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The effect of social support on the health of Indigenous Australians in a metropolitan community

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ABSTRACT

The factors driving the disparity in health outcomes between Indigenous and non-Indigenous Australians continue to be poorly understood. Despite this, studies confirm that social connections are a very important part of Indigenous life, and it is likely these connections play an important role in influencing health outcomes among this population. Examining the support provided by social connections in relation to health behaviour may assist our understanding of health outcomes among Indigenous Australians. The current study is focused on exploring Indigenous participants' impressions of their social network and social support using Participatory Action Research methodology and qualitative methods. The objective was to identify the influence of social support on the health outcomes of Indigenous people within a Western Australian metropolitan community. Seventeen members of the community were interviewed during the study. The participants had extensive social networks that mainly comprised members of their kinship group. The consequences of this social network included: (1) the positive effects of social support from bonded relationships; (2) the negative effects of social support produced by over-obligation and unidirectional support involving bonded relationships; (3) limited or inadequate social support caused by withdrawal from bonded relationships; (4) lack of social support from bridging relationships; and (5) a strong desire for connection and a sense of belonging.

1. Introduction

The current discrepancy between Indigenous and non-Indigenous Australians' life expectancy (10.6 years for males and 9.5 years for females) is an ongoing issue and is attributable to differences across a range of health outcomes, including chronic disease, disability, and injury (Australian Bureau of Statistics, 2012). Research indicates that a substantial portion of the health gap between the two groups can be attributed to social determinants (Anderson, 2007; Booth and Carroll, 2005). The World Health Organisation lists social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport as the major social determinants that contribute to health status (Wilkinson and Marmot, 2003). While it is recognised that Indigenous Australians are affected by these determinants, particularly those related to high levels of unemployment (Australian Bureau of Statistics, 2011a; Carson et al., 2007), additional factors that influence this group include the effects of marginalisation, discrimination, and racism (Larson et al., 2007; Paradies and Cunningham, 2012; Priest et al., 2012; Priest et al., 2011; Ziersch et al., 2011a, 2011b). In addition, it has been suggested that government laws and policies may affect Indigenous people's health status by reinforcing detrimental practices and attitudes (Hunter, 2000; Reynolds et al., 2007).

Theories and frameworks have been developed to illustrate the link between social determinants and health outcomes. They depict a multilevel structure involving three discrete yet closely interrelated levels: upstream, midstream, and downstream (Berkman and Glass, 2000; Carson et al., 2007; Turrell and Mathers, 2000; Williams, 1997). The upstream (macro-level) factors include the socioeconomic determinants of health and societal practices such as racism and discrimination. The midstream (intermediate level) factors include psychosocial aspects that pertain to the influence of social factors on an individual's mind and behaviours. The

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downstream (micro-level) factors include changes to physiological and biological functioning brought about as a consequence of influencing factors operating at other levels.

These conceptual frameworks indicate that midstream factors such as social support, defined as resources provided to people in the context of formal and informal helping relationships (Gottlieb and Bergen, 2010), can intervene in the causal flow between upstream factors and health outcomes (Berkman and Glass, 2000; Turrell and Mathers, 2000). Prior research indicates that social support can be examined within the broader context of social capital, which includes the processes that led to the support, the support itself, and the outcomes of the support (Carpiano, 2006). Alternatively, social support can be examined in a more discrete context where the focus centres on exploring the outcomes of the support (Carpiano, 2006; Croezen et al., 2010; Gottlieb and Bergen, 2010). These support resources include emotional support, intimacy, interactions, and tangible support (House et al., 1988). Social support usually originates from relationships made within an individual's social network (Gottlieb and Bergen, 2010). Therefore, the identification of these networks is paramount when investigating social support (Barrera, 1986). The relationships within an individual's social network are classified according to their level of association. According to Gottlieb and Bergen (2010), bonded relationships occur between intimate associates and, therefore, the individuals are usually from homogeneous backgrounds. In contrast, bridging relationships refer to associations between less intimately connected people, who stem from heterogeneous backgrounds (Gottlieb and Bergen, 2010). Bridging relationships provide opportunity to obtain information, advice, and practical assistance derived from a different perspective (Gottlieb and Bergen, 2010; Granovetter, 1973), which promotes psychologically and physically positive outcomes (McKenzie and Harpham, 2006).

Support gained from bonded and bridging relationships has been reported in the literature focussing on the social capital of Indigenous Australians (Berry, 2009; Brough et al., 2007; Browne-Yung et al., 2013). However, this research has focused largely on the circumstances that instigated these relationships, rather than the social support they facilitated (Brough et al., 2006; Brough et al., 2007; Browne-Yung et al., 2013; Ziersch et al., 2009). Cultural identity and shared history promoted bonded relationships between Indigenous people (Brough et al., 2006; Browne-Yung et al., 2013), while discrimination and historical encounters acted as barriers to the formation of bridging relationships between Indigenous and non-Indigenous people (Brough et al., 2006; Browne-Yung et al., 2013). Although valuable from a social capital perspective, this does not thoroughly address the outcomes of the support; social support research focuses specifically on the support afforded by the relationships forged within a person's social network (Croezen et al., 2010; Richmond and Ross, 2008).

Research investigating the link between social support and health has mainly focused on the protective (positive) effect of social support in relation to mortality, chronic disease, disability, depressive symptoms, and wellbeing (Croezen et al., 2010, 2012; Iwasaki et al., 2005; Kawachi et al., 1996; Shaikh et al., 2008; Veenstra, 2000; Ziersch et al., 2009). Social support also affects health behaviours such as physical exercise and smoking (Croezen et al., 2012; Hunt et al., 2008; Shaikh et al., 2008; Uchino, 2006; Weitzman and Kawachi, 2000). In some circumstances, social support can have a negative effect (Croezen et al., 2012; Richmond and Ross, 2008), and in such instances, high levels of social support do not have a protective effect on health (Richmond et al., 2007). The potential for negative consequences from social support becomes more apparent in populations where stressful circumstances such as poverty or discrimination are prominent (Richmond and Ross, 2008).

The influence of social support within Indigenous Australian communities has not been thoroughly investigated. However, it has been established that connections between individuals are particularly important to Indigenous Australians (Brough et al., 2004; Hunt et al., 2008; Reilly et al., 2008). This often results in bonded connections to a large family and community network, which provides many resources and reinforces cultural identity (Bond, 2005; Brough et al., 2006; Browne-Yung et al., 2013). Historically, Indigenous Australians have been linked through a complex kinship system that supported family and social structure (Beckett, 1988; Smith, 2004). Past policies that led to forced separations have eroded these traditions, which in some areas have resulted in present day challenges to the strength of this culturally based system (Morissey et al., 2007). Nevertheless, the social world of Indigenous Australians revolves around the bonded relationships formed with extended family members, which serves as a basis for individual and social identity (Schwab, 1988). Social engagement with non-Indigenous people appears to be hindered by discrimination and perceptions of negative racial stereotypes (Brough et al., 2006; Browne-Yung et al., 2013), and high levels of interpersonal and systemic racism towards Indigenous Australians have been reported in numerous studies (for example Larson et al., 2007; Paradies and Cunningham, 2009; Priest et al., 2011; Ziersch et al., 2011a). Further, the historic conflict surrounding the colonisation of Australia that involved the non-Indigenous colonisers' systematic attempts to oppress and assimilate Indigenous Australians has left a legacy of social disruption and separation (Dudgeon et al., 2010; Hunter, 1993). These negative interactions have also served to reinforce Indigenous cultural identity and the importance of connections between Indigenous people (Brough et al., 2006).

The present study focused on exploring Indigenous Australians' impressions of their social network and social support using a combination of qualitative methods and Participatory Action Research methodology. The objective of the study was to identify the influence of social support on the health outcomes of Indigenous people within Western Australia.

2. Method

2.1. Methodology

Participatory Action Research (PAR) methodology was employed throughout the study because it empowers and emancipates participants and is recommended when engaging marginalised groups such as Indigenous people (van der Velde et al., 2009). The PAR process encompassed collaboration and consultation with the participants and members of the wider Indigenous community. This involved: a committee comprising eight elders (leaders) and respected community members, who provided guidance during the research; two female community members who acted as liaison people to assist with the study; and a community feedback and consultation meeting. Prior to the study, the liaison people had been involved in capacity building within the community and were respected and trusted by the participants. Qualitative methodology involving interviews was also used for data collection.

2.2. Community

The study was conducted within a metropolitan Indigenous community located in the south west suburbs of Perth, Western Australia. This community was approached because of prior associations with the researchers. The community was serviced by a multi-cultural community centre, which was well regarded by the Indigenous community and was very supportive and sympathetic to the needs of the local Indigenous people. This centre was