FASD and Aboriginal Peoples

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Context of this paper

Aboriginal Peoples do not have a high incidence and prevalence of FASD and the face of FAS portrayed by researchers in 1973, was based on an American Indian population. Recent research suggests that Aboriginal Peoples' cultural traits have been labelled as FAS.

This paper highlights some pertinent findings of an extensive 2003 review of existing research on Aboriginal Peoples and FASD. Caroline L. Tait and her team, through the Aboriginal Healing Foundation developed **"Fetal Alcohol Syndrome Among Aboriginal People in Canada: Review and Analysis of the Intergenerational Links to Residential Schools"**.

The following highlights were prepared specifically for the FASD and the Criminal Justice System CD-ROM.

Pages from the AHF paper are identified to reference specific research studies' details. The entire AHF paper is available at http://www.ahf.ca/assets/pdf/english/fetal_alcohol_syndrome.pdf.

The term **Aboriginal Peoples** commonly includes Indians/First Nations, Métis, and Inuit.

In the Aboriginal Healing Foundation (AHF) 364-page review, studies used the terms "Aboriginal" or "Aboriginal/non-Aboriginal" to denote someone with one parent being Aboriginal and the other not Aboriginal.

Most studies done on FASD in Aboriginal Peoples are done from a position of cultural disparity. This may account for the repeated generalization of diverse peoples and cultures as one group and for the portrayal of cultural traits and behaviour as FASD-linked.

Incidence and prevalence of FASD in Aboriginal Peoples

Studies fail to prove high incidence and prevalence of FASD in Aboriginal Peoples.

Pockets of high incidence of alcohol abuse/misuse and FASD exist within Aboriginal Peoples of Canada but the findings with specific subgroups cannot be generalized to the entire country. No research has examined a general population of Aboriginal Peoples for the presence of FASD (pages 93-109).

Incidence is the number of new cases of a specific anomaly (e.g. FASD) entering a population at a specific time. **Prevalence** is the frequency in which that anomaly is seen in that population regardless of when they were found or at a specific time.

No studies were designed to address incidence and prevalence of FASD in Aboriginal Peoples (pages 93-95, 100). Furthermore no studies have been done to determine the incidence and prevalence in non-Aboriginal populations (pages 97, 99). Therefore comparisons of rates between Aboriginal Peoples and non-Aboriginals are impossible. On the basis of this, studies suggesting Aboriginal Peoples have incidence rates 5-10 times higher are inappropriate (pages 93-95, 99).

With the lack of research rigour, there is concern with informal labelling of FASD in Aboriginal individuals by service providers (e.g. teachers, social workers) on the basis of suspected alcohol abuse (page 205-206).

Methodology of early studies has been found by subsequent researchers to have been in error. Methodology issues include retrospective studies targeting perceived affected (page 220), lack of standardized diagnostic criteria and physical measurements (pages 9, 11, 217-230), use of white middle class psychiatric testing tools (page 206), lack of FASD education to make the diagnoses (pages 100), and many selection biases including studies based on referral of known

chronically handicapped children, examining Aboriginal Peoples in a community and non-Aboriginals in a clinic setting, presumption of English comprehension, alcohol consumption based on recall from 18 years previously, inclusion of multiple FASD affected children birthed by one mother as indicative of a generalized FASD problem, and subjects selected for study solely because of race (pages 93, 95-109, 206-208).

While alcohol use by young women and the potential for FASD may be increasing, studies to date have failed to establish that Aboriginal Peoples have a high incidence and prevalence (page 8-9, 11, 97, 99, 119).

Aboriginal cultural traits and FASD

Many Aboriginal groups have a cultural trait of wide set eyes, large folds at the inner corner of the eye, broad nose, flat mid-face. Many of the behaviours labelled as FASD are also linked to culture and life experiences prevalent in Aboriginal Peoples (e.g. poverty and residential schools).

Researchers question the results of the first American study published in 1973. That study defined and described fetal alcohol syndrome on the basis of study subjects' appearance. The small sample size with the majority of subjects being American Indian children led to defining common Aboriginal cultural traits as the FAS face (Page 8, 207-208). Questions also arise with the attribution of Aboriginal cultural behaviours as FASD behaviour (pages 206-208). Research has not addressed the influence of environment on behaviour (e.g. cognitive and behaviour problems associated with poverty, education levels, unstable home life, and learned behaviour, page 208).

Studies in Canada and the USA targeted specific Aboriginal populations when FAS was suspected (e.g. Yukon and northern British Columbia). More than one study examined the same accessible communities where alcohol abuse was said to exist (pages 94-97). These studies continued to overlap FASD with Aboriginal cultural behaviours and facial traits (pages 11, 97, 99, 219).

The diagnosis of FAS does not require confirmation of fetal alcohol exposure. If Aboriginal Peoples do not have the currently-defined FAS face and behaviours, numbers could be higher. However, those who have the facial and behavioural traits without exposure may be identified as FASD affected, pushing numbers too high.

The potential for misdiagnosis of FAS based on cultural traits, lack of confirmed consumption of alcohol, and association with the perception that FASD as an Aboriginal problem may contribute to the lack of recognition and diagnosis of FASD in non-Aboriginals who do not possess the same genetic phenotype and therefore exhibit different facial appearances (pages 97, 102). This could mean rates are far higher in the non-Aboriginal population but remain undetected.

What is becoming more clear is that disruptive challenging behaviours often thought to be related to FASD may well be caused by other life experiences to which Aboriginal Peoples have been subjected excessively: residential school disruption of home and community, multiple foster homes as a cause of behaviour rather than the result of FASD, poverty, parental alcohol abuse, and family dysfunction from multiple intrusions and judgements by others (page 208, 243) and intergenerational trauma (page 234).

FASD diagnosis in individuals affected by all these social factors results in labelling individuals as having brain damage (243) when FASD/brain damage does not exist.

Métis, a large and growing segment of Aboriginal Peoples, have not been researched. Inclusion of Métis population figures in population rates skews results (page 15). In addition, most of the studies fail to address the off-reserve Aboriginal population which is reported to be 70% of Aboriginal Peoples (page 15).

Racial susceptibility

In a 1971 study, Aboriginal Peoples were identified as lacking the enzymes to metabolize alcohol. However in 1976 the exact opposite was found and reported. The original finding has never been replicated (pages 14, 18-20, 23-24, 94-96).

Other factors

Drinking patterns

Numerous studies examined alcohol use/abuse/misuse by Aboriginal Peoples. One study examined drinking patterns of Indian and Inuit women finding that although 11 of 49 Inuit and 12 of 35 Indian women drank during pregnancy, those rates were lower than both white and mixed race women (page 103). Binge drinking was a pattern of Inuit and Indian women (page 103). Other studies have not verified the same findings.

With limited research, women's drinking patterns suggest that surveillance of Aboriginal women and children by social agencies may account for some binge drinking while Caucasian women are able to drink more discreetly (page 95).

When pregnant Aboriginal women have been studied they have been included as a subgroup (pages 17, 24-30, 122-146). Aboriginal women are more likely than Aboriginal men and non-Aboriginal women to abstain from alcohol use (page 17).

Based on national surveys researchers estimated alcohol use by women in Canada is 67% (page 17). Another survey found half of the women in Canada between 25-44 years of age were regular drinkers with 4% drinking 14 or more drinks per week (page 17). Through the Aboriginal Peoples Survey, use of alcohol by Aboriginal women 15 years and older was reported as Métis (67.5%), off-reserve First Nations (61.5%), with Inuit women having a higher abstinence rate (not specified) (page 17).

The negative association of Aboriginal Peoples in the media (page 23-24) and the general negative image of Aboriginal Peoples (page 32) contribute to the "drunken Indian" stereotype (page 23).

Patterns of drinking have been established historically from the time of its introduction into Aboriginal society (page 31) to laws banning Indians from bars and preventing possession in their own homes. Laws led them to become furtive; they took their liquor to the bush to drink it rapidly before it was confiscated (page 32). Alcohol abuse was identified as a means to cope with poverty and may be a form of resistance (page 35).

Multifaceted issues

The history of colonization resulting in insubordination of women from their former traditional roles (30), individual and institutional discrimination (page 30-34, 77-92); mental and physical health, nutrition (page 81-85); economic and social marginalization (page 18-29), low levels of education, chronic poverty (page 34-37), intergenerational and collective trauma from assimilation policies and multiple foster homes (page 42-54); inappropriate psychological tests that do not fit the culture of Aboriginal Peoples (page 12); plus numerous others are cited as complex issues to explore prior to a FASD diagnosis.

In 2000 the Law Commission of Canada identified residential schools as causing the most damage to a group of children (page xix).

Tait said the effect of the environment in which families live or are raised has not been examined for any FASD-affected population.

No studies have shown that affected children are born to women who drank a single drink of alcohol each day of her pregnancy (page 108).

Perpetuation of FASD

Services that are not culturally-appropriate contribute to the failure of Aboriginal Peoples to use those services leading to perpetuation of the problems while those that deliver Aboriginal programming (e.g. friendship centres) may not have sufficient funding to be effective with the numbers of people requiring the services (pages 251).

In addition, Tait suggests that no recognition has been given to the positive effect of traditional practices and healers in working with FASD-affected Aboriginal Peoples (page 251).

Labelling of FASD behaviours

Primary and secondary behaviours of FASD (e.g. trouble with the law, difficulty with time and money, disrupted school experiences, incarceration) have been documented as being higher in Aboriginal Peoples (page 246). This disproportionate representation has been attributed to long-term colonial oppression within the structures designed to exert control over Aboriginal Peoples. The risk with labelling these individuals' behaviours, in the absence of physical characteristics, as FASD is that these individuals are treated as if they have brain damage. This creates a perpetuation of the problems rather than permitting a community development response (page 246-47).