Egeland, 2007). Limitations related to the quantitative stage of this research left important questions unanswered, and we recognized the need to draw from more interpretive approaches for better understanding how one's social embeddedness within their families and communities can impact health.

This paper draws from narrative analysis of interviews with a national group of 26 First Nation and Inuit Community Health Representatives (CHRs), which occurred in 2005. Across Canada, there are roughly 1000 First Nation and Inuit CHRs present in 577 First Nation and Inuit communities, and 90% of the CHRs are women. CHRs were chosen as interviewees for this study through a purposive sampling strategy, the strength of which lies in the selection of information-rich cases (Miles & Huberman, 1994). CHRs are front-line community workers who perform a broad range of health-related functions ranging from environmental health to health delivery, medical administration, counseling and home visits, education and community development, and mental health. These services are critical in rural and remotely located First Nation and Inuit communities who do not have a permanent physician. CHRs are well integrated within their community's

everyday context and they hold localized, cultural knowledge of health and wellness. In 1986, the National Indian and Inuit Community Health Representative's Organization (NIICHR) was formed following the first national CHR conference; NIICHR is accountable to political leaders in First Nation and Inuit communities through their own CHRs.

Qualitative research in the field of health geography seeks to understand the 'situated' experiences of health and health care, and the meaning people attach to them (Eyles, 1985; Kearns, 1997). The nature of qualitative inquiry forces researchers to recognize the interplay between the humanity of the people they study and their own humanity as well, thereby acknowledging that researches are not independent from the *researched*, but that they are a *vital part* of the research process (emphasis added) (England, 1994). Indeed, the positionality of the lead author, a First Nation researcher who had previously conducted research with Canadian Aboriginal communities, was a significant factor in the development of our interactions with NIICHR, including the establishment of a research protocol, meaning the rules and expectations through which the research would be conducted. The development of this protocol was significant as there is no golden rule that determines best ethical practices for research with Indigenous peoples and communities (Cochran et al., 2008). The development of research agreements with Aboriginal communities is exceedingly important for ensuring that research promotes a process of learning and sharing that benefits both the researcher and the researched (Castellano, 2002).

Through consultation with the Executive Director of NIICHR, which included numerous telephone calls, e-mails and meetings, we came to agreement on the sorts

of research questions to be explored in the interview (see Table 1); these interview questions were also based on the academic literatures of Aboriginal health, population health and social support. NIICHR was very supportive of this research and they expressed a satisfaction that this research would promote a two-way capacity-building process. NIICHR invited the lead author to attend their Annual General Meeting (AGM) to initiate the data collection (see Table 2 for conditions of NIICHR's support).

During the AGM, the lead author had the opportunity to interact with CHRs from across Canada as she attended various training sessions and focus groups organized as part of the three day meeting. During the first few days, she took on the role of participant observer and listened as CHR's spoke about their work, their perceptions about the communities they lived in, and challenges to healthy living. This meeting gave insight into the local community contexts of the CHRs and provided the lead author with indication of how the interview questions would be received. These few days were also important for building trust and establishing a rapport with the CHRs. By the end of the AGM, the lead author had recruited 39 CHRs from various First Nation and Inuit communities representing all provinces, and three Arctic regions of Canada.

Given the broad geographic dispersion of the recruited CHRs (see Table 3), conducting face-to-face interviews was not feasible. In-depth interviews with 25 of the CHRs occurred on the telephone and one interview occurred face-to-face. The major advantage of telephone interviews over face-to-face interviews is cost efficiency (Fenig, Levay, Kohn, & Yelin, 1993; Marcus & Crane, 1986), and in this study, it allowed a breadth of CHR voices to be captured

Table 1

Interview checklist

Health	
-	What does good health mean to you? Poor health?
-	Would you say that people in your community are healthy? Why, why not?
-	Is the health of people in this community better today than it used to be in the past? Why do you think that is?
-	Can you think of someone in your community that has good health?
-	What is it that makes that person healthier than others?
Social support	
-	Social support is generally defined as having someone you can count on in times of need – for instance if you need a hug, if you want to talk, if you need advice, or if you need someone to baby-sit your children – who do you count on in times like this? Family/cousins/employer/friends/church/etc.?
-	Do people in your community have someone to rely on when they need support?
-	Do you think people in this community have good social support? Why/why not?
-	Are there people in this community who do not have such support? (young, elderly, certain professions?) Why is that?
Types and sources of social support	
-	Would you say that this community helps one another? Do people like to help one another? For instance, cutting wood, helping elderly get groceries, give a ride to the city?
-	Would you say families are affectionate with one another in your community? Moms and children? Husbands and wives? Why do you think that is?
-	What sorts of things do people in your community do to socialize and have a good time?
-	Who might community members seek advice from if they needed it? i.e., with finances, family, education, job, etc.
-	What do you think the main social problems facing your community are?
-	In your experience as a CHR, how does social support impact upon community health?
Health and social support	
-	Do you think that having good social support might make someone a healthier person? Why?
-	Think of someone in your community with good social support. Would you consider that person to be of good health? Why/why not? Are there other things that make that person's health good as well?
-	How does the health of your community compare to that of other communities (North versus south, isolated, urban, etc.)
-	Are the differences related to the 'place' of the communities or would you say is it the people within the communities?

Table 2
Conditions of NIICHRs support for this research

- A full ethical review of the qualitative research intents from McGill University's Review Ethics Board;
- Research recruitment efforts would not compromise CHR participation at NIICHRs 2005 Annual General Meeting;
- There would be no overlap with NIICHRs research on CHR responsibilities;
- CHR could withdraw from the research at any time;
- CHRs would be compensated for their interviews.
- Copies of the interviews would be provided to CHRs.

from First Nation and Inuit communities in various geographic regions across Canada. A limitation of this method is that it can be difficult to establish trust via telephone interviews which can significantly impact the information that interviewees are willing to share. However, telephone interviews have been validated as a methodologically valuable data collection technique (Sweet, 2002), in particular when they follow initial face-to-face meetings (Marcus & Crane, 1986). We found the use of telephone interviews an important method as it gave the CHRs a relative blanket of anonymity. The physical distance between the interviewer and the interviewees during the telephone call translated into greater security and increased willingness to discuss more sensitive topics (e.g., alcoholism, family violence).

Table 3
Community characteristics of CHRs

Geographic region	First Nation/Inuit ^a	Location ^b
Nunavut	Inuit	Remote
Labrador	Inuit	Remote
Manitoba	First Nation	Remote
Yukon	First Nation	Remote
Northwest Territories	First Nation/Métis	Remote
Northwest Territories	First Nation/Inuit/Métis	Remote
Ontario	First Nation	Remote
Quebec	First Nation	Remote
Quebec	First Nation	Remote
British Columbia	First Nation	Rural
British Columbia	First Nation	Rural
British Columbia	First Nation	Rural
Alberta	First Nation	Rural
Alberta	First Nation	Rural
Alberta	First Nation	Rural
Saskatchewan	First Nation	Rural
Ontario	First Nation	Rural
Ontario	First Nation	Rural
Ontario	First Nation	Rural
Quebec	First Nation	Rural
Quebec	First Nation	Rural
Quebec	First Nation	Rural
New Brunswick	First Nation	Rural
Nova Scotia	First Nation	Rural
Prince Edward Island	First Nation	Rural
Quebec	First Nation	Rural/urban

^a Refers to the community area served by the CHR.

^b Rural areas as sparsely populated lands lying outside urban areas (i.e. those with population densities lower than 400/km²), and remote areas refer to communities in the territories, and/or those CHRs who work in nursing stations or outpost settings. Urban areas are those adjacent to and/or connected (via transit, commuter patterns and economic exchange) with census metropolitan area or metropolitan area.

As a result of the relatively small populations of the communities represented in this research (i.e., from <100 to 3000), CHRs are well positioned to comment on the health and social patterns they see in their communities through their position as CHRs, and also in their roles as community members, friends and family members. Interviewees ranged in age from their late 20s to their early 60s, and all but one of the CHRs was born and raised in the community they now work in. Most had left their communities only to seek post-secondary schooling and many commented that they worked as CHRs because they wanted to help their communities. This is significant as First Nation and Inuit communities endure a disproportionate burden of disparity related to mortality (e.g., suicide in particular) and preventable disease, workforce participation, poverty, education, sub-standard living conditions, and crowding (Adelson, 2005). The burden of health and social disparities borne by these communities is rooted fundamentally in colonialism and a historically marginalized position within the Canadian social system (Waldram, Herring, & Young, 2006).

CHR were provided with copies of the interview checklist before the interview, and many expressed that they had considered their responses in advance of their interviews. In fact, some CHR voiced that they had sought feedback from their friends, family and co-workers prior to the interview. Informed consent was sought prior to all interviews as was mandated by the Ethics board of McGill University. The lead author conducted all interviews from June to August 2005, and the interviews ranged in length from 45 to 90 min. All interviews were conducted in English and were tape-recorded, with permission by the CHRs. To maintain consistency, all interviewees were asked the same questions in the same order and the CHRs were encouraged to draw from their experiences, perceptions and personal stories to illustrate their understandings of the topics covered in the interview. The fact that the interviewer had met with all CHRs prior to their interviews was critical for building trust, and in fact, many of the CHRs expressed an increased level of security in sharing their stories with a First Nation researcher.

Once transcribed into electronic format, hard copies of the interviews were mailed to all participating CHRs for their input or clarification, and none proposed changes. The interviews were analyzed primarily by the lead author and a research assistant. The data were organized through the method of coding, a technique used to connect data, issues, interpretations, data sources and report writing (Miles & Huberman, 1994). Coding has also been labeled as content or narrative analysis (Berg, 1998). To facilitate coding of the interview data, the first step entailed careful labeling and sorting of the data into themes and sub-themes. These sub-themes merged as components or fragments of ideas or experiences, which are often meaningless when viewed alone (Miles & Huberman, 1994). During this part of the analysis, a number of unedited phrases were selected from the interviews that most appropriately described respondents' insights about varying issues related to social support and health. These quotations are those which were included in the results, and pseudonyms have been used to protect the identity of the interviewees. In

this stage of analysis, the utility of narrative analysis shone as a key analytic strategy for understanding how one's health is implicated in positive and negative ways by the virtue of their social ties. Narrative analysis is a form of interpreting a conversation or story in which attention is paid to the evaluations of the speaker and their local context (Kearns, 1997; Popay, Williams, Thomas, & Gatrell, 1998; Wiles, Rosenberg, & Kearns, 2005; Williams, 2003). Through narrative analysis, researchers can understand 'the contingent, the local, and the particular' (Wiles et al., 2005), thereby connecting the speaker to varying levels of social context at once. In this research, CHRs discussed their perceptions about how individual health is affected by their social ties to their family and community, and they were able to articulate these perceptions in the context of their professional and personal capacities. Narratives of experience and life story enable a more nuanced understanding of the cultural and geographic processes that can shape the way societal resources are understood and accessed by Aboriginal people (Browne and Smye, 2004).

Results

We present the results describing the health impact of social support across varying social-structural levels, beginning with the individual (i.e., micro-level) and moving outward to family (i.e., mezzo-level) and community (i.e., macro-level) (Bird, 1993; Gottlieb, 1985).

The individual

CHR described the influence of social support on individual health across four interconnected dimensions that work at the psychological level – physical, mental, emotional and spiritual. CHRs indicated that social support is strongly connected to mental and emotional health. Intimate (i.e., family) and institutional (i.e., paid workers) supports are significant for the development of one's psychological resources, including self-esteem, confidence, and sense of purpose:

Self-esteem is the foundation to health...in order for a person to feel good about themselves... If the person feels in their heart and soul that they have some good qualities, they are able to cope with issues (**Annie**).

Social support also provides one with a sense of security and assuredness. As CHRs discussed, often the mere act of talking over a problem can help one feel less burdened. Verbalizing a problem can also bring clarity to an issue, which may enable the individual with an improved sense of self-esteem and confidence in their abilities to deal with other stressors.

CHR also discussed the role of social support for improving an individual's sense of spirituality, which is important for health. Similar to the impact of social support upon mental and emotional health, CHRs expressed a strong sense of belonging and purpose related to one's spiritual orientation and the activities celebrated by those who share these beliefs. Being in the presence of other like-minded people, those who share similar goals and

beliefs about their place in the world, can greatly enhance one's psychological well-being as the ideals of their faith are acknowledged and respected:

I think that inner culture is really important, like people who are following more traditional ways, or traditional forms of lifestyle...They teach you how to take care of yourself first, and how to look after your family, and how to interact with different people (**Michelle**).

Finally, CHRs defined a strong connection between social support and physical health. In the majority of examples, CHRs connected improved access to health information with the development of healthy choices and behaviours among their community members. For instance, many CHRs mentioned the positive impact of hosting health education seminars in their communities (e.g., hand-washing, cooking classes):

As CHRs, we see it all the time... People come in and they want to know how to lose weight or whatever, so we give them information on nutrition and exercise. From our support, sometimes they succeed (**Norma**).

CHR voiced the perception that as the individual gains access to health information, they can draw upon that knowledge to live healthier lifestyles and consequently, teach their family members and friends as well. Institutional supports, those paid to provide support through formal community institutions such as a women's support group or as an employee at a teen centre, are also important for providing places wherein individuals can escape the pressures and responsibilities of their intimate social roles and obligations. CHRs were adamant, however, that in spite of the health promotion efforts of institutional supports, individual community members are often limited in significant ways by their own poor material circumstances. Widespread poverty prevails in many First Nation and Inuit communities, and this can be particularly challenging in northern and isolated First Nation and Inuit communities wherein the cost of living is double to triple that of southern Canada. As Delores describes, the high cost of living is problematic for her community members:

If you choose a healthy lifestyle it is really expensive, and a lot of our members here don't have that benefit so they can't really do it... They will make the small choice of buying the odd fruit and vegetable, and in my role as a CHR I try and stress that they need more good foods, but I know in my heart that they can't afford it, so that's the problem we have is the dollars (**Delores**).

CHR defined community events, activities and resource centres as safe environments, those that encourage a sense of belonging, cultural identity and good health. Such resources are especially important among individuals who endure adversity in their home environments such as alcoholism or violence. As Julie explains, however, individuals may not take the steps to draw from these resources to learn about living healthier lifestyles because, at the psychological level, their behaviours and feelings have become normalized by their social context:

Maybe the person doesn't want to change. Or maybe they are always [feeling] down or they think negatively because people [close to them] always put negative things in their head. Now how can that person think positive when there is all that negative stuff in their life? (Julie).

As Emma describes, individuals may decide not to reach out to available social supports because they have grown accustomed to the social context of their family environments:

There are also times when you see the negative social support. Individuals are looking for help. They are reaching out, but all around them, people seem to be doing the same thing they are, the drugs and alcohol (Emma).

Family context

As reviewed earlier, family and home are important symbols of safety, strength, comfort and unity. All CHRs described the family as the most powerful institution through which social support influences health:

Family is the key here. A lot of them [community members] that moved off the reserve for a better life, they end up coming back home. I think it's just because they find it safer than when they are off-reserve. The world changes so fast and so much...but you always know you can go home to family (Delores).

The family unit provides the individual with a sense of love, affection and belonging. Being part of a family reminds the individual that they are responsible not only for their own health, but for the security of their family members as well. As Debbie relates to her own personal experience with alcoholism, her decision to get sober and healthy stemmed from her motivation to be the best mother she could be:

I grew up in an alcoholic home, and I now have children of my own. I was young when I started having my children and I thought, I don't want them going down the same path as my family and myself, so I quit drinking...It was all for my children (Debbie).

Beyond the love and affection shared within the family context, the family unit is also critically important for pooling financial and intellectual resources, which are essential when trying to solve problems or make decisions. As Martha explains, her family has grown closer through their abilities to communicate:

What has really helped me and my family...is having a family conference... We just let the kids talk about any kind of issue that they have... It is good, we have good communication and that makes a big difference... That is one good way of getting involved with your family, is communicating (Martha).

A troubling issue raised by a number of CHRs, however, points to the fact that the family unit can also permit forms of love and belonging which may be better described as

dysfunctional. As is the case in many First Nation and Inuit communities, legacies of abuse and family violence can significantly impact one's ability to display loving and nurturing behaviours toward their families (Richmond, 2007). Overtime, these behaviours can become normalized. Diane explains that because of abusive pasts, some parents are unable to openly display acts of love and affection:

Not all families are like that [loving]... It is the way they have been brought up... I noticed a couple of families here that are not very affectionate with each other. I never see them giving them a pat, or say like if you are watching a ball game and one of these children are playing in the game, they don't say like "hey that was good, good job out there, that was a good play you did," they never say that, they just stand there and look (Diane).

The family context is the origin through which individuals learn social norms and behaviours. Core values, ideals and behaviours are permitted early in life through the reassurance and feedback received from those closest to the individual, typically family members. The family can therefore influence an individual's health as it normalizes and encourages health-promoting or health-damaging behaviours. The effects of negative health behaviours can have devastating consequences for families, particularly when they occur in response to larger social problems, such as poverty:

Many in this community are financially challenged and it's harder for them to catch up and keep up with the 'in things,' which is especially hard on the children. For instance, now parents need to buy 2 pairs of shoes for their children [for school]. It's hard on one's health because they can't provide all the things for their family that they would like to. We often see increases in alcohol, drug, or prescription drug abuse, as people are trying to cope with those things, and it affects their health and their family's health as well (Michelle).

The social institutions of a family can make it difficult for an individual to change health behaviours once they have become an entrenched feature of family life. The social bonds and sense of belonging associated with the family context, therefore, can be harmful and helpful for health. Through the example of a teen returning home from drug and alcohol rehabilitation, Laura describes how the family can actually sabotage the recovery process:

It is a whole life change, yeah when you get sober, and then when people go away for treatment and they come back [like if it's a young person] they have to come back into the same house. And the people are all still doing it [the drugs, the alcohol, the abuse]. They don't have the kind of support they need, they don't have a chance (Laura).

Community context

CHR perceived the supportive behaviours of the community to influence health in both positive and negative ways. In the context of organized social events such as

picnics, community celebrations, dances for instance, CHRs described these events as crucial forms of positive social interaction and important for getting people together for fun:

They have dances for the young people, then they will have dances for the older generation like the fiddle playing and all that, then they will have concerts... We also have summer festivals... We just had one this weekend. Fun days for the kids at the beach all summer, BBQs, and they hire a clown... So all day Sunday that's what they did, and oh, the people that showed up! (**Sandy**).

These events are not only sources of fun, however, but also important ways to promote positive lifestyle choices and to keep cultural traditions alive:

Every now and then we have be sober dance, and that is a big hit because we specify that it is alcohol free, and drug free type of thing where everyone is welcome (**Martha**).

As Martha alludes to, many First Nation and Inuit communities have struggled, and continue to struggle, with alcohol and drug addictions. 'Dry' dances are drug and alcohol-free events. CHRs spoke of these events as fun, safe places for their communities. Events such as these are necessary in communities wherein there may not be many other safe social outlets for community members. The 'recovery movement,' which refers to the process through which individuals and their families recover their lives from cycles of alcoholism, drugs, and abuse, is very strong in many First Nation and Inuit communities. As Emma explains, her community is taking the steps it needs to reconcile its social problems, therefore making the community a healthier place to live:

We are starting to change now, and I think it is going to be for the better. We have a big struggle on our hands to make our community a better place, and we need to start with the community members, and what they want and need to have a more positive life... Things are starting to change now, slowly, very slowly, but they are changing (**Emma**).

In many communities, these positive changes are occurring through established support programs wherein individuals can learn the skills needed to live a healthier lifestyle (e.g., alcoholics anonymous, drug rehabilitation, nutrition and parenting classes). However, such institutional supports are not always perceived as accessible by community members (Richmond, 2007). Issues such as community politics and the legacies of colonialism can work to reduce levels of trust, thereby preventing community members from seeking the institutional supports they require:

If you don't trust anyone, how are you going to be able to work with the people? So that's a big thing: trusting. A lot of people don't speak of their past unless they can trust you. Small communities always gossip. That's a major problem up here (**Martha**).

Beyond issues of lacking trust, logistical issues are also important, as institutional supports are available only during work hours. This means that during evenings and

on weekend, the support of the health workers and their programs may not be available:

When they need to talk, they will come and talk to somebody that works here [health centre]. They don't really have the type of friends that they can trust. They feel more comfortable to come here and talk to somebody... But that does nothing for them on the weekend if they are in the middle of a crisis and we are closed (**Laura**).

While the community context of First Nation and Inuit communities can positively influence individual health through provision of programs and services, individuals are also exposed to the social pressures of their community ties and friends which can support behaviours that are health-promoting or health-damaging. As was reviewed in an earlier section, healthy living does not occur in isolation. One's success is strongly influenced by the social norms and cultural contexts of their friendships, as well as those they interact with on an everyday basis, such as fellow employees:

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. They are separated from them (**Laura**).

As Laura explains, it can be easier to succumb to the pressures of one's social contexts than it is to be socially isolated. However, as individuals attempt to improve their health behaviours and lifestyles, they often have no choice but to limit contact with members of their social context, which can include their friends and families:

They try to have a positive lifestyle, but it's the friends around them that are doing the exact same things they are [drinking]. They don't realize that they have to change their circle of friends in order to make themselves better... You have that loyalty. They don't want to lose these friends because they have known them so long, and some of them are family members. For someone to quit doing drugs, it would practically mean leaving their families as well (**Emma**).

In some cases, this may mean physically removing one's self from their communities, for instance by moving to a new community. Nora explains how her husband had to do just that as he conquered his battle with 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**).

Discussion

Our analysis draws from cultural (Bird, 1993) and epidemiological frameworks (Gottlieb, 1985) to critically examine the social structures (i.e., individual–family–community or micro–mezzo–macro-levels) through which social support influences health in First Nation and Inuit communities. CHRs explained that social support is fundamentally connected to sense of belonging, which is established through embeddedness of individuals within their family and community contexts. Such embeddedness is critical for the development of self-esteem and identity formation, and also for learning the ideals, behaviours and expectations of one's social context. Associated with this context are a set of rules which an individual obeys in the maintenance of their social embeddedness, such as attendance at family holiday meals, weekly telephone calls. Participation in the social activities and behaviours associated with the family and community contexts are important as they reinforce an individual's sense of belonging. Over time, these social activities and behaviours become normalized, and a culture of expectation is created.

While sense of belonging is critical to the development of an individual's sense of identity, for instance as a sister, friend or employee, the CHRs interviewed in this research study expressed an overwhelming concern that not all forms of belonging are uniformly health enhancing at the psychological level. Our results beg the generally held assumption that social integration works primarily as a health-protective resource, in particular that related to tight-knit social relationships such as family. Indeed certain social and cultural institutions through which individuals develop sense of identity can sometimes harm health, for example in the case of domestic violence (Mitchell & Hodson, 1983; Muhajarine & D'Arcy, 1999) or smoking behaviour (Stead, MacAskill, MacKintosh, Reece, & Eadie, 2001). These institutions can set an individual on a destructive trajectory, as they idealize, promote, or 'trap' individuals within these health-damaging behaviours. Because of the conformity pressure and loyalties one feels toward their families and friends, it can be very difficult and even impossible to disobey the social rules associated with these relationships. In the event that an individual seeks positive change, they may be restricted by the very nature of their social embeddedness, which exerts a high level of social pressure to conform to expected behaviours and cultural norms (Gottlieb, 1985). In the example of battered women, for instance, Mitchell & Hodson (1983) suggest that separation from their husbands may mean disruption of a major portion of their social ties. As many CHRs in the present study discussed, lifestyle changes often require individuals to physically remove themselves from the social environment which had enabled these health-damaging behaviours. Indeed, while these changes are considered necessary for improved health, they can leave the individual feeling lonely and isolated, and in some cases individuals may not have the material resources they require to leave, or become independent of, their social connections. This issue can become even more complicated by the geographical context of First Nation and Inuit communities. As many of these

communities are located in northern and/or remote locations, leaving one's community may require significant resources and long distance travel.

In terms of improving health among First Nation and Inuit communities, our results emphasize that individual health behaviours are invariably reflective of the social norms, values and expectations held at the family and community levels. Changes in the health and wellness of individuals must therefore be rooted in efforts that focus on large-scale social investments, those that involve families and communities in health promotion. CHRs were adamant that local governments must play a role in facilitating these changes through policy interventions and programs that increase opportunities for positive social interaction and health education at the family and community levels. Community and nation-wide celebrations (e.g., National Aboriginal Day), cultural events and other social events provide opportunities for community members to connect with and learn from one another in settings that will work to normalize healthy behaviours. These events are critical for improving sense of belonging, sharing information and promoting success among those individuals currently engaged in the recovery process. From the social capital literature, other authors (Cattell, 2001; Ferlander, 2007; Mignone & O'Neil, 2005) have pointed to the mixed health outcomes related to bonding social capital (e.g., homogeneous networks based on similarity in terms of age, gender, social class), such as that described here. These authors advocate the need for bridging social capital (e.g., heterogeneous, outward-looking networks that extend across social groups) that which enables an individual and community with resources and opportunities (e.g., employment, education) that extend across a wide social network to improve health. As Mignone and O'Neil (2005, p 31) point to, 'communities with flexible, inclusive and diverse networks tend to develop a social environment more conducive to health because fewer people will be left out of opportunities, dialogue, information and resources.'

CHR's also acknowledged the dire material circumstances that characterize the self-esteem and confidence of their communities as a whole. In 2005, for instance, the unemployment rate of the Aboriginal population was 2.5 times that of non-Aboriginal population. CHR's identified the negative dimensions of social support as symptomatic of larger structural problems, including stress related to poverty and psychological stress. In another related analysis (Richmond, 2007), CHR's identified strong links between declining levels of trust in First Nation and Inuit communities, dependence on government, and reduced access to social support. Indeed, the poor material circumstances that plague so many First Nation and Inuit communities cascades from the community level and down to that of the individual, wherein poverty manifests as widespread social dysfunction, indicated by high rates of substance abuse and violence. Part of the solution to improved social environments for First Nation and Inuit populations must therefore come from structural changes at the macro-level, those that work to shift cycles of poverty and poor health to that of healthy, autonomous communities. As CHR's pointed to improved health behaviours are important at the individual and family levels, but large-scale material

investments are also fundamental for initiating change in the social environments of these communities, and providing brighter futures for the growing population of Aboriginal children and youth. Individual community members can learn to live healthier lifestyles, for instance by recognizing the need for a nutritious diet, but if the social environments of First Nation and Inuit communities continue to be marked by poverty, legacies of abuse, and inadequate employment opportunities, the success of such efforts will be gravely compromised. While CHRs admitted that social and behavioural changes in their respective communities will take time, all were optimistic that positive changes are possible through determination by local and national decision makers, and the commitment by community members themselves to work toward making their communities healthier places. Community planners and national advocates for health and social programming must do more to initiate and support the positive changes occurring within First Nation and Inuit communities; this is important for ensuring that when individuals are ready to make changes to live healthier lifestyles, they have access to the social and material resources they need to succeed.

Conclusion

Previous work in this area of research has focused almost exclusively on the health-enhancing dimension of social support. In this paper, we have taken a more critical look at the health–social support relationship and its potential for affecting health in a negative way. Based on in-depth interviews via telephone with 26 First Nation and Inuit CHRs, our findings indicate that there are health-enhancing and health-damaging properties of the health–social support relationship, and that the negative dimensions significantly outweigh the positive ones, particularly when they operate in response to poor material conditions. Social support operates at different structural levels, beginning with the individual and extending toward the family and community. The social activities and behaviours associated with these varying social networks are important as they reinforce an individual's sense of belonging. As Gottlieb (1985) argues, however, though increased interconnectedness may lead to greater network density and a greater tendency for sharing of information and other health-enhancing properties, high-density networks can also exert more conformity pressures and social obligations to behave in health-damaging ways. We have illustrated that social support can impact health in both positive and negative ways, and the assumption that tight-knit social ties (i.e., family, partner) always lead to improved health is critically flawed.

Within the Aboriginal health literature, there has been little critical analysis of the means through which social ties influence health at the individual, family and community levels. First Nation and Inuit communities are highly integrated places and the social structures of these communities are often quite complex, mainly because community members are so interconnected through family, work and politics, among other social structures. The results of our analysis suggest it is through the normalization of negative health behaviours by family, friends and greater

community that poor health is proliferated in the community contexts of the First Nation and Inuit CHRs who participated in this study. The poor material circumstances that tend to characterize these communities add yet another layer of complexity to this relationship, as it significantly reduces the autonomy of individuals to make choices that run counter to prevailing norms. In this context, opportunities for change may be stifled as individuals are bound by limited income and dependence on family and/or community resources. Research, policy and interventions must therefore pay close attention to the social context within which health behaviours and material circumstances interact to influence health outcomes among First Nation and Inuit communities.

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