

# Aboriginal health with particular referrence to aboriginal mental health essay sa...

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Sociology begins with individuals' experiences in order to explore the collective themes and patterns of human behaviour that shape our society and the distribution of health within it (Willis, 1993). This essay will describe the "sociological imagination" and then apply the concepts of the sociological enterprise to Aboriginal health and illness. The discussion will include how a sociological perspective contributes to understanding social exclusion and its affects on aboriginal mental illness .

The "sociological imagination" asserts that people do not exist in isolation but within a larger social network (Willis, 1993). Sociology begins with individuals' experiences in order to explore collective themes and patterns of behaviour that shape our society (Willis, 1993) and the distribution of health within it. This facilitates a connection to be made between "private troubles" and "public issues" (Mills 1959 cited in Germov, 2002) and further enables health problems to be viewed as social issues (Germov, 2002).

Evan Willis (1999 as cited in Germov, 2002) suggests that understanding the interrelated cultural, historical, structural and critical factors is the key to the sociological pursuit. A historical and cultural awareness involves examining how the past and culture impact upon a current health situation. Considering the structural factors entails understanding how the organisation and institutions of society and health influence peoples lives (Germov, 2002). By examining how these factors influence individuals and their behaviour, we are able to better understand the social determinants and distribution of health and apply a critical awareness in order to improve upon the society in which we live (Lupton and Najman, 1995).

From a historical perspective, the effects of colonisation and the subsequent depopulation, dispossession and degeneration of traditional Indigenous societies is fundamental to understanding the adverse health status of Aboriginals in Australia today (Davis and George, 1993). Dispossession and the subsequent marginalisation and exclusion of the aboriginal population from precious resources has resulted in reliance on social welfare benefits and relegated the majority of the Indigenous population to the lower socio-economic brackets of society (Short et al., 1995). Lack of income has resulted in poor education and relatively few aboriginal people have entered into government or medical professions, rendering the aboriginal population relatively powerless to directly influence policies and health service delivery (Davis and George, 1993). Consequently, the inequality of aboriginal health compared to that of the majority of Australians is predominantly located within and determined by the political and economic structures and institutions of the dominant Anglo-Australian society, from which the aboriginal population have been excluded (Saggers and Gray, 1991).

In Australian society the dominant cultural model of health is the biomedical model (Davis and George, 1993), indicative of this fact is 94.4% of expenditure in the health care arena is spent on services, procedures and research associated with bioscience (Sax, 1990). Based on Anglo-Australian cultural beliefs and espoused by the power of government and the medical profession, biomedicine is concerned with the scientific labelling of disorders and disease of the human body (Lupton and Najman, 1995). The biomedical model focuses on three main areas; the individual, medical intervention and

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curative measures (Davis and George, 1993). This encourages a public health response that targets the individual to change their risky behaviour, rather than considering the societal conditions that provide the environment in which the risks arise, or preventative measures aimed at the the milieu (Sax, 1990).

Differing cultural beliefs and values are an important factor underlying the inability of Western biomedicine to effectively address the health problems of Aboriginal society (Reid and Tromph, 1991). The research of Holmes et al. (2002) and Winch (1989) determined that aboriginals often avoid health services because of their concern that Western medicine does not accommodate traditional priorities and cultural beliefs surrounding health. Culture encompasses understandings of health and illness as socially constructed ideals, for aboriginal people:

Health does not just mean the physical well-being of the individual but refers to the social, emotional, cultural and spiritual well-being of the whole community.

(Swan and Raphael, 1995; p. 14)

Burdekin (1994) suggests that Aboriginal people should not be viewed from a reductionist biomedical model of abnormality; as aboriginal concepts of health are more holistic, health and mental health should not be divorced from each other or the impact of the environment and the larger society. Accordingly, it seems a sociological approach would be beneficial to

understanding the underlying social circumstances and structures that influence Aboriginal health and mental illness.

The adverse mental health of the Aboriginal population compared to the rest of society is a consequence of stress relating to the grief, loss and trauma associated with the continued social exclusion of Aboriginal people (Mathews et al., 1995). Galabuzi (2002) suggests that social exclusion is characterised by the powerlessness of oppressed sections of society to completely participate in the entirety of society due to structural disparities in access to cultural, political, economic and social resources. Colonisation has resulted in non-Indigenous society dominating the lives of aboriginal people on almost every institutional level, including law, education, welfare and health (Saggers and Gray, 1991). Throughout history, these powerful societal institutions have been based on Anglo-Australian cultural ethnocentric beliefs, with detrimental effect to the mental health of Aboriginals (Mathews et al., 1995) .

The current high levels of loss, traumatic and premature mortality, the separation of children from their families through family break up and justice policies, plus institutionalised racism, disadvantage, and other effects of white colonisation; contribute to the present high level of stress and mental health problems.

(Swan and Raphael, 1997)

By using a sociological approach, we are able to see that aboriginal mental illness is associated with the powerless position of aboriginals in society enforced by the social structures and institutions of the wider society.

Similarly a sociological approach considers health and health care provision as relational to the individual's location within society and the process of interaction connected to that locality (Najman and Lupton, 1995). For example, Brown (2001) points to the interaction of aboriginal patients and mental health practitioners and the propensity to diagnose according to dominant Western psychological labelling systems. According to Maher (1999), these psychological and biomedical labels are insufficient explanations to Aboriginal people, because they often do not consider cultural and spiritual beliefs of causation; in effect severing the patients' connection with the spiritual world. This perpetuates stress due to feelings of isolation, exclusion and powerlessness because Aboriginal people believe that personal empowerment is about 'right' connections to spiritual ancestors, the land and the community (Brown, 2001).

The research of Tsey et al. (2003), determined that for aboriginal people the psychological stress of discrimination contributes to mental illness, as well as alcohol and substance abuse. Racial profiling and targeted policing has led to disproportionate levels of criminal institutionalisation, eroding aboriginal community cohesiveness and further compounding the racist views of much of the wider Anglo- Australian society (Biles and McDonald, 1992).

Accordingly, Tsey et al. (2003) assert that Australian society must examine the relationship between aboriginal society and criminal institutions in order

to go beyond common racist views that aboriginals are all “ criminals and substance abusers”. In effect, Tsey et al (2003) are asking us to take a look beyond our common held assumptions in order to debunk and lay bare the truth of the situation, a major goal of the sociological enterprise (Germov, 2002).

A sociological perspective further contributes to our understanding of health and illness by uncovering the social determinants and conditions that underlie our individual experiences of health and illness (Najman and Lupton 1995). For the aboriginal population poverty is one such determinant and a product and propagator of social exclusion, of which the impacts on health and mental illness are well recognised (Wilkinson, 1996; Najman and Lupton, 1995; Reid and Tromph, 1991; Saggars and Gray, 1991). Racial inequalities in health status have a tendency to mirror inequalities in socio-economic status (Wilkinson, 1996). However, Galabuzi (2002) contests that examining the social determinants of health should reach beyond class inequality, as a mediator of exclusion from the political, economic, cultural and social structures that determine access to resources and subsequent health status. According to Galabuzi (2002), we should be exploring how processes of social exclusion such as racial discrimination intersect with unemployment, education, poverty, law, income disparity and health service consumption, to generate health inequalities for effected sections of society.

A sociological perspective establishes that health inequalities are determined by the history, structures and cultural factors that impact on our society.

Strategies to improve health must therefore stretch beyond the confines of

individual curative actions and consider the collective themes and patterns of behaviour that shape our society and the distribution of health within it.

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