"Sometimes you just feel like you have had enough":
A community-based study on men's experiences with stress

by

Caitlin M. Mills

A Thesis submitted to the Faculty of Graduate Studies of
The University of Manitoba
in partial fulfillment of the requirements of the degree of

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ABSTRACT

"Sometimes you just feel like you have had enough": A community-based study on men's experiences with stress

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Background: The health status of Aboriginal people in Canada is consistently poorer on all indicators compared with the health of the non-Aboriginal population of the country, and while significant attention has been drawn to this issue, there has been little improvement over the past three decades. The impact of stress (the deviation from homeostasis) on health has been established in the literature, and it has been suggested that the experience of biological and social stress needs to be further explored in relation to Aboriginal health. A focus on stress, however, must not simply look at stress experiences in isolation, removed from their particular contexts and focused solely on individual risk factor levels, but also address the broader social and environmental factors in stress.

Purpose: The purpose of this study is to examine the stress-coping strategies used by First Nation men living in a Manitoba First Nation community, as well as the kinds of changes they would like to see happen in their community in an effort to help individuals and the community deal with stress.

Methods and Analysis: This qualitative study involves a secondary analysis of interviews conducted with twenty-five adult men and women living in a Manitoba First Nation. The focus of this study is on the ten interviews conducted with the male participants. A purposive maximum variation sampling method was used to recruit participants for the original study with the assistance of two local community members. These interviews were semi-structured using open-ended questions that focused on how individuals talk about stress and coping. I used the transcriptions of these interviews to conduct a thematic analysis of the stress-coping dynamic among male adults in this community. Each line of the transcriptions was assessed and grouped into particular categories. I then developed a strategy for coding the information and paid particular attention to the topic of coping.

Benefit to the Community: This work fits into a larger study on diabetes that Dr. Sharon Bruce (University of Manitoba) and colleagues began several years ago. The relationship between stress and diabetes emerged as an important area of interest for community members. This First Nation is interested in using these data to help them as they develop programmes and targeted initiatives in their community.

CHAPTER ONE

Introduction

The health status of Aboriginal people in Canada is consistently poorer on all indicators compared with the health of the non-Aboriginal population of the country, and while significant attention has been drawn to this issue, there has been little improvement over the past three decades (Waldram et al, 2006; Adelson, 2005; Martens et al, 2002; Young, 1994). Lower life expectancies, increased morbidity and mortality rates, and an increase in the prevalence and incidence of chronic diseases, such as diabetes mellitus, have been documented in the literature on the health of Aboriginal people in Manitoba and Canada (Shah, 2004; Martens et al, 2002; Young, 1994).

The effects of stress, defined simply as the deviation from homeostasis (Chrousos & Gold, 1992), on health has been established in the literature (Lloyd et al, 2005; Kiecolt-Glaser et al, 2002a, 2002b; Surwit et al, 2002; Mooy et al, 2000; Haffner, 1998; Raikkonen et al, 1996; Surwit & Schneider, 1993), and it has been suggested that the experience of biological and social stress needs to be further explored in relation to Aboriginal peoples health (Mitchell & Maracle, 2005; Bartlett, 2003; Rock, 2003; Daniel et al, 1999a, 1999b; O'Dea, 1991). Stress can provide an interactive model by which the investigation into social and biological factors associated with health and disease can be assessed and adequately related to present-day conditions affecting Aboriginal Canadians.

In an attempt to consider the larger social and political context in which health and disease is produced, while positioning the experiences of Aboriginal Canadians within a framework that identifies the impact of colonization and structural violence on this community, I have conducted a secondary analysis of interviews with men living in a Manitoba First Nation that looks specifically at the sources of stress they identify in their lives and the coping strategies they have developed to deal with stressful situations.

Rationale

Stress is a phenomenon that has been given much attention by researchers across many disciplines, particularly by those interested in the psychology-disease relationship (Lyons & Chamberlain, 2006:142). Social stress and the effect the social environment has on individuals is seen as a powerful determinant of health and well-being (Mitchell & Maracle, 2005; Bartlett, 2003; Daniel et al 1999a, 1999b; Farmer & Ferraro, 1997; Taylor et al, 1997; Turner et al, 1995), and has been used to describe the situational factors that can have an impact on overall health (Fremont & Bird, 1999; Thoits, 1998; Link & Phelan, 1995).

There is some literature on the epidemiology of social stress including stressful life events and chronic stressors (Turner & Marino, 1998; Link & Phelan, 1995; Turner et al, 1995; Pearlin, 1989), and the impact of stress on the lives of Aboriginal peoples living with diabetes (Mitchell & Maracle, 2005; Iwasaki et al, 2005; Iwasaki et al, 2004; Bartlett, 2003; Rock, 2003). However, there are no data at the present time that are

specific to the stress experiences of Aboriginal adults living on-reserve in Canada and the coping mechanisms that they have relied on to manage this stress.

Mitchell and Maracle (2005) provide an overview of the concepts of historical and intergenerational trauma for Aboriginal people, but they neither use interviews nor personal narratives to really assess the stress experience for particular individuals, nor address the life-worlds of Aboriginal people trying to cope. Their focus is on fitting a model of 'post-traumatic stress disorder', which they wish to rename 'post-traumatic stress response', to Aboriginal people. Such an action further pathologizes Aboriginal Canadians by depicting them in a particular way. "To be identified as either 'sufferer' or 'victim' shackles individuals and groups to a particular history and burdens them with the responsibility for a history that was never theirs to decide," (Adelson, 2001: 78). It also fails to look at the coping mechanisms utilized by individuals and families.

I wish to suggest that we augment the existing framework that treats stress as an isolatable and de-contextualized factor. A focus on stress must not simply look at stress experiences in isolation, removed from their particular contexts and focused solely on individual risk factor levels, but also address the broader social and environmental factors in stress. Such an approach emphasizes the process, rather than the specific traits of persons involved, illuminating the social, political and historical context of the individual and the community. The inadequate attention to the stressful life experiences or the ability for men and women to cope in what are sometimes quite tragic circumstances, illustrates the need for further investigation into this aspect of Aboriginal health. Such

work has the potential to help support existing (local) initiatives to develop appropriate and meaningful programming in communities.

Background of the Study

My research is based on data collected in a community-based participatory study on the relationship between stress and diabetes in a First Nations community in Manitoba conducted by my thesis supervisor, Dr. Sharon Bruce. The diabetes and stress study arose out of a diabetes complications screening study when members of the community expressed interest in looking at the effects of stress on health. Working under the principles of OCAP [ownership, control, access, and possession][1], a governance structure was developed jointly by my thesis supervisor and the Community Diabetes Working Group. Twenty-five individuals were interviewed for the stress and diabetes study. My analysis is based on the interviews conducted with the ten male participants of the study.

Purpose of the Research

The purpose of this study is to examine the stress-coping strategies used by Aboriginal men living in a Manitoba First Nation community, as well as the kinds of changes they would like to see happen in their community in an effort to help individuals and the community deal with stress. The research questions framing this study are the following:

- What are the major sources of stress identified by men in a Manitoba First Nation?

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[1] The principles of OCAP were developed by the Steering Committee of the First Nations Regional Longitudinal Health Survey, and are discussed as an expression of self-determination in research. See also Brian Schnarch, 2004. "Ownership, Control, Access and Possession (OCAP) or Self-Determination Applied to Research: A Critical Analysis of Contemporary First Nations Research and Some Options for First Nations Communities." *Journal of Aboriginal Health; January: 80-95.*

- What are the techniques community members have developed to cope with stress?

- Do community members identify coping strategies beyond the individual level? In other words, are coping strategies identified at the individual, family and community levels?

- What kinds of resources do community members identify as required to alleviate stress?

The questions regarding coping and community resources have especially important implications for programme development and individual-level as well as community-level strategies. These issues are important to address because they delve into a contextual analysis that is necessary for better appreciating the situational factors that are involved in shaping the bodies of individuals, social groups and entire communities. If, as Kleinman argues, "symptom and context can be interpreted as symbol and text," (1988:42), then the (con) text can be extended to explain the meaning of the symptom which holds some symbolic value. If the text is read, the symbols can be illuminated.

Benefit to Community

My work fits into a larger study on diabetes that Dr. Bruce and her colleagues at the University of Manitoba began several years ago. The relationship between stress and diabetes emerged as an important area of interest for community members of various ages, likely because it resonated quite deeply with many members of this First Nation. The extent to which diabetes has affected the community, coupled with the concern regarding the level of stress individuals and their family experience, is reflected in the

strong support of this work. This concern was described by the community to Dr. Bruce who has initiated further analysis into this aspect of diabetes research and Aboriginal health.

Because my work is based within the community and is not an investigator-imposed project, I hope that it can provide a space within which individual and community needs may be adequately and appropriately addressed while recognizing the unique relationship between all of us involved in the research process. This First Nation community is interested in using these data to as they develop programmes and targeted initiatives in their community. A report has been provided to Chief and Council to help facilitate this process and provide some of the necessary information they may require.

Research Ethics

This project fits within a larger study that was approved by the University of Manitoba Health Research Ethics Board and community-level partners in this First Nation. I also received ethical approval from the Health Research Ethics Board for my portion of the analysis. I have done my best to follow strict ethical guidelines throughout the process of this work, as my project deals with sensitive and highly personal information. I have been diligent at maintaining confidentiality and attempting to foster an environment built on respect, compassion and dignity.

CHAPTER TWO

Review of the Literature

1. Diabetes

Diabetes is one of the most costly and burdensome chronic diseases that is increasing in incidence and prevalence across North America and around the world (Dabelea & Hamman, 2004). The World Health Organization (2006) stated that the incidence of diabetes is increasing so dramatically that the current estimated number of people living with diabetes – 177 million – will increase to 366 million by the year 2030 (*see also* Wild et al, 2004). The economic burden associated with such a large number of people living with diabetes is staggering. According to the American Diabetes Association (ADA) (2003), the cost of diabetes to the U.S. economy is more than $132 billion dollars each year, and based on this figure, the Canadian Diabetes Association (CDA) estimates that diabetes and its associated complications cost the Canadian healthcare system approximately $13.2 billion dollars each year. This figure is expected to reach $19.2 billion by the year 2020 (CDA, 2006).

While diabetes can exact an extremely devastating toll on the healthcare system, it can also be a particularly difficult disease for individuals, families and communities to manage. Out-of-pocket healthcare expenses vary depending on where you live in Canada and access to adequate and appropriate prevention and management programmes has not been guaranteed (CDA, 2005). For First Nations people in Canada, whose crude prevalence rate of diabetes is between 8 and 25% - a range three to five times higher than non-First Nations people (Adelson, 2005; Martens et al, 2002; Young et al, 2000; Young,

1994) - this proves especially challenging as those living on-reserve or in rural and remote communities try to access services. Diabetes is one of the major causes of blindness, cardiovascular disease and amputation of the lower extremities (Muller-Wieland et al, 2003). The micro- and macro-vascular complications associated with diabetes (this includes retinopathy, neuropathy, nephropathy, and cardiovascular disease) are connected to an increase in morbidity and mortality. Depending on the progression of the disease and the extent to which diabetes-related complications have become a factor, patients may have to leave their place of employment and apply for disability insurance. Family members, friends, and other care-givers may be required to make special arrangements for their friend/relative that requires them to also leave work for varying amounts of time. There is a significant period of adjustment to living with a chronic disease that can mean patients experience some amount of depression, guilt, anxiety, and anger (Kirkham, 2003).

1. i. What is Diabetes Mellitus?

Diabetes mellitus refers to a heterogeneous group of disorders that share a common feature of elevated blood glucose levels (hyperglycemia) (WHO, 1985). It is a complex metabolic disorder that disrupts the normal metabolism of carbohydrates, lipids, and proteins in several different forms (McKinlay & Marceau, 2000). Diabetes is a chronic disease with many suspected causes said to be related to an interaction of genetic and environmental factors (Young et al, 2000). The two most common forms are "type I" (formerly known as insulin-dependent diabetes mellitus), and "type II" (formerly known as non-insulin dependent diabetes mellitus). A third form of diabetes is called

"gestational diabetes" (GDM), and is defined as glucose intolerance that first appears during pregnancy (ADA, 1998).

Although the etiologic classification of diabetes using well-defined physiological measurements has continuously changed and remains in flux, the broader category of risk factors associated with the onset of the disease has been consistent. Genetic and environmental risk factors have been identified, including: family history; ethnicity; history of migration; birth weight and *in utero* exposure; obesity (both total body fat and patterning of upper body fat); physical inactivity; diet; and stress. While the interaction of multiple factors is likely to occur, the degree to which these interactions increase the relative risk of developing the disease is hard to establish. Support for a life-course approach to diabetes epidemiology (an approach which looks at the possible connections between early childhood and later health outcomes) is growing (Ben-Shlomo & Kuh, 2002) as analyses at this level would be able to establish the temporal relationships between risk factors and their effects during sensitive periods of life (Dabelea & Hamman, 2004: 789). In such analyses, one risk factor for the development of diabetes – that of stress – will be able to be studied more thoroughly with particular attention not only to individuals, but to communities of people who have disproportionately high rates of diabetes.

1. ii. The relationship between stress and diabetes

The relationship between blood glucose levels and stress – which Chrousos and Gold (1992) define as the deviation from homeostasis – has been explored in human and

animal studies in the biomedical literature (Lloyd et al. 2005; Riazi et al. 2004; Sapolsky, 2004; Surwit et al. 2002; Lloyd et al. 1999; Daniel et al. 1999; Strausbaugh et al. 1999; Thernlund et al. 1995; Surwit et al. 1992). An analysis of the association between stress and diabetes could prove useful for those interested in developing a clearer understanding of those factors involved in the etiology of diabetes, and could potentially provide some insight into the reasons why diabetes has reached such epidemic proportions.

Stress and stressful experiences have been associated with the onset of diabetes in individuals predisposed to the disease for some time as researchers have looked at the connections between stress at home and at work and the triggering of both types 1 and 2 diabetes (Lloyd et al, 2005:121). Bjorntop (1997) argues that the psychological reaction to stress triggers the hypothalamic-pituitary-adrenal axis (HPA axis) which leads to increased cortisol levels and the disruption of insulin action. The HPA axis is a significant part of the neuroendocrine system that controls reactions to stress and helps to regulate various bodily processes. In a case-control study looking at whether or not psychosocial stress during certain periods of life could be a risk factor for insulin-dependent diabetes in children, Thernlund and colleagues (1995) found that negative life events in the first years increased the risk of developing insulin-dependent diabetes mellitus (1995:1327). 'Negative life events' in this study were determined by using a life-events questionnaire; measures of child behaviour, family function, parental social support and socioeconomic status were also included. Similar to Thernlund (1995), Aikens and colleagues (1992) found that not only is stress associated with type I diabetes onset, it can also greatly affect metabolic control in already diagnosed diabetic patients.

"Variability in daily stress was positively related to future metabolic control, supporting the hypothesized direct causal role of stress," (Aikens et al, 1992:117).

Lloyd and colleagues (1999) examined the relationship between stressful life events and alterations in glycemic control in adults with type 1 diabetes, by using a number of questionnaires that looked at self-care, treatment adherence and problem-solving, ways of coping, depression, and the difficulty of life events, as well as measures of glycemic control (HbA1c). They found that those who had poor glycemic control were significantly more likely to report severe personal stressors (Lloyd et al, 1999:1278), and that this relationship highlights the importance of coping and social support – elements in this process that need to be further explored.

It is important to note that much of the literature regarding the role of stress in the onset and course of type 2 diabetes is based on animal studies, and few studies on humans have been conducted (Surwit et al, 1992). Studies of stress and diabetes among animals, most famous among which is Cannon's (1940) experiments with cats, have consistently demonstrated that the energy-mobilizing effects of stress can be disastrous for blood glucose control in diabetics (Surwit et al, 1992:1414). Stressors activate the HPA axis, causing the release of increased amounts of glucorticoids, which stimulate the release of glucose in the liver (a process called gluconeogenesis) while suppressing insulin secretion (Surwit et al, 1992:1414). This process results in an increase in blood glucose levels with decreased insulin action. Stress-induced increases in blood glucose cannot be adequately metabolized (Surwit & Schneider, 1993:380). The multiple pathways by

which the activation of the central nervous system can influence glucose metabolism indicates that stress exposure for diabetics or pre-diabetics (i.e. those with impaired glucose tolerance or insulin resistance) can be extremely problematic. Among sand rats and genetically obese mice, the extent of hyperglycemia is dependent on the environment within which the animal lives and whether or not the animal is exposed to stressful stimuli (Surwit et al, 1992:1417). Blood samples taken before, during and after stress exposure have shown that stress disregulates glucose metabolism (1992:1418).

The effects of chronic compared with acute stressors have also been explored. Strausbaugh and colleagues (1999) studied male Sprague-Dawley rates and compared the physiological mechanisms involved in the responses to both acute and chronic stress. They demonstrated that "repeated exposure to stress appears to alter the physiological state of the animal," (1999:14632) and inhibits the inflammatory response. These findings are significant, as they could explain the clinical association between repeated stress and the aggravation of certain diseases (1999:14629).

There is a limited amount of work that has explored the effect of stress on the human body and the relationship between stress and diabetes. Mooy and colleagues (2000) demonstrated an association between stressful experiences and the diagnosis of type 2 diabetes in a large population (The Hoorn Study). The number of stressful events reported by the participants was positively associated with undetected diabetes as measured by an oral glucose tolerance test (2000:197). This relationship remained significant after adjusting for confounding factors such as family history, high alcohol

consumption, and physical activity. These results support the theory that chronic psychological stress is associated with diabetes (Bjorntop, 1997).

Many of the studies that have looked at stress and diabetes in human populations have used data from the Pima Indians. According to Surwit (1992), environmental stress was found to activate the sympathetic nervous system of the Pima (who are at high risk for developing type II diabetes), elevating circulating levels of glucocorticoids (Surwit et al, 1992:1414). This might be deleterious to persons with type II diabetes as they already have compromised glucoregulation. "Exaggerated glycemic reactivity to behavioural stress also appears to be characteristic of at least some individuals who are predisposed to developing type II diabetes," (Surwit et al, 1992:1418).

These findings have also been supported by those who have looked at the effects of westernization and migration among Indigenous populations and Australian Aborigines (Daniel et al, 1999; O'Dea, 1991; Scheder, 1988; O'Dea, 1984). O'Dea's research on the effects of westernization (defined in her work as a lifestyle of reduced physical activity and an energy-dense diet) among Aboriginal Australians (1991) suggests that they are particularly vulnerable to certain health conditions, including obesity, type II diabetes and coronary heart disease, which can accompany a change from a traditional hunter-gatherer lifestyle to one that is more sedentary. She examined published data that explored the effect of westernization on this community and argued that the dramatic change in diet and physical activity, accompanied by a disruption of traditional cultural and social structures and the increased level of stress associated with such radical changes, makes

Aboriginal peoples susceptible to obesity and type II diabetes. The traditional diet

composition and the pattern of food intake would have provided an adaptive advantage

for Aboriginal people who faced times of food shortage (and abundance), but this was

specific for a hunter-gatherer lifestyle. A change in lifestyle would greatly affect the body

as it had biologically adjusted to fit the "feast-and-famine" pattern of food intake. There

could, then, be a dramatic shift in the patterning of disease if a predisposed population

experiences the rapid change in social, political and economic structure that accompanies

westernization.

O'Dea's earlier work (1984) examined the effects of a seven week reversal in lifestyle

from an urban to a hunter-gatherer lifestyle on the health of ten diabetic Australian

Aborigines. Various measurements were taken both before and after the participants

spent seven weeks in an extremely isolated location in the northern Kimberley region of

Western Australia. Baseline metabolic studies were conducted immediately before the

experiment and data on body weight, daily caloric intake, and total energy intake were

also monitored. Among the participants, O'Dea found a drop in fasting glucose and an

improvement in postprandial glucose clearance; a drop in fasting plasma insulin

concentration; an improvement in insulin response to glucose; and a fall in fasting plasma

triglycerides (1984:596). These changes she argues are a result of weight loss, the change

to a low-fat diet (the test diet was 13% fat) and an increase in the level of physical

activity that the participants would have experienced as a result of reverting to a hunting

and gathering lifestyle during the experimental period (1984:601).

Daniel and colleagues (1999) explored how the social conditions under which people live can directly affect their health by comparing glycated hemoglobin concentrations in indigenous and non-indigenous peoples living in industrialized countries. They argue that "biological responses to environmental stress could mediate vulnerability to the wide variety of outcomes that define the poor health of indigenous populations," (Daniel et al, 1999:405). They found statistically significant differences in hemoglobin A1c concentrations between culturally distinct population groups of indigenous peoples, Greek migrants and Caucasian Australians. The mean hemoglobin A1c concentration was more than 18% greater for indigenous than non-indigenous persons, and this difference remained after controlling for possible confounding variables (1999:409). The results were similar across indigenous population groups including Native Canadians, Australian Aborigines and Torres Strait Islanders. In an effort to explain these findings, Daniel and colleagues implicate social environmental stress related to westernization. Although there would have been similar changes experienced by the Greek migrants studied, "the nature of their relocation enables continuity with traditional culture and a lack of dependence on external resources compromising their autonomy as a people," (Daniel et al, 1999:409). The impact of social change, low control, and difficult living conditions "may be inherently stressful at the biological level for indigenous populations in westernized countries," (Daniel et al, 1999:405). Work in this area that seeks to further explore the effects of chronic stress could greatly augment the literature on stress and diabetes and focus the attention more specifically on social and environmental stress and its effects on the body.

The relationship between stress and diabetes is an extraordinarily complex one that involves physiological, psychological, and sociological processes. While the literature on this relationship within the field of diabetes epidemiology has begun to explore the effects of stress on the diabetic body, it remains almost exclusively focused on individual health, glycemic control, and stress management. Few studies have moved beyond an individual-level analysis to explore the broader effects of stress on entire *communities* (Schoenberg et al, 2005; Iwasaki et al, 2004; Rock, 2003; Scheder, 1988). Scheder's (1988) seminal work among Mexican migrant workers in the United States illustrates how although an emphasis on individual health behaviours is important in diabetes research, it can hide the fact that stress-producing social, political and economic factors are also at play and negatively effect health outcomes. "The prevailing research focus on obesity, nutrition, and individual health behaviours – although undeniably contributors to health outcome – obscures the social issues more fundamental to the etiology of the disease," (1988:251). Scheder describes the Mexican migrant experience in the United States as one that comes out of a particular historical context and that is an experience of social marginalization, disrupted social and family supports, discrimination and racism. This environment "...provide[s] the setting and exposure for individuals to express physiological symptoms," (1988:254).

Schoenberg and colleagues' work in the United States (2005) examines lay perspectives on stress and diabetes among a multiethnic sample of adults. They discuss how stress regularly enters the explanatory models of diabetics, but that this is a relatively new area for biomedical researchers who have tended to adhere to rigid ideologies about stress, de-

socializing the determinants of illness and people's perceptions of illness (Schoenberg et al, 2005:175). The participants in their study reflect on their own experiences with stress at particular moments in their lives, as well as the on-going issues that they have to deal with which expose them to chronic stress. Schoenberg and colleagues' argue that "frequent references to these stressful settings compel us to examine the connections between larger political and economic forces, stress, and diabetes pathogenesis and management," (Schoenberg et al, 2005:184).

Rock (2003) also argues that the biomedical emphasis on the individual body differs significantly from the definition that diabetics themselves use to talk about the disease. Her work explores the approaches to defining and preventing diabetes that have been taken and is based on ethnographic work among the Cree of northern Quebec. She suggests that an understanding of distress could augment existing biomedical definitions that are focused on the individual body, by incorporating the social context and life world of the sufferer. The rates of diabetes and its associated complications are rising quickly in Aboriginal communities; yet, these communities seldom reported a case as recently as fifty years ago. "Systems of appropriation, exploitation and exchange – in other words, political economy – have helped shape the genetic composition of human bodies...More specifically as regards to Aboriginal populations, the alarming rise in type 2 diabetes incidence closely corresponds with changes wrought by colonization," (Rock, 2003:148).

Stress could be used as a framework through which the study of diabetes in particular populations, such as Aboriginal peoples, could be done. This approach would help to

locate some of the literature in psychology and physiology discussed within a broader

social, historical and political context. The term 'stress' can be played with and explored

in greater depth, so that it is considered not simply as 'a deviation from homeostasis' in

particular moments, but as something that has a significant temporal aspect. Researchers

need to also relate these ideas to the literature that exists on appraisal, coping, and coping

mechanisms, thereby providing a sense of the on-going dynamics of the stress

experience. A consideration of social stress and how it operates across generations,

affecting individuals, families, and communities, would be necessary in helping to further

illuminate the relationship between context and disease.

2. Stress

I would like to acknowledge and address the varying approaches both within and across

academic disciplines that have explored the concept of stress and which have helped to

inform my analysis. This will illustrate how complex the phenomena of stress really is,

and highlight how discussions overlap and diverge at many points.

2. i. The Stress Concept

At the start of the twentieth century, models of stress emerged that focused on

physiological responses. In 1929, Walter Cannon used stress within an evolutionary

framework as a way to explain the disruption of homeostasis when the body responds to

an emergency. In his studies of the physiology of emotion (1932), Cannon said that

perceiving danger leads to a physiological response that prepares the person or animal to

attack or flee (Lyons & Chamberlain, 2006). The *'fight-or-flight' response*, as it is

known, involves an increased activity and arousal rate such that the body is able to react quickly to a situation of perceived stress. This response activates the adrenomedullary system which calls for the release of glucose, stored in the liver as glycogen (Bartlett, 1998; Sapolsky, 2004). Cardiovascular output is increased which increases heart rate, and vasodilation of the blood vessels supplying the brain and muscles occurs. Other bodily changes associated with the arousal of the autonomic nervous system are also triggered, such as an increase in the rate of breathing. Cannon's work in this area was the first to describe subjects as being "under stress" – terminology that implies a measurement as to the degree of stress (Lazarus & Folkman, 1984:2), and, coupled with the work of Freud and Pavlov emerging at the time, helped initiate a movement towards psychosomatic medicine in western Europe and North America (Bartlett, 1998:25).

Hans Selye, one of the most frequently cited stress researchers, is credited as being one of the earliest researchers to link stress and illness (Lyons & Chamberlain, 2006: 143). Selye used the term stress in a particularly technical way to mean "a set of bodily defences against any form of noxious stimulus (including psychological threats)". His *General Adaptation Syndrome* (GAS) dominated the psychological and physiological literature in stress for a number of years as it more clearly defined stress both in terms of environmental demands ('stressors') and physiological reactions and processes in the body that are created by these demands.

The General Adaptation Syndrome emerged out of Selye's work with laboratory animals. He was studying sex hormones at the time, and began injecting rats with ovarian extracts.

He noticed a number of morphological changes in their bodies after exposure to such hormones, including hyperactivity and adrenocortical enlargement. After assuming that he had discovered a new sex hormone, Selye went on to establish a control group to compare his results. The control group was injected with a saline solution and then observed. To his surprise, the control group also exhibited such changes in their bodies. Selye concluded that the reason for both the experimental and control groups having similar outcomes must be related to what both groups had in common – living in an enclosed laboratory environment where they are subjected to repeated handling, dropping, and inspection (Sapolsky, 2004:8).

To test the idea that what he was observing was actually the rats' response to their lab environment, Selye subjected rats to a number of other extremely intense experiences including exposure to hot and cold temperatures, X-rays, non-stop exercise, and insulin injections. In his observations, he noted that after exposure to such stressors, the rats had developed peptic ulcers, enlarged adrenal glands and atrophy of immune tissues – similar findings to his earlier work (Sapolsky, 2004:8).

Selye went on to formalize his theory on stress-related disease and argued that the fight-or-flight response was only one of the initial reactions to stress exposure, and that two other physiological responses occurred (Sapolsky, 2004). In the 'alarm phase', the body activates the nervous system and specific hormonal levels change. This is followed by a 'resistance phase', where the nervous, hormone and immune systems all remain in an elevated state as the body attempts to adapt to the stressful experience. The final stage is

one which Selye called the 'exhaustion phase'. At this point, the body is unable to adapt, the immune system is weakened and extensive physical damage can occur. Together these three phases are said to comprise the General Adaptation Syndrome. It should be noted, that physiologists and other researchers continue to use this kind of stress-response framework in their discussion of stress and health, although the terminology used - allostasis and allostatic load (*see* Sterling & Eyer, 1988; McEwen, 1998) - differs from what was proposed by Selye in his work.

In the 1940s, the stress concept was further explored in the field of medicine by Harold Wolff, who wrote about life stress and disease. Although Wolff also conceived of stress as a reaction of an organism to various demands and 'stressors', he differed from Cannon and Selye in his conceptual model (Lazarus & Folkman, 1984). Wolff wrote (as quoted in Hinkle, 1973:31):

> I have used the word [stress] in biology to indicate that state within a living
> creature which results from the interaction of the organism with noxious stimuli
> or circumstances, i.e., it is a dynamic state within the organism; it is not a
> stimulus, assault, load, symbol, burden or any aspect of environment, internal,
> external, social or otherwise.

The importance of Wolff's emphasis on stress as a "dynamic state" is that it implies some amount of interaction between the body and its environment (Lazarus & Folkman, 1984). It means, therefore, that this relationship is no longer conceived in terms of a unidirectional, linear system that remains static, predictable or unengaged. The body

exposed to various stressors must, ultimately, be engaged in some form of response, triggering its cognitive, physiological, and neuroendocrine systems. Wolff's formulation of the biological processes involved is very similar to the psychological processes in 'coping' (Lazarus & Folkman, 1984:3), which will be discussed in subsequent sections. These processes alone do not necessarily imply a definite time frame, furthering the idea that there is an ongoing relationship between the organism and the environment. This conceptualization of stress as a dynamic process is extremely important to consider when looking at the effects of stress on health, the impact of context on disease, and the ability of individuals and populations to cope with the environment within which they live.

Stress continues to be a hotly debated and much contested term across many disciplines, despite having comprised a significant part of the research on the psychology-disease relationship (Lyons & Chamberlain, 2006:142). A considerable amount of discussion has occurred since some of the earlier stress research was conducted by Cannon, Selye, and Wolff, with researchers arguing for stimulus-based definitions, or response-based definitions. Stress serves as a useful device to guide our understanding of the experience of deviating from homeostasis. Lazarus suggests that "stress be treated as an organizing concept for understanding a wide range of phenomena of great importance in human and animal adaptation. Stress, then, is not a variable, but rather a rubric consisting of many variables and processes," (Lazarus & Folkman, 1984:11-12). This experience, operating on physiological, psychological, social and emotional levels, is something that continues to be a highly diverse but extremely extensive phenomenon for organisms of all kinds. In that sense, it is necessary to maintain some basic definition and become familiar with the

terminology used and schools of thought dominating stress research. While I have chosen to define stress simply as a 'deviation from homeostasis', it has been conceptualized in psychological research in three main ways (Lyons & Chamberlain, 2006:142):

- stress as a response;

- stress as a stimulus; and

- stress as a process.

2. ii. Stress as a response

Response-based definitions have viewed stress as a person's physiological and psychological reactions to an event or situation (Lyons & Chamberlain, 2006:142). The stress-response literature emerged out of Cannon and Selye's work at the beginning of the twentieth century and emphasizes the physical sensations that may be experienced during stress, such as tension, distress, increased heart rate, and increased perspiration.

2. iii. Stress as a stimulus

The most common definition of stress that has been adopted by psychologists has been that which defines stress in terms of stimuli (Lazarus & Folkman, 1984). As a stimulus, stress is seen as something in the environment, external to the organism, which impinges on an individual and initiates a set of physiological and psychological processes similar to those described by Selye's GAS theory. Stress stimuli, or 'stressors', have been further broken down and classified as major changes affecting large numbers of persons; major changes affecting one or a few persons; and daily hassles (Lazarus & Cohen, 1977).

Major changes affecting large numbers of persons are typically universally stressful and include such events as war, natural disasters and relocation (refugee movement). It is the intensity and breadth of such events that is of particular interest, as the length of time for exposure varies considerably (Lazarus & Folkman, 1984:12). Other research, particularly in the areas of public health and refugees outlines the ways in which such catastrophic events such as war and displacement can affect individual and community health (*see, for example*, Igreja et al., 2006; Wexler et al., 2006; Nachman, 1993; Morrissey, 1983).

Traumatic events affecting a smaller number of people or just one person could also be called 'major life events' and include the death of a loved one, getting a divorce, losing one's job, or a sudden illness (Lyons & Chamberlain, 2006; Lazarus & Folkman, 1984). These experiences are all of a negative nature and involve some amount of threat or harm. Holmes and Masuda (1974) argue that any changes, including those that are positive, can be considered stressful and that researchers ought to be careful not to exclude other major life events in their analyses. Bartlett (1998) has criticized the major life events paradigm because: it does not consider the meaning of the event for the individual who is assumed to respond passively to the stressors he/she experiences; does not account for the amount of time that has lapsed between the event and the point of recollection; does not address how events experienced in the present time might affect how the subject remembers experiences in the past; and does not recognize the possibility that such experiences could be of a chronic nature (Aneshensel, 1992).

The third category that Lazarus and Cohen (1977) identify is that which looks at events of a chronic nature or 'daily hassles'. Living in overcrowded conditions, feeling lonely, having an argument with a partner, and working in an unsupportive environment are examples of such daily hassles. Although these are less 'dramatic' events than some of the others mentioned previously, it has been argued that the cumulative effect of minor daily events may have a significant impact on one's well-being and health (Kanner et al, 1981; DeLongis et al, 1982). The authors of these studies have looked at the effect of hassles (minor negative events) and uplifts (minor positive events) on self-reported health (Lyons & Chamberlain, 2006) as well as on immune function (Stone et al., 1994). Hassles have been found to predict health outcomes better than major life events (Bartlett, 1998).

As with other stress theories, there have been a number of criticisms of this approach as it focuses on daily life events. Lyons and Chamberlain (2006) provide a brief summary of the issues that are not considered by this framework, including methodological issues such as reporting bias, and the underlying assumptions this kind of approach has made regarding the nature of stress. They suggest that stress is likely to be much more idiosyncratic than recognized and that analyses of the stress concept need to include how individual perception affects interpretation.

2. iv. Stress as a process

The third conceptualization of stress is that proposed by Lazarus (1978) which sees stress as a process – a transaction between individuals and their external world (Lyons &

Chamberlain, 2006). The transactional theory of stress incorporates some of the research into the physiological mechanisms involved in the stress experience and augments this with a cognitive-phenomenological approach. Stress responses are said to come about only if the individual sees a potential stressor as stressful. Stress is, therefore, not simply internal or external to the individual, but a *relational* concept which incorporates individual and environmental factors (Lazarus & Launier, 1978). Instead of individuals being considered passive reactors, they are seen to evaluate each situation and engage with or respond to the environment in a number of different ways.

Coyne and Lazarus (1980) argue that a transactional theory of stress is a superior framework in stress research, because it is not limited to a stimulus-response model. The transactional perspective incorporates psychological processes and feedback loops that emphasize environmental stressors, dispositional properties of persons and stress responses. Older models have assumed that the process is static, linear, and sequential, with each piece happening within a particular time before proceeding to the stage in the process. The transactional theory turns stress into a relational concept, where once separated entities are combined at a higher level of analysis (Lazarus & Launier, 1978). "When one thinks in process-oriented, transactional terms and acknowledges the existence of feedback loops, one is forced to abandon firm notions of linear causality". (Coyne & Lazarus, 1980:146).

2. v. Stress physiology: the effect of stress on the body

In attempting to highlight the complexity of the stress experience, researchers in biology and physiology have looked at the causal pathways through which the stress-health link is mediated and the biological mechanisms involved (Bartlett, 1998). The nervous, endocrine, and immune systems are the three primary mechanisms involved in stress and the disruption in their functioning has been widely studied (Sapolsky, 2004; Kiecolt-Glaser et al, 2002a, 2002b; Cohen et al, 2001; McEwen, 1998).

The nervous system is made up of neurons (nerve cells) and is divided into the central nervous system (CNS) that consists of the brain and spinal cord, and the peripheral nervous system (PNS) that consists of all other neurons. The PNS is further divided into the somatic nervous system, which is responsible for motor and sensory neurons, and the autonomic nervous system (ANS) which is responsible for the body's involuntary muscles and the internal organs. The ANS is even further subdivided into the sympathetic and parasympathetic branches. It is this system and its two branches which are significant factors in the response to stress. The sympathetic branch of the ANS is involved in energy expenditure and bodily excitation, and is thus activated during stress. Messages from this system exit the spine to reach every blood vessel, sweat gland and organ in the body, helping to mediate arousal, activation and mobilization (Sapolsky, 2004). Sympathetic nerve endings release noradrenaline/norepinephrine[2] throughout the body, while adrenaline/epinephrine is secreted by the adrenal glands, located just above the

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[2] *Adrenaline* and *noradrenaline* are the terms used in the United Kingdom. Researchers in North America refer to the same substances as *epinephrine* and *norepinephrine*. (Sapolsky, 2004:22).

kidneys (Sapolsky, 2004). These substances help to inform and activate various organs in the body and prepare them to respond.

The parasympathetic branch operates in an opposite fashion, and works to restore energy and reduce activity levels. It is the process that is involved in sleep, promoting growth, and energy storage (Sapolsky, 2004). These processes are arrested when the sympathetic nervous system is activated during stress, so that blood flow can be directed towards muscles, such as the heart via the sympathetic nervous system.

Another physiological mechanism activated by stress is the endocrine system. The endocrine system consists of a number of glands located throughout the body which secrete hormones. Two of the hormones most particularly vital to the stress-response are epinephrine and norepinephrine (released by the sympathetic nervous system), and another class of hormones referred to as glucocorticoids – steroid hormones secreted by the adrenal gland which act similarly to epinephrine (Sapolsky, 2004:30). Hormones can be carried through the bloodstream to various parts of the body where they can either have a direct effect on an organ or stimulate the release of another chemical substance that acts on particular tissues or organs (Bartlett, 1998:87). Epinephrine acts within seconds, while glucocorticoids accumulate, helping sustain this activity over minutes and hours.

Glucocorticoid stimulation is controlled by the brain. When something is perceived as stressful, the hypothalamus, which is the head ganglion of the ANS and is connected to

the pituitary gland located in the brain, secretes a number of hormones into the hypothalamic-pituitary circulatory system (Sapolsky, 2004:30). Corticotropin releasing hormone (CRH) acts quickly to trigger the pituitary gland to release adrenocorticotropic hormone (ACTH). The pituitary gland releases eight different hormones which affect other glands in the body. Because none of this could occur without the initial stimulation of the pituitary gland, it is considered the master-gland of the endocrine system (Bartlett, 1998:87).

When ACTH is released into the bloodstream, it acts on the cortex of the adrenal gland causing it to release corticosteroids. This class of hormones can be subdivided into mineralocorticoids, which regulate the balance of minerals in the bodily fluid surrounding the cells, and glucocorticoids, which control blood sugar levels, regulate blood pressure, and are involved in immune functioning (Bartlett, 1998:88). During stress, cortisol, one of the glucocorticoids, initiates the release of glucose from the liver and inhibits the normal inflammatory response, while the pancreas begins to release glucagon. The combination of these two factors helps to raise blood glucose levels (Sapolsky, 2004).

The third mechanism stimulated during stress is the immune system. The immune system functions to protect the body from infection and illness when exposed to foreign microorganisms (antigens). Under normal circumstances, the immune system is able to distinguish between cells that are part of the host environment, and cells that are not. If a foreign cell is found in the body, immune defences are engaged by white blood cells - lymphocytes and monocytes. Two classes of lymphocytes – T cells and B cells –

originate in the bone marrow (although T cells mature in the thymus) and attack

infectious agents in different ways (Sapolsky, 2004:146). T cells initiate cell-mediated

immunity when they are secreted into the lymphatic system from the thymus gland. They

increase their activity when the macrophage (a type of monocyte) has presented them

with some kind of foreign body. A particular variety of T cells, called cytotoxic killer

cells, work to attack and destroy the antigen. Humoral immunity involves the activation

of B cells which release antibodies – large proteins that then attach to some feature of the

antigen and begin to destroy it (Bartlett, 1998:89).

Because the immune system is distributed throughout the body, it relies on blood-borne

chemical messengers (cytokines) to communicate between different cell types (Sapolsky,

2004: 149). For example, when an antigen is first detected by macrophages, the cytokine

interleukin-1 is released and travels to the thymus where T helper cells are then informed.

T helper cells release interleukin-2, which stimulates T cell growth, and the rest of the

response unfolds.

During a period of stress, normal immune function is inhibited. Stress suppresses the

formation of new lymphocytes, their release into circulation, and shortens the time they

remain circulating in the body (Sapolsky, 2004: 151). Furthermore, the production of

antibodies is inhibited and the communication system between lymphocytes is disrupted.

Much of this occurs as a result of the presence of glucocorticoid hormones.

Glucocorticoids, as mentioned above, are one of the classes of corticosteroids released by

the endocrine system and involved in normal immune functioning and the regulation of

blood glucose levels. Despite being a normal product of the endocrine system, and something that is automatically released during stress, glucocorticoids actually suppress the immune system. The reasoning behind this is still unknown, and molecular biologists continue to investigate this area (Sapolsky, 2004). Some researchers, such as Sapolsky (2004), have attempted to understand this process in evolutionary terms, thinking that perhaps immunosuppression during stress exposure is the by-product of some other adaptive mechanism as yet unidentified. For whatever reason, the body secretes hormones that ultimately suppress its own immune system. Glucocorticoids can cause the thymus gland to shrink, can interfere with the production of interleukins, and can even kill lymphocytes (Sapolsky, 2004:152).

Other hormones of the sympathetic nervous system, beta-endorphin and corticotrophin-releasing hormone in the brain, have also been identified as having some connection to immune suppression during stress, although the mechanisms involved with these chemicals are even more poorly understood (Sapolsky, 2004). Exploring all of these routes will be an extremely challenging but necessary part of any stress research that takes place in the future, perhaps helping to illuminate further the relationship between stress, coping and health.

Building on the idea of a transactional approach to stress, as presented by Coyne and Lazarus (1980), it is necessary to link these physiological stress responses to some of the psychological responses that could be involved in this process. This way of thinking emphasizes the dynamics between the two areas (which themselves are subject to change)

and reiterates the idea that one static, linear model is not an adequate representation of this entire process. Such an analysis requires some consideration of stress, appraisal, and coping. This terminology is often used interchangeably with 'stress response', although it focuses most specifically on the psychological elements of this phenomenon. The coping literature is extensive and provides considerable insight into what mechanisms are involved and how they are involved in the stress process.

3. Coping

3. i. Appraisal and Coping

Two of the most important concepts that have emerged in the literature on stress and which are central processes also associated with the transactional approach, are appraisal and coping. Lyons and Chamberlain (2006:149) provide definitions of these terms that should be noted: appraisal is a cognitive process which involves classifying or categorizing information; coping comprises the cognitive and behavioural efforts that a person uses to manage demands that they perceive as exceeding their resources. Both appraisal and coping have been studied extensively (*see for example* Thoits, 1995; Banyard & Graham-Bermann, 1993; Folkman et al., 1986; Lazarus & Folkman, 1984; Wheaton, 1983; Folkman & Lazarus, 1980; Pearlin & Schooler, 1978), and are recognized as playing a significant part in the stress process (Skinner et al., 2003; Bartlett, 1998; Lazarus & Folkman, 1984).

According to the transactional approach proposed by Lazarus (1978), two forms of appraisal (primary and secondary) occur when responding to a stressor. In primary

appraisal, an individual appraises the event itself, asking her/himself what the event

means to her/him (Lyons & Chamberlain, 2006:149). There are three kinds of primary

appraisal: 1) irrelevant; 2) benign-positive; and 3) stressful (Lazarus & Folkman,

1984:32).

When the event is viewed as potentially stressful, an individual then engages in

secondary appraisal (Lyons & Chamberlain, 2006:149). At this stage, a further form of

appraisal takes place where a person evaluates what might and can be done and,

therefore, whether or not s/he has the resources to cope with the event (Lyons &

Chamberlain, 2006; Lazarus & Folkman, 1984). Secondary appraisal refers, then, to the

process of judging what resources the individual has access to and what options are

available in dealing with the event (Bartlett, 1998:44). As Lazarus & Folkman (1984)

argue:

> "It is a complex evaluative process that takes into account which coping options
>
> are available, the likelihood that a given coping option will accomplish what it is
>
> supposed to, and the likelihood that one can apply a particular strategy or set of
>
> strategies effectively." (1984:35).

It is important to note, however, that neither the processes of primary nor secondary

appraisal remain static, formulated, or predictable. What might be assessed as irrelevant

or benign in one scenario may not be the classification used should the scenario be

repeated in the future. The process of appraisal is continuously changing as the stressful

transaction with the environment unfolds and the events are reinterpreted (Cohen & Lazarus, 1983).

The research on coping is diverse in terms of the definitions presented and the measurements used to establish the variables that constitute 'coping'. There is some agreement among researchers that in its simplest form, coping is said to comprise the actions taken to deal with stress (Banyard & Graham-Bermann, 1993; Folkman & Lazarus, 1980; Pearlin & Schooler, 1978). Folkman and colleagues (1986) define coping as the person's constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources (1986:993). The two major functions of coping involve regulating stressful emotions (emotion-focused coping) and altering the troubled person-environment relation causing the distress (problem-focused coping) (Folkman et al. 1986:993). A number of studies have provided significant support for the idea that both functions of coping are usually present, such as the work presented by Folkman and Lazarus on college examinations (1985), and their work with a community sample of middle-aged men and women (1980). Cohen and Edwards (1989) have even suggested that having flexibility in terms of the coping styles used exerts a protective effect on health.

3. ii. The coping process

The strategies that are used in response to a stressful situation are termed coping processes (Lyons & Chamberlain, 2006:151). Lazarus and Folkman's (1984) discussion of coping as a process suggests that there are three main features that should be addressed

when analyzing coping (1984:142). Observations and assessments are concerned with what a person *actually* thinks or does, suggesting, perhaps, that some personality traits, such as whether or not the individual is 'type A', are involved in the earliest part of this process. Secondly, the person's thoughts and actions are examined within a certain context. This is a particularly important aspect of psychological or other explorations into human action and behaviour, as it locates the individual within a particular time, recognizing that situational and environmental factors play a significant role in the coping process. It also suggests that coping researchers need to explore the ways in which internal and external factors alter perception and responses, challenging those who may see these as always predictable events. This leads directly into the third aspect of the process – that of change in coping thoughts and actions. "Coping is a…shifting process in which a person must, at certain times, rely more heavily on one form of coping, say defensive strategies, and at other times on problem-solving strategies, as the status of the person-environment relationship changes," (Lazarus & Folkman, 1984:142). The unfolding nature of stress and coping could, therefore, never be adequately portrayed by researchers if these phenomena are described as static measures. Furthermore, there should be no assumptions made about what constitutes 'good' or 'bad' coping in these descriptions; coping is simply the efforts made (be they emotion or problem-focused techniques) to manage the demands faced (Folkman et al, 1986).

The dynamics of the coping process are driven by the continuous appraisal and reappraisal of the person-environment relationship (Lazarus & Folkman, 1984). Shifts in this relationship will alter how one responds or reacts, and could result in coping efforts

being directed at changing the environment or changing the meaning of the event for the individual (i.e., being directed inwards). The emphasis on the process, rather than the specific traits of persons involved, helps to illuminate the social context of the individual and, perhaps, the collective group of individuals, such as those living with mental illness.

The complex nature of the stress and coping process – and even finding the appropriate terminology to describe these phenomena – poses an extraordinarily challenging task for researchers in this field who seek to define it or are interested in creating one model that could be applied to all analyses of stress and coping. It is evident that a number of approaches could be taken and that the application of particular aspects of the theoretical frameworks already outlined is likely to occur in any future work in this field.

3. iii. Other variables

Social Support

Epidemiological studies have demonstrated the importance of social support or social integration in terms of broader health outcomes and well-being (Berkman, 1995). Social support can take the form of structural support (the quantity and form of social ties) or functional support (what support provides the individual) (Lyons & Chamberlain, 2006:162). There are four broad classes of supportive behaviours that have been identified (House, 1981) : positive interaction; emotional support; tangible support (material aid); affection and intimacy. Family members, friends, community members, and coworkers can provide assistance and encouragement, help build esteem, and provide information to persons in need or simply on a daily basis in periods where stress is not

experienced. Support-giving can re-instill a sense of control that may have been lost during a traumatic experience.

3. iv. Resilience and Resiliency

Some psychologists have explored the concept of resilience (or 'resiliency') with regards to how people respond to stress and their exposure to 'risks'. Resilience has been defined simply as "the capacity to recover or bounce back" (Davidson et al, 2005: 43). Masten (2001) argues that "resilience refers to a class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development," (2001: 228). However simply or complexly it is defined, this literature needs to be addressed as it provides an additional perspective to the study of stress and coping.

Interest in the topic of resilience grew through the 1970s as researchers looked at children 'at risk' for psychopathology. Garmezy's work (1991; 1985) looked specifically at adverse outcomes associated with poverty among disadvantaged African-American children in the United States. In a review of the literature on resilience, Masten (2001) indicates that there have been two major approaches taken that characterize the design of studies aimed at explaining the variation in outcomes among 'high-risk' children. *Variable-focused approaches* used multivariate statistics to test for any linkages between the measures of the degree of adversity, the outcome of exposure, and the characteristics of the individual exposed that may function as protective factors. *Person-focused approaches* compared people who have different profiles (i.e. those said to be resilient versus those who are not) across time, to determine what differentiates the two groups.

Early images of 'resilient children' in both scholarly and lay work implied that there was something unique or remarkable about these children. Despite being exposed to various 'risks', such as low socioeconomic status, early childhood trauma, or the disruption of family life, some children were able to survive and did not develop the kinds of psychopathologies found in other children. These groups of children were compared and seen as two groups on the opposite ends of a scale that measured 'resilience' – in this context equated with 'success'.

Masten's (2001) historical review of the work in this field also addressed how resilience has been used as a framework. She notes that it is an inferential construct that requires two kinds of judgment:

1. An assessment of *threat*, where it can be said a person has been exposed to 'demonstrable risk'; and

2. An assessment (or an evaluation) of the *quality of adaptation*, where the criteria by which adaptation or the developmental outcome is compared is seen as "good" (2001: 228).

Judgments of this kind, however, need to be questioned as they could be severely biased towards the interests of the researcher. One needs to ask <u>who</u> is defining resilience and by <u>what</u> standards? Any assessment, therefore, simply reflects the ways in which resilience is being conceptualized and measured by a particular researcher who brings with him/her a particular set of cultural norms. These norms and values inform the work and will influence the kinds of outcomes seen.

A focus on resiliency is potentially problematic, because such an approach could disregard the situational factors, such as socioeconomic status that, ultimately, affect how 'resilient' one is able to be in particular circumstances. Resilience scholars have tended to write in ways that make it seem as if all humans have an equal amount of this ability to overcome negative situations. Resilience is "…something every human has – wisdom, common sense" (Heavyrunner & Marshall, 2003:15). While each person has adopted some method(s) for coping with difficult circumstances, such a simplistic view of resilience locates this ability to 'survive' or 'endure' entirely within the individual. Perhaps more appropriate conceptualizations, such as that argued by Ambler and colleagues (2003), suggest that what we mean by resilience is what has been seen in the past as the 'underground support system'.

There is a dearth of literature exploring both of these ideas – coping and resilience – as they relate to men and women in living in First Nations communities in Canada. The existing literature emerged as an alternative to the "deficit-based research" that focused on what was lacking in Aboriginal communities by presenting some of the more positive aspects of Aboriginal health. The work that looks at resilience and Aboriginal peoples is primarily based in the United States, and focuses on the ability of American Indian children and youth to 'survive' home situations which may have been abusive or traumatic (Anderson & Danis, 2006; Gilgun, 2002; Cummins et al, 1999). The research on resilience that does not directly speak to American Indian children, explores related issues, such as the resilience of parents raising a child with fetal alcohol syndrome (FAS)/fetal alcohol effect (FAE) (Beckett, 2002), or how Native American families have

"reservoirs of resilience" in that cultural traditions that they may practice can promote

positive mental health for children and adolescents (Keltner, 1993). This work, however,

does not incorporate broader level factors into its analysis, and remains focused on the

individual level, thereby neglecting to explain the dynamics within and between

individuals, families and communities trying to cope.

More recent work by Richmond and colleagues (2007) explores resilience among

Aboriginal men and women through the concept of "thriving". They defined thriving as

"one's ability to flourish in response to adversity," (2007:1827), and looked at the

importance of social support in promoting thriving. They used data from Canada's 2001

Aboriginal Peoples Survey (APS) to examine the self-reported health status of

participating adults (their indicator for "thriving") with measurements of social support.

While, as the authors indicate, this type of approach emphasizes a movement away from

illness-based research towards one that promotes health (Richmond et al, 2007:1827), the

information that this study provides cannot answer the question of how people cope and

risks further stigmatizing those men and women who are labelled "not thriving".

Despite its complexity, the relationship between stress, coping and health is an extremely

important relationship for researchers in many disciplines, particularly those involved in

medicine and community health researchers, to address in their analyses of both

individuals and larger groups of people. Stress provides an interactive framework that

touches on the biological, physiological, psychological, and sociological aspects of

everyone's life, helping to illuminate areas of distress, strength or the connection between

mind and body. While there is clearly no single theory that could be adequately or

appropriately applied across multiple scenarios, as a theoretical lens, stress can be used as

an interdisciplinary tool by researchers who seek to explore and explain various

phenomena occurring in people's lives.

4. Anthropological Approaches to the study of stress

I would now like to turn the discussion to the literature on stress existing in the social

sciences, particularly within the fields of physical and medical anthropology. These

approaches explore the individual experience of stress, and locate this within particular

cultural, historical, and political frameworks, thereby simultaneously recognizing the

individual and broader social levels involved. This kind of approach differs significantly

from that taken by psychologists, who focus specifically on the individual.

Some of the most seminal research on stress within the domain of physical anthropology

was conducted in the 1970s and 1980s by the American anthropologist William Dressler.

Dressler has explored the relationship between modernization, culture change and

physical health in various populations in the Caribbean, South American and the African-

American community of the United States. He noticed that changes in lifestyle that came

as a result of modernization and which required economic resources that surpassed those

available to the individual and his/her family, resulted in the experience of "life-style

stress" (1987). In his work in a community on the island of St. Lucia (1984), he noticed

that stress there was felt as a result of worries related to personal finances, employment

issues, interpersonal and familial relationships and the loss of a loved one. This stress

would manifest itself in the body in various ways, including emotional distress and high

blood pressure/hypertension. In this sense, the stress of dramatic social and economic change – coming after two decades of modernization and the transition from an economy based on the export of sugar to one based on tourism and importing consumer goods from abroad – was embodied by the people in this community.

Dressler's work in the city of Ribeirao Preto, in the state of Sao Paulo, Brazil (1987) also highlighted the connection between social processes and individual health. Dressler and colleagues examined individuals from a random sample of twenty households taken from four larger clusters based on residential and economic factors. They measured blood pressure in a single clinical session, as well as at various times throughout the day, and calculated life style stress using two component indexes previously validated. They then compared these with covariates including years of education (self-reported), family income (self-reported), measures of perceived stress (using a validated questionnaire where items were rated on a four-point scale), and dietary data (using the 24-hour recall technique). Dressler reported that "life-style stress, operationalized in a manner consistent with theory and measured with highly reliable indicators, is a significant predictor of diastolic blood pressure," (Dressler et al, 1987:404), lending further support to the notion that sociocultural factors have an impact on individual health.

Other scholars within anthropology have approached the relationship between the experience of stress (variously defined) and the body in a slightly more philosophical way, exploring different individual conceptions of 'the body' and 'health' and discussing these in relation to broader social and cultural systems. Critical medical anthropology

refers to the application of critical theories when looking at medical systems, particularly when analyzing biomedicine (Brown, 1998). This approach has led some researchers, such as Nancy Scheper-Hughes and Margaret Lock (1987), to look at the assumptions, or 'truths', we have made in understanding, explaining and describing mind-body dualism. By doing so, we problematize concepts such as stress – which I have so far discussed in a very biomedically-oriented way – and look at how it has been talked about in different contexts. Much work has been done by anthropologists in this area, and their research provides another critical perspective essential to an analysis of the concept of stress, emotional and physical health and well-being.

Some of the earliest seminal research was conducted by the psychiatrist/anthropologist Arthur Kleinman. Kleinman's influential work in China (1986) probed the question of medicine as a cultural system, wherein individual persons and communities used *illness* – defined as the lived experience of monitoring bodily processes (1988:4) – as a cultural idiom that linked beliefs about etiology, the experience of symptoms, illness behaviour, therapeutic treatments and practices, and the evaluation of these outcomes. Kleinman's notion of the explanatory model (1988) suggested that illness is much more complex than a particular biology, and that it (as well as the biology) is tied to particular systems of knowledge that are historical and socio-political products which differ between social groups and cultures. Illness, then, is a reflection of an embodied social experience.

Kleinman applied his theoretical framework to a discussion of the experience of *neurasthenia* in China and his clinical work based in the United States (1988).

Neurasthenia was first used in the United States in the early part of the twentieth century as an appropriate diagnosis explaining a myriad of symptoms that had, in that past, been seen as an indication of hypochondriasis (Ware, 1992). It was described as weakness of the nerves and nervous exhaustion, manifest by a number of complaints, including chronic fatigue. In China, Kleinman found that a diagnosis of neurasthenia reflects social and familial crises experienced by individuals who then feel demoralized and alienated (1988:20; see also 1982; Kleinman & Good, 1985). It is a way of describing the emotional distress that some persons may be experiencing as a result of political, economic or social hardship in a non-stigmatizing way. Being labelled 'mentally ill' can have severe consequences for the individual and his/her extended family, and carries a significant negative connotation that is not culturally appropriate. By describing this emotional distress as neurasthenia – a physical rather than a mental problem – men and women have a way of expressing their embodied social experience in a culturally appropriate way.

More recent accounts of a collection of symptoms very similar to what has been described as neurasthenia have been documented in North America. *Chronic fatigue syndrome* 'appeared' in the medical community and entered the vocabulary of the general public in the mid-1980s (Ware, 1992:348). Its cause remains unknown, although it has been debated extensively by those who have suggested it originates as a virus (DeFreitas et al, 1992), or that it results from some kind of immune dysfunction (Lloyd et al, 1989). The symptoms of chronic fatigue syndrome can include severe, persistent fatigue; joint pain; headache; weakness; dizziness; sore throat; memory loss and difficulties

concentrating (Ware, 1992:348). Norma Ware's discussion of this condition highlights

what Kleinman described in China, in that the name 'chronic fatigue syndrome' (or

'neurasthenia') describes a particular collection of bodily symptoms which are reflective

of some amount of embodied 'distress'. The symptoms, then, carry significant meaning

as they are physical manifestations of the emotional frustrations related to the stress one

is experiencing within a particular social position:

> "While symptoms of illness are undeniably biological phenomena experienced by
>
> individual bodies they are something else besides; they are coded metaphors
>
> capable of speaking eloquently to troubling aspects of social life by covertly
>
> expressing feelings, sentiments, and ideas that are normally disallowed,"
>
> (Scheper-Hughes, 1988:429).

Mark Nichter (1981) has described this as the 'somatization of distress'. Nichter's work

with Brahmin women in India has led him to encourage researchers and clinicians to

recognize the multiple possible symbolic references behind the symptoms presented

before them.

One of the most thoroughly discussed illnesses within the anthropological literature is

that of *nervos*. Nervos (which has also been referred to as *nervios, nevra, ataque de*

nervos) is a common medical complaint made by people in various parts of the world,

including the Americas, Europe and the Middle East. It is described as "the

psychosomatic expression of social stress originating in family, community, or work-

related conflicts and tensions," (Scheper-Hughes, 1988:432) and is manifest in symptoms

that can make the person feel weak, dizzy, sad or depressed, unable to eat, and wanting to withdraw. Nancy Scheper-Hughes' research in a community in northern Brazil describes how women, especially, in this community have used nervos as a way of expressing how they are "going mad from hunger", they are isolated and how they are excluded from society as poor women (1988). Setha Low's work in Costa Rica (1981) describes how nervios is used to represent the frustrations people feel by being socially and economically marginalized.

Similar work has been conducted by Dona Davis in Newfoundland (1989). Davis' work added to the literature that examined menopause in different cultural settings. She explored the relationship between the experience of menopause by women in a small Newfoundland village and their changing status during this time. She found that women described this change in their bodies, their social status, and their identity in terms of 'nerves', reflecting the ambivalence and uncertainty of this time in a woman's life.

Nervos is a relatively broad syndrome used to describe the distress experienced by some in various social and cultural contexts at a particular time. It could be thought of as one overarching category, wherein multiple other 'folk illnesses' might be found. Such illnesses might be slightly more particular in focus, etiology and treatment. Two examples of this prove useful to a discussion of the concept of what has been described as 'stress', but which, as can be seen, may also be referred to in many other ways. *Susto* (often translated as 'soul loss' or 'magical fright') is a 'folk illness' because it does not fit within the biomedical literature and the Diagnostic and Statistical Manual (DSM) used by

western psychologists and psychiatrists, and describes a set of symptoms which includes feeling tired, listless, apathetic about one's appearance, and suffering from insomnia and a poor appetite (Rubel et al, 1984). Within the western biomedical context, the occurrence of a combination of symptoms that include a disruption in appetite, sleep, and mood, as described above, would likely be diagnosed by clinicians as *depression*.

Depression is a commonly diagnosed disorder in North America that Shweder (1985) notes is articulated in the west as an experience of 'soul loss', a feeling of emptiness and a loss of the sense of self. The definition of clinical depression found in the DSM-IV-TR (2004) indicates that five or more diagnostic criteria need to be present for a period of at least two weeks, representing a significant change from the previous level of functioning for the individual. This criteria must include depressed mood or loss of interest or pleasure, as well as some combination of the following: a change in appetite and marked weight loss or gain; disturbed sleep patterns; psychomotor agitation or retardation; fatigue (mental or physical) and loss of energy; intense feelings of guilt, nervousness, helplessness, hopelessness, isolation/loneliness, anxiety and/or worthlessness; trouble concentrating, staying focused or making decisions; and recurrent thoughts of death or suicide.

The cross-cultural applicability of this predominantly clinical term is questionable, as there are multiple meanings, definitions and understandings of this concept complicating research in this field. Despite this, the study of depression within Aboriginal and American Indian communities has grown, as depression is the most frequently diagnosed

problem among American Indians presenting themselves for treatment at mental health facilities (Manson et al, 1985). The prevalence and incidence of depression in these communities is difficult to estimate, as the terminologies used to describe and define depression can vary greatly within and between population groups, posing challenges for clinicians and counsellors working in this field. This also indicates that any estimation of the prevalence of this condition is likely very low.

Laurence Kirmayer has done an extensive amount of research looking at the mental health of Aboriginal peoples in Canada, focusing particularly on depression and suicide. He has approached the concept of depression by exploring the ways in which bodily experience and social interaction affect how illness is experienced and expressed by individuals. He has drawn attention to the issue of metaphor (1992) and how illness expressed in the individual bodies of First Nations people living in this country reflects situations and realities in the social and political world. Kirmayer and colleagues' (2003) argue that "there is clear and compelling evidence that the long history of oppression and marginalization has contributed to the high levels of mental health problems found in many [Aboriginal] communities," (Kirmayer et al, 2003:S15). Aboriginal people have a shorter life expectancy, higher infant mortality rate and an increased rate of death among young people by accident and suicide (Kirmayer et al, 2000). Age-standardized suicide rates of Aboriginal youth are between three and six times higher than the rates for the general population (Kirmayer, 1994). It is important to consider figures such as these that speak, at some level, to the degree of violence and trauma within communities, in relation to the lived experience and the realities of everyday life for people living on-reserves.

"These suicides are the end result of a toxic mix of poverty, powerlessness, depression and, increasingly, young age and each individual suicide simultaneously attests to and hastens further community chaos," (Adelson, 2005: S56).

5. Men's Health

"Numerous epidemiological studies have reported increased prevalence rates for women as compared to men for stress-related disorders such as acute stress disorder, post-traumatic stress disorder and major depressive disorder," (Carter-Snell & Hegadoren, 2003: 35). Given that the presence of major depressive disorder increases the risk of someone attempting suicide, it is interesting to see that in the Aboriginal population, one of the strongest risk factors for suicide attempts is male gender (Adelson, 2005; Malus et al, 1994). In 1999, suicide accounted for 38% of all deaths in youth aged 10 to 19 and for 23% of all deaths in those aged 20 to 44 (Adelson, 2005:S56), indicating that is *young* men who are most likely to make a suicide attempt. Despite these figures, research on the health of Aboriginal men remains extremely limited. Much of the research has taken a particularly clinical focus, looking at the rates of trauma (Karmali et al, 2005), cardiovascular disease (Brown & Blashki, 2005), and alcohol and drug use (Coleman et al, 2001), for example. Other work has focused on approaches to rehabilitative therapy and counselling techniques for men who have abused their partners, have been childhood victims of abuse, or who are incarcerated (Zellerer, 2003; Ellerby & Stonechild, 1998; French, 1997; Levan, 1996; Waldram & Wong, 1995). While these are necessary points of inquiry, they are grounded in a western biomedical model that ignores individual experiences and presents Aboriginal men in a particular way. None of the work in this

area has explored the concepts of stress and coping which strongly influence both physical and emotional health. In fact, there are no data at the present time that look at how Aboriginal men living on-reserve in Canada talk about stress, what the sources of stress are in their lives, and what they do to try to cope with these stressors.

Chapter Summary

Diabetes is a particularly difficult disease for individuals and families to cope with, especially for First Nations people living in rural or remote communities. The prevalence rate of diabetes for First Nations people in Canada is three to five times higher than for non-First Nations people, indicating that this is a very real and urgent issue. Much of the existing literature in diabetes epidemiology has focused on genetic, diet and lifestyle factors as possible explanations for these rates. Other researchers have begun to explore the effect of stress on glucose metabolism and diabetes management and have suggested that stress is another possible factor effecting Aboriginal peoples' health. While psychologists and physiologists have focused particular attention on how an individual experiences and responds to stress, biological and medical anthropologists have looked at how stress affects entire communities. It has been suggested that the health of Aboriginal people in Canada has been compromised as a result of the history of colonialism and structural violence, and that this kind of chronic stress (however it is defined) could be a factor explaining the disproportionately high rates of certain diseases in this community, including diabetes. Members of government, researchers and community leaders need to address these issues as they affect Aboriginal people, especially when considering population-specific community health initiatives or targeted interventions. This kind of

work could be of particular benefit to Aboriginal men, as there has been little non-clinical

work or research done addressing their health needs.

CHAPTER THREE

Methods

1. Theoretical Framework

"Context is currently mostly understood to be the role of group or macro level variables

in the determination of disease in populations," (Frolich et al, 2001:777).The relationship

between context and disease is an essential dynamic wherein the tensions between

agency, practices and social structures can be studied (Frolich et al, 2001:776). How one

is able to assert oneself as the agent, the mechanisms that one uses to do this, and the

structures that one must work within or through in order to manage or deal with a

particular situation, are important concepts to consider in community health. Context

operates in such a way that individuals' health experiences depend not simply on their

biological or genetic composition, but also on the attributes of the area where they live

(Shouls et al, 1996). The epistemological construction of 'context' in this sense could be

applied to micro-level analyses where housing, neighbourhoods or communities are

assessed, or to macro-level analyses that account for historical, political, and geographic

variables. The appreciation for context is of particular importance in this study, as I seek

to understand how many factors influence the lives of Aboriginal men in this community.

Structural violence is a term that was originally developed by liberation theologians in

the 1960s, and is used to describe the social structures – economic, political, religious,

and cultural – that stop individuals, groups and societies from reaching their full potential

(Farmer et al, 2006: 1686). In his discussion of health and human rights, Farmer (2005;

1998; 1992) identifies the ways in which structural violence operates through institutional

policies, social structures, and government relations to create an environment that removes outlets for human agency, disregards equality, and compromises health care. He draws the reader into an analysis of an entire network of factors to outline the complexities of discourses on health and human suffering. The role of structural violence (as embedded in inequitable micro- and macro-level institutional systems) in the shaping of individual and community-level experiences cannot be ignored and needs to be seen as mediating mechanisms that guide and predict health outcomes.

Epidemiological studies assessing the risk factors for a disease such as diabetes mellitus, that neglect to incorporate or address the contextual factors – both at the micro- and macro-level – could seriously limit our understanding of various conditions, further individualizing and simplifying complex disease processes. Studies in Aboriginal health need to be geographically broad and historically deep, as described by Paul Farmer (2005:42) in his work with marginalized populations in the developing world, so that they recognize the legacy of a history of colonialism and unequal power relations on the lived experience of the individual as well as the community within which they live. I have attempted to address these requirements in this work as many of these same systems of power have influenced the lives of Aboriginal Canadians. As researchers investigate social variables even further, they will augment existing biomedical research by engaging in a "theoretical quest to explain the mechanisms through which risk factors influence health outcomes," (McKinlay & Marceau, 2000).

Structural violence has shaped and dramatically influenced Aboriginal peoples' lives. "The Indian Act (1876) is the most comprehensive piece of federal legislation directed towards the management of Aboriginal peoples in Canada...The Indian Act defines Aboriginal peoples as Crown wards, subjects for whom the state has a responsibility to provide care," (Kirmayer et al, 2003:S17). Canadian legislation under the Indian Act determined two broad legal categories of Aboriginal peoples: those with Indian 'status' and those without. This designation determined whether or not the federal government would legally recognize a person to be 'Indian' by having 'status' and, therefore, how the government would facilitate the administration of programmes to Indians as well as their assimilation into Canadian society (Waldram et al, 2006:11). Many groups also signed treaties, which were created by the government to remove land titles and Aboriginal peoples themselves. This was done in an effort to support European migration to parts of western Canada. After the formation of Canada in 1867, the churches (Catholic, Anglican, Methodist and Presbyterian) were given control of the administration of education to Aboriginal peoples and in 1880 the first residential schools were formed (Waldram et al, 2006:15). Children were removed from their homes and sent to Church-run schools (in many cases these were far away from their homes) where they had little or no contact with their families, were not allowed to speak their own languages or practice cultural traditions, and in many cases were subjected to emotional, physical and sexual abuse. In addition to the disruption and damage the experience of residential schools has done to Aboriginal peoples, particularly with respect to losing important aspects of their culture, the government (supported by the beliefs of the missionaries) created policies which outright banned the practice of traditional ceremonies, including the potlatch,

which was banned in 1884 and the Sun Dance, which was banned in 1886 (Waldram et al, 2006:16).

The impact of colonization and assimilation on Aboriginal people in Canada is considered to be one of the critical issues related to the rising rates of many diseases (Mitchell & Maracle, 2005; Iwasaki et al, 2004; Rock, 2003; Bartlett, 2003; Kirmayer et al, 2000; McDermott, 1998). Aboriginal Canadians share a history of oppressive policies and racist practices that have resulted in high rates of poverty, infant mortality, and premature death (Adelson, 2001:77). Some of these trends are presented in a report prepared by a number of government ministries, entitled *Healthy Canadians – A Federal Report on Comparable Health Indicators* (2002). Data from this report indicate that in 1999, First Nations lost almost five times as many potential years of life to accidental injuries and three times as many years to suicide (Reading, 2003:185).

For Aboriginal people in Canada, the complex networks that have worked to shape and influence their lives are products of centuries of colonial rule, displacement, unemployment, poverty, racism and sexism. The residual effects of colonial forces and the loss of culture have been identified as health issues as they relate to suffering and intergenerational trauma (Mitchell & Maracle, 2005:14). Cultural continuity is a term that has been used to summarize a collection of six indicators, including Aboriginal control over government and government services, health care delivery, educational services, language and 'cultural facilities', that are said to be measurements related to the risk of suicide in Aboriginal communities (Chandler & Lalonde, 1998). Cultural *discontinuity*,

then, meaning a lack of community control, together with oppression has been linked to high rates of depression, alcoholism, suicide and violence (Kirmayer et al, 2000). Even when the violence itself is not longer obvious in overt, physical forms of abuse and neglect, there can still be "the slow erosion of community through the soft knife of policies that severely disrupt the life worlds of people," (Das et al, 2001:1).

This network of factors, working on biological, social, political, historical and geographic planes, is used by Rock (2003) to argue that social suffering can be a model for understanding Aboriginal health. "Social suffering results from what political, economic and institutional power does to people and, reciprocally, from how these forms of power themselves influence response to social problems," (Kleinman et al, 1997:ix). The physical and emotional stress that has been endured by generations of indigenous persons is bound within a relationship that is inseparable from life history.

2. Methods

Stage One: Study Design

The project on which this thesis is based was designed to use qualitative interviews to address the lived experiences of adults (18 years of age and older) living in this First Nation community in Manitoba, and to explore the topics of stress and coping for adults within this community. This design provided a safe, comfortable environment within which participants could openly speak about their lives. Semi-structured interviews that focus on individual narratives are regarded as a highly effective technique for learning

about individual-level perceptions, interpretations, and discourses of experience (Creswell, 2003; Patton, 2002; Rice & Ezzy, 1999).

All participants in the project were members of this community and lived on the reserve. Both men and women over the age of eighteen were approached by Dr. Sharon Bruce and asked if they were interested in participating in this study. A number of participants then introduced Dr. Bruce to their friends and family members whom they felt would also be willing to be interviewed. Approximately twenty-five personal interviews took place, each one conducted by Dr. Bruce; five individuals were interviewed twice. I participated in four of these interviews. These interviews were semi-structured using open-ended questions that focused on how individuals talked about stress and coping. An interview guide is included in Appendix A of this thesis. These questions were designed with the hopes that they would initiate a deeper discussion and help to illuminate the many areas in which stress may be triggered and coping mechanisms required.

Stage Two: Secondary Analysis

I have used the responses from the ten men interviewed by Dr. Bruce to conduct a secondary analysis of this data. My analysis has looked specifically at the topics of 'stress' and 'coping' in terms of individual and collective action; the individual body and the body of the community. I have then considered this material in relation to the broader social and structural issues that have an impact on the community.

I used the transcriptions that were made of the interviews conducted by Dr. Bruce in my analysis of the stress-coping dynamic among adult males in this First Nation community. I transcribed five of the interviews myself. I reviewed all data using a thematic analysis. The preliminary analysis consisted of an overview of all of the interviews – including those conducted with the women – as an attempt to familiarize myself with the participants and the issues that were raised in the material. I then began to focus on the interviews conducted with the men. I created an overall summary of this material which listed the main points regarding stress and coping raised by the participants, including the definitions they gave, the sources of stress at the individual and community levels that they recognized, the tone of the material and where their emphasis was placed, and my overall impressions. I then created 'profiles' or short biographies of each person, which included demographic information and information that helped summarize their life stories. I was able to compare each of the summaries that I had made and look for any similarities or differences between them.

I then moved into a more in-depth review of each of the transcripts when I conducted my second reading of them. I assessed each line of the transcriptions and grouped them into particular categories. The categories were based on the kinds of themes that emerged from the information elicited in the interview process, thus developing as the process of analysis unfolded. This approach to data analysis reflected my interest in looking at individual experiences and locating them within a particular context, rather than developing a rigid framework that could obstruct, misrepresent, or restrict the flow of personal narratives.

The second part of my analysis involved developing a strategy for coding the information in the interviews. I wanted to pay particular attention to how the participants talked about stress and coping at the individual, community and broader level. I created a second set of 'profiles' for each person interviewed based on the individual, community and broader level factors that they said had an impact on the stress they experienced in their lives. Once this was done, I was better able to refine the categories that I had created after my second reading, and developed fourteen different thematic categories. I then explored each thematic category in some depth, as a way to better see the similarities and differences between the participants; see where particular themes overlapped with each other; and see what the most pertinent issues were. Throughout this entire process, I was able to verify my findings with the information I gathered after spending a considerable amount of time in the community working on the stress questionnaire. I was able to assess the accuracy and validity of the data from the interviews as well as my understanding of the information against the data that emerged from the stress questionnaire. These data complemented each other.

This work then led me to develop three over-arching themes that I believe summarize the issues raised in the interviews. It should be noted, however, that these are not mutually exclusive categories and there is considerable overlap and interconnection between all of them. I have chosen to use these three broader themes as one way of presenting this volume of material, because I believe they help to refine and organize the information in a way that is systematic and clear, but simultaneously acknowledges and presents its complexity.

CHAPTER FOUR

Results

Characteristics of the Community

This study is based in a First Nations community located in rural, southern Manitoba. The name of the community will not be given so as to protect its identity and the identity of the participants of the study. The population of the community is approximately three thousand persons. It fits the broader demographic profile of a Canadian First Nations community as it has a predominantly younger population. There is year-round road access in the community and a community health centre based on-site.

Characteristics of the participants

Twenty-five individuals were interviewed for the stress and diabetes study. My analysis is based on the interviews with the ten men who participated in this study. All of the men interviewed lived in the same community, and their ages ranged from 18 years to over 50 years, with eight of the interviews conducted with people younger than 50. Seven of the men were parents with young or adult children, and three of the men were employed full-time in the community.

Addressing the research questions

The research questions that framed this study were developed as a way to identify the major sources of stress that men in this community face; the kinds of techniques that they have developed as a way to cope with the stress in their lives; and the types of resources that these men believe their community needs in order to alleviate some of this stress.

What is stress?

In order to begin to explore some of these questions, however, it is important to provide a sense of how 'stress' is conceptualized, talked about and responded to by people in this community. The participants were first asked what they thought the word 'stress' means. Their responses varied, with some people describing it as somewhat of an external factor:

"Something you are not born with. It is something that you either develop yourself or you get it from the community, leadership or somewhere else." (Male, age 50+).

"Stress is an everyday problem that you just gotta know how to handle." (Male, age 35-50).

For other people, 'stress' is something that is more personal or internal, and is the word used to describe feeling a certain way:

"[When] I am all confused and complicated." (Male, age 18-34).

"Sometimes you just feel like you have had enough." (Male, age 35-50).

"[Stress is]...something you develop as you develop in yourself as a human being." (Male, age 50+).

It is important to note that although the word 'stress' has connections to the biomedical literature, it was maintained and used regularly by the participants.

One of the objectives of this study was to look at what the participants described as sources of stress in their lives. It became clear through the interviews that the sources of stress were broad, covering a number of aspects of their personal and social lives. These sources of stress overlap with each other in many different and complex ways. They could be thought of as issues that operate at the level of the individual, such as interpersonal relationships and addictions issues, or they could be thought of as broader, community-level factors, such as class divisions within the community or the lack of trust in community services.

Emerging Themes

I will begin this next section by briefly exploring some of the themes that have emerged from the interviews with the men participating in this study. I have developed three broad categories as an attempt to capture all of these issues and organize them in a way that reflects the tone of these interviews and presents the significant themes in a meaningful way. These categories are not exclusive but interconnect and overlap in many ways, as they speak to realities for individuals, groups and the community.

1. "Bearing Witness"

The first theme that I will explore is the idea of "bearing witness". I am using the term "bearing witness" to describe the stressful experience one has when observing a situation or an event (or series of events) that is troubling, disturbing or traumatic in some way. Unlike Farmer (2005), I am not using this to describe my own 'witnessing', but believe

that it is an appropriate way to encapsulate a kind of stress that these men described experiencing in various aspects of their lives.

For men in this community, the idea of "bearing witness" is manifest in several ways:

At home

For some, intense poverty and economic deprivation has meant that they and their families live in substandard housing, relying on monthly social assistance cheques to pay for the food, clothing and other items that they need. As one man said:

> "...there's just not enough to go around, and it's hard to imagine having to live with the thought of your children being hungry and not being able to actually do anything about it because you're dependent on the government for this or that. Like that in my mind could be...unbearably stressful." (Male, age 18-34).

> "Well, like 90% of the reserve is on social assistance...There's not a lot of people who have jobs around here. And uh...it's just hard to imagine how to make ends meet without employment. Unimaginable." (Male, age 18-34).

> "Stress in our community is very high because of living conditions, our experience, our leadership, our employment rates..." (Male, age 50+).

Some men and women struggle with addictions issues and frequently consume drugs and alcohol in the home or nearby.

"But, uh, in this community you'll see that a lot of people, they don't stay together long. And it, it has to do with that. With the drugs and alcohol." (Male, age 18-34).

"But, but like I said, the most, I believe, the major factor is uh, their indulgence in uh, drugs and alcohol." (Male, age 18-34).

"And there's a lot of people that are, like they're gambling...addictions and the children are suffering. Like some people here, like I do a lot of home visits, like they live more like, uh, how should I describe it...uh, third world conditions. Yeah, like I mean uh, they're getting their assistance and they're getting their child benefit but, most of them are gambling and drinking." (Male, age 50+).

Aside from the effects of long-term use of these substances on a person's body, there is the concern that potentially violent and abusive behaviour could erupt, directly affecting those around him/her. Even if a situation does not become dangerous, there are still children, young people, and adults who *see* this happening all of the time and struggle with the notion that their parent, sibling or friend is using these substances. One of the men described his impression of what is happening to children and young people in this situation:

"...cause some of them [kids], they don't even want to go home. Maybe they have problems at home. They don't want to go home on the weekend, their parents are drunk..." (Male, age 35-50).

"Some of it is alcohol-related that these kids go through. Some of them...some of the stress that they have is...they seen an older brother or an older sister be molested, and they don't know, understand, they don't know how to cope with it." (Male, age 35-50).

Gambling was often mentioned alongside drugs and alcohol as another issue that can significantly affect the home life. One man described how he is concerned about the number of children in the community who are neglected when their parents or caregivers leave them for long stretches of time and go to play bingo or the VLTs. Some children in this man's extended family have approached him and expressed how frustrated they are:

"And my [family members] – the ones I mentioned before – one wants to kill the Bingo caller because [gives name] spends so much time there. He's going to burn the complex down, the bingo hall, because there is no food in the fridge and he's hungry all the time. Damn that bingo. Another [relative] of mine doesn't like the slots. He says he's going to burn the complex down because his Mom goes to Bingo or else they're at slots all day and they never have anything to eat, and their Mom and Dad don't get home until it's time to get up in the morning, everything. They don't see their parents 'til two or three in the morning and then they just see them sleeping when it is time to go to school, you know." (Male, age 35-50).

For this man, and likely for many other people, the effects of gambling and other addictions issues on people in the community are particularly difficult to deal with both directly as they drain already limited financial resources and can compromise

relationships, and indirectly as they 'witness' these issues being played out in various ways.

At work

Beyond the home, "bearing witness" can be an unfortunate, residual part of one's job; a significant source of work-place stress that is difficult to escape from. One of the participants in this study, whom I will call *Bill*, spoke passionately about what he confronts as part of his work in the community. *Bill* is a young man in his thirties and a father of three children. The nature of his work requires him to make regular visits to community members' homes, where he sees first-hand the conditions in which people live. *Bill* says he would describe the community as both beautiful and unsightly. When asked what he meant by 'unsightly', *Bill* said:

" Um, poverty. Um, I guess that would lead to a depression. You know, the alcoholism, the abuse of the children. And when I say abuse of the children what I mean is uh...sometimes I go to a home and children 8 years old are taking care of kids 2 years old, and it's like Child and Family Services (CFS) cases. And uh, it's sad. Unfortunately, a lot of that exists here."

For *Bill*, the word 'stress' means more than having to worry about his own family:

'Stress' is..."[h]aving to worry about my clients. Having to worry about the environments that my clients are in, and uh, environments their kids are in. As I stated earlier, with the children there, I take that home with me and I don't forget about it. It does weigh a lot on my mind...it does."

Bill describes himself as being in a "no-win situation". He both lives and works in the community. The community is small so many people know where he lives or knows how to get in touch with him.

> "It's unfortunate, because I love this place. You know I live here and I don't ever want to leave. But having to see what I see and deal with what I deal with...I do need a little bit of private time."

The demands are constant, and despite trying to protect his time and his family, *Bill* has frequently been contacted in the middle of the night – something that has been difficult on his wife and children:

> "As well [people phone me after 5pm – some paraphrasing], so people uh...you know I've let the job linger on, I'll go and take care of it then...and then, then of course I'm spending too much time away from home and my partner would say, uh, well you know, like there is only 24 hours in one day...and how many of those hours are you going to spend with your family here."

The work-home balance is a challenge for anyone, but for *Bill* it appears especially important to maintain. He is almost hyper-vigilant about his relationship with his children, and relies heavily on the idea of providing a safe and supportive place for them in order to get through some of the stresses in his own life:

> "I look at my children and I realize that this is what I need to do with my life to make sure that they...can find, um, can get an education where they are able to determine their own future..."

Bill, like the other men, has thought very deeply about the dynamics between community members, between family groups within the community, and between the various structural factors that determine people's lives. He has a number of ideas and suggestions for how to improve the quality of life for everyone – particularly at the moment as people try and 'cope' in trying circumstances.

> "We need something in our reserve to uh, provide for our children. Some avenue where they can get out to go and do something out of their own free will. To uh…just kind of get away form their parents and let them not have to worry about what's happening to the children."

Many of the men focused on the positive effect recreation opportunities and individual counselling could have in the community, because they provide something for people to do, a safe place for people to go, and the opportunity for people to share some of their stories.

What is important to consider in regards to 'bearing witness' is the profound effect that this phenomena has on an entire community. The day-to-day burdens that men and women must face can be overwhelming and dictate how they are able to live their lives. People feel burnt out, and this kind of chronic stress could negatively affect their health. With competing priorities, residents are limited in the amount of time and energy they have to focus on other issues, such as supporting the potential within individuals or community development.

2. "Frustrated Potential"

One of the other striking themes that emerged out of these interviews is what I am calling 'frustrated potential' – that is, being in a position where you are unable to foster your own or see others foster their own skills, abilities and talents in various fields. There are degrees to this, which could range from the basic - learning how to play a certain sport or doing a certain activity that you are interested in or where there is some obvious natural talent; or to the more profound – having access to educational opportunities, or being able to develop the interpersonal skills that help maintain healthy relationships and which allow for personal growth. 'Frustrated potential' overlaps with the ability to reflect on experiences and develop coping mechanisms.

'Frustrated potential' emerged as a theme in the interviews with the men in this study as they spoke of two powerful issues: recreational programming and opportunities; and the education system.

Recreational Opportunities

All of the men interviewed in this study expressed some concern regarding the limited recreational opportunities available to residents in the community. The lack of resources or investment in recreation programming, particularly for children and young people, has meant that there is nothing for people to do and no place for them to go:

> "And there's not enough happening for our young children, and also the adults and the elders. Like basically there is nothing happening, there's nothing in place…for them to keep busy." (Male, age 50+).

"There's not really much going on. Like I first said about the youth, teens, elders and even adults. There's no activities going on at all. There is some, a little activities going at school, but that's only during school hours, which they only take an hour a day, so...and once the teachers are gone, like 3:30pm, 4:30pm, there's nothing there for them." (Male, age 50+).

"There was hockey games, baseball games, they used to take us to Indigenous Games all the time, and we don't have that now." (Male, age 18-34).

"...lots of people really want to play sports like beyond teams and stuff like that. They are interested but no one does anything for them." (Male, age 18-34).

PI: "Yeah, there's a lot of talent..."
1015: "Yeah, but no one really sees it. Or not enough funding to like further the talent." (Male, age 18-34)).

One man also commented on the lack of activities even happening at the school:

"Just, in short, the teachers...most of them come from [outside the community], and they get here at ten to nine and they don't have...and when that buzzer rings, they are the first people on the road, flying down the road and the buses are next." (Male, age 35-50).

The participants naturally made a connection between the limited number of activities available to people of all ages in the community, and the possible physical and emotional outcomes of this. One man spoke openly about some of the concerns he has had regarding the health of one of his children who has a chronic health condition. He tries to encourage him to eat well and be physically active in order to maintain healthy blood glucose levels. It has been a challenge to be active, though, because there is no recreation centre to go to and no organized sports teams initiated at the community level:

> "... [Child's name] is the one that is not really active. I don't know why...and yet he played when he was younger...I just think it's the place where we live, because when we stayed in [names town], he was involved in hockey, soccer, baseball. Everything was there, everything was within that community cause it's small – you could just walk. But here there is nothing here really since we got here. Well, even before we left there was nothing really. No solid foundation like a sports facility, or recreation centre. There is nothing." (Male, age 35-50).

More recently, his son has had to rely on his father's encouragement and his own walking programme in order to get the exercise he needs. Many of the community members believe that programs and facilities within their community would help facilitate activity and involvement.

When asked what kind of impact this has on kids when there is nothing to do, one man responded bluntly:

"You should go check our pre-natal class – you'll see what they do…There's only two options…there's three options, well, maybe four: you can drop out of school, and when you drop out of school you can get into drugs and alcohol; once you do that then you can get…then you can become a mother or father." (Male, age 35-50).

"They'll go…there's nothing out there for them [young people]. There's no resources, there's no help for them. If there is, nobody's telling them about it… But, uh, they'll go into drugs. It's just like an everyday thing. That's how they'll get away from reality." (Male, age 50+).

There were several comments made by the participants about the lack of recreation opportunities and the turn to smoking or the use of drugs and alcohol. The use of these substances appeared both as a means to cope with the stresses people were experiencing in their own lives, and as something for people to do to occupy their time (because there was nothing else to do). As several men alluded, if there are few recreational activities available for community members then other activities start to take over, particularly for children and teenagers:

"…to keep the kids occupied you've gotta give them something to do besides drugs and alcohol….you gotta attack the drugs and alcohol, probably…You've got to give them an alternative for the late night parties or open something at night for them. Give them something to challenge them so they can stay off it." (Male, age 35-50).

One young man spoke extensively about trying to organize various activities amongst his friends and peers living in the community. Most of these activities were sports, such as hockey and baseball. Despite showing some of their own initiative, this man and his peers were not supported – financially or morally – in their efforts to get these activities started:

> "No, everything is about money I guess. If you want to start something all you, you need to deal with the by-law, whatever you need there, take this up to...the Chief says he never has any money for anything. Like, um, we were supposed to go to [names place]...but he said that there's no money for recreation." (Male, age 18-34).

> "There used to be a team that played hockey at [names place] but they quit playing because they really didn't have any money to go over there, to come back...no, like, support. You have to do everything on your own, use your money and everything. It's hard." (Male, age 18-34).

What is interesting to note in his comments, is a clear gender effect where girls and young women are either not involved, not invited to participate or are assumed to be uninterested:

> "Girls, all they really do out here is get high, smoke, drink and whatever. Nothing really for them out here." (Male, age 18-34).

Working and living in an environment where few opportunities exist can seriously affect the mental and emotional well-being of the people. The frustration can lead to anger, resentment, and hopelessness, even among children:

"Uh, well, they're [kids] angry, they're rebellious, they're acting out. The same thing they're doing at the schools..." (Male, age 50+).

There was a particularly troubling sense of despondency from one of the young men interviewed and from the others who talked about how people give up because they feel so discouraged:

"Yeah, it just kills their momentum and they want to quit and whatever." (Male, age 50+).

One man expressed considerable frustration and concern regarding the changes he has seen in one of his pre-teen sons who, at one point, had been involved in a number of different activities within and outside the community (when they were available). Things have changed, however:

"...there was nothing...so he basically gave up...but didn't give up, but there was nothing he could do except play...throw the ball outside." (Male, age 35-50).

Some of the community members are so frustrated with the situation that they have even left, or have considered leaving:

"Also...well since I was growing...like since I can remember – maybe fifteen, sixteen – like our leaders, like our Chief and Council claimed that whenever they

go on the election run, when they are campaigning there, gotta put...they're going

to develop new strategies for kids so they can have recreation and all that...that's

all they say is that, like, they're gonna help the kids out, they are going to develop

programmes and nothing ever comes of it. So that is why we...that's why we left,

cause there was nothing here." (Male, age 35-50).

For the individual, the experience can be frustrating at different levels: you are not able to

participate in activities that you might enjoy, or that might bring you some peace in your

day; you cannot develop other skills that such sports, arts and music, or social

programming could provide; and you do not make new social connections or have the

chance to build new relationships with colleagues and peers. You may also see others in

the community suffer as a result of this. The potential within each person, therefore, is

not fostered or allowed to grow – something that could be especially disheartening for

parents and families to witness.

By not having certain services available to community members, such as recreational

facilities or organized programmes, the community as a whole loses the opportunity to

help foster various skills in its members and to be able to provide them with the kinds of

activities that could help them cope with the other stresses they might be experiencing in

their lives. The community loses something in the long-term, as it does not build a local

'infrastructure', in a sense, of skilled individuals. It also risks losing young, capable

community members to other towns and cities where there are more services available to

them and their children. The consequences of all of this for 'building community' is devastating as the investment in people and the community is not made.

Education

The second significant area that speaks to the theme of 'frustrated potential' is that of the education system. Some of the men interviewed in this study were parents and caregivers of young children, and had particular concerns regarding the quality of the education their children (and other children in the community) were getting; the stresses children and teenagers faced as they struggled through the school system; and the limited number of students in the community who graduate each year. Other men who talked about schooling spoke from the perspective of a student, or as community members genuinely concerned with the progress young people were making.

One of the fathers in this study described his uncertainties about the quality of the education that his children were receiving, both in terms of the curriculum and the teaching methods used. He has had some experience living and attending school outside of the community and has some additional post-secondary qualifications. Perhaps because of this, he is able to reflect on what occurs within the classrooms each day, what this means for the students who graduate, and what the long-term impact of this is on the community as a whole.

> "For a community to develop and to have better quality for their members, I don't know how it has been going, like I'm...I graduated in [states year] and so far we haven't developed. All we have developed is [indicates number of professionals]

...and there's teachers, we've got tons of teachers, but...that's where the problem in our school starts. Cause we've got these teachers that went through the PENT (Preparation for Education of Native Teachers) programme – not through the regular session..." (Male, age 35-50).

As with many schools within and outside First Nations communities, the school in this community is often dealing with issues such as absenteeism and bullying. These issues seriously affect a student's ability to learn, classroom dynamics, relationships with other students and teachers, and the ability for a student to succeed in their studies. One man spoke extensively about his concerns for students. He is a parent and has considerable experience working with children and young people in various counselling-type positions. He believes the frustration that children experience in school and some of the behavioural issues that occur are a result of a disconnect between literacy levels and appropriate grade placement:

"...some of them come in and they put them in a grade 9 level, grade 10 level, really, they're only a grade 5 level. Like some of them can't even read. Yeah, and they're still in grade 9. So, I think they're stressed out. That's when they start acting out..." (Male, age 50+).

"I think they were depressed. That's exactly what that one guy said, "depressed". Because sometimes you have to read and everything and you have to participate on this, at the school, or when...or then when they do exams. So, they didn't

know what to do, 'cause they can't do it...So, again it was, they just act out." (Male, age 50+).

"Most of those kids are not even in school. And the kids that do go to school, they're not learn, they're not learn...I don't know if they're not learning or anything, but...[some kids] are more or less causing trouble. That's why they don't want to, that's why other kids don't want to go to school cause they're being bullied and....That's how it is like...now when a kid gets into a fight it depends whose kid that is whether he stays in or goes." (Male, age 35-50).

The resources of the school are often stretched, and the extra help that an educational assistant can provide in a classroom, for example, may not always reach every student:

"Well, there is [staff at the school to support students], but our school is also overcrowded." (Male, age 50+).

Attendance, safety, and the quality of the education are all factors that can influence whether or not a child stays in school and is able to graduate, and there seemed to be quite a significant level of concern among those interviewed regarding how few students graduate from high school each year. One man made a comparison between his community and another Manitoba First Nation of comparable size. Despite many similarities, this other community, he said, has far more graduates each year. In his mind, much of the reason behind this has to do with the general lack of encouragement and motivation that kids are getting from members of his own community:

"...cause they [neighbouring community] push...they push their students to become...to do whatever they want them to..." (Male, age 35-50).

At the moment in this community, as this man suggests, there is not enough interest expressed by fellow community members in the lives of the children and young people. This could have a residual effect on children as they may not be motivated to attend school, be supported in their efforts to succeed in school, and lose interest in pursuing post-secondary education or training. One man who did go through high school in the community and was able to finish several years of post-secondary education, suggested that none of these issues are at all new:

"There's nothing really changed [since he graduated]. So that's what there really isn't much people...there isn't much graduates going on to other professions other than teaching. Other than, what can I say? Cause there is hardly anything...there is no, how would you say, motivation?" (Male, age 35-50).

"They don't go out and actually decide I am going to do this for three years, cause there is no set guidelines or role models, or however you want to say it for our youth to graduate. Cause most of our youth that graduate aren't going nowhere. Once they graduate that's it, because there is no other, there's no...they're not expected to do any work cause they don't know who is out there and who has completed what. There is no role models, there's...nothing." (Male, age 35-50).

Some of the men interviewed felt that students and young people see no other option, or are not provided with an opportunity to meet people who have finished school and pursued higher education or additional training. When asked if students who do graduate from high school go and try and get other experiences, one young man said:

"[They] stay here and don't leave, even if they graduate. Most of the people just stay. They don't even care or anything. I mean, they have that education, they have that option, they could just easily go and get a job but they don't take it, I guess. Or else, sometimes they don't get funded, so it hurts them, I guess, in a big way...That's why I really want to finish school...that's my goal." (Male, age 18-34).

For the few people each year who do graduate from high school and want or are encouraged to further their education, there are even more challenges once they attempt to leave their homes. Leaving your home to go to a new city for college or university is a significant change in a young person's life, and can be incredibly taxing. Students face a number of challenges, even in the most ideal of circumstances. As one young man said, however, there are additional challenges that a young person who has spent his/her entire life in a First Nations community faces when they try and leave:

"...but for ones who have never stepped off the reserve or have been off the reserve or lived off the reserve for that matter, um, it would be pretty intimidating for them. It would be a bit...that might cause some stress as well, not knowing where to access the services that you require if you are, say, a sponsored student or if you are going on social assistance or whatnot." (Male, age 18-34).

One man reflected on his own personal experience with these issues and with the other issues that can arise for young Aboriginal people who leave their home communities:

"You get pulled back. Cause when you come back, like, when I was going to school in [names place], I used to come back and people used to tell me what are you going to school for? There's nothing out there. You're not going to get anything, you're just going to come back and live on welfare. That's the same old saying that people do it are just trying to bring you back so you can live with them, live in their style. But…that's gotta be broken…" (Male, age 35-50).

The 'pull-back' factor could seriously undermine someone's pursuits and efforts to move forward. While it is difficult to explain why this might occur, the effects of this are clearly detrimental to individuals' growth, levels of confidence, and careers. The lack of encouragement from one's own peers and family is extremely damaging.

The lack of encouragement from the broader community is also severely damaging. Two of the men addressed the discrimination and racism that Aboriginal people can face:

"Yeah, I think so, it does play a big factor – racism. And when they [teenagers] are not accepted in the public or when they go somewhere…somebody, you know, looks at them a certain way just because they are Native, you know. I think that is very stressful, you know." (Male, age 35-50).

"Yeah, even neighbouring communities, like, um, they stereotype the Native people. As soon as they see that you are Native – you are an alcoholic, a drug

abuser, or a thief. That is another thing that is a stigma that you carry with you when you go off the reserve." (Male, age 35-50).

"...racism is a big thing, and again when you ask, like, when you do a resume they ask for three references and you include that and then they say 'Do you have any other references?'" (Male, age 35-50).

According to the men interviewed, individuals cannot necessarily develop their skills within the community and yet are not encouraged or supported when they seek additional training elsewhere. Despite the fact that these are the kinds of opportunities that people should have as they develop the skills needed to survive, become well-rounded individuals, and contributing members of society, they do not seem to exist. The system that does exist, particularly with respect to education, is clearly not satisfying the needs of this community or providing its members with the support required to foster their potential.

3. "Support"

The third theme that emerged out of these interviews is what I am calling 'support'. Support is another somewhat nebulous concept that could be thought of in a number of different ways. I am using the term here to describe the physical, emotional and social support that people receive (or do not receive) from various actors and sectors in their lives. Support is something that could be provided by a partner or friend in a personal relationship, extended family members and neighbours in a community, or, in even

broader terms, leadership and those in government. The excerpts presented below describe support in all of these ways, but focus most specifically on how the lack of support in these areas can determine so much of peoples' lives.

Relationships

Interpersonal relationships, particularly those with a romantic partner, were frequently mentioned by the men in this study. Their focus was on the process of developing and maintaining a relationship with someone. Relationships, therefore, were seen as stressful for a variety of reasons. They are challenging bonds to build and maintain, and require constant effort. When there is some amount of tension, what can be a very positive aspect of one's life can become more difficult and cause distress. Arguments and fights between partners were frequently mentioned as sources of stress:

"I'm still working on my relationship. It's more like it's stressing me out." (Male, age 50+).

"When my girlfriend gets me mad that's how I feel. I feel like all tight and so I ignore her..." (Male, age 18-34).

Abusive or otherwise 'unhealthy' relationships were also seen as a source of stress:

"Well, there's...bad relationships that could cause stress." (Male, age 35-50).

"My relationship with it [abuse] was just, for me was just being overly stressed because of the verbal abuse. The things I didn't want to hear. She said it, and

so…that kind of just brought me down. That can cause stress, because you can't

do anything. Then you just have to go somewhere and…" (Male, age 35-50).

The break-up of a relationship can also pose its own challenges for those involved:

"What is stressful for [me] is [my] separation. I have been separated…for two

years. After [my spouse] left I was depressed and considered suicide." (Male, age

18-34).

"…a lot of these people, like I don't understand, like even my age, like, they live

in relationships that they can't control. Either they lost their wives, stuff like that,

they lost their jobs and everything. Their health just goes right down. Yeah, they

start drinking, stuff like that…" (Male, age 50+).

What is often a 'primary' level of support for individuals experiencing challenges in their

lives can also prove to raise its own sets of challenges. The greatest effect of this might

be in how additional stresses are added to someone's life, or in the effect of not having

this support to rely on when trying to cope.

Family life

The men in this study spoke about the challenges they have faced, or see others face, at

home. The family unit – something that is often a critical component of social support –

can be a significant source of stress, and these men spoke about this in several ways.

Much of what they said is tied to other factors, such as economic strain, employment

issues, separations and parent-child relationships, making this a complex web to attempt to untangle.

The poverty and economic deprivation that individuals and families face can influence how and where a person lives, as well as how they interact with members of their extended families:

> "But there's just no money in the reserve. Like the way, uh, like I'm gonna talk about that again. Like, uh, these people are saying to me, these young adults, which are twenty, like they, um, they go in cycles. They'll live with one family member for a few days, the other family member, like they'll keep on moving right through the month. That way they don't have to, um, share expenses…" (Male, age 50+).

On some level, this could be a method of coping for the young person who can remain mobile and control their contact with family members and friends but also benefit from having a place to stay if needed; however, this can be a source of stress for their family members and friends who must feed them and provide them with some assistance when they appear at their homes.

Other families struggle with the relationships between children, siblings, parents and grandparents, as well as the responsibilities for the caregivers. Parent-child relationships were frequently mentioned as sources of stress. Some men suggested that many parents do not know how to parent or look after their young children and that they have not been

shown how to raise a family. There appears to be a generational affect, in a way, because children and young people grow up to raise their own families the only way they know how – from their own experience. One man was quick to raise these issues when he was asked about sources of stress:

> "…lack of parenting, there was no parenting for them [adults in the community] at all and some of these are very young parents themselves. They come in here and they don't know what to do and uh, sometimes they will do something to jeopardize their children, their marriage." (Male, age 50+).

In addition to feeling some parents are uncertain of how to raise a family, this man explained that people in the community are also concerned about the interpersonal relationships between parents and children, particularly teenagers and young adults. If arguments and disagreements occur frequently then it is a challenge to build strong, healthy relationships. One man described the outcome of what he sees in the young people he talks with who live in environments where there is a significant amount of family tension:

> "…like in some cases it's from as you go to teenagers, the disconnection from the parents, the connection between the parent and the teenager isn't there and they'll have younger siblings and they're kinda pushed aside and that's how they felt and everything…" (Male, age 50+).

While in some scenarios a child may feel pushed aside or neglected because of the family dynamics, in others these feelings are amplified when a parent enters a new relationship.

Some young children are left alone or to care for their younger siblings while a parent is out of the house and others are sent to stay with relatives. As this man suggests, this often happens when a parent is dating or entering a new relationship:

"...sometimes the children, just, um, end up like the one that stays home – she's the father or the mother, but once, but again, when the mother or the father finds another relationship the children are abandoned, so they have to go to the...either the uncle, aunt, niece or grandparents." (Male, age 50+).

The emotional distance that could develop between a parent (or caregiver) and his/her children then gets translated into other aspects of their lives, as they spend even less time together and remove themselves even more from each others' lives:

"That's another thing, lack of parent support, parent involvement when something is happening." (Male, age 50+).

"It seems like, um, their parents don't really say anything to them. They don't care how they act or anything. So it just makes them think that they could do whatever they want. That sort of thing. So they feel like they could do anything at school, they could do what they want and not listen. You know, whatever, drink, smoke... " (Male, age 18-34).

"They [parents] try to discipline them, but they don't want to listen. So, I don't know, they just sort of give up hope on them." (Male, age 18-34).

The death of a loved one was also mentioned as being a source of stress for these men. In many cases, it was the death of a mother or aunt that they found particularly upsetting. The frequent number of deaths of family and community members, often within a short period of time, is also disturbing:

> "...those are some of the things that I can think of that were stressful, besides losing my Mom and my cousin in the same year, and then the year before losing my uncle and my niece...it was kind of stressful..." (Male, age 35-50).

For one man, some of the stress that he is facing has not only to do with the death of his partner, but also with the responsibility of caring for his partner's children. He has found this to be increasingly difficult as he has entered into a new relationship:

> "So, the only father they [his wife's children] really know is me, since they were small. So, um, when my [wife] passed away and then I went to this new relationship. And these kids, they see me as their [Dad] and now it's kind of like, I have two of my own children at home, they're teenagers. I have five but three moved out already, so, um, my [new partner], now will not accept the other children...like that...I'm kind of um, disconnected from them now. I don't get to see them, they don't get to see me..." (Male, age 50+).

Family and the Community

Family is central to peoples' lives. It organizes relationships and roles and can provide emotional, financial and practical support for children, young people and adults. The family is where values are passed on, lessons are learned and a sense of continuity and

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togetherness can exist – even in times where it is lacking in other areas of life. However, from what these men described, as much as the family can provide a means to cope, it can also be a source of stress. Because the family as an institution is so central to peoples' lives in this community, it affects everything. As these men indicate, 'Family' membership determines social status, political manoeuvrings, and how the entire community operates.

Some of the descriptions of the relationships between Family groups within the community were particularly passionate, and resonated strongly throughout the set of interviews. Each of the men talked about the long-standing divisions in the community:

"Uh, like I said the respect was lost from them and like that's what we're trying to focus on right now is to reconnect the community itself. Like it's all fallen apart. Like, this part of the reserve is different from this part. This age group is different than this age group and all that, it's all divided. Like in our community is in age groups and who you are – really from your last name. It's all divided, who you're related to and that. If you're on the wrong, on this side, you're labelled. Like, how should I describe that, it's more like, uh, like more…cattle, I should say. Like you have your top breed and the ones that are no good are, you'll get top dollar for a top breed and just uh, way less – they're not going to herd them. You have to be a full breed, I should say." (Male, age 50+).

"Ever since I remember there has been distinct groups. Like, cause as I grew up I knew, cause we stayed on that side and that's who we hung around with." (Male, age 35-50).

The divisions between Families in the community not only affect interpersonal relationships but can get amplified in the political arena. There were many comments about leadership, the electoral process in the community, and how frequent political change affects employment:

"Every time, like we change Chief and Council, new, every two years, like when there's a different leadership, then everything changes again. Just an example, before this leadership, before this new Chief, all the people that were working...then this new Chief came and within two months all these guys were laid off left and right..." (Male, age 50+).

"It is hard for people to move around, to move off...and also you got the instability of Chief and Council. Not too, too sure if you want to be committed to a job cause you don't know how long that job is going to...how long you are going to have that job. People don't really look at the long...well, the Chief and Council don't really look at the long term to certify their people properly..." (Male, age 35-50).

While changes in leadership can affect job creation, it is the favouritism and nepotism that the men spoke of that influences *who* is able to get a job in the first place. If there has

been a history of tension between certain large Families, and one of those Families finds itself in a position of power, they can dictate hiring practices and determine training opportunities for whomever they want, regardless, some said, of ability:

"Any kind of training comes out, the first ones in there are always appointed by the Chief." (Male, age 35-50).

"Yeah, like, the whole staff at the [names organization] got trained over when the new leadership came in, because the other ones were supporters of the other [group]. Then they fired that bunch...Before that, it used to be just, like, as long as you could hold a pen you got a job." (Male, age 35-50).

"...People who don't even have any experience get jobs....Like when a job posting goes out, the people that applied for it, even if you've got the skills for it, you are not guaranteed to get it. It is the person that has favouritism or they're upper...like [gives name]. [He/she] has poor people skills, and [he/she] is rude and interrupts." (Male, age 35-50).

"Yeah, she got it. She just had to apply. She already had it – she didn't have to apply, all she had to do was put in her name that she was applying for it." (Male, age 35-50).

"And we just figured, and we looked at each other and we just said, ah we might as well forget about it. Cause it's...it is all fixed, or whatever you want to call it. It's nepotism." (Male, age 35-50).

One of the men interviewed was at the 'receiving' end of this, and benefitted from his connection to leadership:

"Well, they have the power and the authority and sometimes they hold up their power to help certain people, and I was one of the fortunate ones." (Male, age 50+).

Some of the participants spoke generally about the anxiety that exists in the community based on the politics of Family. Family, in this sense, could incorporate blood relatives as well as close friends who may benefit from knowing a person in power. One man was very direct in talking about the fear of retribution or retaliation against you if you say anything that challenges the system – particularly as it relates to leadership and employment:

"People deny it because they don't really want to face the truth, they don't want to face what is happening...cause that is where the community is right now. They are in denial cause of what is happening to them. They can't say anything to anybody and they just hide it, saying that's not the truth. Me, I just tell them why don't you just say what you gotta say and get it off your back, it's not going to hurt. You may lose your job but you can always get another one." (Male, age 35-50).

Coping and Coping Mechanisms

In an effort to handle the stress they faced, the participants talked about having developed various 'coping mechanisms' that they found helped them to alleviate some of the difficult feelings that they were faced with on a continual basis. Several of these strategies were actions or activities that they did alone, such as: having a hobby; turning to religious texts, prayer and meditation; going for a walk; or getting away from the community for a few hours. Some of the activities that the participants mentioned involved doing things with others, such as: going to a movie with family; visiting relatives and friends; or playing games outdoors. Whatever the mechanism chosen by these men was – be it some kind of physical activity, social activity or something to meet their spiritual and emotional needs – the purpose was to provide some outlet or escape from their present situation.

There are challenges in all of this, however, and some of the men described how they often have difficulty trying to cope with things. One of the hardest things to do, they indicated, was dealing with the emotional aspects of stress and learning to verbalize how you feel:

> "Just that we don't know how to express how we feel and then what is bothering us. That could make things more stressful and then to become sick." (Male, age 35-50).

"Stress...we don't know how to express, ask, I think that causes a lot of stress that way. Some people really get shy and have never been taught." (Male, age 35-50).

The honesty in these statements shows a significant level of reflection on the part of this man, as well as a degree of struggle. Perhaps, as men, they have found it difficult to 'manage' their stress because, as indicated, they have not had the opportunity to learn *how* to; perhaps, as community members, they have few outlets they can rely on to help them cope. Regardless, these men have several of their own ideas and suggestions for things that they would like to see happen in the community that could improve peoples' lives. It is this sense of 'resilience' that is particularly profound amidst this trauma.

Profile: *"Tom"*

I would like to end this section by presenting the story of one man in the community. I am doing this as a way to illustrate how an individual is engaged in thinking about stress and coping, and can then move to a point of giving meaning to these experiences and provide suggestions for the betterment of the community. This ability was by no means expressed only by this one man, and indeed all of the participants reflected on the community and were able to articulate the changes that they would like to see take place. However, it was the intensity with which this man spoke and the clarity of his vision that deserves notice. The name of the man in this story has been changed to protect his identity.

Tom is a young married man and the father of two children. He has lived on and off in the community for most of his life, spending some time as a child in various other towns and cities across the province. Perhaps because of his experience now as a father, or because of his general interest in community development, *Tom* is particularly concerned about the children and young people in his community. He will talk a lot about the things he sees kids having to deal with, such as: bullying; in-group family fighting; the lack of resources or opportunities; and what he refers to as a "lethargic attitude".

Tom gets frustrated when adults complain about children and young people, particularly because he sees them getting labelled with stigmatizing terms such as 'troublemaker'. He commented, "Didn't other people get into a fight or two at one time when they were younger? But they're not labelled a troublemaker…" .

Like many people interviewed in this study, *Tom* believes that the stress people in his community are feeling greatly affects their health. Stress allows for "…the loss of direction, what to do, how to borrow, where to access it from and what not. And that can also lead to bad eating habits as well. You know, tons and tons of sugar consumption, fatty foods and…poor hygiene." He sees a growing need in the community for more organized activities to be provided for everyone as a way to relieve stress. *Tom* also thinks that there needs to be a youth healing councillor who could provide some training in anger management and help rebuild a sense of community that he feels is not there.

His emphasis on community-level supports for individuals and families as a means to help people cope with the various stressors in their lives is especially interesting given that when he talks about how he copes with stress, he focuses on individual-level factors. For *Tom*, 'coping' with stress has been an on-going learning experience. "Like I didn't really know how to cope with it until I started actually reading...reading books and finding out different methods that a lot of people employed." Music has helped him release some of his stress and anger, as has going out for a walk to a nearby lake, or writing a letter to himself.

Tom feels that he needs to balance his family obligations with work, and his desire to be some kind of mentor for people in the community. "I feel that everybody has the power to succeed in whatever they want to succeed in, be it in sports or education or going out there and playing at concerts or going out there and being a comedian or an actor...it is just, it is just accessing the right resources to accomplish what you want...".

Despite the many challenges that people face in this community, there is still a considerable amount of hope and trust in the future. What *Tom* and the other men have described is a community that has been overwhelmed, at times, with varying types of trauma and one that still grapples with many complex issues. However, there is a strong sense of resilience. The community is still there, the people are still there, and the ideas for what could be done to make life better for everyone are there in the community members themselves.

Solutions

I would like to complete this section by presenting some of the more hopeful and positive aspects to these stories as a reflection of how capable and strong members of this community have been despite considerable hardship.

While the initial tone of their words was critical, the men in this study moved quickly into more of an applied area. They could describe the various complex sources of stress operating at different levels for them and for other residents in the community, but they could also describe how individuals coped with their stress. They then related all of this back to existing community services and the areas that they felt needed improvement and further development. Their recommendations emphasized building stronger, local, community support systems and included the following:

1. Establishing organized recreational programmes and constructing facilities where these could take place;

2. Expanding existing mental health and counselling services to meet the needs of persons dealing with addictions issues, grief, post-traumatic stress, and other issues; and

3. Having community-wide activities, events and ceremonies that would be open to people of all ages and from all families as a way to help foster a stronger sense of community and build new relationships.

Some of these men had already been involved in organizing several activities in the community or had made specific suggestions for expanding existing community resources. Examples of these included:

1. Establishing a safe place for children and young people to go if they do not feel comfortable at home. This would require opening up the building that once functioned as the recreation centre and having it supervised 24-hours each day with support staff and security. This kind of facility would give children and young people an alternative place to stay if they are in danger at home, have no where else to go, or are in crisis;

2. Taking advantage of the community's proximity to a large lake. If the area surrounding the lake was cleaned up and some facilities were built nearby, it could be another place where community members could go in the summer months. Children could take swimming lessons, and students with their lifeguard certification could work and monitor the area;

3. Developing local after-school programmes that would keep children busy for several hours after school was finished and while their parents may still be working. This could give children the opportunity to be involved in different activities, sports programmes and leisure events, and also give parents some time alone or to complete other errands without having to worry about where their children may be; and

4. Having regular "theme" evenings where everyone in the community is invited to participate in an organized event based on something suggested by a community member. These events, as one participant indicated, have been based on

something children see on television or popular culture, such as recreating a "Fear Factor" night or an "Amazing Race" night. These peak young peoples' interests in particular as they reflect things that they regularly see and are interested in.

These reflections, alone, indicate that these men are engaged and interested in community development. This kind of reflexivity is something that leaders need to recognize as they work to address local issues. It is also something that should be recognized in the scientific literature that looks at Aboriginal men and men's health in general. This literature, as has been argued, tends to view Aboriginal men in a particular way that focuses much attention on pathologies. Individual action, agency and resilience are seldom discussed and emotional health and well-being in only a select way. By creating a space for these men to talk, we can see the degree to which their sensitivity towards and passion for their community could be of significant benefit for community development.

CHAPTER FIVE

Discussion and Conclusions

Revisiting the theoretical framework

The theoretical framework from which I approached this work, on the broadest level, recognizes the relationship between context and disease and the impact that social structures have on health. Foucault (1988) used the term "bio-power" to explain the ways in which power relations work in and through the human body. This kind of approach examines the interconnections between persons and social relationships within the body politic – the system of power that regulates, disciplines and exerts itself over a population (Scheper-Hughes & Lock, 1987). As Turner (1994) argued, the body is not independent of the social forces surrounding it, but is continuously constituted by them. "The body has a history and is as much a cultural phenomenon as it is a biological entity," (Csordas, 1994:4).

The purpose of this work was simply to explore the area of stress and coping for a group of Aboriginal men living in a First Nations community. However, in their discussions of stress and coping, the participants in this study ended up describing how various systems and sources of power, such as socioeconomic status, Family relations, and politics, influenced their lives and their well-being. We can see that stress and coping are strongly influenced by political and economic factors existing in the community which then influence personal relationships, community development, and health.

I would now like to return, briefly, to the goals of this research which were: to determine the major sources of stress identified by the participants; to determine the kinds of coping mechanisms participants have developed to manage this stress and explore these at different levels; and to determine the types of resources participants felt were required in the community to help alleviate stress. By examining each of the themes presented in the results section in turn, I will address these goals and consider what they mean for the community and for future research in this field.

Bearing Witness

One of the themes that emerged from the interviews is what I called "bearing witness" – that is, the experience one has when observing or coming to know of a situation that is disturbing or upsetting in some way. In the context of this study, there is an underlying sense of chronology to this as well, where there is repeated exposure to certain traumas. Substandard living conditions, poverty, abuse, unemployment and the struggle with addictions issues were clearly a source of stress for some of the men interviewed and for some of the other community members they mentioned. The experience of being poor and knowing that your family was also poor, was described by the participants as being extraordinarily difficult. The issues that stem from this, including food security, malnutrition, lack of clothing, and poor housing, are all related to this kind of stress.

This stress, however, can be experienced at different levels. While some spoke of their own living situations, others spoke about seeing this happening to fellow community members and the distress this type of 'witnessing' brought to them. In many instances,

the participants described feeling overwhelmed by their experiences. Knowing that neighbours and friends do not have enough money to properly feed their children was particularly challenging for one man who lived and worked in the community. The anger at this injustice was exacerbated for some by the knowledge of the number of people living with addictions issues. Drugs, alcohol and gambling were emotionally-charged topics raised by these men who seemed frustrated by the lack of progress made in addressing these issues – both for individuals, and the community.

Some of the possible explanations for why community members are witnessing these kinds of experiences likely relate to a combination of structural and individual factors. There are only limited employment opportunities in the community, meaning that many people are without full-time work. They must then rely on some level of social assistance or on part-time or seasonal labour for their income. Others rely on disability insurance as they are unable to work due to their poor health. There are many large families in the community, and relatives will often live together – meaning that those with work in the family have to stretch their resources even further to support both immediate and extended family. It also means that there is the opportunity for severe overcrowding in homes. The Band Council is responsible for providing housing to community members, and to maintain the houses that are constructed. Of course, should any vandalism or excessive damage unrelated to the normal weathering of homes take place, the Band must pay for the repairs; this is an additional drain to community resources. There is also the question of how quickly repairs to existing homes are made, and how often (or how many) new homes are constructed in the community. Some men suggested that the

demand for these homes far outweighed the pace of construction. Funding for on-reserve housing is the responsibility of the federal government and is administered through the Department of Indian and Northern Affairs. While funding formulae are likely very complex, it should be noted that issues regarding overcrowding are not new. In 1991, 21 per cent of on-reserve houses had more than one person per room compared with the national figure of 1.7 per cent (Waldram et al, 2006:22). This figure has since dropped, albeit only slightly, and data reported from the late 1990s indicated that 19 per cent of on-reserve houses had one than one person per room (Waldram et al, 2006:22).

These structural constraints are amplified by the other issues an individual or a family might be dealing with in their private lives. A person struggling with addictions issues may not be adequately able to manage other aspects of their life, and can cause great worry for those around him/her. Friends and family members may have concerns for their health and well-being, and may also be burdened by the financial and emotional strain addictions can cause an entire family. This leaves what may have been an already financially disadvantaged family in an even more precarious situation. As was made clear by one man's description of his family member's situation, excessive gambling or leaving the home to go drinking means that parents are absent and children can be left alone to care for themselves and their siblings. In other situations, children are left at a neighbour's house or with relatives while their caregiver's are gone, causing some stress for the children and burdening those who are left with the responsibility of looking after them.

What is particularly crucial to consider here is the long-term impact bearing witness to these kinds of situations has on individuals, families and the community. It should be a point of concern for researchers and community development workers, as this kind of phenomenon speaks to an underlying, chronic stress that people must live with each day. There is a large volume of biomedical literature that looks at how major and minor life events – including those changes, such as war, which affect a large population and events, like a death in the family, that affect a smaller number of people – have an impact on health (Lyons & Chamberlain, 2006). Much of this literature addresses the effects of severe distress, and makes reference to how war, trauma, and displacement due to refugee movement can affect health. The literature related to what have been called "daily hassles" (Lazarus & Cohen, 1977) looks at the effect of living conditions and various kinds of support on individual self-reported health. This approach has suggested that the cumulative effect of these kinds of stressors is particularly significant. However, the literature does not look at the issues in a First Nations context, or those related to the kind of chronic stress mentioned by the men in this study.

Bearing witness to poverty, be it in one's own life or in someone else's, is something that has an effect on children, young people, adults and seniors; men and women. It shapes peoples' lives and affects their health and well-being.

The idea of bearing witness is discussed in some of the existing anthropological and nursing literature, but in a somewhat different way from how I am using the term. I am using the term to describe the witnessing that takes place by the community members

themselves, and am not using it to describe my own experiences working in the community. This differs from the way in which other scholars have approached the concept. Farmer (2005) organizes the first section of his book on health inequalities and poverty around *his* witnessing of the experience of the poor and sick in Haiti, Chiapas and Russia, and reflects on the kind of emotional toll this took on him in the process. He argues that although his account can only be a partial one, the act of bearing witness at least can be done on behalf of others as an act of solidarity and compassion (Farmer, 2005:27).

In one sense, then, Farmer's philosophy is similar to how some of the men in this study talked about bearing witness in their work lives. They share a kind of stress and sense of frustration at the injustices they see every day and their inability to significantly improve community members' lives, and they take these frustrations home with them each night. As one man indicated, when you live and work in the community, your job becomes a twenty-four hour a day ordeal, seven days a week. So much of what they are seeing – particularly the poverty and unemployment – is related to broader structural issues that are beyond any one individual's efforts for change. While this knowledge alone was obviously a challenge for men in this study, it must be doubly challenging for those who *live* it each day.

The idea of bearing witness has been raised in academic circles that explore the area of nursing philosophy and the application of these philosophies to clinical care. Naef (2006) argues that for nurses, bearing witness is of utmost importance as it "is a moral way of

engaging in the nurse-person relationship," (2006:146). "Bearing witness to other people's lives…is a way of being and staying connected through a shared sense of humanity," (2006:147). It is something that nurses are said to be a part of every day, as they are present with patients who are experiencing changes in their health, changes in the quality of their lives, vulnerability, suffering, and contentment.

Bearing witness in the clinical encounter is something that is almost encouraged by Naef (2006) and her colleagues in the field (Drought, 2002; Cody, 2001; Milton & Cody, 2001), who see it as an opportunity for improving the quality of the nurse-patient relationship and the quality of the care itself. When it does not occur, then, there is an opportunity for understanding that is lost. In this sense, being present with (or witnessing) another person's realities is something that could be regarded as an opportunity – therefore, something that is positive. As Bunkers (2001) argues, "we [nurses] must realize that we are in community with those who suffer," (2001:200).

Again, this approach to bearing witness places the focus of the witnessing onto the subjective "I" – the person entering into the act of witnessing, and their reflections on this action. This position relates best to the experience of the men working in this community who, like nurses, encounter clients every day. They are positioned in such a way as to be fully engaged in their clients' lives. While Naef (2006) and others see this as a unique situation to be in, they do not comment upon the struggles that nurses and other health care workers face as a result of this. What the men described seeing in their community each day and the kind of stress this caused them as a result provides some insight into the

challenges that employees have when their work lives involve facing difficult situations such as child poverty and malnutrition. As well as facing these circumstances each day, these men live in the community – meaning that there is no break from this. This unique perspective – particularly as it comes from Aboriginal men living on-reserve – indicates that there is a strong need for support for workers who are consumed by these issues and who may require their own type of counselling services as they come to terms with what they see. This could help to alleviate or even prevent some of the distress that these workers face.

Frustrated Potential

The second overarching theme was what I called "frustrated potential". I used this expression to describe the environment where one is not able to foster their own abilities or see others foster their own abilities. This term could be applied to contexts where one does not have the opportunity to develop (or refine) a particular skill, such as learning a musical instrument or learning how to play a certain sport that is of interest to them; it could also describe the situations where certain crucial opportunities for growth and development are not provided – such as having access to particular educational opportunities. The frustration in this comes from not only having limited or no access to programmes yourself, but also in knowing that there are other capable, talented and interested persons who do not have access to such services. Coupled, then, with this frustration is a sense of loss at what could have come to be had certain things been available.

Frustrated potential appeared to be a particularly relevant term to use when I considered how the participants talked about the experience of children and young people in the community. All of the men in this study expressed a considerable amount of concern for children, and addressed this indirectly through the topics of education and local recreational programming. There was a generalized anxiety over how the perceived 'limits' of the community were affecting children, particularly with respect to education. The local school was said to be overcrowded, underfunded and a source of stress for some young people. For a number of complex reasons, there are few graduates each year and of those who do graduate from high school, few attend a post-secondary institution for additional training. The participants made a connection between lack of role models and few youth engaging in educational pursuits. For those men who were parents, this seemed to be an especially critical issue as they had a great desire for their own children to pursue higher education. They saw, generally, the possibilities in many young children in their community but they also saw how the children can be influenced by other pressures and affected by other stresses. It was this that caused a certain frustration for these men as they described the lost opportunity for young people who have so much potential.

The men's concerns regarding recreational programming centered on the limited number of organized activities that were available in the community – particularly for children, teenagers and young adults. With few outlets available, community members were left with nothing to do, nowhere to go, and an even more limited social network. As a result, as one man indicated, parents in the community had to look beyond the reserve to find

organized activities for their children to participate in. This often required additional funds which was certainly not possible for a family with a limited income. It was also something that was not always explored by parents or caregivers. Further to this, some of the participants related the lack of organized recreational programmes to what they saw as the physical and emotional outcomes of this; that is, inactivity, feelings of anger, frustration and futility, and compromised health.

These types of issues that were raised by the participants are related to the somewhat more political discussions that exist in the sociological literature on boredom and social meaning. Barbalet (1999) argues that boredom can be used as an explanatory variable for a variety of social processes (1999:644), and this rings particularly true for this study when considering the limited number of recreational activities described by the participants. "Boredom is an experience of having plenty of nothing," (Raposa 1999:60) and involves some combination of restlessness, irritability and an active discomfort with one's disinterest (Jervis et al, 2003:40). Although not described quite as overtly as this, the study participants conveyed a strong sense that people in this community are intensely bored. What was not felt directly was described by some of the participants as existing in other people and this caused some concern, particularly for those who are parents of young children. One man described what he saw as the process expressed by young people: if there is nothing available for people to do, and there is no way, financially or otherwise, of them having access to programming elsewhere, then people come up with their own ideas. It is this, he says, that increases the likelihood of teenagers having sex, using drugs and drinking alcohol.

The descriptions of the community provided by the participants are very similar to those provided in Jervis and colleagues' (2003) account of what they have called "the realities of postcolonial reservation life" in a community in the north-central portion of the United States. Their work is one of the few studies that has looked at the experience of boredom in a cross-cultural perspective. The authors' interest in boredom in an American Indian context is particularly novel, given that the existing literature on boredom has focused almost exclusively on 'western' definitions that are inappropriate or inadequate when considering Aboriginal people living on-reserve (Barbalet, 1999; Conrad, 1997; Brissett & Snow, 1993). Scholars have associated boredom with affluence, modernity and individualism (Spacks, 1995; Brissett & Snow, 1993); basically, as a product of increasing leisure time that was a result of the rise of capitalism and the changes brought by industrialization. This perspective, however, "does not consider what 'leisure' means in a context of pronounced unemployment," (Jervis et al, 2003:53); a context within which my study is based.

Jervis and colleagues (2003) described a relatively isolated American Indian community in the United States where mobility was limited and residents were often required to travel long distances for services. There was no public transportation and much travelling was weather-dependent. The community had few amenities and there were no movie theatres, shopping malls or appealing recreational facilities where residents could go. Any organized activities that existed revolved around the schools in some way, meaning that for those who had graduated or dropped-out there were even fewer options. These descriptive characteristics are identical to those that were described by the men

interviewed in my study and describe a set of conditions that likely reflect many First Nations communities.

Jervis and colleagues' (2003) study indicated that boredom was framed in terms of there being "nothing to do" and this was linked to three characteristics of reservation life: scarce employment; few recreational options; and transportation difficulties (Jervis et al, 2003:45). The authors noted that the lack of employment was of particular concern to the young men they interviewed, and related this to the general changes in men's roles and sense of identity. "[A]n environment of scarce employment and diminished opportunities to engage in traditional activities that demonstrate male worth may have left younger men in a structurally difficult situation with regard to fulfilling the role of an adult male," (Jervis et al, 2003:52). In this way, we can appreciate how changes brought by colonialism and relocation have had an effect on individuals. "When aboriginal ways of occupying oneself, conceptualizing the self, and finding meaning in life have been seriously disrupted, a segment of the population can be expected to feel anchorless – and, thus, susceptible to boredom and trouble," (Jervis et al, 2003:54).

One aspect to the disruption of the self is that of role loss, and some researchers have looked at this in relation to mental health, Aboriginal youth, and identity formation (Cheah & Nelson, 2004; Kirmayer et al, 2003; Hunter, 1995). Cheah and Nelson (2004) explored the role that culture plays in emerging adulthood among a group of aboriginal Canadian students and a group of non-aboriginal Canadian students between the ages of 18 and 25. Results from their survey indicated that aboriginal students strongly

emphasized the importance of role transitions and family responsibilities as necessary markers for adulthood. The significance of family and the sense of having a place in an interconnected web of family relationships were important aspects of being an adult (Cheah & Nelson, 2004:504).

Hunter (1995) reviewed the existing literature on Aboriginal youth mental health in the Australian context and explored the issues related to the significant changes in social and family dynamics that have taken place in the past fifty years. Hunter (1995) argued that the Australian state's involvement in Aboriginal family affairs posed a particular threat to male social roles as men's traditional involvement in economic and religious activities was replaced by an increasing dependence on welfare (1995:379).

Kirmayer and colleagues (2003) looked at the social origins and the political context of mental health problems in Canadian Aboriginal communities. Their discussion of youth is particularly critical in relation to the questions regarding identity:

> "The community context for the socialization of youth has changed dramatically with colonialism. Adolescence and young adulthood have become prolonged periods with ambiguous demarcations and social status. Moving from traditional times where 'everyone was important and everyone had a role', colonialism has resulted in impoverished roles and opportunities within many communities, leaving youth without clearly defined direction." (Kirmayer et al, 2003:S20).

The authors go on to note that there are significant gender differences in the ways that changes in local culture have affected traditional roles:

> "For young women, there has been more continuity in social roles and many are involved in child-rearing as well as work and school. They may suffer from role strain as they try to fulfill multiple tasks. Young men, in contrast, have experienced a profound disjuncture between traditional roles and the limited opportunities available to them in many Aboriginal communities. The high suicide rates among Aboriginal young men can be related to this loss of valued status and direction." (Kirmayer et al, 2003:S20).

Role loss is an important issue to consider with regards to young men, as it is very closely connected to men's sense of identity, their feelings of self-worth and the methods they use to deal with other issues that they might encounter in their daily lives, such as unemployment or boredom. As Jervis and colleagues (2003) have indicated, feeling unfulfilled often means that young men try to find a new direction or area in which they can find meaning. In an attempt to alleviate the distress caused by the intense boredom, residents in Jervis and colleagues' study described the ways in which they would attempt to escape from their situation: "the connection between lack of work, boredom, substance abuse and trouble was made explicit by several participants in our study," (Jervis et al, 2003:47). Alcohol, drugs, and gambling were seen as viable alternatives to this bored state. Likely because of this, Jervis and colleagues (2003) argue that "the implications of boredom for individual subjectivity and the group sociality are far from trivial," (2003:38).

The similarities between what was said by the participants in Jervis and colleagues' (2003) study and the men in this study are extremely important to consider. While unique in their own ways, these descriptions could reflect the experiences for many Aboriginal people living on-reserve. Tolor (1989) argues that boredom may serve as an 'index of alienation' with complaints about boredom acting as a protest against the conditions of contemporary reservation life. While I do not wish to suggest that everyone in First Nations communities feels as if there is nothing to do or feels unsatisfied with their community, I do think that leaders need to consider the relationship between having organized community activities, boredom and frustration, and alcohol and drug use. These relationships have been suggested by researchers and were clearly articulated by the men interviewed in this study.

The men then went on to connect these issues with the overarching sense of frustration that they, and others, felt. Once people, especially young people, entered into this cycle, it was difficult for them to leave it when there were no new activities made available to them by the community. They then risked losing what opportunities did exist for them. It is in this way that we gain an appreciation for how the experience of frustrated potential manifests itself in, and what it means for, individuals. I would now like to consider what this experience means for the community.

More broadly, the factors that influence the development and maintenance of recreational programming and educational opportunities in this First Nation revolve largely around funding, infrastructure, and political initiative. The men described how there appears to

be inadequate funding to support local events/activities and educational grants. Further to this, there were frequent complaints about what seemed like a general lack of interest by leadership in these issues. One young man described his attempts at acquiring funding for a sports team that he and some friends had organized, in order for them to attend a regional competition. He was told that there was no money available for recreation. While it is very possible that the funds did not exist, this young man described how the messages they received from Council were discouraging and thwarted their momentum.

Some of this young man's frustration also related to how he felt adults, generally, in the community seemed uninterested in the lives of young people. He felt that there was little encouragement or motivation. This could mean, then, that for those who actually do have access to recreation and educational opportunities, there could be a burden regarding family or community support. I will explore the issue of support in subsequent sections of this thesis, but at this time wish to suggest that this further complicates these matters and adds an additional level of distress to peoples' lives.

All of the issues presented here are important to consider in terms of what they mean for individuals, families and community development more generally. By having certain organized programming – both educational and recreational – available to everyone, a community is investing in its residents, particularly the children and young people that live there. These kinds of activities, while appearing quite simple on one level, clearly have an effect on people's lives. These kinds of 'distractions' act as outlets for people to deal with the stress in their lives, provide a space where people may be able to build new

relationships and expand social networks, give something for people to do that is different from the rest of their daily lives, and could be thought of as long-term investments in local human resources. Funding for these kinds of initiatives, which is ultimately provided by the federal government, needs to become a priority as it can clearly affect the health and well-being of many people in many communities.

Support

The third theme that emerged from the interviews was that of "support". Support is a concept that has been described in a number of different ways in the literature, making particular reference to the physical, emotional and social aspects of this kind of assistance. Lyons and Chamberlain (2006) illustrate how psychologists have focused their attention on "social support", and describe the distinction that is made between two main forms: structural social support (the existence, quantity and form of social ties) and functional social support (the functions that support provides to the individual) (2006:162). I used the term support as a broad category under which all of these 'pillars' stood, because the ways in which it emerged through the interviews made reference to several of these angles.

I have chosen to combine several aspects of social support that emerged from these interviews into two main categories. These categories are organized as such to show how the individual operates within his/her own social sphere but also under the umbrella of community life.

i. Support at the level of individuals and families

Relationships were frequently seen by the participants as a possible source of stress. Although interpersonal relationships can be a significant beneficial aspect of social support, the work required to build and maintain relationships of all kinds can be challenging for anyone, and the nature of the relationship itself can influence the kind of support provided. The tensions between people can be difficult to deal with, but for these men it appeared that the residual effects of this strain reached beyond the individuals involved. They most often talked about the effect of relationship break-down on the family unit and the separation of parents and children. The family is central to peoples' lives, and helps to organize roles and responsibilities. It is within the immediate family that values and lessons are passed on between generations and family history is shared. Any change in family dynamic or disruption to this unit has a considerable effect on everyone.

This First Nation community comprises a large number of people who come from just a few different families. The Family, in this sense, is the group of people who share the same last name and could be thought of as the network of extended families. As the participants indicated, Family membership, in part, determines one's social status, defines where one lives in the community, and determines one's political decision-making. Because the relationships between Families in the community have such a strong influence over community dynamics, they can affect the quality of life for many people. Families can be a source of great strength and resilience, and also pain and tension. The men in this study noted a number of 'outcomes' to this, all of which focused on the

negative effects of Family fighting (both within and between). The 'outcomes' they spoke most passionately about, included: favouritism and nepotism in the political arena; favouritism and nepotism with respect to employment practices; and a sense of fear and mistrust. In this way, they identified a kind of support-related stress that exists across multiple domains including at the level of the community.

ii. Support at the level of the community

The participants also identified certain factors that influence the level of 'structural' support available to residents in the community. Many of these factors, again, relate strongly to Families, and it could be said that there is a significant, and constantly shifting, relationship between Families and the politics of the community. The factors that they mentioned operating at this broader level included: a concern for what they described as a lack of sense of community; gossip and fear; and a lack of trust in other people and local services. Their words suggested that a sense of support in several aspects of community life was absent.

What is particularly disturbing about these interviews are the comments regarding the delivery of existing support services within the community. Several men expressed concern regarding the degree of mistrust between some community residents and then described how this influenced people's decisions around accessing care. The greatest anxiety appeared to be related to visiting local social services where fellow community members could be working, and therefore have access to personal information. The men indicated that for many residents they knew, the decision to access social services (and

how one did so) often depended on the staff that one would encounter there. This suggests a disconnect between the existing needs in the community and the demand for and delivery of care. The anxiety and fear must be so great in some people that they would prefer to leave the community for certain services or not access them at all, rather than going to local offices for help.

Service delivery in the community is compromised as a result of the perceived lack of trust and fear of gossip, and this could have particularly damaging effects for many people in the community. It is hard to imagine that any improvements in individual or population health are possible when this pillar of support is missing or functioning for only a select few. The situation that these men have described is crucial for policy makers and leaders in all sectors of government to consider, especially as they evaluate the impact of health transfer in this First Nation. What the participants have suggested is that there is a need for non-community members to work in various sectors, particularly those related to health care, mental health and counselling. At this time and given the existing circumstances, they have suggested that having a balance between local and non-local staff at essential services would be a better way to provide care. Therefore, should someone wish to speak with someone they are familiar with, they can do so; should they wish to have an extra degree of anonymity, the can have that. Of course, confidentiality and anonymity is not entirely guaranteed as it is up to the worker's own ethic.

Support is a particularly challenging theme, because it speaks directly to the positive and negative aspects of a wide variety of issues, including interpersonal relationships and the

issues at the level of community organization and operation. Support as a clearly defined topic was not talked about explicitly by the participants in this study. However, they did approach this theme from a number of different directions. The general tone of these interviews with regards to this topic was negative, and while this may seem to be a logical possibility, few authors have actually approached support in this way (Richmond et al, 2007; Thoits, 1995). In fact, the way in which support was talked about by these men suggests that addressing the negative (or harmful) aspects of relationships, family and community dynamics, and community services, as well as the impact of the absence of support, could help to better address existing needs and aid in the development of local programming.

The literature that relates to social support and First Nations communities has often approached this issue from the direction of some kind of pathology and has focused on the individual. For example, Daniel and colleagues' (2004) looked at mental health or affective measures and smoking status among a rural Interior Salishan First Nation in British Columbia. They conducted a community-based chronic disease survey that measured smoking status and various psychosocial measures, including depression, mastery, affect balance and social support. Their findings were consistent with other reports about relationships between smoking and these psychosocial measures. Although daily hassles and chronic stress were not measured in their study, they argued that "the high prevalence of daily smoking may be an indicator of psychosocial distress," (Daniel et al, 2004:48). They then suggested that smoking is used as a method of coping, and that it is strongly influenced by contextual factors and macro-social influences. Smoking and

mastery were inversely related and this varied with social support. Their work, however, did not explore these larger influences in any detail.

Spicer (1997) and Bezdek and Spicer (2006) looked more closely at how social support networks influence individuals' drinking patterns and abstinence in an American Indian population, and Brady (1993) highlighted these issues in her work among Australian Aboriginal men. The researchers examined how men and women with a history of alcohol dependence have been able to maintain their abstinence despite the pressures to return to drinking that they have faced. Many of the pressures to return, they show, come from the peers in their social circles. In order to maintain abstinence, these people have had to sever the ties with these social networks which, in some cases, were built around a drinking culture. In this way, drinking formed a significant part of their social lives. To not drink, then, meant that they had to be alone or develop a new network of friends. In a small or isolated community, or for those who have limited access to other social networks, this is particularly challenging.

The researchers illustrate how what has most often been seen as positive aspects of social support – that is, personal relationships and social networks – can also have a negative influence over peoples' lives. They also indicate the unique challenges that residents in small communities – Aboriginal and non-Aboriginal – face because of their relative isolation. In order to maintain abstinence or break away from social networks, they need another place to go where they are not 'tempted' or influenced by their histories. This is where community-level supports are most crucial. This was also indicated by the

participants in my study, who felt that their community needed to have more facilities and spaces available for people to go to, recreational activities for people to participate in, and social services such as counselling that could provide some support for residents in need.

Richmond and colleagues' (2007) also discuss the value in having such services available to people. They examined the importance of social support in promoting health among indigenous Canadians by looking at the relationship between various measures of social support and what they called "thriving health". They used data from the 2001 Aboriginal Peoples Survey (APS) and created an indicator of "thriving" – defined as one's ability to flourish in response to adversity (2007:1827) – based on self-reported health status. They measured social support with four indices: positive interaction, emotional support, tangible support, and affection/intimacy. They indicated that men were more likely than women to report thriving health, and the group that was highest in this category was the youngest age group (ages 15-24). This is an interesting finding, given that young men have the highest rates of suicide.

Their findings for social support were similar. Young adults reported high levels of social support, however there was a strong effect based on gender. More women reported high levels of emotional support and affection/intimacy, although among men, only emotional support was significantly related to thriving health (2007:1830). This could indicate a particular need with regards to men's health. Based on this data, it appears that men are

not receiving (or do not have access to) emotional support, even though they indicate that this has an effect on their health.

The information provided by the men in my study does seem to resonate with Richmond and colleagues' (2007) findings. One of the most frequent suggestions for the community provided by these men was that there was a strong need for more counselling services. This included individual counselling to address personal issues, as well as more issue-specific counselling for addictions, stress management, post-traumatic stress, grief counselling, and family mediation. There is clearly a desire for support in this area as men have not had, or have not been recognized to have, a space in which they can address their emotional needs and concerns.

Coping and Coping Mechanisms

The final section I would like to highlight is that which described the ways in which the participants in this study coped with their stress. The methods used varied significantly between each person and also for the same person operating in different contexts or situations. While at some moments these men expressed a desire to be alone, at other times they wanted to be surrounded by friends or family and participate in social events. They referred to doing physical activities, engaging in spiritually and emotionally fulfilling practices, and those actions which brought them some peace or escape from their daily lives.

Although none of the actions mentioned are particularly 'novel' ways to deal with stress - in the sense that they have never been mentioned before in the existing literature – they are interesting as a whole. All the mechanisms described by the men were individually initiated; that is, they were activities or practices that *they* devised and were separate from anything provided by the community. Even those who mentioned spirituality or practicing traditional ceremonies said that they did so alone or with their family – these were not offered to the entire community. Larger events that would have required more time and preparation, such as a sweat lodge ceremony, were said to be semi-regular events organized by family members. They were, therefore, not accessible to everyone in the community as only family or close friends would have been invited to join.

The participants tended to speak only briefly about the ways in which they coped with their stress, and quickly moved the discussion towards the issue of how others in the community did so. When the men talked about other community members, they were somewhat more pessimistic. Some participants appeared frustrated with what they saw others doing, noting that some men and women used drugs and alcohol as means to cope. From their perspective, use of drugs and alcohol were an individual's 'choice'. However, the participants did place the idea of 'choice' into a broader community context. The participants focused on what they felt the community was lacking and, therefore, needed in order to provide for its residents and be in a better position to deal with the issues that it was facing. In this way, the men moved beyond their own lives into an area that was really about building a sense of community and community development. They were able to talk about the community in a somewhat critical manner, as they could describe the

ways in which the circumstances existing in the community at that time – particularly the limited resources and facilities open to its members – were restricting peoples' abilities to cope with their stress. In this way, they could express their own ideas and show a sensitivity to and awareness of larger political and community issues. Perhaps, answering this kind of question about community supports and coping mechanisms provided the men with an opportunity to comment on the community in a way that would not normally exist to them, or they would normally shy away from for fear of gossip and retaliation.

The existing scientific literature on coping and coping mechanisms is vast (*see* Lyons & Chamberlain, 2006; Banyard & Graham-Bermann, 1993; Folkman et al, 1986; Lazarus & Folkman, 1984), although much of this work is among non-Aboriginal populations. The work that refers to Aboriginal Canadians is quite limited. Iwasaki and colleagues' study (2005a) looked at how Aboriginal people with diabetes coped with stress. They conducted a series of focus groups with men and women of First Nations and Métis background who were recruited from a Winnipeg-based clinic. In their thematic analysis of the transcriptions from these focus groups, the authors identified three overarching themes: the individual and collective strengths of Aboriginal peoples with diabetes must be recognized and utilized to facilitate healing from or coping with the experience of stress and trauma; healing must be accomplished holistically by maintaining balance or harmony among mind, body, and spirit; and effective ways of coping with stress and healing from trauma potentially promote positive transformations for Aboriginal peoples and communities at both individual and collective levels (2005a:977). They then developed a series of sub-themes for stress-coping that included the following:

interdependence/connectedness; spirituality; enculturation/facilitation of Aboriginal cultural identity; self-control/self determination/self-expression; and leisure as a means of coping with stress.

Many of the specific coping mechanisms that they listed were similar to what the men in this study talked about, such as the benefits of talking with supportive friends and family, going for a walk to clear your head, and prayer. However, there is a significant difference between the work of Iwasaki and colleagues' and this study. Their study was among off-reserve Aboriginal peoples living in an urban environment. Presumably, the same kind of isolation that exists in a rural First Nations community does not exist in a city. Accessing services, such as health care facilities, recreational services, and cultural organizations is far different in an urban community than on a reserve, and issues connected to access, such as transportation, cannot be compared. Furthermore, their work did not explore *how* the participants in their study got to a position where they could rely on such coping mechanisms; as in, they were already 'coping' and could talk about the benefits of certain activities, but they did not talk about the process of getting there. These kinds of issues were what really came out of the interviews with the men in this study, specifically in terms of how they saw others trying to cope (or not).

The role of leisure in stress-coping has also been explored by some of the same researchers (Iwasaki et al, 2005b). They addressed the role of leisure as a palliative coping strategy that functioned to provide a positive diversion and an opportunity for renewal. Leisure in this study included outdoor-active sport, social and cultural activities.

One of the sub-populations in this study was a group of Aboriginal men and women with diabetes. The authors described how leisure meant that people had the opportunity to be alone or connect with friends and family; people could escape from their lives for a short time; and people could try to regain some balance in their lives.

While their findings resonate with what the men in this study said were the benefits of certain leisure activities, Iwasaki and colleagues' (2005b) still do not address the environment within which people must function. The benefits of leisure activities are lost if a community of people does not have access to these opportunities. For example, in this First Nation community there are no walking paths, sidewalks or trails. The roads are gravel, rutted, and difficult to manoeuvre – even in the summer months. What was clear from the participants in my study was that many of the ways in which they coped with their stress were methods that they initiated themselves. They did not rely on community-based programmes or services as these did not exist. This is entirely different from the urban sample described by Iwasaki (2005b).

It is clear, then, that having services available in the community is essential to providing some kind of positive support to residents. There is no literature on coping and community supports in Aboriginal communities in Canada that relates these services to stress, coping and health. This suggests an area needing further inquiry, specifically as this relates to funding formulas for First Nations communities.

Limitations of this study

As with all research, there are some limitations to this study which I will address:

1. There were only a small number of men interviewed in this study. While some researchers would suggest that these results cannot be generalized, it should be noted that with the kind of approach I took, generalizability was not the intention. I simply wanted to explore stress and coping in this context to see if this then might help to inform local leaders as they made programming-related decisions. I also hoped that this work would benefit the research community by presenting some of the realities for these Aboriginal men.

2. Presumably, those men who were interviewed were interested and aware of the issues related to stress and diabetes (the initial impetus for this work) and were clearly willing to discuss these issues with the researchers. In this way, the sample is not representative of the entire community and is biased towards those men who could (and were willing to) be contacted by recruiters.

3. This thesis is based on secondary data. While I was involved in additional fieldwork in this community, I was not present at most of the interviews conducted for this study. Therefore, I was not able to pursue lines of questioning that I might have wanted to.

4. An interpreter had to be used for one of the interviews which was conducted in an Aboriginal language. The interpreter lived in the community. This raises

questions about the accuracy of the translation both of the questions being asked

of the interviewee and the responses they provided. It is also not necessarily ideal,

as the interviewee could feel less comfortable sharing information when a fellow

community member is in the room.

5. All of the participants were older than eighteen years of age. There are likely age-

   specific issues that were missed because no teenagers were interviewed for this

   study.

Strengths of this study

I am pleased to highlight the strengths of this study:

1. Much of the existing research in men's health has addressed men's issues in a

   particularly clinical way, and the work related to Aboriginal men has focused on

   certain pathologies, such as alcoholism. This study presented Aboriginal men in a

   way that has not yet been done, by addressing their lived experiences and

   providing them with an opportunity to describe the emotional aspect of their lives.

2. The richness of these stories and the level of depth that these men were going to

   suggests that the subject of "men's health" is an area that needs considering in

   new ways that go beyond the traditional clinical lines of inquiry. Research related

   to certain social determinants of health, including the impact of poverty on the

   health of males, is worth pursuing.

3. The information provided by the men in this study also suggests that the needs of men with regards to mental health and counselling issues are not being met. This is particularly crucial when considering the existing rates of suicide among young men, especially among Aboriginal youth.

4. Despite the small sample size, there was a good representation of men from different age groups, families, and economic backgrounds.

5. The participants had a number of their own ideas regarding community development which have been mentioned in this document. This information could be of value to community leaders as they evaluate funding schemes for existing programmes and develop new ones.

Future Research

Although my work sought to simply explore the kinds of stressors men in this First Nation identified in their lives, by refining our understanding of what stress is and what causes stress for people in this community in particular we, perhaps, have a better sense of the breadth of the experience of stress in the community and the depth of the pain. It is this knowledge that now raises the question of how much, or what is the extent, of the effect of all of this stress on the health of individuals in the community and can it explain health outcomes? I believe exploring the relationship between stress and various chronic health conditions such as diabetes mellitus, coronary heart disease and cancer, both in the Aboriginal and non-Aboriginal community, would be of considerable value. This kind of

approach would highlight the intricacies of the body and how we relate to our

surrounding environments.

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