

**Thesis**

**FAS/E in the Aboriginal Community:  
A Woman's Perspective**

**by  
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**Submitted in partial fulfillment of the requirements  
for the Degree of Master's of Arts in the Interdisciplinary Program at the  
University of Manitoba**

**August 28<sup>th</sup>, 2000**

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**FAS/E in the Aboriginal Community:  
A Woman's Perspective**

**BY**

**Christopher Joseph Wilbert Loewen**

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University  
of Manitoba in partial fulfillment of the requirements of the degree  
of  
Master of Arts**

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Of course none of this would have been possible without the three women who agreed to share a piece of their lives with me. And although I understand why you don't want your real names used, I wish you could more openly share in the joy and sense of satisfaction of having completed something I believe will be of use to both Aboriginals and non-Aboriginals alike. Susan, may other women read your words and be inspired to take on the same challenges that you have, thereby taking that first step onto the healing road.

I do not have enough paper to thank my family, so I will do that in person. Suffice it to say that my beautiful daughter, Kiah Katherine Marie, has brought, unbeknownst to her, endless joy. I write this paper in the hope that it may help make the world a better place for you to be. To my dearest and most precious wife Patty, I say thank you for your continuous love and support. I know you find it impossible to believe that I enjoy writing papers, but you continue to put up with me nonetheless.

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Abstract

Alcohol Related Birth Defects (ARND) including Fetal Alcohol Syndrome and Fetal Alcohol Effects (FAS/E) are topics attracting much attention. Prevalence of alcohol abuse among some Aboriginal communities combined with the relative ease of on-reserve research funding have inextricably linked FAS/E with the Aboriginal Community. Given that children can only be affected by alcohol in utero, blame is often placed exclusively on the birth mother<sup>1</sup>. Since the “discovery” of FAS/E in 1968, the medical field has conducted the majority of research. Although invaluable, it has done little to further our understanding of the socio-epidemiological aspects of this syndrome. The historical relationship between alcohol and Aboriginals, social factors, biased diagnosis and colonization all play fundamental roles in understanding the genesis of FAS/E in the Aboriginal Community. Interviews with an Aboriginal birth mother who drank throughout her pregnancies, her mother who attended residential schools and her daughter, provide a personal and intergenerational look at the malaise underlying FAS/E.

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<sup>1</sup> The term “birth mother” is used in this paper to denote a woman who has given birth to a child affected by alcohol and/or who has consumed alcohol during her pregnancy. Although many writers use this term strictly for mothers who have given birth to a child affected by alcohol in utero, because my interest is more in discovering the determinants that would lead a woman to drink during her pregnancy than whether she gave birth to a child affected by alcohol, I use the term as stated above.

Fetal Alcohol Syndrome and Fetal Alcohol Effects in the Aboriginal Community:  
A Woman's Perspective

I started working for an Aboriginal child welfare agency four years ago. The agency serves nine First Nation communities in western Manitoba. My job required that I spend a fair amount of time on one reserve in particular. What I saw was a community of people that was inadequately educated, exhibited low self esteem, lived in relatively poor housing, had major drinking, gambling and sniffing problems, was extremely angry, suffered from high rates of sexual and physical abuse and housed an inordinately high number of school aged children affected by alcohol. Having spent virtually no time on a reserve prior to this, I was completely and totally overwhelmed. I must admit that some of my preconceived notions of "Indians" as drunk and lazy were only reinforced. I knew that if I were to be an effective worker for our agency, I needed context. I needed to understand how a group of people in Canada, at the dawn of the 21<sup>st</sup> century, had come to live in these conditions, fraught with these social ills.

I saw no choice but to return to university. I was made aware of the Interdisciplinary Program at the University of Manitoba. This program allowed me to enroll in courses focussing on three major areas: Native Studies, Education and History.

As the time I spent at Foggy Creek<sup>2</sup> increased, I started to get to know its residents. Relationships formed and a mutual sense of trust began to develop. I – heeding the advice of one of the elders in the community – began leaving my briefcase in the car more often when visiting the community. I spent time at community events.

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<sup>2</sup> Foggy Creek is a pseudonym used to protect the identity of the community.



joined several local committees and continued with my university studies. In time, I became aware that an FAS/E study had recently been conducted on the reserve (Kowlessar, 1997), revealing rates many times higher than the worldwide average: With this information came direction for my studies at university. I decided to explore the precipitating factors that led to this community's high rate of FAS/E, all the while hoping to attain a level of understanding, perspective and context that would allow me to be a more empathic and effective worker.

As I continued my studies at university, I discovered that little or no attention had been paid to examining the socio-epidemiological factors of FAS/E in the Aboriginal community. As time passed and trust grew between myself and the community, residents started to share more and more about their past, providing me with more pieces of the contextual puzzle. In time, one Aboriginal woman from the community, who had heard about my studies, agreed to share her story. Susan<sup>3</sup> had drunk throughout her three pregnancies. She wanted her story to be told so that others might learn and not go through the same torture she endured. As I was looking for the intergenerational effects of drinking, I asked Susan if her mother and daughter would be willing to share their stories as well; they were.

Fetal Alcohol Syndrome<sup>4</sup> and Fetal Alcohol Effects<sup>5</sup> (FAS/E) and their relationship to Aboriginal<sup>6</sup> peoples is a topic attracting much attention. Studies over the

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<sup>3</sup> All names used in this paper are pseudonyms.

<sup>4</sup> "Fetal Alcohol Syndrome is a specific type of birth defect caused by heavy prenatal alcohol exposure and manifested by a cluster of specific features. The FAS diagnosis is employed when children whose mothers abused alcohol during pregnancy have some features in each of three categories (1) craniofacial anomalies; (2) growth deficiency; and (3) Central Nervous System (CNS) effects" (Stratton et al., 1996).

<sup>5</sup> In many cases, children born to mothers who drank may have some, but not all of the physical signs of FAS and may also exhibit cognitive or behavioural issues similar to FAS children. In the past, a 'soft'

past three decades have conclusively proven that the development of the fetus is harmed if the mother drinks alcohol during the pregnancy. They also indicate a higher prevalence of FAS/E among certain Aboriginal populations. These findings have helped focus the blame for children affected by alcohol on the birth mother: especially the Aboriginal birth mother. In order to better understand this issue, it is crucial that the Aboriginal birth mother is heard and that we see her life in the proper context.

My primary objective is to explore the factors that led to an Aboriginal birth mother to drink throughout her pregnancies. To this end I will explore the following critical issues: FAS/E and its relationship to the Aboriginal birth mother and the historical association between alcohol and Aboriginal people. An examination of FAS/E and related issues is dealt with first as it provides the necessary perspective to the historical overview. The historical synopsis is followed by the stories of the three women, an

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diagnosis of Fetal Alcohol Effects (FAE) which was suggestive of possible alcohol related birth defects. was commonly used. The FAE label attempted to capture a child's educational and/or social needs without a definitive medical diagnosis (Aase, 1994, p.8). An FAE label has proven to be unsatisfactory to many as it fails to specify issues or to identify the level and extent of need in affected children. In 1996, the American Institute of Medicine proposed to redefine FAE into two categories, Alcohol-Related Birth Defects (ARBD) and Alcohol-Related Neurodevelopmental Disorders (ARND). Under these definitions, ARBD is used to refer to children who exhibit congenital (physical) anomalies while the ARND classification would encompass those with evidence of central nervous system damage, including patterns in behaviour or cognitive abilities inconsistent with other disabling conditions (Stratton et al., 1996, p.4, 5). For the purposes of this report, the terms FAS and FAS/E will be used throughout to describe those individuals affected by alcohol in utero.

^ "One of the great consequences of the great dispossession and dominance of the Aboriginal peoples by settler people in Canada has been the process of attaching settler, mainly English names to describe various groupings of Aboriginal people" (Chartrand, p.2, 1991). The term "Aboriginal" will be used throughout this paper to denote the descendants of the ancient societies that inhabited what is known as North America. It includes what section 35 of the Constitution Act of 1982 refers to as Indian, Inuit and Métis. The term Aboriginal has been widely used as a self-reference by the three aforementioned groups. In the chapter on capitalization, *The Canadian Style*, published by the Department of the Secretary of State, directs that the form preferred or used by the person being addressed or referred to should be retained if used. It also states that the capitalization of both nouns and adjectives should be implemented when denoting race, tribe, nationality and language (The Canadian Style, 1985). Other forms of nomenclature (e.g. Indians, First Nations) will be used when referencing or quoting authors or participants in this study.

overview of the qualitative research methods I employed in my research and the conclusions I have reached.

Chapter One

FAS/E and The Aboriginal Community

The following chapter examines FAS/E and its attendant issues. These include FAS/E; prevalence rates; bias; ignorance of FAS/E; binge drinking; reasons why people drink; effects of advertising; social factors; effects of abuse; lack of supports; the birth mother and intervention and healing strategies.

Prevalence among Aboriginals

Although not enough research has been done to give definitive national or international figures on the Aboriginal population, a recent review of the published literature on Aboriginal rates in Canada and the United States supports the clinical observation that FAS and FAE affect Aboriginal children disproportionately compared with all other groups (Burd and Moffatt, 1994). The highest prevalence of FAS/E was reported in Aboriginal communities in British Columbia (Robinson, Conroy and Conroy, 1987) and the Yukon (Asante, 1985). They respectively found that 18.5% and 42.5% of children in these communities are presumed to have FAS/E.

A report was done on the effects of FAS/E on a reserve in Manitoba. The First Nation of Foggy Creek requested the diagnosis of its students aged 5 - 15. Data were available for 178 children.<sup>7</sup> Of these, 46% had some alcohol exposure before birth and 30% were exposed to high levels of alcohol in utero. Of the 178 children studied,

eleven were identified as FAS: An additional seven children were

identified as Partial FAS. Thus, in total, 10% of the children studied had

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<sup>7</sup> It is important to note that any parent's request that his or her child not be diagnosed was honoured. No data are currently available on the children who have moved from the community.

physical evidence of being adversely affected by prenatal alcohol exposure. Prevalence of FAS in this community ranges from 31 to 62 per 1000 children, while the prevalence of alcohol related birth defects (FAS plus Partial FAS) ranges from 51 to 101 per 1000 children. (Kowlessar, 1997, p.ii)

Depending on the studies used, these FAS rates are 15 to 180 times higher than the estimated worldwide incidence.<sup>8</sup>

West Region Child and Family Services – a Manitoba Aboriginal child welfare agency - had 216 children in care in October of 1994 when a survey was conducted that revealed the following results:

- i) 67% (145 of 216) of the children in the care of the agency . . . evidenced behaviours and/or learning disabilities that were characteristic of FAS/FAE children, ii) 91% (196 of 216) of the children in the care of the agency were in care because of alcohol abuse within their family, and iii) Between February 1993 and June 1994 the birth mothers of 17 permanent wards died as a result of alcoholism. (West Region Child and Family Services Report, 1994)

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<sup>8</sup> Abel and Sokol (1987) estimated the worldwide incidence of FAS to be 1.9 per 1000 live births. Four years later they revised their estimate, attempting to control for the over-representation of certain racial groups who may be at higher risk than others for FAS, and arrived at a rate (for the western world) of 0.33 per 100 births (Abel and Sokol, 1991). With the increase of available studies regarding FAS, Abel (1995) calculated the worldwide incidence of FAS at .97 per 1000 live births. Sampson, Streissguth, Bookstein, Little, Clarren, Dehaene, Hanson and Graham (1997) have estimated the combined rate of FAS and ARND to be at least 9.1 per 1000 live births.

Biased diagnosis

Critics argue that factors including socio-economic status, myths about drinking patterns and race, all need to be explored before any results are confirmed (National Health/Education Consortium, 1994). Research has indicated that, although alcohol abuse is not specific to low income populations, socio-economic status may influence the relationship between maternal drinking and FAS/E (Sparks, 1993; Stratton, Howe and Battaglia, 1996). According to Streissguth and LaDue “poor women appear to have a higher risk of fetal alcohol effects than middle-class women” (as cited in Sparks, 1993, p.83). Convenience, fundability and myths about alcohol use, have encouraged many funded studies to be done with American and Canadian Indian reserve populations, giving the impression that FAS is more common among Aboriginal peoples when in fact the belief that FAS is a ‘Native’ issue may be based more on research methodology than fact (Jones, 1997). At a workshop I gave on FAS/E, a participant asked if non-Aboriginal children could “get the disease” too.

Research conducted on Aboriginal communities is convenient for a number of reasons. In many cases, the researcher is presented with a relatively homogeneous group. This homogeneity helps ensure a “purer” sample group: that is, individuals with similar background including social conditions, religion, education, parenting styles and so on. Most Aboriginal communities are comprised of a relatively small number of inhabitants living within government defined boundaries. This allows the researcher to include the majority, if not all, the community's residents in the study. And finally, many Aboriginal people defer to outside “experts” who are predominantly non-Aboriginal. This deference

may allow researchers to “get away with” research techniques that would not be tolerated in other settings.

Funding that looks to research problems within the Aboriginal Community is relatively easy to acquire. Many Aboriginal leaders are only too happy to agree to having research done on their community, as the resultant data, substantiating anything from deplorable living conditions to high rates of suicide, often guarantee more money in the community's coffers.

May (1994) argues that Native children are more likely to have the diagnosis of FAS on their birth records than others and are more likely to be diagnosed with FAS if the child shows any signs of cognitive and/or behavioural problems in school. Some researchers argue there is a race/class bias to the diagnostic process, and that physicians are more reluctant to ask about prenatal alcohol use or entering an FAS diagnosis in the official medical record, especially with non-Aboriginal middle and upper income families (Aase, 1994; Sampson, Streissguth, Bookstein, Little, Clarren, Dehaene, Hanson and Graham, 1997). This may lead to the tendency of underreporting of FAS/E in these specific groups (Sparks, 1993). At times, “a child is labelled with Attention Deficit Hyperactive Disorder (ADHD) or some other disorder, because the physician avoided asking a mother about her alcohol use, and in effect, prevented ‘blaming the mother’ for her behaviours” (Nanson and Hiscock, 1990, Shaywitz et al., 1980, as cited in Jones, 1997, p. 8).

An Aboriginal woman (Personal Communication, Susan Nurse, August, 1997) was called in to her son's school because of his misbehaviour. The first question asked of her at the meeting was “Did you drink during your pregnancy?” When pressed, the

counsellor who asked the question admitted she would not have done so had this woman's skin been a lighter colour.

### Ignorance about FAS/E

If women are unaware of the harm alcohol can inflict on a fetus, there is little incentive for them to quit drinking while pregnant. The dangers of FAS/E have clearly not reached everyone. At an FAS/E conference held by the Assembly of Manitoba Chiefs (September, 1997), one of the Directors of Education for one of Manitoba's bands stood up and admitted that prior to that day, he had never heard of Fetal Alcohol Syndrome and that its existence helped explain the many problems they were facing in their school. A Treatment Worker at a child welfare agency in Winnipeg<sup>9</sup> (Personal Communication, October, 1997) related the story of a 15-year-old girl living on reserve who "knew" alcohol could not hurt her fetus since "my friend drank whisky throughout her entire pregnancy and her baby seems fine".

### Binge Drinking

Binge drinking, or drinking to excess in "one sitting", is all too familiar a pattern in many Aboriginal communities (please see Chapter Two of this thesis). The intensity of the mother's pre-natal alcohol consumption is a key factor in determining the effect on the fetus. A study by Streissguth, Barr and Sampson (1990) shows that binge drinking increases the chances of damage in children. In fact, studies have shown that as little as one drinking binge by the birth mother can harm the fetus (Fournier and Crey, 1997, p.177). Several animal based



studies (for example, Chernoff, 1997, Abel and Dintcheff, 1978, Pierce and West, 1986) have found that the incidence of fetal damage increases with condensed rather than uniform exposure to alcohol (as cited in Stratton et al., 1996). May (1995) notes alcohol is absorbed into, and remains in the placenta well after the mother herself has overcome the effects of alcohol use.

### Why People Drink

“Several theories accounting for alcohol addiction suggest that in many cases alcohol is used primarily to escape or forget painful emotional experiences rather than primarily for its euphoric-inducing quality” (Richards, 1993, p.47). The disease concept of alcoholism offers invaluable heuristic utility in clinical situations on both individual and systemic levels. The effectiveness of this model stems from its ability, in part, to remove the moral stigma of alcoholism and its attendant guilt (Wallace, 1977). The disease model also acknowledges that the addicted individual requires treatment rather than punishment (Sparks, 1993, p.8). It is “the nature of alcoholism . . . that its victims are rendered by the disease itself less and less capable of spontaneous recognition of the severity of their symptoms” (Johnson as cited in Weiner, Morse and Garrido, 1991, p.15).

### Advertising

Although many efforts have been made to better inform the public of the dangers of FAS/E, there is no evidence that informational efforts reduce the number of women who drink heavily (Streissguth, Darsy, Barr, Smith and Martin, 1982). Dedam, McFarlane and Hennessy (1993) report that heavy drinkers do not acknowledge the risks associated with drinking as frequently as do moderate or light drinkers. Women who are

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<sup>9</sup> The worker has asked that her name not be used.

at greatest risk of having children with alcohol-related birth defects have been observed to be the least responsive to broad informational campaigns (Weiner et al., 1991). The majority of public education campaigns "have been based on the theory that awareness and knowledge are catalysts for behavioural change. Evaluations of health promotion campaigns in general suggest that programs may be ineffective because the information does not reach the desired population" (Weiner et al., p.14). The unique therapeutic needs of this 'desired population' require the development of specific strategies relevant to the nature of the drinking behaviour.

Lack of success has been linked to fear or implied punishment in the message and to the lack of information on how to change undesirable behaviour. Sparks (1993) is clear that messages that arouse fear are often ineffective and insufficient. This fear mongering can actually backfire, resulting in an increase in alcohol consumption. Viewing the drinking behaviour as a moral or volitional issue has given rise to simplistic solutions manifested as the slogan therapy of 'just say no' (Weiner et al., 1991). "Guilt is likely to create a vicious circle of self-recrimination and continuing alcohol abuse" (Weiner et al., p.16).

Clarren (1996) joins those who feel that educational campaigns have not hit the target population.

It has not as yet been demonstrated that stories and warning in the media about the adverse impact of drinking alcohol during pregnancy lead directly to a reduction in the incidence of FAS and related disorders.

However, it has become clear to us that every time a widely viewed piece

on FAS appears in the press or on television, there is a sharp increase in requests for appointments for FAS diagnoses. (p.87)

### Social Factors

Limited social opportunities for parents also affect the incidence of FAS/E and increase the possibilities for abuse and neglect. "Poverty, lack of adequate housing and exceptionally few family supports, all have detrimental effects on the ways in which children are supported by birth parents" (Jones, 1997, p.14). Statistics Canada (1999) reports that in Canada, 24% of the Aboriginal population are unemployed compared with 9.8% of the non-Aboriginal population. For those reporting some income, Aboriginals average \$15,699.00 per annum compared to \$25,414.00 for their non-Aboriginal counterparts. Regarding education, over 64% of Aboriginals on-reserve have not completed high school while only 34% of non-Aboriginals fall under that category. Foggy Creek is no exception. 18.5 % of the reserve is unemployed with an average annual income of less than \$10,000.00. Only 10% of the residents of Foggy Creek have completed grade XII. Of the 8% who have gone on to university, only 33% have obtained a Bachelor's Degree or higher. The average total income of lone-parent families on the Foggy Creek reserve is \$14,779.00 while in the rest of Canada the average rises to \$29,962.00.

Unresolved childhood issues, lack of supports for the parent and continued alcohol use, often lead to frustrations with parenting, displaced guilt, and unrealistic expectations on both the self and the child (Smith, 1992). Continued alcohol or drug use can lead to emotional issues for the child. Miller & Jang "found that children of alcoholics had greater socialization difficulties than did children of non-alcoholic

parents” (as cited in Smith, p.95) and that the negative impact on children increased with the severity of the alcoholism. Deren shows that children raised in alcoholic homes often develop emotional, psychological and/or behavioural problems as the result of unstructured, chaotic and sometimes abusive family environments (as cited in Smith).

Smith (1992) argues that a number of ‘risk’ factors need to be taken into account when assessing risk for alcohol affected children who are living with birth families. These factors include parental style, parental stress and psychopathic issues. Burns and Burns for example, found that alcoholic parents showed little sensitivity to the needs of their infants and often demonstrated an abnormally high level of egocentrism in the way they parented (as cited in Sparks, 1993). In some cases, parents themselves may lack the information needed to parent or may be struggling through childhood issues of their own (Jones, 1997).

#### Effects of Abuse

A high correlation between FAS and childhood neglect and abuse is shown in American statistical profiles. Jones, McCullough and Dewoody (1992) in their study found that 50-80% of confirmed child protection/abuse cases involved drugs and alcohol abuse. 75% of all fatal child abuse cases involved at least one addicted parent and 90% of all FAS children had some involvement with child protection services by their fifth birthday. Other reports note that as few as 3% of FAS children live with their family of origin and 23% of mothers had died by the child's 10<sup>th</sup> birthday (Stratton et al., 1996).

#### Lack of supports

The Report on the Community Consultation on Fetal Alcohol Effects and Fetal Alcohol Syndrome (1993) held in Winnipeg reported that

one of the most serious issues presenting at the community level is the lack of sufficient and appropriate supports for families dealing with FAS/FAE problems. Children with FAS/FAE may suffer from a wide variety of physical and behavioural problems that put birth parents, and foster or adoptive parents under enormous stress. This is often compounded by the fact that community social services cannot adequately meet the needs of parents or children. (p.72)

### The Birth mother

Grant, Cara, Streissguth Phipps and Gendler (1995) describe a "typical" birth mother. She is

a single woman in her late 20s, born to substance abusing parents. Raised in a foster family for at least part of her childhood, she was physically and/or sexually abused as a child, and ran away at least once. She did not complete high school and began to use alcohol and drugs herself as a teenager.

The typical client has been in jail more than once, and arrested more often for prostitution, assault, theft, or other crimes, than for drug charges. She has been through drug treatment and relapsed. She does not use birth control or plan her pregnancies; and now has three or more children, with at least one in the foster care system. She is abused by her current partner, her housing situation is unstable, and her main source of income is welfare. She is unlikely to be involved in any kind of supportive social group. (p. 2)

The executive director of FAS Interagency in Winnipeg (Personal Communication, December, 1997) estimates that 20% of the birth mothers on their caseload are themselves alcohol-affected. "This, combined with psychological characteristics such as coexisting psychopathology and low self-esteem, often leaves them ill prepared to deal with a drug-affected child who may have behavioural problems, physical disabilities, and/or mental retardation" (U.S. Department of Health & Human Services, 1992, p.4).

Alcohol abuse among pregnant women. While American studies show that in the United States the incidence of drinking while pregnant has shown a decline over the past ten years (Stratton et al., 1996), there still remains a small proportion of women who abuse alcohol during pregnancy. Alcohol, for them, has become a powerful reinforcement (Sparks, 1993). Of the 7% of the female population considered to be heavy drinkers and most 'at risk' for having children with FAS/E, alcohol use generally continues throughout the pregnancy (May, 1991). These women tend to have a strong mistrust of the medical system and are the least likely to access prenatal care for their support (Chasnoff, 1988). The women of Foggy Creek have repeatedly voiced their mistrust of "western doctors" and the medical system in general. When they make use of medical supports, they tend not to report or to under report alcohol use for fear of reprisals from the physician or from the child welfare system. They may not know, or else not believe that alcohol will damage the fetus (Stratton et al.).

#### Intervention Strategies

"Carefully planned, individual intervention strategies should be considered with this population" (Weiner, et al., 1991, p.15). "While additional research is needed to

further define how to bridge the gap between motivation and action, sufficient information is available to develop programs which target women at highest risk”

(Weiner et al., p.16).

Non-judgmental approach. The research is clear that a non-judgmental approach must be taken when dealing with the population group in question. It is also clear that to date, there are not enough programs of this nature available. Diane Malbin (Personal Communication, December, 1996), a counsellor and noted expert in the FAS field, has recently completed an exhaustive search regarding the establishment of effective, holistic intervention programs. She found none. Given its complex nature, whatever approach taken to assist the target population, FAS/E requires “multilevel intervention strategies that acknowledge the influences of the larger social environment as well as of the family. Programs must be comprehensive and should involve the parents” (U.S. Department of Health & Human Services, 1992, p.9). We must “clearly define the population of at-risk women and in so doing achieve an appropriate fit between the target population and intervention strategies” (Weiner et al., 1991, p.17).

Prevention of alcohol-related birth defects requires the development of programs directed to the special needs of addicted women and their families (Weiner et al., 1991, p.13). Many mothers who give birth to alcohol affected children have their child apprehended at birth and “women who are poor, First Nations and single parents are most at risk for child apprehension in Canada” (Boyd, 1994, p.187). There may also be the assumption that because she drinks, the mother does not care about her child. The belief has been that the addicted mother may not care about her child, is unable to parent and needs to “detox” before she is allowed to have her child back. The problem with this

philosophy is that taking away the one thing that matters most to the mother and asking her to 'heal' is often counter-productive. Fortunately the trend is changing to one that encourages children to remain with their mothers whenever possible. Nonetheless, this is not a simple procedure.

Achieving and maintaining sobriety carries a complex set of stresses for a pregnant woman: she must leave her previous life and family, she may have few resources, and, if she can find a treatment program that accepts pregnant women, it may not have transportation or child care. (Sparks, 1993, p.6)

Treatment specific to Aboriginal birth mothers is needed. Studies indicate that substance-abusing women have improved outcomes in treatment when allowed to bring their children with them (Glider, Hughes, Mullen, Coletti, Sechrest, Neri, Renner and Sicilian, 1996). The Royal Commission on Aboriginal Peoples (1996) has made numerous recommendations encouraging the federal, provincial, territorial and Aboriginal governments to establish Healing Centres/Lodges. Their purpose would be to provide direct services, referral and access to specialist services and provide residential services oriented to family and community healing. The Centres/Lodges would be under Aboriginal control. In developing policy to support health, the governments must "acknowledge the common understanding of the determinants of health found in Aboriginal traditions and health sciences and endorse the fundamental importance of holism, equity, control and diversity" (RCAP, 1996).

Dr. John O'Neil (Personal Communication, 1997), a medical anthropologist at the Health Sciences Centre in Winnipeg, was one of four members of the RCAP Health



Policy Team. O'Neil recommends the establishment of a Healing Centre that addresses many Aboriginal health concerns, rather than further stigmatizing the community with the establishment of an FAS/E specific clinic. This broad-based approach is one taken by May (1995) as well. He argues that

embracing a narrow paradigm such as the disease model of alcoholism will not be productive for either a full understanding of many behaviours or for a truly successful prevention effort . . . Embracing individual disease concept and terminology for prevention efforts tends to limit the perspective, which when applied to strategies and solutions, may 'blind' or 'obscure' many prevention possibilities. (p.1558)

Community-based healing. The residents of Foggy Creek are tired of being 'passive recipients' of information from so-called outside experts. Many of its people have spent time in off-reserve alcohol treatment centres only to return to the dysfunction of their daily life. For many, the return to dysfunction means the return to drinking. A return to the environment in which the drinking initially took place can cause relapse. "Recent psychological literature strongly supports the theory that taking drugs in a particular environment causes the drug taker to be conditioned to that environment" (Sparks, 1993, p.9). Removing a dependent user from her community and providing treatment "does little to permanently break the associative links that control the craving for drugs" (Chasnoff, Marques, Strantz, Farrow and Davis, 1996, p.19). Because the environment itself can become the stimulus for continued alcohol abuse, the community itself needs to heal, and that cannot and will not occur until power is given back to the Aboriginal People.

Dr. Michael Moffatt, Professor and Head of Pediatrics and Child Health (Personal Communication, 1997) feels that “things in the health field will not improve until the Aboriginal have full control, and the sooner this occurs the better”. He suggests that women from the Aboriginal community in question, who have experienced health crises in the past and are on the road to recovery, would be ideal in helping other community members currently suffering similar circumstances. He adds that “because women seldom drink alone, the entire social environment needs to be considered; and that needs to come from the community”. May's (1995) research concurs with that of Moffatt's.

Past efforts have focused too exclusively on interventions that are clinic-based and do not consider the importance of the overall life cycle and living situation of the drinking female, particularly her occupation, marital status, and the drinking pattern of her husband/partner. (p.1563)

Drs. Moffatt, May and O'Neil are not alone in their support for a grassroots approach to Aboriginal health care. Dr. Paul Steinhauer (1996) states that

Communities should be encouraged, wherever possible, to define their own needs and to help themselves and their neighbours, rather than being the passive recipients of what outside professionals think is good for them. But it would be important that the community shared the ownership of such initiatives, so that participants' mastery and sense of control over their own destinies were affirmed rather than undermined. (p.7)

Grant et al. (1995) echo the negative impact of outside so-called “experts”. Alienation from community resources only exacerbates the problems of maternal chemical dependency. The result is that those women at highest

risk for delivering children with serious medical, developmental and behavioural problems are the least likely to seek and receive prenatal care and other assistance from agencies designed to help them. (p.1)

The available literature informs us that although the overall incidence of women who drink while pregnant has decreased over the past ten years (Stratton et al., 1996) the four to seven percent of heavy drinkers are the least likely to reduce alcohol consumption during pregnancy (May, 1991). This helps explain why in most studies conducted, "a very small number of women produce all of the FAS children [and that] this is . . . true in Indian epidemiological studies of other problems as well" (May, 1994, p.137). To better understand why things are the way they are today for many Aboriginal people, it is imperative to have a comprehensive understanding of their past. This understanding will provide us with an appreciation for why there exists an abuse of alcohol on many reserves today and what precipitated the current relationship between Aboriginals and alcohol.

Chapter Two

Historical Relationship between Aboriginals and Alcohol

Most scholars agree on the origins of the introduction of alcohol to the Aboriginals of North America. Scholars agree that prior to contact with Europeans the Indians of northern North America<sup>10</sup> possessed no intoxicants.<sup>11</sup> A collective finger points to the fur trade as both the genesis and one reason for the continuation of alcohol distribution to them. Studies have examined both the fur trade and other factors to determine their effect on Aboriginal drinking.

About the studies

The authors whose works are examined in this analysis include sociologists, historians and anthropologists. Only one of the scholars studied is female and none are Aboriginal. Field work and historical reviews were the two primary types of research conducted. The works studied focus primarily on the fur trade era, missions in the settlement era at the turn of the 20<sup>th</sup> century and contemporary Indian life. Although the works span five decades, the conclusions reached concerning why Indians drink are remarkably uniform. Relatively few new theories are offered by the most recent authors, and none conclusively dispels those proffered by the earlier writers.

Fieldwork. Included in those who conducted fieldwork is Lemert (1958) who lived with his subjects - the Homalthko, the Sliammon and the Tlahoose on the British Columbia coast. The Forest Potawatomi are studied by Hamer (1965) who spent time in

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<sup>10</sup> Several tribes in the southwestern United States, including the Apache and Zuni, drank indigenously produced alcoholic beverages before European contact. The Pina and the Papago too drank alcohol, but reserved its consumption for ceremonial purposes (MacAndrew and Edgerton, 1969).

a small community in the Upper Peninsula of Michigan conducting his research. Brody's (1970) work examines the lives of Indians who have migrated from their reserves to a Canadian city and provides a unique perspective, as Brody lived on Skid Row for 18 weeks while conducting his research. Robbins (1975) examines the increase in conflict that often accompanies economic change focussing on his time spent with the Naskapi Indians of Schefferville, Quebec. Hill (1978) critically examines MacAndrew and Edgerton's concept of drunken behaviour drawing from his personal experiences in living with the Santee Dakota, Winnebago, Omaha and Yankton tribes in Sioux City, Iowa. For his research, Lithman (1979) draws on his prolonged residence in a Canadian Indian reserve community.

Historical Reviews. The majority of the authors who used existing studies rather than conducting fieldwork did so because they were studying past societies. Dailey (1968) relies on information left by the French Jesuits who sought to convert the Indians of New France. MacAndrew and Edgerton (1969) analyze societies around the world to support their theories regarding the effect of alcohol on behaviour. Lurie (1971) argues her hypothesis about Indian identity in her work. White (1984) analyses early accounts of Indian-French interactions between 1760 and 1820, and comments on the effects of this relationship. Waddell (1985) focuses on alcohol use by the Lac du Flambeau Chippewa of 1804-05. His primary source is the fur trade journal of Northwest Company official Francois Malhiot. Two of May's articles (1992, 1994) examine, clarify and dispel the many myths surrounding Indians and their relationship to alcohol. And finally,

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<sup>11</sup> This is significant, as those Indians in the southwest who were already familiar with alcohol had developed coping mechanisms to deal with its effects. The Indians of northern North America had no

in his book Mancall (1995) examines hundreds of documents pertaining to the era between 1650, when the rum trade began, and 1760, when the American Revolution disrupted the colonial economy.

#### A Cautionary Note

Caution must be exercised when examining interpretations of Indians' behaviour and alcohol. In the case of the Jesuits writing from New France at the turn of the 20<sup>th</sup> century, it is important to remember that they "were obliged to please and shock" their audience to ensure continued financial support (Dailey, 1958, p.52). Waddell's (1985) analysis of the fur trade journal of Northwest Company official Francois Malhiot also argues the need for caution, as most of Malhiot's opinions of the Chippewa were formed when they visited the post each year - a time of peak drinking intensity.

#### Women and alcohol

There is an assumption for most of the authors that when they refer to Indians drinking, they are referring to men. Most of the authors who do write about women make a connection between women drinking and promiscuity. Dailey (1968) talks of men causing women to get drunk in order to seduce them. Hamer (1965) mentions women who make amorous advances toward white men after a few drinks arousing jealousy in their mates. Women are accused by their partners at drinking parties of having extramarital sex (Lithman, 1979). Apart from the examples above, when women are included in the literature on alcohol they are often seen as suffering from the negative effects alcohol has on their husbands and/or fathers (Dailey).

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experience and therefore no such mechanisms in place (Mancall, 1995).

### The Influence of the Fur Trade

Although no one disputes the fur trade origin of alcohol, a number of factors helped influence its impact. These include: The influence of politics and profit; The influence of gift giving and kinship; A guarantee to the British, French and Indian of reciprocity, and The financial success of the British colony.

Politics and profit. Rotstein's (1972) look at Indian trade practices in early North America examines the complex social environment into which the relationship between European and Indian began. In the warlike environment of North America, politics took precedence over trade. For the Indian, politics dealt with "life and death issues of intertribal relations [while] economic life had not yet been differentiated as a separate . . . sphere of social existence" (p.1). European traders focussed on profits and regarded economic transactions as impersonal activities. Yet for the Indian, trade was personal and followed established political patterns. "A council was held, gifts had to be exchanged and most important of all, a political bond, a 'peace', or 'alliance' had to be established or confirmed" (Rotstein, p.1).

Much of the interchange between European and Indian trade was, to the Indian, formal and social rather than economic. The Indian's concern was primarily security, for during much of the 17<sup>th</sup> century, the Indians were engaged in intertribal war. In fact, "unlike the system of international relations of the modern world where peace is assumed to exist unless war is declared, an Indian tribe was in a state of latent or active hostility with other tribes unless peace had been formally declared" (Rotstein, 1972, p.4). In this milieu, the giving of gifts was a necessity, often required to resolve major conflicts.

Gifts were given to the Indians by the French to ensure their loyalty in times of war against the English: The English likewise gave presents to renew their alliance with the Iroquois and others. Over time, many treaties and alliances were formed across the North American continent. "It was in this political setting that the fur trade took root and these political institutions governed the basic patterns of the trade" (Rotstein, 1972, p.13).

The influence of gift giving and kinship. While some historians may have equated gift giving with bribery and attributed its introduction to Europeans, White (1984) offers another explanation. He suggests that its widespread use may stem from the social and cultural meanings it embodied for American Indians (p.185). In examining Ojibwe culture in the Lake Superior region between 1760 and 1820, he demonstrates the importance of a "reciprocal confidence" that needed to be established between trader and Indian. As the trader was a stranger and in a considerable minority, he had to make an agreement with the Ojibwe on their own terms in order to establish trust before commencing business. Because the Ojibwe believed that tangible objects were symbolic of one's feelings, "gifts communicated something about what each partner to the relationship wanted from the other" (White, p.186).

For the Ojibwe, the family, or kin group determined the flow of goods and services. Consequently, their flow outside the kin group was structured in terms of kinship. This helps explain not only why terms like father, brother and children were often used by the Ojibwe to describe their relationship with the European, but also why they asked to be pitied. "In Ojibwe idiom, to 'pity' another is to adopt him and care for him as a parent or grandparent cares for a child" (Landes in White, 1984, p.187). While a brother to brother relationship often typified the relationship between two Indian groups,



it was that of parent to child that most closely resembled the relationship between European and Ojibwe. This diplomatic idiom “fits with what is known about the paternalism of European authority” (White, p.189). As a father would to a child, the Europeans contributed the majority of the tangible gift giving. In return, the Indians gave not only furs, but also their loyalty and at times, military support.

Significantly, “in diplomatic dealings between Ojibwe and the Europeans, rum, brandy, whiskey, and other forms of alcohol seem to have crystallized the idiom of kinship more than any other gifts” (White, 1984, p.191).

Reciprocity. It was early on established that alcohol served as an ideal symbiotic gift: The Indian received a novel physical sensation while the trader was assured Indian expertise in soliciting furs sought after by the European public (Dailey, 1968). Malhiot's journal shows that rum was given as a gift or in exchange for provisions, and that it was precisely this gift that encouraged Indians to trade with the Northwest Company as opposed to its rivals. It further reveals that the fur trader dispensed liquor to the Chippewa to obtain provisions for the winter and “to quiet restless Indians and to keep peace” (Waddell, 1985, p.259). On several occasions, the British and French provided the Indian rum to obtain military support (Hamer, 1965). In what is today the United States, many traders and colonists believed that the alcohol trade was necessary to support British interests in North America (Mancall, 1995). In Canada, French colonizers, including missionaries, bureaucrats and traders, realized the importance of the liquor trade. Its existence was debated on one side by missionary's intent on spreading

the faith and on the other by merchants intent on increasing trade.<sup>12</sup> The lack of colonists – who may have ignored the fur trade for agricultural pursuits – caused trade to be crucial to the economy of New France. The demand for liquor by Indians pleased the European fur traders as it ensured a continuous supply of pelts. At the same time, the problems liquor brought to Indian communities so angered the missionaries they launched an attack on the trade (Mancall, 1995).

Success of the British colony. By the late 16<sup>th</sup> century Britain and her colonists believed that the integration of indigenous people of America into the crown's colonies was pivotal to the success of the British empire and that this integration depended on the creation of trade relations: furs, slaves and skins in exchange for liquor (Mancall, 1995). Trading alcohol to Indians was acceptable to some because trade (market economy) could be portrayed as a step toward becoming "civilized". The policy of giving gifts (including

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<sup>12</sup> In Canada, in 1678, the alcohol trade became the focus of a debate that pitted the church, whose mission it was to spread the faith, against the merchant's plan to increase trade. The church clerics saw the trade as thwarting their proselytization efforts while the European fur traders encouraged it, knowing that those Indians who wanted alcohol would continue to bring in pelts in exchange. The bishop of Quebec, Francois Xavier de Laval de Montigny, was so incensed at this 'demonic destruction' that in 1660 he ordered the excommunication of any trader who sold alcohol to the Indians. The immediate demand for the lifting of the excommunication order by the civil authorities displayed the gulf between the two groups. The Indians who continued the purchase of alcohol with pelts gave traders all the incentive they required. And so, when, in 1678, Frontenac called a meeting on the brandy trade, "the economics of the trade dominated the discussions"(Mancall, 1995). The reality was that the French crown relied heavily on the fur trade for the colony's revenue. As a result, anything that might threaten the trade was cause for alarm. Arguments in favour of continued trade were many. One justification stated that if the French did not supply the brandy, the Dutch would. Some argued that the English remained a threat, in that Indians who visited their colonies might fall into heresy and never convert to Catholicism. Chavel de St. Romain went so far as to state that not only did Indians need to drink because deals were closed by drinking together, but that "if Indians were denied the freedom to live as we do, they will never become Christians" (Mancall). LaSalle argued that an end to the liquor trade may cause the Iroquois to wage war against the French, and that the health of the colony depended on it.

Opponents argued that some Indians had become so indebted to the traders that "their behaviour threatened the fur trade" (Mancall, 1995). Jean Bourdon de Dombourg felt that limiting the brandy trade would limit the fur trade thereby focussing the French colonists' energies on agriculture, which he felt would lead the colony to success.

lots of alcohol) often outweighed the consequences of a drunken binge by the Indians. And even though various laws were put in place that made liquor trade with the Indians illegal, "the logic of the market overcame the force of the law" (Mancall, p.45). The French too realized the importance and power of alcohol. As Dailey (1968) states, "despite the threat of both secular and ecclesiastical punishments, ranging from the stock to excommunication, . . . efforts to abolish the liquor traffic were unrealistic" (p.46). To be sure, without the fur trade the financial success of the colony could not be assured. And so with the continued success of the fur trade came a continued increase in Indian drinking.

#### The Maintenance of Aboriginal Drinking

Although history helps explain the availability of alcohol, its use and abuse by the Aboriginals after the fur trade and into the era of settlement and to our own times, is more difficult to account for. As the literature attests, Aboriginals today drink for a plethora of reasons. These include: Intoxication as a learned behaviour and one that is situationally variable; The breakdown of the family; A lack of sanctions against drinking; Alcohol use as cultural adaptation; Alcohol use to confirm "Indianness"; Alcohol use to resolve identity issues; The Potlatch; Drinking to get drunk; Drinking until the stock is depleted; Alcohol and the supernatural; The "White Man" as solely responsible for Indian alcohol abuse; Helplessness of the Indians; Alcohol itself to blame; and the biophysical makeup of the Indian.

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Although the king, in 1679, issued a proclamation declaring that "the trade could remain open so long as no liquor was carried into the Indian communities" (Mancall, 1995), the widespread disregard for the edicts' limits, sealed the triumph for the trader.

Intoxication as a learned behaviour and one that is situationally variable. Perhaps the most common explanation of scholars is best expressed by MacAndrew and Edgerton (1969). Their theory holds that societies provide their individuals a 'time-out' period, allowing drunken individuals to avoid social sanctions that are normally applied to aberrant behaviour. Their landmark work "Drunken Comportment: A Social Explanation" challenged the then accepted notion that alcohol acts as a disinhibitor, resulting in impairment of judgment and loss of self-control. If this were the case, they argue, one would expect alcohol to have a constantly predictable effect. Their belief, that one's behaviour while intoxicated is learned, helps explain why drunken comportment is situationally variable.

MacAndrew and Edgerton's (1969) exploration of a wide range of societies adds credence to their theory of learned behaviour. For centuries, the Bantu of South Africa drank alcohol without any trouble within their own traditional world. Now that they have departed tradition for the world of the European, they find themselves incapable of handling alcohol. The argument then, is that even though the Bantu beverage has not changed, the circumstances surrounding its consumption have, and as a result, so too their drunken comportment. Hill (1978) points out that in all social encounters - whether alcohol is involved or not, an individual's behaviour will reflect the setting he is in. What is deemed acceptable in one situation may be unacceptable in another. Lithman (1979) concurs, stating that "there is ample evidence that people have a very discriminatory sense of what inhibitions one is allowed to 'lose' during drunkenness, and how and in what areas of social life one is allowed to act when lacking in judgment and self-control" (p.121). Robbins' (1973) study of the Naskapi supports the theory of drinking as a

learned behaviour. He found that individuals who showed little or no signs of inebriation after 6-10 beer would, on another occasion, appear intoxicated after only ½ a beer. In other instances, "persons reacting aggressively to alcohol would sober up as soon as someone new entered the interaction" (p.110). Lemert's (1958) study of the Salish Indians of British Columbia further supports the learned behaviour theory. While comparing Indian drinking to white drinking he finds a preponderance of exaggerated symptoms of drunkenness "including blariness of the eyes, head rolling, and staggering in the Indians he studied" (p.58). He suggests that this display is at times, a stereotype of drunkenness rather than the real thing. Lemert too noted the quick transitions that were made from drunken to sober behaviour depending on the situation at hand. MacAndrew and Edgerton report that from the earliest times records were available, Indians feigned drunkenness in order to "avail themselves of the excuse that this state conferred" (p.152).

The above argues that people over time 'learn' what is, and is not, acceptable behaviour while intoxicated, act accordingly and in effect "become living confirmations of their society's teachings" (Lithman, 1979, p.121). The argument continues, noting that because alcohol affects many of our sensorimotor capabilities, it has in certain societies, become a symbol for what is known as 'time out', or a "state of societally sanctioned freedom from the otherwise enforceable demands that persons comply with the conventional properties" (MacAndrew and Edgerton, 1969, p.89). To bolster their hypothesis MacAndrew and Edgerton refer to James Ritchie's study of the Maori (as cited in MacAndrew and Edgerton, pp.53, 54) which demonstrates how drunken behaviour is situationally variable. Maori drinking in a small New Zealand community falls into two classes: drinking 'sessions' and drinking 'parties'. Besides exhibiting

completely different form, function and duration, the two events produce quite different comportment. Ritchie's finding that in the latter stages of these parties, violence and sexual undertones are quite common is echoed by Lithman (1979), who has recorded the various drinking situations he experienced while living on an Indian reserve. He too sorts drinking into two categories: the first finds alcohol as only incidental to the pursued activity, while in the second, "alcohol serves to symbolise to the participants that a specific chain of events is likely to unravel" (p.122). In the first instance, nobody gets drunk, loses control or displays alcohol affectation. In these instances it is the structure of the event that determines the use of alcohol. In Lithman's second category (one of which is also the drinking party), violence and sexual undertones are also present.

The breakdown of the family. Several writers include evidence that animosities between spouses often manifest themselves at drinking parties. Lithman's (1979) research on Indian house parties indicates that husbands and wives lack the resources to live up to the other's expectations. Men are often unable to be the 'breadwinner' and provide the kind of life for their family expected of them. Women lack the knowledge and authority to positively affect their children's education. As this dissatisfaction is difficult to express - it may lead to a break up of the family - "the drinking party becomes the arena for blunt communication between many married couples" (p.128). For the Potawatomi, promiscuity and jealousy often accompany the drinking party. After consuming small amounts of alcohol, the Potawatomi women often make amorous advances on the men, particularly the white men. The jealousy that exists in the community can be traced to "the breakdown of the traditional kinship system and the disparaging attitude of wives toward their husbands" (Hamer, 1965, p.118).

Many of the writers have examined the issue of status with respect to drinking patterns. In Potawatomi tradition, husbands held higher status than did their wives. Support for this lies in the double standard that existed for infidelity: a woman was punished while her partner was not (Morse as cited in Hamer, 1965). By the end of the 19<sup>th</sup> century, man's dominant status declined as acculturation increased, bringing an increasingly negative stereotype of men by the women. This has led to intoxication as a "means of fantasy for regaining the high status which Potawatomi men held prior to the coming of the white man" (Hamer, p.120). Hamer argues that today's social structure proves difficult for men who traditionally found prestige in the role of hunters and warriors. High unemployment rates too, have made it almost impossible to improve their social status in a market economy.

A lack of sanctions. Whitaker's study of the Sioux (as cited in Lurie, 1971) concurs with MacAndrew and Edgerton's 'time-out' hypothesis. His study, which found social sanctions against heavy drinkers and alcoholics virtually non-existent, is not unique. Indeed, Dailey (1968) reports that for the North American Indians of New France at the turn of the 20<sup>th</sup> century, losing control over one's mental capacities not only had no shame attached to it, but was "a sought after means of transcending the physical to obtain a spiritual experience" (p.52). Among the skid row Indians in a Canadian city, the rare reference made to alcoholism was made with no reference to guilt or anxiety (Brody, 1970, p.221).

Many scholars reviewed agree that when an individual drinks, society's rules and norms are situationally lifted. Why sanctions were not imposed is examined by Hamer (1965) who studied the Potawatomi Indians of Michigan. He attributes the non-

imposition of sanctions with respect to intoxication to the lack of community structure.

This lack of structure in turn prevented “the development of an organized approach for coping with the problems of acculturation” (p.120). Following this line of thought, Fields (as cited in Lithman, 1979) argues that the extent of public drunkenness is inversely proportional to the rigidity found in the social structure. Horton (as cited in Lithman) relates alcohol use in a society to the anxiety generated by culture contact situations “where established norm systems become problematic as other values are introduced in a society (e.g. through the penetration by a colonial power)”. Galinée, a missionary in New France in the mid 1600s, notes that for the Indians “it is a somewhat common custom amongst them when they have enemies, to get drunk and afterwards go and break their heads or stab them to death, so as to be able to say afterward that they committed the wicked act when they were not in their senses” (Kellogg, 1917, p.183). For the Potawatomi of Michigan, by the mid-1800s, with alcohol use on the rise and the entrenchment of deculturation, the continued lack of community sanctions led to acts including incest, murder and theft that went largely unpunished. As intoxication was the rationalization, the perpetrator went free (Hamer). Under the influence of alcohol, the intoxicated individual “was given full licence to behave as he pleased, even if it meant killing a person” (Dailey, 1968, p.49).

Alcohol use as a cultural adaptation. The behaviour of Indians under the influence of alcohol, according to Waddell (1985), is an effort to “adapt existing cultural behaviours, institutions, and values to new social circumstances” (p.246).

Anthropological studies have shown that Indians tried to integrate alcohol into existing ceremonies (Mancall, 1995). Examples include the eastern North American Indians' use



of alcohol in rituals of hospitality and mourning (Mancall). According to Hamer (1965), for the Potawatomi, alcohol has come to replace those things which were a part of their culture. Alcohol has, for them, become an escape “from the prosaic pattern of subsistence living” (p.120). The white man's world of material goods and social activities have not sufficiently compensated their loss of ceremonies, dances, war parties and hunting expeditions. Merton (as cited in Lithman, 1979) argues that drunkenness may result when individuals find it impossible to reach the goals emulated by the surrounding society. For the Homalthko, drinking brings a sense of aboriginal solidarity in the midst of white man's society. One way in which continuity can be established with the old culture is through the telling of stories and the singing of drinking songs (Lemert, 1958).

Alcohol use to confirm “Indianness”. Hamer and Field's theories, which attribute an increase in alcohol abuse to a lack of community structure, are taken one step further by Lurie (1971). She contends that Indian drinking “is an established means of asserting and validating Indianness and will be either a managed and culturally patterned recreational activity or else not engaged in at all in direct proportion to the availability of other effective means of validating Indianness” (Lurie, p.315). She maintains that Indians will get purposefully drunk in order to confirm the stereotype of the drunken Indian. This act ensures a continuance of the Indian-white boundary. Hamer (1965) found that the stereotype of the Indian as a drunkard by both whites and Indians provided for a reciprocal understanding and predictability of their roles. “The Potawatomi conform to this self-fulfilling prophecy by accepting their status of inferiority associated with their frequent intoxication” (p.121). Lithman (1979) describes what he calls “the

symbolisation of the ethnic boundary” in the form of an ethnic brawl that occurred between Indians and whites in a bar in a town near the Indian reserve. It was, for the Indians, a form of protest “to demonstrate to white men that the Indians do not accept the rules of the game” (p.131). As evidence for her boundary argument, Lurie points out that for some Indians, drinking has become a form of protest and “can even help restore credit where one’s Indian investment in the Indian community is called into question” (p.331). Unfortunately, the protest has gone on for so long it has for some become a way of life with disastrous consequences for those concerned. Lemert (1958) also believes Indians act out the white stereotype of the drunken Indian when they become intoxicated. This stereotype, he says, “functions in the psychic process to excuse otherwise socially unacceptable aggression and depredations” (p.66).

Alcohol use as “Identity Resolving Forums”. Robbins (1975) hypothesizes that along with economic change comes an increase in both interpersonal conflict, “and an increase in occurrence of those cultural processes (drinking interactions) which serve to resolve this conflict” (p.99). His study of the Naskapi Indian males in Schefferville, Quebec, demonstrates that these drinking interactions provide the opportunity for the resolution of this conflict and serve as identity resolving forums. A person is permitted to defend, claim or rectify an identity and receive information from others, which confirms the identity being sought. Robbins suggests that these interactions “serve as a vehicle of the reordering of interpersonal relations unsettled by economic change” (p. 113).

The Potlatch. According to Helene Codere (1957), for the Northwest Coast Indians of British Columbia the Potlatch ceremony<sup>13</sup> was also used to maintain and confirm social positions. It was a competition for power; “a form of activity that both manifests struggles for status and serves as an identity-resolving forum” (Robbins, 1975, p.185). This competitive view is not held by all who have studied the Potlatch. According to Cole and Chaikin (1990) potlatching “provided a forum where matters affecting property, rank and precedence could be settled” (p.26). Drucker and Heizer (1967) state that for the Kwakiutl Indians of the west coast, Potlatches were not a competition at all, but rather an opportunity to publicly make a claim to one's hereditary rights. The Potlatch did not give or create social status; it validated it. Even for the lowborn man, potlatching provided a security of identification. The essence of the potlatch for the Tsimshian Indians was to acknowledge the changes in status that occur in one's life cycle, including marriage and birth (Rosman and Rubel, 1971).

Before contact, access to potlatch goods was determined by inherited social rank. However, the introduction of a wage economy brought two significant changes. First, goods used for potlatching changed from locally produced to those available from the

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<sup>13</sup> Potlatching was declared an offence January 1<sup>st</sup>, 1885. The ceremony was found to retard civilizing influences and “encourage idleness among the less worthy Indians” (Cole & Chaikin, 1990, p.14). Sir John A. Macdonald felt it impossible for the Indians to improve their lot or progress in any meaningful way if they did not acquire property. Although condemnation of potlatching did address the moral aspect (women prostituted themselves to ensure sufficient funds for a potlatch), the main objection was of its interference and incompatibility with the habits of labour and industry. Potlatching not only took time away from agriculture, ranching, fishing and education, but destroyed any accumulation of monetary savings. The potlatch law was passed as reform legislation and was intended to promote the health and economic progress of the Westcoast Indians: And in this respect “falls within the western liberal, philanthropic, reform tradition” (Cole & Chaikin, p.24). The law was in keeping with the Aboriginal protectionist/assimilationist philosophy of the day. Twenty years later, in 1913, Duncan Scott, then deputy superintendent general, echoed this philosophy when he stated that “The happiest future for the Indian race is absorption into the general population” (Cole & Chaikin, p.42). Paternalism, long since a part of government policy, was, in the mind of some, moving toward oppression.

Hudson's Bay Company and other traders.<sup>14</sup> Second, the means of obtaining these goods expanded from those acquired from inherited social rank to those activities through which money could be obtained - fishing, hunting and wage labour (Codere as cited in Robbins, 1975). These changes now both allowed those, who heretofore, were unable to improve their social rank, to purchase potlatch goods, thereby improving their identity, and threatened the identity of those who pre-contact had exclusive access to potlatch goods. "The result would be an increase in identity struggles wrought by the increase in social mobility" (Robbins, p.116). This mobility was a historical phenomenon, for prior to contact "wealth was derived almost solely from territorial resources controlled by the chief" (Cole & Chaikin, 1990, p.11). Post-contact, Potlatches for some became "the road to greatness, the path to glory" (Cole & Chaikin, p.11).

Lemert (1958) points to the Potlatch as one reason why the Homalthko Indians drank. Alcoholic beverages were a mark of status and prestige. "Being able to get hard liquor symbolizes the economic success of him who can pay the bootlegger's exorbitant price, the skill to manipulate white friends, and also an ability to circumvent the white man's law which forbids him to have the liquor" (p.60).

Drinking to get drunk. Although research has revealed the impetus of some Indian drinking, it remains clear that for some, the 'high' generated by alcohol is the prime reason for its over consumption. Lemert's (1958) study of three Salish tribes in B.C. convinced him that for them, the objective in drinking was to get drunk. He points

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<sup>14</sup> Codere (1957), who studied the Northwest Coast potlatch has concluded that for the Southern Kwakiutl Indians, the potlatch became a substitute for warfare after the establishment of a trading post in 1849 (as cited in Cole & Chaikin, 1990, p.8). She notes that after this date, the Kwakiutl's native blankets, which had been used in gift-giving ceremonies, were supplanted by those from the Hudson's Bay Company.

to the consumption of home brew before it is completely fermented, the gulping of drinks, the drinking until the supply is exhausted and the preference for strong liquor when obtainable, as support for this assertion. Lithman's (1979) statement that people drink because they like to do what they can do when they are drunk, is one explanation for why one may drink to excess. Mancall (1995) believed some Indians took advantage of the custom of exonerating inebriated perpetrators by purposely getting drunk and exacting revenge on their enemies. For the Whitehorse Potawatomi, the most important criterion in selecting alcohol is that it have a high alcohol content (Hamer, 1965). According to Mancall "Indians treated alcohol as if it were some sort of medicine that had to be taken in great quantity if the drinker were to derive any benefit from it" (p.70).

Drinking until alcohol stock is depleted. The practice employed by some Indians today, of drinking alcohol until the stock has been completely depleted, may have its roots in customs dating back to the fur trade era. The Jesuits report that although the custom the Indians had of consuming everything at once was not new, the introduction of alcohol was. Consequently, their 'brandy feasts' were conducted as were their 'eat-all feasts', in which one could be beaten if not everything was consumed (Dailey, 1968, p.48). Lemert (1958) writes of the Homalthko custom of drinking home-brew from a tub. A cup is passed from person to person. Each participant must drink his share or risk insulting the party's host. The party continues until all the brew is gone.

Alcohol and the supernatural. Dailey (1968) examines the similarity between intoxicated behaviour and that resulting from dream experiences for the Indian tribes of

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Suttles (1954) found that the Salish Indians too substituted potlatching for warfare and store bought blankets for native ones (as cited in Cole & Chaikin, p.8)

New France at the turn of the 20<sup>th</sup> century. Because the effect of alcohol was not understood by the Indians, intoxication was included in the category of the supernatural (p.49). The Montagnais of the St. Lawrence Valley believed liquor had magical powers while some Plains Indians in the 1600s valued alcohol for its supernatural powers (Mancall, 1995). "Under its influence the inebriated person was given full license to behave as he pleased, even if it meant killing a person. This was identical treatment accorded those compelled to act out their dreams" (Mancall). Dailey argues that it was likely that alcohol was used as a shortcut in attaining certain spiritual experiences, i.e. consuming alcohol in lieu of days of fasting. Since dreams were the only way one could communicate with the spirit world, dream quests were a significant part of Aboriginal life and all were involved at some point in this quest. Mancall suggests that the disorientation achieved by alcohol use afforded the Indian a greater sense of personal power. As it was difficult to distinguish between a dreamer and an intoxicated individual, both were considered sacred (Dailey). Both the Aztecs and the Mayas believed that alcohol allowed them to come into contact with the sacred and conducted ceremonies which dictated proper drinking practices (Mancall).<sup>15</sup> The Indian could not blame himself for his behaviour while intoxicated for he was not in possession of his mind. The belief was that that when one transcended one's body, the person became qualitatively different (Dailey).

"Whites" to blame for alcohol abuse. A recurring theme among those who have written on the subject of Indians and alcohol is that of "responsibility" - or lack thereof -

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<sup>15</sup> The importation of brandy and wine from Spain promoted the desacralization of drinking for the inhabitants of what are today Mexico and the southwest U.S. Although Indians continued to drink for religious reasons and "drank to excess to fulfill their spiritual commands properly", drinking became increasingly secularized (Mancall, 1995, p.132).

with regard to alcohol use. Hamer (1965) speaks of the Indians putting sole responsibility for an increase of drunkenness among the Indians on the whites.<sup>16</sup> Dailey's (1968) analysis of the Jesuits' opinion about the Indians reveals how some violence committed by Indians was justified. Besides being a defensive reaction against a perceived threat against their society, it was also a way to demonstrate their aggressiveness towards whites. The justification used was that as it was the white man who provided the alcohol. "No guilt or blame was attached since it was the liquor that had control over the person" (p.52). Mancall (1995) asserts that many Indians blamed their alcohol problems on colonists who, if not directly involved in the trade, allowed it to continue, despite growing evidence of its social costs. The Potawatomi of Michigan have complained over the years to the local authorities that the white men are bringing alcohol into their community and using it to attain sexual favours from the women. The subsequent requests for white intervention imply that the responsibility for the promiscuity that exists lies with the white man.

Helplessness of the Indian. It is important to note that these notions that the white man was responsible have not occurred in a vacuum. As Lemert (1958) notes, the limiting of alcohol sales to Aboriginals over the years has only served to further inculcate the widely held belief that the Indian is helpless to control his drinking. "The administration of the law itself has also shown a tendency of police and magistrates to mitigate or dismiss the punishment of Indians who have committed crimes while intoxicated" (p.65). Horton (as cited in MacAndrew and Edgerton, 1969), who examined

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<sup>16</sup> Interestingly, this dependency and projected responsibility could be considered a classic trait associated with alcoholism (Hamer, 1965, p.111).

drinking practices in non-Western societies in which drunken aggression was common, found strong penalties for this aggression rare. Hamer (1965) denotes this attitude as a "patronizing tolerance" by the law-enforcement officers, who often penalize the Indians less heavily than white men for infractions committed while intoxicated (p.121).<sup>17</sup>

Alcohol itself to blame. Responsibility for actions taken while under the influence of alcohol was foisted not only on the European, but on alcohol itself. The Indians studied by Lithman (1979) felt they were not responsible for what they said while they were drinking. "You are not responsible for actions, you are 'smashed'" (p.128). MacAndrew and Edgerton's (1969) examination of the Tarahumara Indians of Mexico reveals a similar finding. Although 90% of all transgressions committed by the Tarahumara are committed under intoxication, they blame the alcohol and therefore excuse the transgression itself. *The Jesuit Relations* reports on an Algonquin who thought he should escape punishment for a murder he committed because he was drunk at the time and did not know what he was doing (Dailey, 1968). Even when the Indians committed crimes against their own people, "the blame was attached to the white man and his liquor, not to oneself" (Dailey, p.55).<sup>18</sup> Many even forgave the perpetrator if he

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<sup>17</sup> Such was not the case in Manitoba after Bracken (1955), in his report of the Manitoba Liquor Enquiry Commission observed that "there is no physical reason why Indians should be denied liquor while other people are permitted to have it" (p.617). His report gave way to greater availability of alcoholic beverages in the province and increased Aboriginal involvement in the justice system. It was at this time that "policing agreements with the Royal Canadian Mounted Police . . . introduced consistent enforcement of Canadian law to communities where, until that time, Aboriginal law still operated" (Report of the Aboriginal Justice Inquiry, 1991, p.77). Prior to World War II, Aboriginal prison populations were no greater than Aboriginal representation in the population. However, by 1965, 22% of the inmates at Manitoba's Stony Mountain penitentiary were Aboriginal: This number jumped to 33% by 1984 and 46% by 1989. Also in 1989, Aboriginal people accounted for 67% of the inmate population at the Portage Correctional Institute for Women (Report of the Aboriginal Justice Inquiry).

<sup>18</sup> Liquor had come to symbolize contact and its demoralizing effects to both the Indian and the Jesuits. Dailey (1968) wonders whether it ever crossed the minds of the Jesuits that the white man's way of life and his business practices negatively impacted the Indians. "For them, liquor became the scapegoat . . . Their



were intoxicated at the time of the incident.

Biophysical makeup of the Indian. This displacement of responsibility and justification for the use and abuse of alcohol is also seen in those who blame the biophysiological makeup of the Indian for their inability to 'hold their liquor'. According to May (1994), the notion that Indians metabolize alcohol more slowly than non-Indians is a myth.<sup>19</sup> Only one study has reported this and "it was criticized as highly flawed in its use of controls and other methods" (p.124). All other studies have revealed either equal metabolization rates between Indians and non-Indians or found Indians metabolized alcohol more rapidly than did their counterparts. What is perhaps most significant about the "myth", is that it is widely held by Indians themselves. A survey conducted among the Navajo asked respondents if they felt Indians had a biological weakness to alcohol, and 65% responded "yes". May argues that metabolism is an individual trait with more variation found within ethnic groups than between them, and that sociocultural variables are major factors in alcohol related behaviours.

Although Indians have long been stereotyped as having greater problems than other cultures with alcohol and alcoholism, the scientific literature is inconclusive. Of the six U.S. published studies on Indian drinking prevalence, two show a higher prevalence of drinking among Indians, one shows prevalence rates similar to the American population and three show a lower overall prevalence (May, 1992). Interestingly, a survey on a Navajo reservation conducted in 1988 by May and Smith showed that while

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own shortcomings were rationalized to be the fault of liquor, so that drunkenness was blamed even for the fact that the Indians were hard to Christianize" (p.54).

<sup>19</sup> The quicker one is able to metabolize alcohol, the quicker one rids the blood of its effects. The myth that Indians metabolize alcohol more slowly than non-Indians provides an argument for why some feel they are unable to hold their alcohol (May, 1994, p.124).

fewer Navajo adults drink alcohol (52%) than other people in the general population of the United States (67%), there is a general belief that alcohol use and abuse is more widespread in their population than it really is (May, p.6).

The aforementioned studies, analyses, data and opinions have examined the introduction, distribution, use and abuse of alcohol by the Indians of North America over the past three and a half centuries. As stated, alcohol's introduction to the Indians of what is today known as Canada, was closely linked to the fur trade, and the willingness on the part of some Indians to bring in pelts in exchange for liquor was all the encouragement the traders needed to continue its distribution. And although the alcohol trade was discouraged by some, its economic impact on both traders and the French colony itself proved too powerful a force for its detractors.

The question of why alcohol continues to this day to be used and abused in certain Aboriginal communities at a rate disproportionately higher than the rest of North America has been examined by a myriad of writers. Their findings provide pieces to a complex puzzle comprised of paternalism, ignorance, conflicting ideologies and exploitation. As one reads the literature on Indians and their relationship with alcohol, one is struck not only by the similarity in the researchers' findings regarding why Indians drink, but also by the similarities in Indian alcohol use today compared with the past 350 years. If we can, as has Dr. May, discount the "inconclusive" difference in biophysiological makeup between Indian and non-Indian as justification for a higher prevalence of Indian alcohol abuse, it is difficult not to conclude that the social conditions which encourage alcohol abuse among the Indian population exist, in some form, as surely today as they have over the past 3 ½ centuries.

Chapter Three

Methods

My research combines an overview of the available literature on FAS/E and an historical analysis of the relationship between alcohol and Aboriginals with a case study of an Aboriginal birth mother who drank throughout her three pregnancies. Much has been written by the experts about FAS/E from the medical perspective; epidemiology, physical and behavioural characteristics and prevalence over the past 30 years. While a great deal of quantitative data exist detailing the percentage of children with FAS/E by socio-economic status, country and cultural background, little has been written about FAS/E from a sociological perspective. And although the Aboriginal community has been targeted as having some of the highest FAS/E rates in the country, little has been written either by, or about this community that seeks to understand why.

Much of what has been written points a finger squarely at the Aboriginal birth mother: Yet, her voice has, and continues to remain largely silent. I wanted her voice to be heard. I wanted her to tell me what caused her to drink during her pregnancy even when she was aware of the risks. And if she was unaware, why was she not made aware? Did she not care about her fetus? Does she love her child less than does a non-Aboriginal mother? By speaking with a birth mother, I was able to gain insight into these and other questions. By speaking with her mother and daughter, I was able to better understand the intergenerational effect of alcohol vis-à-vis FAS.

As it was one of my goals to determine the factors that contributed to each of the informants' life experiences<sup>20</sup>, three main areas were explored with each informant. The first area focused on the informant's personal history. In this phase, a family tree was established, as well as events the informants identified as significant. Information gathered during this "oral history" phase was used to help formulate the second set of questions. These included questions about other family members and/or friends relevant to the study. The purpose here was to determine how family members were affected, and what effect friends and family had on the informants. The third set of questions dealt specifically with the informants' experience with and attitude toward alcohol; their feelings regarding pregnancy; and their thoughts on FAS/E in particular. To collect my data, I used qualitative research methods.

### Qualitative Research

The two major theoretical perspectives that dominate the social sciences are *positivism* and *phenomenology*. Whereas the positivist "seeks the facts or causes of social phenomena apart from the subjective states of individuals", the phenomenologist "is committed to understanding social phenomena from the actor's own perspective" (Taylor and Bogdan, 1984, p.1,2). The phenomenologist uses qualitative methods such as participant observation and in-depth interviews that produce descriptive data. These descriptive data are comprised of people's own written or spoken words and observable behaviour. One area which distinguishes qualitative research from quantitative is that the former is inductive: that is, qualitative researchers begin their studies with no

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<sup>20</sup> In one way or another, every event that occurs in our lives is significant and contributes to our overall state: but I am particularly interested in the factors that have contributed to the informants' views on

preconceived theories and utilize a flexible research design that entails only vaguely formulated research questions. Qualitative research is both holistic, in that the people and their settings are viewed as a whole, and naturalistic, where the goal is to be as unobtrusive as possible. In-depth interviews are modelled after a normal conversation. Because qualitative researchers attempt to experience reality as others experience it, it is imperative that they set aside their own beliefs or preconceived notions. "Although qualitative researchers cannot eliminate their effects on the people they study, they attempt to minimize or control those effects or at least understand them when they interpret their data" (Emerson in Taylor and Bogdan, p.6, 1984). Qualitative research is descriptive in that the data are collected in the form of words or pictures. As Bogdan and Biklen (1992) point out, "qualitative researchers do not reduce the pages and pages of narration and other data to numerical symbols [but rather] try to analyze the data with all of their richness as closely as possible to the form in which they were recorded or transcribed (p. 30).

Validity, or research that ensures a connection between what people say and do and the data collected, is another component of qualitative research. The quantitative researcher is more concerned with reliability and replicability than with validity. To many, the use of in-depth interviews, or oral history begs the question of reliability. Hockett claimed that for the historian, legends and traditions were of no value "in the absence of corroboratory evidence of a documentary, archaeological, or other kind, for the simple reason that they cannot be traced to their origins" (as cited in Montell, 1970, p.ix). External evidence, according to Hoopes (1979) is "the best check on the overall

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alcohol and pregnancy.

reliability of the oral document" (p.124). Tosh (1984) agrees, adding that "if the full significance of an oral testimony is to come across, it must be evaluated in conjunction with all the sources pertaining to the locality and people spoken of, or else much of the detail will count for nothing (p.180).

However Deutscher (1973) argues that reliability has been over emphasized in social research:

We concentrate on consistency without much concern about whether we are right or wrong. As a consequence we may have been learning a great deal about how to pursue an incorrect course with a maximum of precision. (in Taylor and Bogdan, p.7, 1984)

Indeed, while the subjective nature of qualitative research cannot guarantee complete reliability " a qualitative study is not any impressionistic, off-the-cuff analysis based on a superficial look at a setting or people [but rather] is a piece of systematic research conducted with demanding . . . procedures" (Taylor and Bogdan, p.7).

Identifying Informants. Through my work as an FAS/E consultant for an Aboriginal Child & Family Services agency, I was able to make contact with a number of individuals interested in my proposed study. There was one particular Aboriginal birth mother whom I met several years ago and have spoken with about my proposed study who agreed to be interviewed. I interviewed this birth mother, her daughter and her mother, offering an intergenerational perspective to this study. While focussing on only one woman and her family may result in a study with less breadth than one including many informants, it provides greater depth. No one was contacted until both my thesis

presentation and ethics proposal were accepted.

In-Depth Interviews. In-depth interviews, which are unstructured, open-ended, flexible and dynamic, were utilized as the primary data collection tool. This required face to face encounters between the researcher and informants. I collected oral histories as the first phase of the in-depth interviews. Rather than a standardized interview or questionnaire, the interviewer is the research tool. An interview guide was used as a tool to help formulate the questions in a methodical fashion. (Appendix A). Written permission from each of the participants was acquired prior to the interviews. (Appendices B-D). I followed the guidelines of the Faculty of Education Research and Ethics Committee's Department on Human Subjects.

A birth mother, her mother and her daughter were interviewed in the course of this study. I interviewed the birth mother four times, and her mother and daughter each once. The interviews lasted between ½ an hour and 1-½ hours yielding roughly 8 hours of interviews. All of the interviews were taped and transcribed. Field notes and observer's comments were written up as soon after the interviews as possible. The transcriptions, notes and comments were submitted on a regular basis to my advisor to allow feedback and to guide my subsequent interviews. The interviews produced 225 pages of prose text. A "member check" was done with the birth mother after each interview to allow her to read the transcript. This was done in case she felt she had said something that she did not want published. Nothing has been removed from the original prose text.

Oral History. Although various types of in-depth interviews exist, oral history was one method of data collection used for this research. Oral sources may fall into one

of two distinct categories. The first-hand recollections of people interviewed by an historian are usually referred to as *oral history* (Tosh, 1984; Hoopes, 1979) whereas *oral tradition* incorporates “the narratives and descriptions of people and events in the past which have been handed down by word of mouth over several generations” (Tosh, p.172). Oral history “was the first kind of history” (Thompson, 1978, p.19), and although the ‘first historians’, Herodotus and Thucydides used both kinds extensively centuries ago (Tosh, Dunaway & Baum, 1984), oral history as an organized academic activity dates only from 1948 (Dunaway & Baum, Montell, 1970; Yow, 1994), when Allan Nevins launched ‘The Oral History Project’ at Columbia University.

Oral history attempts “to give social history a human face” (Tosh, 1984, p.176) and “through oral work the community [may] discover its own history and develop its social identity, free from the patronizing assumptions of conventional historical wisdom” (Tosh, p.177). Because oral history can be used “to describe and empower the nonliterate and the historically disenfranchised . . . it allows heroes not just from the leaders, but from the unknown majority of the people” (Thompson, 1978, p.18). Its non-discriminatory nature permits all individuals to participate in sharing their story.

One of the main strengths of oral history is that it relies on speech and not on the restricted skill of writing (Dunaway & Baum, 1984, p.48). Oral tradition is the only method of reconstructing the past in those parts of the world without writing, or where we cannot read the writing (Vansina, 1991). “Accuracy of local historical legends is not the most important question to be faced by the person who gathers and analyzes them, but rather the essential fact is that these folk narratives are believed by the people who perpetuate them (Montell, 1970, p.xviii). As E. W. Burgess explains:



In the life history is revealed as in no other way the inner life of the person, his moral struggles, his successes and failures in securing his destiny in a world too often at variance with his hopes and ideals. (in Taylor and Bogdan, 1984, p.78)

Oral history offers evidence of the life of the illiterate and those excluded from the wider society. For example, the stories of the poor Blacks of Coe County, Kentucky, in the early 1900s, are similar to those told by many Aboriginal People today. The telling of these stories not only enables the reader to better understand the past, but also validates and empowers the teller.

#### Data Analysis

Although all qualitative studies contain rich and descriptive data, they can be separated into two groups: descriptive and theoretical studies. Descriptive studies include minimal interpretations thereby allowing the readers to draw their own conclusions. Because the purpose of most qualitative studies is to *develop* or *verify* sociological theory, researchers utilizing theoretical studies “use descriptive data to illustrate their theories and concepts and to convince readers that what they say is true” (Taylor and Bogdan, p.125, 1984).

Grounded theory, introduced by Glaser and Strauss' (1967) argues that qualitative researchers should focus on *developing* social theory and concepts. Others feel qualitative research should be used to both *develop* and *verify* sociological theory. This requires a more analytical approach.

Given the nature of qualitative research, data collection and analysis are ongoing processes that go hand-in-hand. For my purposes, the goal of the analysis was to understand what factors contributed to a woman drinking throughout her pregnancies.

As in all analyses of qualitative research, constructing life histories begins by reading through all the collected data. The next step is to identify major stages and experiences in the person's life. The data is then coded and sorted according to these stages, with each becoming a section in the life history. The final step is editing the life history to produce a coherent document "without putting words in the person's mouth or changing the meaning of his or her words" (Taylor and Bogdan, p.144, 1984).

#### Role of the Researcher

Although I have worked in various Aboriginal communities over the years, the majority of my time has been spent in one particular community. It is in this particular community in which I found my informants. I have built up a trusting relationship with many of the residents which I feel will benefit the research conducted. Having worked for an Aboriginal agency for several years has allowed me insights into Aboriginal life that I believe also proved useful. As an "outsider" and non-Aboriginal, I was constantly aware of my privileged and honoured position of being allowed into the lives of an Aboriginal family. Confidentiality was maintained at all times as per the request of the informants.

## Chapter Four

### Women's Stories

The pages that follow contain the stories of three women: those of an Aboriginal birth mother, her mother and her daughter. Although I have summarized several portions of the interviews, all comments made by the women, relevant to my research, remain.

#### Susan's Story

Susan has lived on the Foggy Creek reserve for many years. She started drinking at the age of 12. She quit drinking at the age of 26. Although her journey is her own, it is not unique. Susan was born in 1959, just outside a small community in the southwestern region of the province of Manitoba. She is Aboriginal. She is one of nine children; seven biological and two stepchildren. She has given birth to three children and drank throughout all three pregnancies. Her first child, Brenda, died in 1988 at the age of 12, due to complications associated with Cystic Fibrosis. Her second child, Debra, is 21 and has two children of her own. Her third child, Jeffrey, is 17.

Of Susan's eight siblings, all but one is a current or recovering alcoholic. The one non-alcoholic in the family is her eldest sister, who was born mentally handicapped. Her father, mother and two stepfathers were all alcoholics. Both her biological father and first stepfather died in their early 50s of kidney disease associated with their drinking. Her mother lives with her second stepfather, neither of who currently drinks. Susan's grandfather on her mother's side was also an alcoholic although her grandmother did not drink. No information was available about Susan's grandparents on her father's side.

I asked Susan to go back as far as she could in her memory. Her earliest recollections date back to when she was roughly four years of age. One of her first memories is that of being sexually abused by her uncle's brother.

It was kind of like I was in my own little world. I could just remember, like when I was probably about four or five . . .that's about the only time I could remember, but I was sexually abused at that age. That didn't come to me until I was older. Like it was an older person and never knew growing up. Every time I seen an old person I would just cringe or I would really pull back. Like I never really knew I was doing that until after I sobered up and then I noticed . . . that's when I started noticing what was going on and that's when I started remembering little bits and pieces.

He's dead now. But my mom recently told me he also sexually abused my little sister. And I think he did it worse to her. Not saying that mine was any, you know, easier or better or anything, but she was telling me a little bit more about my sister and it really hurt. Like I had no idea that happened to her too.

Susan's family moved around a lot. By the time she was nine, her biological father had left her mother for another woman, Susan and her six siblings had moved to Brandon and Susan's mother had met another man and began drinking.

She was still drinking. Cause I remember when we moved [to Brandon], I went to see my sister in Winnipeg and then I came back. I went to where we used to live, and I remember coming in, walking into that house and it was empty, but I heard someone upstairs. So I went up the stairs. It was my oldest brother and my stepfather. They were both drunk. And they were just sitting up in the room talking and drinking. And I asked where mom was and they said she already went to the new house. So I knew she'd be drinking because they were drinking. So I walked down to the new house. Sure enough, mom was there and she was drunk. She wanted to go to the grocery store and I thought, "oh shit!" It was so embarrassing. To have her, and then walking into the store with this drunk . . . it was really, ugh!

Susan remembers one occasion being extremely angry with her mother and calling her names.

I remember I called her a bitch. I got really mad at her for something and then she grabbed the belt and she hit me with it. And that's the first time, I think, and then I cut my wrists. I don't know if it was because here was this woman that, you know, hit me for the first time and it really did something . . . I don't know. But that's the first time I tried

to commit suicide. Already then I can already see something was wrong.

It was at age 12 that Susan started drinking and smoking. Her family was still extremely transient. I asked her where she was living at this time.

All over. Kind of all over. Staying with a sister. Staying with mom. Kind of all over. Wherever I went. Stayed with an auntie. Winnipeg, Brandon. There was an auntie too. When I was younger I stayed at her place a lot. And she was the one that talked to me. She did the talking. I probably at that time cared more for her than I did for my own mother because I was . . . there was a person that was talking to me and acknowledged my existence. She was everything. But she was never . . . my uncle stabbed her to death. She had 11 kids - my cousins - and they were all adopted, everywhere. The States, everywhere. But she played a very important role in my life at that time. So her death was just another, you know, being in the violent way, it just got me more angry. And I never knew how to deal with that. Like even when I heard that she was stabbed, I just ended up getting really sick, like really sick, fever, sick, sick, I remember getting sick.

Susan was 15 when her auntie was murdered. Susan tried school, but as she puts it "it didn't work out. There was no support. No one to take it home to. Nobody to give

me encouragement.” She remembers that “pretty well my entire family” was put into those “simple classrooms”. This simply added to “the already low self-esteem” she had of herself. It was at about the age of 12 or 13 that Susan “pretty well gave up on school”.

Then I ended up drinking, like lots. But I remember pretty well the first time, like that I did start drinking, I blacked out. All I knew was that I really enjoyed it because blacking out meant I wouldn't remember. It took me away. It took me away from myself. In fact I enjoyed it. Ya, I really enjoyed it because there was no longer any of this pain.

Susan spent the next few years drinking and “scrapping”.

I could really get out there and start scrapping and doing everything. We did a lot of fighting back then cause back then people didn't lay charges against you like they do today. You can't even look at anyone. But back then we did lots of it, you know, my sisters and my brothers.

Two years later Susan was pregnant.

And then I ended up getting pregnant and I had my first child when I was 16. I drank lots with her. I drank lots. Probably weekly. Like every weekend for sure, if not more. Cause I wasn't just a person that would drink for a day or two. Like I'd drink longer than that. Like I could remember being pregnant with her drinking so much that

you know you try to drink and you take a sip of the beer and all it does is foam up all inside you. And so then I learned quickly if that happens, I don't know if it's because of all that bile or whatever, I don't know, but it just totally just foams up on you and you can't even hold it down. So I learned that I all I've got to do is drink whiskey and that'll calm it down, and then you can drink more beer. So that's what my oldest daughter was basically swimming in, a lot of that. And even like my fighting and that, was still going on when I was pregnant with her. So I could have lost her in many ways. Not just with the drinking, but with the fighting and the carelessness and . . . I remember driving pregnant with her and passing out and, you know, stuff like that and waking up just before I hit the ditch and things like that.

Brenda, Susan's first child was born in 1976 in Brandon, Manitoba. Susan remembers waking up after giving birth and asking about her baby. She was told that her child was sick, had been rushed to a hospital in Winnipeg and that she (the baby) might die.

So, there I was, you know, just 16 at the time, and my mom . . . my mom at the time was not around. She was going to try to recover somewhere I think at a dryout centre somewhere at that time. So I just . . . all I knew is that I



had to go find this baby. So the day after, I think it was, when they still couldn't tell me, you know, if she was dead or alive. I remember, like I was all stitched up and I was in a lot of pain and I could barely sit but I was determined to go find that baby. It's kind of sad, you know, thinking about it, you know this kid going out to find this baby. But maybe I was looking for something at that time too, something, I don't know.

Brenda had been sent to the Intensive Care Unit at the Health Sciences Centre in Winnipeg.

She just had all these tubes. I couldn't even carry her for the first while. And then after a while they were able to get her out of there but she was still hooked up to a bunch of stuff. But I'd sit there from probably 8 in the morning till it was dark. And I stayed sober for a while that time. Then after probably, you know, coming, I can't even remember, maybe a month after going every day, every day to the hospital, the nurses advised me to take a break and, you know, just go home for a while, which I did. But I started back drinking again and just carried on with my drinking.

Brenda was eventually diagnosed with Cystic Fibrosis. She experienced countless operations in the ensuing years. For the next 2 ½ years she moved back and forth between hospitals in Brandon and Winnipeg.

So I think with her being born and the way she was and all what was going on, added to more confusion in my life. And like I said, I never did have my mother to talk to about it, to cry with, to talk with. So I was really alone, like really alone with this baby now, this sick baby. But I ended up in another relationship and I got pregnant again.

Debra was born on October 4<sup>th</sup>, 1978. When she was 1 ½ Susan decided, for the sake of Brenda's health, to move to Alberta.

Then I ended up in a relationship there. I was no good with relationships. It's like when I found out I was pregnant I just wanted to go there. I just kind of went away from that relationship. A lot of violence happened like in between that time too, like there was a lot of fighting going on in my life. Like a lot of violence. But ya, I ended up with my second child. With this one I drank, but not as much, but I tried everything to drink. I couldn't even hold the whiskey down with this one. That's terrible to say, but the whiskey wouldn't even stay down. Like I tried like all kinds of different things. Like just to drink. It was bad. So I experimented throughout my pregnancy to try and see if I could drink. I did a little bit but . . .well, I don't know what a little bit is though. But I did drink with this second one. But whether there's some damage done, I don't know, I

really don't know with my second one. My first one I really think there, there, you know . . . some damage through my drinking was done to the first one. To the second one, I don't know. Like she's struggling today. She is struggling in many ways. But here the second one really got it bad because not only was she being neglected through my drinking, but all my time went to the other one, whatever time she got. So the second one I think really got it really bad.

Susan admits that she didn't do a lot of the parenting at this stage in her children's lives. Her sister and mother helped out. I asked her if Child & Family Services ever got involved.

I remember once they came to my house. And a lady came from welfare. She said something. I says "Ah" this is my attitude back then. Like she said she was going to take them and I said "Just fuckin' take them" and I slammed the door and after she never came back. But I don't know. I don't know what I would have done if she did. I don't know. Maybe I would have just let her too, I don't know. Like those days were just . . . Basically I just lived moment to moment. Whatever happened, happened sort of thing.

Susan explains her attitude towards life in the following way.

But during all this time I lived believing that I was like our sis. (She is speaking of her eldest sister who was born with a mental handicap.) Because my mother was told at one time that all Native kids were simple. My mother still looked at the non-Aboriginal person as the "know-it-all". Like they know everything and whatever they said was the gospel truth. She said, "Oh what can I do? I thought that was the truth back then?" And that basically she didn't push us in anything because she knew she would be expecting too much if she did try. And all through this time, from the time I was 11 till the time I gave birth to my second child, there was a lot of suicide attempts in between. I can't even tell you how many now. I don't know.

By the time [Brenda] was four. her doctors pretty well gave up on her. They said, "This child's going to die". She was a skeleton. Like she was a walking bag of bones and coughing. She couldn't breath and she barely ate and she was a mess, and so I decided to take her somewhere else. So I brought her to Alberta, and that's where they pretty well took her in, put her on all kinds of medication, everything. In fact the doctors said she was the worst case of Cystic Fibrosis to live. I got her to Calgary, and they

gave her lots of medicine and kept her alive for eight more years after that.

In 1980, at the age of 20, while living in Calgary, Susan met her biological father for the first time. She, along with one of her siblings and a sister-in-law met her father in a bar.

I met my dad. Am I ever glad I didn't meet him before because . . . like I said, I'm going in to meet this person, but nobody's ever told me anything about him. So, you know, I guess growing up I still had probably a belief that I had a dad out there who's wonderful. He knew my sister-in-law but he didn't know who I was, or my other sister. But he looked up and he said "which one is my daughter?" And I said "me". You know, that's basically how it was. We sat down and drank, got stoned. That was my encounter with my dad. He was a drug dealer and probably a pimp. Useless, useless, useless man. But again, I have to come to terms with all that.

Then [1983] I ended up with my third child, and I drank with this one. I think there is some, definitely some effect from my drinking with him. This one hurt because I just started realizing what the damage alcohol could do to a child. That's just been recently. But it hurt. Dammit, it hurt when I started realizing what I actually was doing. I

don't know if even back then, I don't know if you could have reached me anyway, because there was so much pain and very little contact as far as my mother goes. Knowing her, she might have been telling me to quit drinking too. But nobody could get to me, you know, get through to me at that time.

Susan spent a lot of time in hospitals as a result of drinking over the years, but she related the following experience as one that stands out most in her mind.

We were drinking. Oh my, we were drinking lots. We were drunk and I guess this guy tried to stop me and I cut him up too. I don't remember going to the hospital. There were other times I woke up in the hospital after drunks and then I knew I did something, but half the time I didn't know what the heck it was I did, if I took pills or did something, or . . . The same old life. Like it wasn't going nowhere. It wasn't changing. Nothing was changing. It was just pure hell. So when I came to, I opened my eyes and I seen the hospital again and I went "shit". You know, nothing's changing, nothing . . . It was like I was numb by this time. I just didn't care. I just didn't. I remember closing my eyes, but I felt something on my neck. Something thick on my neck and I was trying to think, what the heck happened, and then I heard somebody . . . people

talking and I kind of opened my eyes. There was two police officers right at the foot of my bed. Then I heard them talking about there might be attempted murder charges laid against me. I don't know. I just . . . I didn't really care at that time. I didn't know if they were going to put me in jail. I don't know who it was that I hurt. I didn't even know I hurt anybody at that time, really, to tell you the truth. But I knew they were talking about me. I remember it was a man and a woman cop. And so when they finally realized I was starting to wake up they . . . I remember the male saying "Make sure you handcuff her" and the female cop said "Well, look at her. Look at her, she's not going nowhere". And she was right because I didn't care what they did with me . . . I didn't care if I was going to jail or if I actually killed somebody. I didn't care because I felt I deserved to be locked up anyways. I don't know, I just didn't care where they were taking me. And then, cause that's when they told me, when they were taking me out of the hospital, that they were taking me to an institution, a mental institution. If I tried to run there would be a warrant out for my arrest. Looking back on it I must have looked like a little puppy dog, you know, just walking. I just didn't care. I didn't even ask questions.

They wouldn't even say what for, what you have to do or who I hurt. I didn't care. I don't even know how long I was locked up now. Probably two, three months, I don't know. I remember going in and the doctor would come and check me out. Check out my stitches and stuff. I had about 50 some on this arm. But there were stitches on the inside too. Same with my neck, on the inside. But I don't remember doing it. But that's the time I was, just really concerned I was crazy. This really did it so I . . . at that time this is proving that there is something wrong with me, that all those simple classrooms that I had, had to be there because there was something wrong with me. The way I was treated, like it's through my whole life, us being Native and stuff like that, but it really, really screwed me up bad. So it confirmed it like I said, so when I came out of the hospital, I didn't even go home to see my kids. I went straight to the bar and just got drunk.

Susan quit drinking on July 12<sup>th</sup>, 1985. Although Susan does not point to any one singular event as the seminal point in her healing process, she does talk about a number of significant occasions that played a role in this process.

I remember I was sitting at a booze can in Calgary. And that's where you can, like drink all the time. And this one guy came up to me and, he was a friend of my brother's,



and he was just looking at me, and then he said to me, "You don't belong here". And of course I got angry, you know like, "Who the hell are you?" and, but what he said, you know, somehow it affected me because I just got up and I just smacked him. I slugged him pretty hard. But what he had said really did something to me. And then after that, like I was no where near on any safe ground, mind you. I did go back drinking. I don't even know how many recovery centres I went through, lots. Like I'd only get a few days sobriety and end up drinking again. But that was when I started to try to do something.

She then recalls the last time she visited a booze can.

And then the final one, the final one I remember. I had been out drinking and I ended up back in a booze can. And I got a lickin', a bad lickin'. I don't remember. My sister-in-law tells me, she tells me, she told me she remembered what happened. I must have blacked out because I don't even remember this. She said this guy made an advance at me and she said you got up and told him, you know, told him off and you swung at him and then he swung at you and she said the next thing she knew was three great big women came from upstairs from this place we were at. And she said they all jumped on you, they choked you so

bad she said. They knocked you right out and they were kicking you and things like that. But again, I don't remember nothing. But I do remember coming to. And I just looked over. I seen they were all after her, all on her this time, and then I got up and I just started swinging again.

So after that I went home, and then the person I was living with at that time made me go to the hospital because I was all beat up and stuff like that and in pretty rough shape. So I went to the hospital and they wanted to keep me. They did some X-rays on my face because I had a lot of blows to my head, like big bumps on my head and stuff, and it showed that I had three breaks in my jaw. So they told me that they wanted me to stay in of course, and that they were going to call in a plastic surgeon before they would do anything - to help with the wiring and stuff.

So that night they asked me if I wanted painkillers, something for the pain and I said, and just motioned my head "no". And I didn't feel anything. I really didn't feel any pain. And that's what I find really sad, is when a person, you can be beaten up so bad, and there is just no more physical pain left in that person. And that's where it went to with me. And I was just laying there.

Then all of a sudden, I don't know what happened.

It's like for the first time in my life my eyes were opened [and] I saw all my kids around me - my three kids - and I was just looking at them and I was wondering, "I know these kids are mine but who are they?" Like, you know, because my life has been so, so mixed up, and the drinking made my life so hazy and . . . And so for the first time I seen my children and they were crying and it's like my eyes were opened for the very first time in my life. And then I realized, you know, that I had three beautiful children but I didn't know who they were. You know I really didn't.

And then it hurt me because I saw them crying, but all of a sudden I felt pain. I just felt pain all over . . . and it felt good. It really felt good because I hadn't felt pain in so long. Like inner pain, but not that physical part. So I said, ya, I finally said I need something, so they gave me something for the pain.

But that night when they wheeled me to my room and stuff, and I was in the hospital room and that's when I said "Okay God, I'm throwing the towel in now and I can promise you I'll try to stay sober one day at a time now. Just, that's all I can do, and I knew that. Like I couldn't take it any further than that. And to this day I still can't. I

can't tell you if I'm going to be drunk tomorrow, because I might be. But if I can work on just for today I can handle that, so that's what I was doing for myself with God in my own room that time. And I really meant it. I can literally feel myself, you know, when I think back on it, feeling complete defeat against alcohol, and admitting, you know, just totally admitting 100% that I was beaten by it and that there was no way out: that I knew it would kill me at a very early age if I continued. So anyway, I said "Okay, if the price for what I've done, you know, how badly I've screwed up is to suffer to be wired up and suffering for six months, however long it's going to take to be wired up, so be it, I'll go through that pain." But that's nothing compared to what I was, you know, the inner pain I talked about. Almost feeling like a zombie most of the time and stuff.

I kind of looked at the operation as being second, and you know, I'd just have to go through. So the next day the plastic surgeon was there and they sent me down for more X-rays and they couldn't find any breaks in my jaw. So they just said it was probably just due to the X-ray machine or whatever, or faulty whatever. But whatever it was, it didn't really matter because I was ready to go

through whatever I had to. I like to think it was kind of like a little miracle, and now I realize there's so many of those little miracles that we don't even pay attention to. But that was my last time I drank.

Susan mentions going to numerous detox centres over the years and explains what it was about these centres that hadn't worked for her.

Well, it was really difficult, I think, cause none of them were Aboriginal, none of them. But I'm not blaming them for my drinking. Like I'm not saying that, but I think a lot of it was the same old, same old thing for me. I don't know. Maybe if I had something to relate to, it would have been better or easier, I don't know. Like the more that I think about it. Like I was so disconnected from society, like really disconnected and not growing up with my people. I wasn't even connected there . . . and not having an identity to start off with, like it was just, it was hard, it was difficult.

I asked her what she felt was so important about her identity, or lack thereof.

I think not knowing nothing about yourself. Imagine growing up with a life not knowing nothing. Not knowing where you came from. Not knowing your background. Not knowing your grandparents and then being put down for who you are, but you don't understand why. You

know, being called "You're a dirty Indian", things like that, you know. Not fully understanding what it was all about.

Like for me it was more confusing because I didn't grow up with them. You know, I didn't grow up on the reserves.

Susan explains what she feels would have helped.

I think knowing the history of my people, knowing what I was up against, knowing that I wasn't just this defect walking around confused. Like I was so confused about everything. But I couldn't connect it to anything, cause I didn't do any research. I never knew anything. My mother never let me in on any of the history or anything. And it was like I was just there.

Susan goes on to talk about the importance of disconnecting with certain people and activities in order to maintain her sobriety. She completely disassociated herself from her father who "wanted nothing to do with me after I sobered up." She quit hanging around booze cans and the people that drank. I asked her what she did to occupy herself.

I did a lot. I did, like, I realized that my daughter was going to die. And I knew that if I didn't start working on some of the guilt I was feeling that I wouldn't be able to live with myself. So I really threw myself into, like I continued with a lot of AA meetings and things and I worked at building our relationship. Cause I look at our relationship before and it was like, you know, just so silent.

I'd go to the hospital and she'd sit on my lap: there was never no talking, never no nothing, and it was how we, the only way I knew. I remember having her on my lap one time. I was looking at her and I seen some tears in her eyes and I finally asked her, like, "what's the matter" type thing, and we started talking. And so I kinda had to start from learning how to talk. But I had three years to work with her. And I asked God at that time, just give me two things, that's all I'm asking for. Like I know you're going to take her in the end. Like I knew that. But the thing was, is don't take her before I'm ready - give me that time. And the other one was, don't let her die without me there. So that's the two things I focussed on and worked at.

Susan also talks about the process of sobering up. She says how difficult it was sobering up

into another completely different world . . . sobering into a life I did not know. So it was hard and like, when I sobered up, I kind of sobered up into that kind of identity. And that's who I became to know me as for the first time basically. I guess as a caregiver. As someone who, who was, how can I say it, someone's life relied on me. That's how important I became. In my world I needed to be sober to help this child. I needed to keep learning what I could.

I think, working with her, you know, with all that I did with her, keeping her alive, really taught me a lot about how powerful and strong I really am as an individual. Like with her I did things that . . . she brought out a lot in me. She brought out a lot of strengths that I didn't think I had. She helped me to fight the system. Because I knew that if I was passive, or whatever, none of what I did would have happened. Like, there was a time when, I remember I went into the hospital and she was laying in the crib and I couldn't recognize her. Her face, I couldn't recognize. Her little legs were just going steady. You know, kicking steady and she was a purple, bluish colour. And the only way I recognized her was she had a birthmark on her leg, and that's the only thing. And they had, like I said, they had her two arms tied down. You could tell she had cried so much. Just little sounds were coming out of her, so I just got really mad and untied her and wrapped her in a blanket and I says, "I'm taking her out of the hospital". And the nurse tried to stop me and I says, "Stay the fuck away from me", I told her. "What's the matter with you?" The nurse said can you wait and we'll call the doctor right away. So I thought for a second and I says okay, but if he's not here right away, I says, I'm going to leave with my



baby, and I'm taking her home. So anyway, the doctor came, and he was there quite quickly and I told him, I says, "I don't know what you guys are doing to her, but look at her." I said, "I don't even recognize her." So he checked her over, and he yelled at that nurse and he was really mad because she had dehydrated so bad that I don't know what would have happened if I didn't show up. But I was mad and was able to voice myself in the right way, in the right time to make things happen, you know, for her.

Susan had three sober years with Brenda. Her wish of having Brenda die at home was granted. Susan called her mother to come out to Calgary when it looked like Brenda wouldn't live much longer. Brenda had been in and out of a coma for quite some time when her mother called from Medicine Hat.

And then that's when I told her, I said, "Mom the doctors were here, they stopped all of her medicine. You better get out here". Brenda had been out of it for quite a while already, like not coming to. She was just completely, you would think comatose by this time. But really, really, like just your faith or whatever you want to think, but mom just walked into the room and Brenda opened her eyes and she looked at her arm and put it around my mom and just said "I don't want to sleep any more". And she closed her eyes and she died.

Susan talks about what her relationship was like with her other two children after Brenda passed away.

Just because I quit drinking didn't mean they had me as a mother, because like I said, my entire time went to her pretty well. I mean, they were fed, kind of like I was I guess. But a lot of my energy went into my daughter. [My relationship with them] wasn't good. It's like I went into shock. Like I said, my identity, what I had sobered up into was this, like I said this important person, but I lost it all again. And I think that was the toughest for me. Like what do I do, where do I go, who am I now that . . . it was hard.

And my other kids, again, like they not only suffered through my drinking. When I did sober up, I spent more time with her of course, and after she died, I kind of went into my own world. And then by the time I realized, like for instance, my daughter needed me, it was already too late, cause she was in her teens, and now I'm trying to play mother role. She thought "like, right". You know there's this person that cares all of a sudden and wants to be a part of my life, like, get out of my face, you know. But I understood that, so that's what kind of helped. So she kind of went on her little ways for a while, like drinking and

doing her own experimenting. So they suffered a lot, a lot along the way.

Like my daughter just went wild with the drinking and running around and I couldn't hold her down. At that time I had gotten into another relationship and he tried to sexually assault her. And again, because we had gotten a trailer, like we were buying a trailer, our life was kind of, I thought, going somewhere. And then that happened and I knew right there my whole life was cut again and I went through the motions and again I went into shock. I went through the motions of taking her to the police station and doing a statement and things like that. And then she had to live with that.

I asked Susan why she felt her daughter went through that wild drinking stage.

Well, she has a lot of potential of full-blown alcoholic too I believe. It's there. But I keep talking to her. And I think with her maturing up and having somebody to talk to. Like I keep telling her you know, you've got me to talk to. I says, I look back and I have nobody, like nobody to talk to, nobody to tell me what was right and what was wrong. I think she still needs lots of work, mind you, but I think she's on the right path. Like getting to love herself as a Native person, and that's where it all has to begin.

I wanted Susan to give me some concrete examples of what she has done to continue on her road to healing.

Oh, I think the biggest, biggest thing that helped me was going back to university and learning about my people, and not feeling that I was 100% a total defect. After I realized what I was up against - not just me but my people, like a lot of Aboriginal people - with my past history and what's going on today, and not taking all that blame upon myself and kind of putting some of that blame back to society. Saying, "Here you take it". You know, talking about the residential schools, what they did, everything like that - you take that part and just give me my part I need to work on: that chunk that I need to work on. And so that's what I'm doing now. I can live with that, that part of me. But I just couldn't live with . . . feeling 100% to blame for everything.

I asked if she could be more specific about the importance of history in her life.

Talking about kind of what we're born into. Like, when my mom had me, I was born into a woman that was raised in residential schools. It helped me to understand why my mother raised us the way she did. It helped me to understand so much about my life. And in the end, I'm not crazy, and I'm not, like I said, a dirty soulless Indian here.

You know it helped me to understand that and where that all came from, and why I felt that way. I did a paper on my mom at the university. And I'm telling you, I must have cried for two weeks straight it hurt so bad. But mind you, by the time I did this paper I had done my own journey. I had already gone into my own childhood and dealt with a lot of my own issues of my own childhood.

So by the time I was looking at my mom, I think it helped me to be able to focus on her rather than on myself, because I did a lot of my own kind of healing in that part. So when I did this paper on my mom, and I actually went to the residential school she went in, like where she spent her childhood in, I could actually see her standing there, the little girl, alone, scared and oh, it was so awful. And I couldn't help it because everywhere I looked I can see this little girl and I just wanted to grab her and protect her from what was done to her.

Susan's mother was in residential schools until her teens when "she was let out. Had done her time. Released." She talks about what her relationship with her mother is like now.

It's beautiful. It's wonderful. I still have to overlook a lot of things in her. But isn't that what really means true friends, when we can do that? Like there's things she does

that get me angry, that I have to let it go and know that in her heart, I know she really, really loves all of us. Like, it hurts sometimes, because now she's raising foster children and she can hug those kids and hold those kids and do everything, kind of like what I can do now for my child. But my younger siblings, even my older ones, they're wondering how come she's doing that to them and she still can't even tell us that she loves us today or hug us. You know, when you do hug, you can feel the tension. I understand what's happening here, but for the ones that haven't done any healing, I understand their anger and their confusion even though they're adults. I understand why they're getting jealous at a little child and whatever have you. Like I can understand it, but my mom can't understand it right now.

I asked Susan how her relationship with her mother had evolved.

Well I think a lot of it had to do with me, with my own healing. Like I had to go back into my own childhood and then not only did that, I took it further and went back into her life: what it would have been like and then I even took it as far back as my grandmother. And then through my healing, when I started to heal, I then really hated her when I was looking at my past for what she did: or rather, what

she didn't do. What she neglected to do as caring for us as kids and things. And so I made a complete circle. And then I hated her and now today I just love her unconditionally.

I wondered if she looked at her daughter Debra, and the way she was with her child, as breaking the cycle of dysfunction that was so much a part of her (Susan's) life and that of her mother's.

Helping. No, I wouldn't say stopping because it's going to take more generations. It's becoming more aware of what we're doing. It's educating Felicity now. We can work with Felicity at a very young age and now start, you know what I mean, so it's going to take more than just now because I think it's just really starting for us.

I asked if Debra drank when she was pregnant?

Maybe in her earlier part before she knew she was pregnant, she could have possibly drank then. But once she found out she was pregnant, that was it. She quit completely.

A number of times Susan emphasizes that she still has a ways to go in her healing. She explains what she means by this.

Well I look at this as forever. My healing is going to be forever. There's been so much damage done each time that

it's not over in a lot of ways. It's not like something I can say, well this is my past, I've dealt with it, door's shut, carry on, because like I said, a lot of siblings are still drinking and they are where I was at.

### Agnes' Story

Agnes was born in 1934. She was one of nine children, although there were "quite a few others" that died in their infancy. Her father was a cattle farmer, who also raised horses, pigs, ducks and chickens. Although they were poor - "I think my mom had to go to get us second hand clothes" - they had food all the time. Her mother tended the garden and milk was provided by their cows. When Agnes turned 16, her mother passed away and things "went right down to nothing". Her father drank from as early on as she can remember. I asked her what he was like when he drank.

Well he was good to us kids, but my mom was afraid of him. She used to run away from him when we used to hear him coming with the buggy. Could just hear him talkin'. And then she'd take off and run. I'd run with her. But towards when I was getting a little older I told myself I wasn't going to run even if he does hit me. But he never did. But I remember one time he hit my mom. I think she was mad at him, coming home so late. I remember him swinging. She just fell on the ground. I remember that.

Agnes' doesn't know why, but her mother never drank. She indicated that it was not as socially acceptable, when she was younger, for women to be seen drinking. Also.



she remembers that "Indians" were not allowed into pubs or allowed to buy beer.

Nonetheless, her father "used to find a way of getting it anyway". He eventually sold everything - "the cows, the animals" - to get money to buy alcohol.

In 1951, at the age of 17 and a year after her mother's death, Agnes got married and left home. Although she soon left her husband because she wasn't getting along with him, she "moved back with him. Like, you know, a place for me to go." As for her father, "all he did was drink, drink. Sometimes we'd go there, he won't have any food to eat. We brought him groceries."

Although her marriage wasn't working very well, she stayed with her husband.

We were both 16, ah 17 when we got married. And in those days, if a girl gets pregnant, she's supposed to marry the boy. So my parents and his parents must have got into some kind of agreement for us to get married cause I was having a baby.

He didn't drink when we got married, but then after we had about a couple of kids, then he started drinking, running around. He's got other kids besides my kids. He was mean.

Over the years his physical abuse increased along with his drinking. He got another girl pregnant and left Agnes six months after their seventh child was born. Agnes recounted that she was ambivalent about him leaving. On one hand, she wasn't sorry to see him go, but on the other "with seven kids, that's a lot of work". Agnes did the best she could to provide for her children. She went on social assistance after her husband left

and moved into Minnedosa.

Oh, God. It was awful. The house was cold, it wasn't even heated. We all piled up in one big bed, to keep warm. The hardest part of my life.

Agnes lived and cared for her children in Minnedosa for 17 years. Richard left her in 1962. A short while later she started a relationship with Norman. She had a daughter, Shania with him in 1964 and a son, Nelson, in 1971. Agnes did not drink with her first seven children, but began to drink when she reached the age of 29. I asked her why she began to drink after she met Norman.

Okay, well, I've grown up with this guy, and he always drank. So, I started going out with him. Come to the house, bring a 12 or something. I just started to drink with him. I started drinking and I quit when I was 42.

For Agnes, drinking was an escape. "You didn't worry about anything when you were drinking. You know, get away from all my problems. Have a few drinks." She drank through her last two pregnancies. She thinks that her drinking affected her son Nelson "because I've tried to commit suicide so many times when I was carrying him" and because he had trouble in school and only went up to grade nine. Her daughter Shania seems to have been developmentally unscathed as a result of Agnes' drinking. She is a schoolteacher at a reserve in Manitoba.

I said to Agnes that Susan had told me that almost all of her siblings had been, or were, alcoholics. I asked her if she knew why that might be the case.

Oh I don't know. I don't know, maybe because they see

me drink when I was, you know, and they were already growing up. Oh gee. Maybe growing up without a dad. Maybe it had to do with my drinking. Ashamed of me that I drank.

Agnes feels that her drinking affected her parenting style. She used to leave her children to go to a party or go to the pub. She would return either late at night or towards morning. "When I start thinking of it I feel so, you know, hurt, that I done those things."

I knew from Susan that Agnes had attended a residential school when she was younger. She went to both Labrette and Camperville. She started when she was "about six or seven" and quit when she was 14. Agnes remembers that all of her siblings went to residential school except for Timothy and Linda. Those that attended were gone from September to June each year. Agnes experienced no abuse in LaBrette but this was not the case in Camperville.

There was a priest there. He used to touch our breasts. I guess not only me. I didn't tell anybody till Susan. I think when we were assigned to do cleaning. I think this was in his office, I believe, it happened. But I didn't tell anybody. That I remember.

Agnes does not remember ever being visited by her parents during her residential school experience.

Agnes feels the fact that very few of the children were at home during ten months of the year had an influence on her parents' ability to parent. According to Agnes, her

mother

never used to hug us or tell us she loved us. That's the same things I did with my kids. I never hugged them or tell them I loved them. Cause I followed . . . nobody ever taught me that. So when my kids were all small, like just make sure they were clean and fed.

Agnes says her sister is the same way. "She couldn't hug her kids or tell them she loved them. But now she's learning with her grandchildren. Just the way I am learning. And Cassandra (her foster child) makes a lot of difference - I have her there." This inability to parent, she feels, was also passed onto her and subsequently to her children. "It affected them the same way as Susan. Like they're having problems with their kids right now. Oh, it's hard."

I asked Agnes about her siblings drinking patterns. All of them but Beth drank. When I asked about Linda, she stated that Linda was dead. "Her husband stabbed her. Alcohol, they were drinking."

I asked Agnes if she felt that the arrival of Felicity (Debra's child) signified the birth of something new, a "new sort of hope" to stop the intergenerational abuse. In response, she again brought up the importance of her foster child.

Like with Cassandra. If she didn't come into our lives, I don't know. She came to us when she was five. So, expressing myself more. I tell her I love her, you know. Like I'm able to hug my kids now, which I never did while they were growing up.

I wanted to know how Agnes arrived at this point in her life: what occurred in her life to help her with this transformation.

Okay. I worked for Child & Family Services in Brandon for seven years. This lady came to my house one day and she asked me, "Do you want a job?" I never worked in my life. "What job", I asked her. "To be a family aide". And I asked her, "What's that?" So she said, she explained to me, you go to this home, you work with the mom, and you kind of be a role model. Like you know, teach her parenting, help to look after her kids. That's where I started that. That's when I started caring. When I went to work, and I felt good about myself. Take half of my assistance off because, you know, I felt good.

I asked Agnes what the general perception of "Indians" was when she was younger. She used the words "bad" and "drunk" to describe what others and she herself believed to be true of them. And when I asked her if that perception was passed on to her children, she said, "I believe so, yes". She also indicated that she felt this "inferior" perception was still a part of some Indians' belief. A number of her children were taken to "that mental hospital for testing. I don't know what they figured was wrong with them."

Susan remembers when I took her there. She asked me, "What was wrong with me then?" Just testing you, I guess, see how smart, or . . . And David was put in O.E.C.

[Occupational Entrance Centre] at one time but he got out of there. And the rest, I think they just went as far as grade nine I believe.

When I asked Agnes why she thought there was a higher degree of alcoholism and FAS/E in certain Aboriginal communities, she said, "maybe because the people don't think of themselves as good as, you know, your White people, and they drink." I asked her if she felt that was the case with her.

I guess some of it, but I guess mostly for me, I don't know. Sometimes I think it was just being alone, and I wanted somebody. And I used to try and commit suicide so many times. I was trying to get back at this guy I guess, because he didn't want to stop drinkin'. He was a real bad alcoholic.

I asked Agnes what happened when she turned 42.

I just got so fed up, tired, not succeeding. And I went to Winnipeg to the dry-up centre for two weeks. They told me I had to stay three weeks, but I came home in two weeks. I learned quite a bit from there. I think I fell off the wagon about three times after that. That was it.

I wanted to know how one goes from "somebody that's suicidal and wants to get away from everything, that's lonely, that's depressed, that hates life - to this." She said the two major factors were quitting drinking and meeting Dennis (her current partner) who does not drink.

Now I want to live. I always talk at the [Family Aide] meetings - like she'd tell us how we'd feel when you were drinking. And I'd always end up saying, "I don't want to die now. Every time I feel a pain I run to the doctor." And I'd burst out laughing.

Agnes loves that she is now able to hug her kids and tell them she loves them.

When I asked Agnes what she thought separated her from so many other people who are not able to do what she's done she said it was "up to the person to decide."

Like you can't do it for them. Just make up your mind you want a better life. But I'm happy now. With Cassandra and the dog. I got great-grandchildren.

#### Debra's Story

Debra was born in 1978 in Brandon, Manitoba. She is the middle child of Susan's three children. Her brother Jeffrey is 16. Her sister Brenda passed away in 1988 at the age of 12. I asked Debra what some of her first childhood memories were.

Moving lots. Moving to different places. My sister being sick. We lived in Brandon, moved to Calgary. Lived lots of places in Calgary. We'd move twice a year or something and we'd stay somewhere for so long and then end up moving somewhere else in Calgary. And we had family out there so I remember being with them. Spending time with them. But we moved back when my brother was born, and we lived out here for a little while and then we ended

up going back out to Calgary. I guess when I was four years old we moved back.

When I asked her why they moved to Calgary she said she guessed her "mom needed a change or something, I don't know. My sister was sick too, and doctors." I asked her what she remembered about her sister.

She was sick all the time. Every little thing got her sick.

She was in the hospital quite a bit. She was hardly at home. But we were close and we shared a lot, talked a lot.

She used to get a lot more attention than I did.

Debra was not happy with the attention that her older sister received.

I acted out in anger for attention. I'd throw temper tantrums. Get mad. Take off. I was jealous. I'd take her things to get her mad. When she was at home she was hooked up to IVs and stuff and she couldn't get out of bed, so I would take her things and stand at her door and tease her with them. Make her cry. Things like that. Go in her room. Just stuff like that I guess.

I asked Debra if seeing her mother spend so much time with her sister affected her feelings towards her mother.

That's when I would have my temper tantrums. I wouldn't get angry like that at my sister, cause for one thing she was a lot bigger than I was. I wouldn't get angry like that with her but with my mom, if I didn't get my way I would get



really angry. Rip things off the walls, and flip things over, cry. Just anything I could do to get attention I guess. Or to get her mad, cause I was mad. Stuff like that. It would get her upset. Sometimes she would cry. And sometimes I would feel good when she cried. And I don't know why - I was young, but if I got her mad enough I'd feel better.

I wanted to know if she remembered when her mom drank.

When I was younger, ya. I remember her drinking when I was smaller, but as I got older and she quit drinking, there was still, there was still yelling and putdowns. There wasn't . . . I don't remember much spankings. Some of the boyfriends she had would hit us, but from her, I don't remember her ever spanking us much. Like if we got really out of hand then we'd get a spanking, but there was lots of yelling. When she got mad she'd put us down. Well with me, what I remember, put me down.

When Susan was drinking she would sometimes be gone for long periods of time.

Debra remembers being dropped off at various places when this occurred.

My grandma. Uh, baby-sitters, my auntie Bernice, my uncle Sean, um . . . But they'd take care of us for a couple of days or something, or else . . . I don't know. In Calgary I remember she brought us, brought me with her to this lady's house - my uncle's ex-girlfriend I guess you can say.

And she left me there for a few days with her and they were still partying there. And she came back a couple of days later and she was still drunk, and I didn't want to see her. I was angry with her I guess. But . . . I remember her just taking off for a couple of days at a time. It was never a couple of weeks or, I don't remember a week straight or anything. But I remember a couple of days.

I was curious to know how things changed after her mom quit drinking.

With the drinking it changed with that she was home. But there wasn't, with her, it's hard to explain. The yelling didn't really stop. And the putdowns didn't really stop. Her getting angry with us didn't stop. Just the drinking changed I guess you can say. But things kinda stayed the same but the drinking, that was better, cause she was home with us and she was taking care of us. But everything else basically stayed the same.

Debra goes on to talk about her ambivalent attitude towards her mother.

I remember just wanting to be with her, but being angry with her. Like I missed her lots and I cried for her, but when she did come home I was mad with her and wanted to ignore her and everything but wanting her to stay.

She talks about how her mother treated them when she sobered up.

Fine. I guess the things that a mother does. Cook for us,

clean us up, clean the house. Things like that I guess. But she took care of my sister. She had to spend a lot of time with my sister, so. And then Jeffrey was younger than I was, he was a baby so she had to basically spend most of her time with them two. And I was healthy, and I was the middle child, so I wasn't a baby. I basically took care of myself. I was outside playing all the time and stuff like that I guess.

Debra gives further examples of what her mother was like after she quit drinking.

In a way I find her to be, like she's changed a lot. Like now she can tell us that she loves us and she can hold us, but, and she can care for us. But when she gets angry she still says things that hurt. In a way she's still the same but she's not, like. She still has some of the anger I guess we can say. She . . . she has a little more patience. But when she gets mad, she still does use some names that hurt. She'll call you a suck or "Oh, you have to have it your own way". Just little names. She doesn't use harsh names. Like she won't go out and call you a bitch or swear at you. Just little names that hurt. And I don't know if she realizes that she does it. She still does things like that once in a while.

I find her that she can, she can hold a grudge. She

can stay angry. Like if, if I'm the one to get angry with her then, I guess to her it's okay, next day it's over and done with. She'll come and talk to me and everything, and that's fine. But if she's the one to get angry with me or something, she'll ignore me for a few days or she'll tell me she can't . . . she's not going to be around me if I'm going to be that way. She . . . I guess you could say over-reacts. Everything seems to turn into a big issue when it comes to hurting her feelings. So, it's that way I guess. She can hold a grudge for a few days.

I asked Debra where she felt her mother's anger was coming from.

Her bringing up. Um, because we've talked about her growing up, and her not being told she was loved, or held. And I understand like with us, like now I understand why it was so hard for her. But before I couldn't understand. I guess just her growing up. The abuse she took. She's been through a lot. She's been abused a lot. I guess that's where her anger comes from. Doesn't have much patience I guess.

Debra talked about how things changed after her sister died.

My mom was depressed for quite a while. She cried lots. Um, I guess I was old enough to understand that my sister wasn't there, but still young enough . . . I didn't understand,

um, why it had to be us. She, I don't know. She didn't start drinking again or anything. I guess it took her a while to come out of that depression. Every year on her birthday, she would cry. And I guess I'd be scared to bother her at that time, cause she was very emotional. And it was like that for a few years. I think that's when she started to, to hold us more, I guess you can say. Pay more attention to us. I found that she always paid attention to my little brother. Cause he's always been the baby and he needed that attention. But she started paying attention to me and by the time I was nine I guess I was already a very angry child. I was picking on other kids. Still yelling and having temper tantrums. I found that I beat my little brother up quite a bit. And I hurt him lots. Felt better when I hit him, but then later on I would feel really guilty for doing it. I picked on him quite a bit, and other kids.

I asked Debra what school was like for her under the current circumstances: having her mother spending so much of her time with her (Debra's) sister

Um, it was hard. I moved schools lots. I was a very, um . . . I had a very low self-esteem. I guess to get attention and to keep other kids from calling me names I had to, to be the tough one I guess, to . . .so things wouldn't happen to me. I didn't like going to school. I'd make up excuses. Pretend I

was sick. Just to avoid going. I hated moving schools. I hated moving. Never really got to be close to anybody. I just had one friend that I did get close to and we're still friends now. And I met her in grade five, and she didn't mind the way I was, or the way I acted or the way I looked. I guess you can say she's still my best friend now. Even though she's still out in Calgary. We hardly talk. But when we do talk we can talk for hours.

I next asked Debra how the fact that she was Aboriginal affected her childhood.

In Calgary there was a lot prejudice, name-calling. When I would go to a school there would be just a couple of Native people in our school. I think that's why too I didn't really like going to school, because of the names. I didn't like being Native because I thought all Native people were alcoholics and . . . cause that's all what they'd tease us about, what they would say - names all the time, so, I didn't like what I was.

And when I moved to Brandon, I think it got worse because the kids my age, at that time, the ones I hung around with, were all Native and they were all getting into trouble, and I fell into that group. I guess I found them to be like me. They gave me security because they understood what was - like the friends that I had at that

time, their parents were still drinking and abusing them and all this stuff.

I asked her if she was ever ashamed of being Aboriginal.

Ya. When I was living in Calgary they would ask what I was, and I would say I was Spanish to all the people. Wouldn't let them know I was Native. And then when we moved to Brandon it was, it was different. Like I was still ashamed inside because I knew the way the Native people, like . . . I didn't know how the Native people were, but from what kids would call me and say to me, put me down, that's how I thought they were. And then, when all my friends, when I moved to Brandon, were Native, I guess I was proud because I was . . . a lot of the kids were scared of us cause we were Native. And that was what protected me I guess from the name-calling. They stopped calling me names, because I was a Native, and I guess they figured because I was Native then they couldn't say nothing to me, because then I'd end up doing something. So I guess that's what protected me, was my Native friends and being Native at that time . . . in Brandon.

But being in the bigger city, there's a bunch of different races and a lot of prejudice, but being in Brandon, and it's so small, there's basically only two races there, so I

guess it changed when I moved to Brandon. I don't know.

I wasn't ashamed to be Native when we moved to Brandon.

Debra explained that although her mother was now going to school and "trying hard to take care of us", she (Debra) didn't want anything to do with her. "I guess I felt that she didn't care for so long, why should she try now. I didn't want to be around her." I wanted to know if Debra was spending time with these particular friends and staying away from her mother as a form of punishment to her mother - a way of getting back at her for her neglect.

I guess sometimes it was trying to get back at her, but a lot of the time I wasn't really thinking about my mom. I just didn't want to be around her. I didn't want to be there. She babied my brother quite a bit. He got what he wanted. He got his own way. Didn't get punished. I didn't like being in the house cause whatever he wanted he got. With me, I had to do something for it, and I didn't understand that. I had a lot of resentment towards my brother. I didn't like him. I didn't want to be around my mom. Just cause, when we were together we argued, and then when I would get mad, that's when the names would start, back and forth. I would call her names, she would call me names, and I just didn't want to be there. I'd rather be with my friends where I felt comfortable, where I felt that they'd protect me. I can do what I want, I could say what I want, and rather than be



at home with rules to go by and this and that. So I chose to be with my friends.

Debra explained that as time passed, she spent more and more time away from her home.

I started taking off when I was thirteen. I'd run away for weeks, I guess you can say, and my mom would have to send the cops after me to bring me home. I just . . . I didn't want to be home. I wanted to be on my own, and since I was 13 I guess that's how it's always been. I've gotten used to not being home for very long, that I would be home for a couple of months and then end up taking off again. I started getting into trouble. I guess the friends that I had too . . . they were . . . I felt I had to do what they were doing in order to be with them. And to me, I guess it was cool what they were doing.

We were breaking into stores at night. Stealing cars. Beating people up for no reason at all. We weren't taking anything from them people, we were just hurting them. I guess letting our anger out. Drugs, drinking. I never liked doing drugs. I got into drinking when I was quite young. Stuff like that I guess. Getting into trouble in school. Skipping a lot of school. And if we were in school then we were picking on people and hurting other people.

I asked Debra if, because of what she had seen in Brandon, she felt Aboriginal people had a predisposition to drink.

I guess so, ya. Because all my friends' parents were, were alcoholics. They were always drinking. I would go there and I would see what I saw when I was small. Drunk people and watch fighting and arguing and . . . and with all the friends that I had, that I got involved with out there, their families were basically like that and I thought that was normal.

I wanted to know when and how Debra started to change her life: What events led to her decision to give up her current lifestyle and turn things around.

When I was 16 I started getting into a lot of trouble, and I was in and out of . . . I've never spent longer than a few days in jail, but when I would go, it would be so empty, and I would be scared, and I'd cry, and it just . . . I ended up in the mental institution for being suicidal. Um, just being alone was so hard. Depressing. I think being locked up like that made things worse for me. Made me more depressed. Um, I still now have . . . I think I have problems with depression still. I cry quite a bit. But then I was, I was so scared of being locked up. By the time I was 16 I was just too scared of being put back there, that I just stopped hanging around who I was hanging around. I

couldn't trust my friends anymore cause things were just changing. They were all ending up in jail. They were committing suicide. They were hurting each other. They were all turning against each other. They were getting into heavier drugs. I just, I guess I didn't want that anymore. I didn't want to be around . . . I was getting scared.

I was feeling a need to be with my mom, and not wanting to be alone anymore. And at that time, she was living in Winnipeg. And I decided to straighten out and everything. When I got there, I went back to my mom's. I quit school. I only lasted, I think, three days. I couldn't handle it because I slacked off all those years of junior high. They were just bumping me up because of my age, and I didn't get any education. I felt stupid. I didn't want to be around the kids who knew everything. I was scared of being, I guess rejected all over again in school. So I quit, and that got my mom very angry. And the day that I quit I ended up going back to Brandon. When I went back to Brandon, I guess I hid from my friends.

I asked her where she lived when she moved to Brandon.

Different places - I guess that I felt safe. Where I wasn't going to be with the people that were, were getting into trouble still. I still drank quite a bit. I guess that's all I was

doing, was drinking.

Debra ended up leaving Brandon and returning to Winnipeg to be with her mother.

I met up with people there, made friends out there. I wasn't getting into any trouble. I still avoided that. But I drank. I drank lots. Um, I found that I was, I got into a serious relationship and I was sixteen I think when I got, no, almost 17 when I moved back to Winnipeg with my mom. And I stayed with him till I was 18, and it was very abusive. He did drugs quite a bit. He drank quite a bit. I drank quite a bit. I never took drugs. But I stayed there and I felt safe there even though I was getting abused.

I asked Debra what she meant by "getting abused".

Beaten. Quite a bit. Pretty bad. I hid it from my mom. I was ashamed of it. I thought it would go away. Um, the abuse wasn't only from him, it was from his mother too. I was scared to leave.

She would, I guess help, um lock me in the basement and let him hit me. She wouldn't get help for me. Wouldn't stick up for me. She would call me names too. She was a very drug addictive person. She took a lot of pills. She was always doped up. Very scary to be around her I guess. One minute she was normal, the next she was

something else, and . . . but for some reason with him I felt safe. I guess I wanted to feel love and he told me he loved me and I believed him. Um, he was a gang member.

My mom found out he was beating me because I got a pretty bad lickin' from him one time and I got out of the house and I called her, and earlier that night, my cousin Sonja phone me, and he was fighting me, and he pulled the phone out of the wall and by the time I got out of the house and phoned my grandmother, my cousin Sonja was already out looking for me. And my cousin told them that I was all full of blood and that I was beaten up pretty bad, and the police told them that, and that's when my mom found out that I was being hit. She wanted me to come back home. But then she wanted me to go into care. She wanted me to get help, and I didn't want any help. I thought I can just get out of it on my own. I can do things by myself. I guess I felt that I was doing things on my own for so long that I can do this by myself.

He, a few months later, got beaten up pretty bad by a rival gang. He was put into a coma, and by that time I didn't care for him anymore. I felt sorry for him so I stayed with him. I helped him walk again, and read, and learn. I guess I thought if I stayed with him through that and I

helped him through that, he would change. I felt disgusted by him, even after, even after that I guess, because when he was in his coma, I just, I would just sit there and stare at him and just disgust . . . I was disgusted with him. But I was willing to help him change. When he did come out of his coma and everything, and I helped him through that, I was still being hit. And I just couldn't handle it anymore. We were living in G (a reserve) at that time. I was 18 years old. He was in Winnipeg and I came back to be with my mom. And when I was out there in G, um, my uncle Brad was out there, well my mom's cousin, and he drank quite a bit too. So I was always there with him. And I was always drinking. And I wanted to stay with my mom as long as I could to avoid going back to Winnipeg to be with him. And I told him I wasn't going to go back, and that if he wanted to come out here, then that was fine. But when he was on his way back that day, I didn't want to go home. I didn't want to see him. I just didn't want to be with him. Tired of being abused I guess. And the next day that he did come back he ended up beating me up. And I was angry with my mom, again, because that night that he beat me up, the next day she . . . they drove him back to Winnipeg. And she was upset because she had to make the trip and she got

mad with me saying it was my fault and that I should've just talked it out with him. He was my boyfriend, why should she have to take him back. And it hurt me because I expected to be comforted. I expected to be told, you know, everything's going to be okay and it hurt so much when she said that to me. Like, things like that, that's what I mean by putdowns. It's nothing really harsh but the things do hurt that she does say.

And then a couple of days later, she came to the house where I was with my uncle Brad and basically acted . . . like she didn't say anything. I guess for her, she forgets about it, and it's nothing. But she brought me cookies, I guess to make amends. Then she, that's when she wanted to talk about how long I was being hit for and abused and how it felt and that I didn't need that. And I just brushed it off and, it still bugs me, but she should have been there first, right away. But I don't let her know things like that. I don't want to get her upset. I tell my mother everything now. Even if . . . knowing that she will put me down. I feel that she needs to know what goes on in my life now. In order for us to . . . I guess I want things to work between me and my mom now. And in order for that to happen I have to share everything with her, even if it means she's

going to get angry with me. I still want that closeness with her, and I don't want to lose that.

Debra then talked about her fear of her mother returning to drinking.

I guess I worry about that now still. Even though I'm an adult now, I get scared that . . . I have this feeling that if she started drinking I'd be abandoned all over again. I wouldn't have my mom.

She continued to talk about her mother. Debra said she knows her mother "wants what's right for me, and she doesn't want me to do what she did, but she doesn't seem to understand when I tell her that that is not going to happen.

I would never raise a hand to my child, I would never go on a drinking binge and leave my child somewhere. I don't drink around my child. The other day she was saying if she didn't tell me to talk to my baby then I wouldn't talk to her and I wouldn't play with her and I wouldn't love her so much. And I tried to explain to her that that wasn't true. I feel because, now I want a relationship with my mom, I want everything to be fine and it's been like that for the last few years now. I find I'd still be the same with my daughter how I am. I'd give her all the attention I can. I spend 24 hours a day with her. When my mom takes her on the weekends, like my mom will take her for the night, I miss her right away. I need to be with her. I think I would



be that way because I was ready for a child. I wanted to have a child. I wanted to love someone, and give them everything that I could. So I don't feel that because my mom told me to talk to my baby, and this and that, that that's why I do it. I do it because I want to be a good parent. I want to raise my child right. I want her to feel all the love that I can give her. I find I'm very protective of her. Like I won't even put her in daycare cause I get scared that another kid's going to give her a smack or something. At times I find I'm too protective and I want her to explore but I don't want her to get hurt. I watch my mom with her and, my mom is so much better with my daughter than she was with us, and I love that, because she's changed so much and she can show how much she really cares now.

In light of the comments that both Susan and Debra made about their respective mothers' lack of parenting skills, I wanted to know if Debra felt that her relationship with her daughter Brenda was the start of something new.

Definitely, because I know my kids won't have the . . .  
won't have to see me grow up . . . they won't be  
abandoned, they won't be hurt by alcoholism. Not by me,  
anyways. They won't see their mother go through that like  
I did. She's loved so much. Like we show her so much  
attention - me and her father. She's always cuddled. She's

always told everyday she's loved. We spend all our time with her. I constantly talk to her. Even though she's too young to understand, but, you know, just teaching her, teaching her little things like the alphabet and everything, and my mom didn't do that with us. I want her to have a good self-esteem. I want her to feel proud about herself and feel good about herself. Not how I felt growing up. I want her to be her own person, and do what she wants to do in life. Not be scared to take chances, and things like that.

Like with me, I get scared to go back to school. I always think about the negativity when I was younger, and just being around people like that, and I get paranoid. I get scared to take that step just to meet new people and to do things like that. And I still have a low self-esteem. I still have a lot of depression. I try not to cry around my daughter. I try not to let her know that but kids sense when you're upset and I know it bugs her, but I'm trying to be a good mom and I'm trying to do the best I can. And I know I'm a good mom because I give all to her. Everything I have I give to her. And that's what she needs.

Debra acknowledged that both she and her boyfriend still do drink. She said that although he does come home drunk from time to time, "he's a quiet drunk" and "goes to bed right away". I wanted to know if he had ever hit her.

A couple of times. We've been together for three years. Not hit. We would get into arguments and I'd push and shove and this is before she was born, and he would push and shove. But he would only push me back when I would get really angry - hit at him - and he would push me away. One time it did get out of hand, once. My mom says I'm very abused by him. She doesn't know the whole story, and that's what gets me upset. She doesn't like him because . . . I felt I had to tell her what happened to me, and, just to be open and honest with her because that's how I want to be with her. And now she thinks he's like this all the time, and it's not true.

We got into a fight one time when we were drinking. And we were pushing and shoving, and he hit me. I told my mom about that and he's never hit me since. He's never raised a hand to me. He hasn't shoved me at all. I guess when that happened to us, it ah . . . cause before that there was pushing and shoving, but not all the time. Just when we'd get really, really angry and frustrated. Usually he just walks away from me and takes off. And that time he hit me and I kept it from my mom for, I guess, almost a year. And then I finally decided to tell her, and to her, cause he hit me that one time, she thinks that it's, that it

happens all the time. And honestly, it doesn't. He's never pushed me, or he hasn't ever raised a hand to me after that. I guess to him it was a scare, and to me it was a scare. And we worked through it, and that's that. We never fought like that. And after that, the drinking slowed down totally again. Like we never drink around my daughter. Like I said, if we choose one night to go out, then his mother will watch her. I won't allow it to happen. I won't allow my daughter to be exposed to that.

I asked Debra if she continued to drink once she found out she was pregnant with Brenda.

I quit drinking, totally. Never once did I touch a beer. I was scared I guess. Scared of having a sick child. Knowing that if I did drink then that would be abuse already. And I didn't want no abuse. After she was born, I didn't drink. I breastfed her for about two months. And after, I drank a few times after that. And I got pregnant pretty soon after I had her. She was only five months old when I got pregnant again, so not much drinking. And when we did drink, it was only a couple of times when we did go out, and that was when I was at home for a long period of time and wanted to go be with my friends for once, and you know, go out and do something.

I asked Debra with her attitude towards not drinking while pregnant, how it made her feel about her mother and the fact that she drank throughout her pregnancies.

Like she said back then, like she explained to me that they knew it wasn't good but nobody would explain to them what the effects were. And that they didn't know it could cause serious damage and . . . so I just figured they didn't have much knowledge about anything back then. She had a disease and she didn't know what was going on with her kids when she was pregnant, so, I guess I don't have too much, you know, to get me angry because the fact that I know she didn't know too much about it, so, you can't really be angry with her for that.

I reminded Debra of the FAS/E study that was conducted on her reserve a short while ago, indicating a much higher rate of alcohol affected children than in the mainstream population. I asked her why she thought the rate was so high.

There's nothing for people on reserves. There isn't much. Like even with us right now, we do our hardest to take care of our daughter. But when he's (her partner) not working and he has nothing to do, like there isn't much jobs out here. There's not much for people on reserves. So when he's not doing anything - like with me, I keep busy by taking care of my daughter. That's a full time job there. I don't have time to be going out and doing things like that.

But with him, he gets bored and he does go out and drinks, and . . . I didn't grow up on a reserve so I can't, I can't say what the whole life is like. But I guess for people who do grow up on reserves, like the ones that I've seen and the ones, the people that I know right now, they do drink quite a bit. I guess that's all there is for them to do. That's, I guess how they cope with their boredom. It gives them something to do I guess, I don't know.

Debra had the following to say to women who are drinking while pregnant.

I guess what anybody would tell them is that it's wrong, you're affecting your child. What they would probably already have heard. I don't think you can change someone's mind if they're going to . . . if they're already set on what they're doing then you can't really, you know. you can't really do much. But, I would try and explain to them what can happen, and what's best. But there's not really much you can do I guess.

#### Susan's Story - Epilogue

Several weeks ago I got together with Susan. She looked anxious. She asked if we could go outside and talk. Once outside she looked at me, hesitated and looked at the ground. I asked her what was going on for her. After some time, she lifted her face and said she had begun drinking again. She said that it seemed that for her, her purpose for living was in some way, over. She knew her children were "going to make it". She

didn't feel needed in the same way any more. She was so needed by her dying daughter. She had a purpose, a reason for being. Her son and daughter both needed her to ensure they didn't go on the same path she followed as a child. But now, with the confidence that they would be okay, Susan felt she was no longer important, and so she went on a drinking binge. She said, "Chris, I always told you this was not going to be easy, and that I could start again at any time." Susan is scared of the future. What has happened to Susan only reinforces all she had to say about the importance of her identity. She feels that her identity is now in jeopardy. She is no longer engaged with society in the same way. In her mind, her *raison d'être* has ceased to exist.

After Susan and I talked, I asked if she would like to be interviewed one more time. She said she would as her "falling off the wagon" was a reality. While she didn't want people to lose hope by the fact that she had gone back drinking, she also wanted people to realize that she was an alcoholic and always would be one.

Susan began drinking after 14 ½ years of sobriety. Initially she couldn't articulate exactly why she began drinking again. She thought one of the reasons was that she got depressed at times. Normally she could deal with it "but this time I just didn't seem to know what to do with it". Her bouts of depression have increased recently. Prior to this "it was always something I could just talk to my mother about or talk to someone about and be okay. But this time it just didn't want to leave".

She does know that she is struggling with something particular in her life right now and "it has a lot to do with the traditional way of life and trying to find that way of life and I'm fighting it". She's been fighting "it" for some time now but knows it's coming to a point where she's got to do something about it. What she's "fighting" is a

battle between her former "religious belief" - the belief that helped her through her daughter's death - and Native spirituality. After her daughter's death she became extremely angry with God. She's tried going to church recently, but

it's just not for me now. As much as I've tried, and as much as I know that it did help me at one point in time in my life . . . I just know that it's not working now. And I knew it wasn't working for some time, and it has nothing to do with . . . at the time of me trying to look at the traditional way of life. It just happened that it just didn't work any more for me. I'm struggling with it but I am trying to find something.

Susan has a sister who lives in northern Manitoba who is "very traditional" who is in the midst of trying to find her own culture. Susan has been spending some time with her lately and plans to attend a number of sweats and "likely a fast to try and help myself because I really need it." Her ultimate goal is simply to find peace.

Just to find some strength and comfort and to be able to deal with everything. I just can't make this journey by myself any more, which I'm trying to do, and it's just not working.

I asked Susan if she was referring to the 12-step program that AA uses. She said that it (the 12-step program) is something that she believes in even though she's not attending the programs now. "It's just, I know life without something and life with something and . . . there's just a lot going on right now." Her mother and stepfather are



struggling with the decision to put him in an Old Folk's Home. Her brother Stanley has just undergone angioplasty for a plugged artery but continues to drink and smoke and refuses to take his medication.

I asked Susan if she could explain why she felt she went back to drinking after so many years of sobriety. She said that

sometimes, it just gets overwhelming. I just think that it just got to be too much for me. I guess the bottom line is just, when a person goes back drinking they choose to. It could be, I mean I could give you a hundred million excuses, but I think it was something that I did, and I can't really pinpoint one thing.

Susan's binge lasted one night. She drank beer to start but

it was just water to me. I couldn't get nothing out of it, so I drank whiskey and I was quite pleased with that instead. I just couldn't get enough of it and it just wasn't doing what I wanted it to do. And then I suffered. I suffered after. For about two weeks I was craving so bad. Right after, it was like every second, I was craving for something. Like it was whiskey, anything, even cigarettes. I thought I was going to go crazy. A couple of weeks after it was still really bothering me. It was like my skin was crawling. And I wanted to just crawl out of it, you know, it was just horrible.

So nothing's changed, you know. And I knew that.

Like even though I knew it, I still did it. You know, I knew, they kept telling me that when I quit drinking, nothing will improve as far as it goes, like when it come to drinking. Like nothing will improve and it didn't. It's still the same ugly, ugly effects and everything. I was a mess. Even after that I did go out and have another drink. But why did I do it? You know, it's silly. I guess it's because I am an alcoholic. It's something I can't get rid of.

I reminded Susan of the conversation we had had about two months earlier when she first told me of her returning to drinking. At that time she had mentioned that one of the reasons why she may have gone back was that she felt her kids were okay. She remembered saying that and still felt the same way. She said that one of her hopes was that

if anything ever did happen to me, that my kids would survive and they'd be okay. That I'd know it, you know inside, I'd know that they'd be okay. And I feel, I felt that, at that time too that I'd knew they'd be okay if anything did happen to me.

Now she feels lost as a mother. Even though Susan knows her children need her, she feels they don't need her as much any more. Her daughter is taking correspondence courses and doing really well. Her son's marks are "way up in school" and he too is doing extremely well.

Susan has told her family that she went back to drinking. Her son was angry and won't touch alcohol right now. Susan was pleasantly surprised with her daughter's understanding. She just said, "Everyone makes mistakes". Her mother was upset because she knows what alcohol can do to a person and remembers what used to happen when Susan drank. Her husband was thrown for a while but said to Susan that she was there for him when he quit.

Another reason Susan feels she may have gone back to drinking was that so many people had put her on a pedestal.

But I think too, in a way that I might have been trying to tell people that I'm not this almighty strong person and I just needed them to kind of start backing off. I'm only human. I don't want to be looked at as though I'm always in control anymore.

The next step for Susan is to follow the "traditional path". She really wants to "get into it and see if that's where I fit. It's all this, you know, identity. It's finding out who you are and what you want."

As an Aboriginal person . . . it's hard because you come back to your people and you come back into so much anger. And you come back and you're mixed up and I guess my hope is for . . . you know, to fit here. But I realize so many of them are lost and it's hard to get direction. So many of them are, you know, just don't have anything. And it's so much anger. It's within my own

family too. It's everywhere. And I know if I don't do something, like it's going to be that ugly for me too, again.

I asked Susan if she had any final words she would like to share. She said she didn't really know. All she knew was that she just had to keep trying.

I'm just kind of brushing my knees off and getting up again. And I don't know if . . . it means that much that I lost my sobriety, as that I thought it would be. I mean it's 14 ½ years, that's a lot. But I know I learned a lot also so it wasn't like a waste to me. I'm starting over. So what can I say. You just gotta go on.

There are no easy answers or quick fixes for a woman who has been through what Susan has. Over the years she has built up a network of strong people; strong people she has helped and who have helped her. These are now the people who will give Susan her *raison d'être*. She has contributed much in her life. She has shared her stories so many will not have to endure what she did. She has given much of herself so her children and grandchildren will not have to suffer the same pain she endured for so many years. As Susan says, "My healing is going to be forever".

Chapter Five

Data Analysis

I initially read over the transcripts of the interviews several times. I then started reading in search of themes. I was looking for the common elements that linked the stories of these three women. My first attempt yielded 17 themes. This was clearly an unmanageable number to work with. I therefore utilized a “computerized piles” method; that is, I colour coded each theme and then coloured each portion of each interview as it related to that theme. I “cut” each theme from the transcript and “pasted” it into the appropriate file. This left me with 17 sub-theme files. Several more readings allowed me to pare down the 17 sub-themes into 3 main themes. These were Disconnection, Epiphany and (Re)Connection. All three women went through these stages in one form or another. We will look at each of these stages in more detail.

Disconnection

Individuals may become disconnected in many ways: physically, socially, emotionally, psychologically and, as is the case with these women, historically. We may either disconnect from society (our community) or from ourselves. In the case of these three women it is impossible to determine whether the disconnection that occurred for each of them was a result of symptoms such as the abuse, alcoholism and violence they suffered, or whether these symptoms occurred as a result of their disconnection. In all likelihood, the two occurred concurrently, exacerbating and accelerating the rate of each other.

A need to escape. This “vicious cycle” perpetuated a downward spiral, causing the need to escape and a further increase in the symptoms. This need to escape is one of

the most frequent theories accounting for alcohol addiction (Richards, 1993, p.47). All three women recounted that they used alcohol to escape the reality of their lives. Susan remembers one of the first times she went drinking. "I blacked out. All I knew was that I really enjoyed it because blacking out meant I wouldn't remember. It took me away. It took me away from myself." Agnes recalls that "You didn't worry about anything when you were drinking. You know, get away from all my problems. Have a few drinks". Susan and Agnes were not alone. All but one of their respective siblings became alcoholics.

They also, as Lithman (1979) asserts, drank to get drunk. Susan, in her last drinking binge, found that beer didn't do what she wanted it to do and so switched to whiskey. This corroborates Hamer's (1965) position that for some, the most important criterion in selecting alcohol is the high alcohol content.

There exists a connection between this need to escape and the three women's lack of "roots". Both Susan and Debra talk repeatedly about their transient upbringings. Susan says she lived "All over. Staying with a sister. Staying with mom. Kind of all over. Wherever I went. Stayed with an auntie." Debra's experience was similar. Her earliest childhood memories were

moving lots. Moving to different places. We lived in  
Brandon; moved to Calgary. Lived lots of places in  
Calgary. We'd move twice a year or something and we'd  
stay somewhere for so long and then end up moving  
somewhere else in Calgary.

No place really felt like home. It is little wonder they did not feel connected to the rest of

society. They seldom stayed in one place long enough to develop any kind of bond or attachment to anyone or anything. Debra hated moving schools. "I hated moving. Never really got to be close to anybody." To this day her best friend is a girl she briefly met in grade five class in Calgary.

A dirty Indian. Susan says she felt like she was in her "own little world" while growing up.

Like the more that I think about it. Like I was so disconnected from society, like really disconnected and not growing up with my people. I wasn't even connected there . . . and not having an identity to start off with, like it was just, it was hard, it was difficult.

I think not knowing nothing about yourself.

Imagine growing up with a life not knowing nothing. Not knowing where you came from. Not knowing your background. Not knowing your grandparents and then being put down for who you are, but you don't understand why. You know, being called "You're a dirty Indian".

Because Agnes believed that all Native kids were "simple", Susan grew up believing she was mentally handicapped. Almost all of her brothers and sisters were placed in "simple classrooms". Susan's daughter Debra didn't like being Native because she thought, "all Native people were alcoholics". She dealt with this by claiming she was Spanish.

Familial disconnection. This disconnection permeated every facet of these women's lives. Not only did they feel alienated from society at large; they were also

disconnected from their own biological family. Agnes' case is the starkest example. She was physically and forcibly removed from her family and sent to a residential school from the age of "about six or seven" till the age of 14. She was gone from September to June every year, and because her parents were too poor, they were unable to visit her during the year. Debra's disconnection from her family was, on the other hand, largely one of her choosing.

I started taking off when I was thirteen. I'd run away for weeks . . . and my mom would have to send the cops after me to bring me home. I just . . . I didn't want to be home. I wanted to be on my own, and since I was 13 I guess that's how it's always been.

Given Agnes' lack of parenting skills and her fight with alcoholism, it is doubtful that a firm bond was ever initially established between mother and daughter. Susan's mother didn't seem to possess the requisite skills to form a bond with any of her children. As Susan says, her mother ran the household as the nuns ran the residential school. It was clean and orderly, but little or no attention was paid to the other needs of the children. Susan remembers what it was like when she was pregnant at the age of 16 and feeling all alone.

So there I was . . . just 16 at the time, and my mom . . . my mom at the time was not around. She was going to try to recover somewhere. I think at a dryout centre somewhere.

Susan met her biological father for the first time when she was 20. They met in a bar, "sat down and drank, got stoned. That was my encounter with my dad. He was a drug



dealer and probably a pimp. Useless, useless, useless man". One of the only "connections" Susan made growing up was with one of her aunts. "I probably . . . cared more for her than I did for my own mother because . . . there was this person that was talking to me and acknowledged my existence. She was everything." Susan's aunt was stabbed to death by her husband when Susan was 15.

It is doubtful whether Susan was initially "connected" to anyone or anything. She did not know who she was or where she fit in. Susan was sexually abused by her uncle's brother at the age of "four or five". Her home environment was extraordinarily violent. After her father left, her eldest brother "took it upon himself to be the father" and beat his siblings on a continual basis. On the weekends, when her mom's friends came over to drink, "there'd be a lot of fighting and blood all over." It is little wonder that between the ages of 11 and 18 Susan experienced multiple suicide attempts, that she became violent - venting her frustration by "scrapping" at booze cans - that she was nearly charged with attempted murder after cutting up someone with a broken beer bottle and that she was committed to a mental institution for several months.

### Epiphany

The question of how one begins the transition from being so completely disconnected to becoming a part of society and connecting with oneself is one faced by these women. For all three women there was a defining encounter, or series of encounters, that provided the impetus for change.

For Susan, her healing journey began in a booze can in Calgary. A friend of her brother's walked up to her and said, "You don't belong here." What he said "really did something to me." Although she continued to drink, it was the beginning of the end of

her drinking. Susan recalls her last visit to a booze can. She ended up getting into a fight where she was knocked unconscious and then beaten up. Her partner "made me go to the hospital because I was all beat up and stuff like that and in pretty rough shape." X-rays revealed three breaks in her jaw. When offered painkillers, Susan declined. "I didn't feel anything. I didn't feel any pain. And that's what I find really said, is when a person, you can be beaten up so bad, and there is just no more physical pain left in that person."

Then all of a sudden, I don't know what happened. It's like for the first time in my life my eyes were opened [and] I saw all my kids around me - my three kids - and I was just looking at them and I was wondering, "I know these kids are mine but who are they?" And so for the first time I seen my children and they were crying and it's like my eyes were opened for the very first time in my life. And then I realized, you know, that I had three beautiful children but I didn't know who they were. You know I really didn't.

As she looked at her crying children, Susan began to feel pain; "and it felt so good . . . because I hadn't felt pain in so long." That night Susan made a decision. She said, "Okay God, I'm throwing the towel in now and I can promise you I'll try to stay sober one day at a time now. Just, that's all I can do." Susan admitted defeat against alcohol and knew it would kill her if she continued to drink. To this day she can't say whether she'll be drunk tomorrow or not, and so she takes it just one day at a time. That day marked the beginning of Susan's sobriety and her connection to herself and the world around her.

Agnes' epiphany came when a worker for Child & Family Services came to her house and asked her if she would consider a position as a family aide worker. The worker explained that the job entailed being a role model for other mothers, teaching them parenting skills and helping them look after their kids. Agnes had never worked in her life but said that this job allowed her to start caring and feeling good about herself. She was taken off half her government assistance thereby increasing Agnes' self-esteem. She held this job for seven years before she moved from Brandon. She went to Winnipeg to a dry-up centre for two weeks. "I learned quite a bit from there. I think I fell off the wagon about three times after that. That was it."

Debra's transition from disconnection to reconnection was traumatic. At the age of 16 Debra spent time in and out of jail. "It would be so empty and I would be scared, and I'd cry and . . . I ended up in a mental institution for being suicidal." Being locked up brought on fear and depression. This fear of being re-incarcerated convinced Debra to stop hanging around with her friends.

They were all ending up in jail. They were committing suicide. They were hurting each other. They were all turning against each other. They were getting into heavier drugs. I just, I guess I didn't want that anymore. I didn't want to be around . . . I was getting scared

Debra was feeling alone and a need to be with her mother. Although things remained difficult for Debra for the next couple of years, the recognition that her friends' lives weren't going anywhere was the first step of many Debra took on her path to reconnection.

(Re)Connection

I believe that for both Agnes and Debra, the next stage of their life involved a re-connection to a life they had lost. In the case of Susan, I don't believe she was ever initially connected to anyone or anything. So for her, this stage was not a re-connection, but a connection to herself and those around her. This stage involves not only the establishment of a connection, but also the acquisition of the tools necessary to ensure its sustainability. It is one thing to stop drinking; it is quite another to never drink again.

A new identity. Susan had managed to stay sober for several days at a time prior to her epiphany, but always ended up drinking again. This time was different. As Susan says, this time she sobered up "into a completely different world . . . into a life I did not know." She sobered up into a new "identity", as a "caregiver" for someone whose "life relied on me." She needed to be sober to help her newly rediscovered child. Susan knew her daughter was going to die. She also knew that if she didn't start working on some of her guilt she wouldn't be able to live with herself. So she threw everything she had in herself into building a relationship with her daughter. Susan asked God for two things. "Like I know you're going to take her in the end. But . . . don't take her before I'm ready - give me that time. And . . . don't let her die without me there."

I think working with her, you know, with all that I did with her, keeping her alive, really taught me a lot about how powerful and strong I really am as an individual. Like with her I did things that . . . she brought a lot in me. She brought out a lot of strengths that I didn't think I had.

Not a total defect. Another key to Susan remaining on her road to healing was her opportunity to go to university and “learn about my people and not feeling that I was 100% a total defect.” Realizing what Aboriginal people have been through, and continue to endure, allowed Susan to put some of the blame that she had foisted on herself, back on society. Her studies enlightened her about the effects that residential schools had, specifically on her mother. This helped Susan understand why her mother raised her children the way she did, and helped her understand a great deal about her own life. “And in the end, I’m not crazy, and I’m not . . . a dirty soulless Indian”. Susan paid a visit to the residential school where her mother had been abused. “Everywhere I looked I can see this little girl and I just wanted to grab her and protect her from what was done to her.”

The importance of children. Children play a prominent role in Agnes' ability to remain on her healing path as well. When Agnes talks about Cassandra, the girl they've been fostering for the past seven years, she says if she hadn't come into their lives, she doesn't know how she would have coped. Caring for Cassandra has allowed Agnes to hug and say things like, “I love you”; not only to Cassandra, but to her own children as well. She is also able to talk with one of her sisters who is “the same way as I am. She couldn't hug her kids or tell them she loved them, but now she's learning with her grandchildren.”

Agnes attributes two other factors to her successful transition from a woman who was suicidal, lonely, depressed and hated life to where she is today: quitting drinking and meeting Dennis - her current partner - who does not drink. “Now I want to live. I don't want to die now. Every time I feel pain I run to the doctor.”

For Debra, her reconnection came when she knew she was pregnant. Although she does drink from time to time, she would never “raise a hand to my child, I would never go on a drinking binge and leave my child somewhere.” She quit drinking the moment she found out she was pregnant with both her children. She never drank while breastfeeding. “I quit drinking, totally. Never once did I touch a beer. I was scared I guess. Scared of having a sick child. Knowing that if I did drink then that would be abuse already.”

What is important to note is that in the lives of each of the three women studied, their epiphanies and reconnections all involved children. For Susan it was clearly the realization that she had three beautiful children. Agnes' life started turning around when she began working with children taken into care by a Child & Family Services agency. And Debra stopped her drinking the day she found out she was pregnant.

Table 1

Overview of the Three Women's Lives denoting their Similarities

Susan	Agnes	Debra
• born in 1959	• born in 1934	• born in 1978
• one of nine children - seven biological, two step	• one of eight children	• one of three children
• has given birth to three children (the first at age 17)	• had nine children of her own, seven with first husband, two with second husband	• has two children
• alcoholic	• alcoholic	• alcoholic
• sexually abused	• sexually abused	• sexually abused
• multiple partners	• multiple partners	• multiple partners
• physically abused by her partners	• physically abused by her partners	• physically abused by her partners
• drank throughout all three pregnancies	• drank throughout last two pregnancies	• quit drinking when she realized she was pregnant
• began drinking at 12 and quit at 26	• began drinking at 29 and quit at 42	• began drinking at 13, continues to drink
• has attempted suicide	• has attempted suicide	• has attempted suicide
• all siblings but one are alcoholics	• all siblings but one are alcoholics	• brother drinks from time to time
• spent time in a mental institution	• spent time in a mental institution	• spent time in a mental institution

The chart above gives an overview of the lives these three women have lived to date. The similarities are striking. I contend that it is precisely these factors that are the underlying cause for the symptom of FAS/E. These women are victims of colonization and all the ravages it has bestowed upon Aboriginal people.

Chapter Six

Colonization of the Spirit

Through the stories of three Aboriginal women I have attempted to give as accurate a picture as possible of what it was, and is, like to be them. This combined with the literature I reviewed on FAS/E and the historical relationship between Aboriginal Peoples and alcohol, has allowed me to bring together the academic world with the pragmatic reality that is the life of an Aboriginal woman. Although much care was taken to be precise at all times, there exist a number of limitations with regard to both the literature review and the research conducted. With respect to the literature reviewed, it should be noted that only one of the studies examined was written by a woman and none was written by an Aboriginal. It is also significant that a number of the studies conducted were done so by American authors, specifically about American Indians. As well, other than a few paragraphs, all the data gathered regarding drinking patterns, related to Aboriginal males. Two limitations also present themselves related to the research undertaken. One, it is impossible to determine the effect of me being a white male had on the information I received from the informants. Two, as the depth of only one family's experience was documented, understanding their perspective necessarily limited the scope and generalizability of this study.

Colonialism is defined as "the exploitation or subjugation of a people by a larger or wealthier power". To exploit to "utilize or take advantage of for one's own ends" (The Canadian Oxford Dictionary, 1998). Aboriginal People in North America have been colonized and, by definition, exploited. The Aboriginal Peoples of Manitoba are no exception. The implications of this colonialism are of critical importance. First and



foremost, it is imperative that we understand the origins of this exploitation and colonization: for if we do not, any attempts to ameliorate the situation will be largely ineffective. We must, as Frideres (1998) articulates, analyze "Aboriginal-White relations and Aboriginal participation in our society by moving from a micro (individual) analysis to a macro (structural) analysis" (p.2). Micro models that focus on individual actions such as prejudice and discrimination *de facto* see changes in these individual actions as the solution, when in fact the "greatest obstacle is the very structure of our society itself, which prevents [Aboriginals] from effectively participating in the social, economic, and political structure of our society" (Frideres, p.3).

The original inhabitants of Canada are certainly not alone in becoming victims of the colonization process. Although many of the colonized countries in Africa and South and Central America experienced differences, "these do not obscure the fact that the indigenous peoples of Canada were unquestionably colonized and that their position in Canada today is a direct result of the colonization process" (Frideres, 1998, p.3). The following components comprise this process and are true of Canada. First, the colonizing country makes its way into an area through a "forced-voluntary" method. This has the colonizing group, acting in its own interests, forcing its way into an area. Second, the indigenous group's social and cultural structures are systematically ignored, violated and ultimately destroyed. In the case of Canada, government and religious groups - who saw the Aboriginal population as both inferior and in the need of salvation - worked in tandem to first protect, then civilize and finally assimilate the Aboriginal Peoples (Tobias, 1991). The third step sees the indirect rule of the conquered land. Until the 1940s, the Department of Indian Affairs and Northern Development (DIAND) determined which

Aboriginals could and could not leave the reserves. Although certain bands were able to elect their own Chief and Council, the final authority still rested with DIAND. The fourth component of the colonization process is the Aboriginal economic dependence on White society. Nonrenewable resources such as oil, mineral, water and lumber are largely exploited by the non-Aboriginal population. Fifth, low quality social services such as health and education are available to the reserve population. In this arena we have seen an escalation over the years of social assistance recipients, crowded living conditions and alcohol abuse. The racist belief in the genetic superiority of the "Whites" and the inferiority of the Aboriginals is the sixth phase. And finally, a colour-line is established, thereby clearly distinguishing everything from skin colour to body structure. This allows the establishment of a plumb line for determining superiority and inferiority. "The ultimate consequence of colonization is to weaken the resistance of the colonized Aboriginals to the point at which they can be controlled. Whether the motives for colonization are religious, economic, or political, the rewards are clearly economic" (Frideres, 1998, p.7).

As Europeans became more adept at living in what was to them, a hostile land, the Aboriginal became less important. When Indian war power was no longer needed, their usefulness diminished. And when the buffalo disappeared from the Canadian Prairies toward the end of the 19<sup>th</sup> century, the Aboriginal fate was sealed (Friesen, 1984). Unable to participate in the structure and technology of the economy, the Aboriginals became economically redundant leading them to a "culture of poverty". As can be clearly seen by the three women in this study, "when the goals of higher status are denied to people, other forms of adaptation are created - for example, withdrawal and rebellion - in order to deal

with the despair and hopelessness that are central to the culture of poverty” (Frideres, 1998, p.8).

The residential school system was one tool in the government's goal to “civilize” the Indian, eventually assimilating him, thus eradicating both Indian culture and identity. In fact, an act of legislation, passed in 1850 in the colonial assemblies defined who an Indian was, thereby establishing “a precedent that non-Indians determined who was an Indian and that Indians would have no say in the matter” (Tobias, 1976, 129).

As has been stated, both Britain and her colonists believed that a successful British Empire required the creation of trade relations; namely furs, slaves and skins in exchange for liquor (Mancall, 1995). The French were no exception. The threat of severe punishments by both church and government did little to stem the traffic of alcohol (Daily, 1968).

Although blame for the abuse of alcohol among Aboriginal Peoples has shifted over the years from the “white man” to Aboriginal bio-physical makeup to a need to confirm “Indianness”, the one constant is an overrepresentation in Aboriginal alcohol abuse related issues. The Royal Commission on Aboriginal Peoples (1996) concluded that “Alcohol is the addictive substance presenting the greatest number of problems to Aboriginal people and communities in Canada.” The National Native Association of Treatment Directors estimates “about 80 per cent of [A]boriginal people in Canada are affected by alcoholism” (Fournier & Crey, 1997, p. 174). As the Report of the Aboriginal Justice Inquiry (1991) states, Aboriginals account for one-half to two-thirds of the inmate population in Manitoba correctional institutions, even though they account for only 12 per cent of the provincial population. And although few formal FAS/E studies

have been completed in this country, those that have indicated a much higher Aboriginal incidence than in the mainstream (Fournier & Crey, 1997, p.178).

As Green (1989) notes, most pre-contact Aboriginal societies valued women and their work. However, the ravages of colonization and changed social roles have meant that "the European model of the patriarchal family is now normative in most Aboriginal communities [and] the dominant society's low valuation of women and women's work has been laid over Aboriginal values" (p.112). She goes on to state that 80% of Canadian Aboriginal women experience physical, sexual, psychological or ritual abuse. They are not only victims of violence by Aboriginal men but their voices go largely unheard in the male-dominated world of politics (p.112).

The effects of being undervalued, marginalized and abused have taken their toll on the Aboriginal women in this country. As one example, an Aboriginal woman in Winnipeg recently gave birth to her eleventh child affected by alcohol; the previous ten had all been apprehended at birth by Child and Family Services (Executive Director of Interagency FAS, Personal Communication, 1997). Another Aboriginal woman from Winnipeg recently had her fourth consecutive child apprehended by Child and Family Services. She had named each of them Keith (Kathy Jones, 1997, Personal Communication).

Although I agree that there are definitely times when a mother is incapable of providing an appropriate nurturing environment for her infant, we must work harder at keeping mother and child together. Women, from whom power and self worth has been stolen, still retain the ability to give birth. "Take my child away and I will do whatever I can to replace it." Naming all of her children Keith is a clear example of what a woman

will do when her children are taken away from her. So too is the woman who continued to have children despite apprehension after apprehension. These are not women who drink while pregnant because they don't care about their fetus. In fact, I believe it is precisely the opposite. A child is so important to them, that, despite the pain they suffer in losing their child to CFS at birth, they become pregnant again.

Crucial to the three women reconnecting to themselves and to the world around them was breaking free from the long arm of colonization. As Susan recalls, sobering up was like "coming into another completely different world . . . sobering into a life I did not know. So it was hard and like, when I sobered up, I kind of sobered up into that kind of identity." This new identity involved breaking free not only from alcohol, but also from self-degradation. For all three women it involved a connection to their own identity.

The factors that contributed to Susan's loss of her identity also led her to drink throughout her pregnancies. Those that led Susan to connect to herself and the world around her were structural in nature. The numerous detox centres and mental institutions she attended were micro and individualistic and did not effectively alleviate her pain or move her toward connection. For Susan, it was knowledge that made the difference: the knowledge that she was not a "dirty Indian". She needed to come to a place where she felt she had a legitimate place in society at large. As she began to forgive herself, she realized that her loss, pain and suffering could serve a useful purpose. Susan obtained her knowledge primarily by her time at university. Here she learned of her People's colonial past. Here she began to understand the impact residential schools had upon her mother. This enlightenment allowed Susan to not only ameliorate her own situation, but -through a transfer of knowledge -her mother's and children's as well.

Ironically, the impetus for Susan, Agnes and Debra to begin on their healing journey involved their love for children: ironic in that the perception that women who drink during their pregnancy do not care about children is completely undermined. Susan's epiphany came when she "discovered" she had three beautiful children. Agnes' occurred when she got a job with CFS and began working with families. Her love of children so affected her that, as a great-grandmother, she continues to foster a child. Debra quit drinking the day she found out she was pregnant. Her children are the most precious things in the world to her. As with the stereotype of a birth mother's lack of concern for her fetus, gone too must be other related assumptions about mothers who drink while pregnant. If they cared, the thinking goes, they would choose to stop drinking once aware of their condition. This line of thinking makes two crucial presuppositions: one, that they are aware of the damage they may be causing their fetus, and two, that they are in a position to make a choice.

Not all women yet know about the consequences of drinking while pregnant. However, once women are properly informed, the vast majority either reduce their alcohol intake or opt for total abstinence. Information and education about FAS/E is the first line of defense against the proliferation of children affected by alcohol in utero. For many Aboriginal women – already wary of so-called Western medicine and its doctors – it is critical that the information be presented by someone whom they trust and in a way that makes sense to them. For the small percentage of women who, despite being informed, continue to drink during their pregnancy, efforts must be made to employ a different and more effective delivery of this crucial information. Tested and proven mentorship programs such as the Seattle Model (Grant et al., 1995) need to be explored

and adapted to suit the needs of the particular women in question. In this model, women who have already experienced much of what the birth mothers in the program have are used as mentors. These are women who may be recovering alcoholics and/or mothers of alcohol affected children themselves. These are women who can be trusted because they have already “walked the walk”. Individuals with empathic skills, who can comprehend the depths of despair to which one must be at in order to continue to destroy oneself and one's fetus, are critical in helping to heal these birth mothers.

FAS/E information packages that condemn women for their drinking must be examined, as they may be encouraging women - who may already hate who they are and what they do – to continue drinking. As stated, once the information on FAS/E has been presented and understood, almost all women will either reduce their alcohol intake or abstain completely. The bigger challenge is to effectively work with women like Susan, who, despite “knowing” the risks, continue to drink throughout their pregnancy.

Greater understanding as to why certain women – regardless of the information they may have been given on FAS/E – drink throughout their pregnancy, must be a priority. Ignorance around issues of “choice” must be eliminated. There comes a time in people's lives when choice ceases to be an option. Referring to addicted drug users, Young (1994) asserts that “by a series of her acts, her drug dependence has become a condition, which she is in rather than something she does. Criminal law should punish people for acts, not conditions” (p.37). Along with this understanding comes compassion, not condemnation. These women do not have to be told that what they are doing is “stupid”. They do not have to be told that they are “bad women” because they are drinking. They are all too aware of how “bad” they are. It is precisely this

“knowledge” that are “bad” that may encourage them to continue drinking despite the warnings. For some women, drinking may be the only thing that is preventing them from committing suicide. In these cases, it is the “best” thing they can do for their child.

If we can no longer simply blame mothers for children affected by alcohol, it behooves us to look for other causes that, although may be harder to pinpoint, will nevertheless provide invaluable insight into the root cause(s) of FAS/E. What I have discovered in my research is that the causes of FAS/E are at the root of a host of social problems confronting the Aboriginal community at large: whether that be gambling, poor education, lack of self esteem, teenage pregnancies, high suicide rates or low employment. The fact is that many of the social ills confronting the Aboriginal community are symptoms of an underlying malaise that has its origins in colonization. We must stop applying Band-Aid solutions to these complex issues. Treating the symptom is not effective. It will not help eradicate the root cause. Detox centres that do not address the cause of the drinking are seldom successful. Individuals that attend simply return to the dysfunctional environment that helped cause their drinking problem. Taking a child away from a woman at birth does nothing to help her deal with the issues surrounding her inability to effectively parent.

I believe that regardless of the particular social ill effecting Aboriginal communities I chose to examine, my conclusions would have been the same. Aboriginal people that suffer from these problems, or those who have given birth to a child affected by alcohol, have all endured a similar past. Colonization has deprived them of something the majority of Canadians take for granted; a sense of belonging. They lack a reason to get up in the morning. They feel disconnected from themselves and from their



community. Indeed, their spirit has been colonized.

To blame is not to find the answer. The key is to find understanding, and then to move on. Too many Aboriginal people spend so much time "blaming" the "white man" for their woes, they have no time left over to begin to walk the healing road. As Susan discovered, at some point, each of us must take some of the responsibility for what has occurred. To gain understanding, education is crucial: especially historical education. Those women who have begun to heal inevitably have a keen sense of their own history. Context is crucial.

Governments today must shoulder more responsibility. Too often, governments in power are more concerned with the prospect of "five more years" than they are in tackling the real issues. Longitudinal studies that would examine the effectiveness of various programs for Aboriginal birth mothers remain difficult to fund. We cannot undo in a few years what it has taken several centuries to incur. Even if one chooses to look at only the economic side of the issue - at a cost to society of between 1.2 and 1.5 million dollars per child affected with FAS/E (RCAP, 1996) - it is crucial to look at other alternatives than those currently in use.

It is time to stop blaming and instead use our time, energy and resources to understand and end the ravages of colonization. Blaming is easy; truly looking for the causes and then finding the answers is not. Susan, Agnes and Debra have shared their stories because they wanted to make a difference. They wanted to demonstrate to both the Aboriginal and non-Aboriginal communities that the cycle of abuse, alcoholism and low self-esteem can be broken. It is anything but easy, but with greater understanding it can be made easier.

The simple answer as to why an Aboriginal woman would drink throughout her pregnancy is that she doesn't care about her fetus. This explanation requires a limited understanding of a complex issue and places the blame of alcohol affected children squarely on the shoulders of the birth mother. In reality, the issue of FAS/E is not simple, and requires increased awareness, education and understanding from all of us.

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## **APPENDIX**

**Chris Loewen  
168 Leighton Avenue  
Winnipeg, MB  
R2K 0J2**

May 6<sup>th</sup>, 1999

**Letter of Consent**  
***(Birth Mother)***

My name is Chris Loewen and I am a Masters of Arts student at the University of Manitoba working on my thesis. I am conducting a study that will i) help explain why a birth mother of children affected by alcohol would drink during her pregnancy, and; ii) examine the factors that have led to a higher prevalence of Fetal Alcohol Syndrome and Fetal Alcohol Effects in certain Aboriginal communities. Your role is to share some of your life experiences relevant to the study. This will be done through a set of three to five (3-5) audiotaped, in-depth interviews, lasting between one and one and one half (1 - 1 ½) hours each.

Your real name will not be used in the study, nor will the name of your community. You will be in control of the process at all times and may end your participation in the study at any time.

There is a possibility that I would like to share some of the information you have given to me in the course of the interviews with one or more of the other participants. I will only do so if you give me permission to do so.

I will be providing you with a summary of the results of the study as soon as they become available. If you require any additional information about the study, please feel free to contact my advisor, Dr. Zana Lutfiyya at the University of Manitoba at (204) 474-8285.

All the audiotapes used in the study will be transcribed and then kept in a safety deposit box at the conclusion of the study.

I have read the letter of consent and my signature below indicates that I understand what I have read and agree to its conditions.

---

Signature of the Participant

---

Signature of the Researcher

Dated the \_\_\_\_\_ day of \_\_\_\_\_, 1999.

**Chris Loewen  
168 Leighton Avenue  
Winnipeg, MB  
R2K 0J2**

May 6<sup>th</sup>, 1999

**Letter of Consent**  
***(Mother)***

My name is Chris Loewen and I am a Masters of Arts student at the University of Manitoba working on my thesis. I am conducting a study that will i) help explain why a birth mother of children affected by alcohol would drink during her pregnancy, and; ii) examine the factors that have led to a higher prevalence of Fetal Alcohol Syndrome and Fetal Alcohol Effects in certain Aboriginal communities. Your role is to share some of your life experiences relevant to the study. This will be done through a set of three to five (3-5) audiotaped, in-depth interviews, lasting between one and one and one half (1 - 1 ½) hours each.

Your real name will not be used in the study, nor will the name of your community. You will be in control of the process at all times and may end your participation in the study at any time.

There is a possibility that I would like to share some of the information you have given to me in the course of the interviews with one or more of the other participants. I will only do so if you give me permission to do so.

I will be providing you with a summary of the results of the study as soon as they become available. If you require any additional information about the study, please feel free to contact my advisor, Dr. Zana Lutfiyya at the University of Manitoba at (204) 474-8285.

All the audiotapes used in the study will be transcribed and then kept in a safety deposit box at the conclusion of the study.

I have read the letter of consent and my signature below indicates that I understand what I have read and agree to its conditions.

\_\_\_\_\_  
Signature of the Participant

\_\_\_\_\_  
Signature of the Researcher

Dated the \_\_\_\_ day of \_\_\_\_\_, 1999.

**Chris Loewen  
168 Leighton Avenue  
Winnipeg, MB  
R2K 0J2**

May 6<sup>th</sup>, 1999

**Letter of Consent**  
***(Child)***

My name is Chris Loewen and I am a Masters of Arts student at the University of Manitoba working on my thesis. I am conducting a study that will i) help explain why a birth mother of children affected by alcohol would drink during her pregnancy, and; ii) examine the factors that have led to a higher prevalence of Fetal Alcohol Syndrome and Fetal Alcohol Effects in certain Aboriginal communities. Your role is to share some of your life experiences relevant to the study. This will be done through a set of three to five (3-5) audiotaped, in-depth interviews, lasting between one and one and one half (1 - 1 ½) hours each.

Your real name will not be used in the study, nor will the name of your community. You will be in control of the process at all times and may end your participation in the study at any time.

There is a possibility that I would like to share some of the information you have given to me in the course of the interviews with one or more of the other participants. I will only do so if you give me permission to do so.

I will be providing you with a summary of the results of the study as soon as they become available. If you require any additional information about the study, please feel free to contact my advisor, Dr. Zana Lutfiyya at the University of Manitoba at (204) 474-8285.

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I have read the letter of consent and my signature below indicates that I understand what I have read and agree to its conditions.

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Signature of the Participant

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Signature of the Researcher

Dated the \_\_\_\_\_ day of \_\_\_\_\_, 1999.

### **Interview Guide**

In order to obtain the information required for this study, I will be documenting the life history of an Aboriginal birth mother of a child(ren) affected by alcohol in utero. Although I will be conducting in-depth interviews with i) the birth mother; ii) her mother, and : iii) her child(ren), increased attention will be given to the birth mother. I may conduct other interviews with relevant parties depending on the information obtained in the initial interviews.

I plan to follow the same general interview format for all the initial participants. The three main areas I intend to cover are i) the participant's personal history; ii) the significant influences (e.g. friends and family) on the participant and their experience with alcohol, and; iii) the participant's attitude and knowledge regarding Fetal Alcohol Syndrome and Fetal Alcohol Effects.

**i) The Participant's Personal History** - This phase of the interview will be used to discuss things that are non-threatening to the participant. Although I will be using an interview guide during the interview process, the structure will remain loose and will, in large part, be directed by the participant. My intent at this stage is both to make the participant feel at ease and to gather general information that will allow me to focus in on and formulate questions more specific to my research.

Probe questions may include the following:

- When and where were you born?
- What events in your life do feel to be the most significant? why?
- Tell me about your family. What are the names and ages of your siblings? What is each of them doing now?
- What was your childhood like?
- Were there events in your life that you feel were different or significant because you are Aboriginal?
- What was school life like for you? Were there any events that occurred that have had a major influence on your life?
- What do you know about the history of the Aboriginal people? Do you feel your peoples' history has had any effect on you? How?

**ii) The Influences (i.e. friends, family, other) on the participant and their (the participants') experience with alcohol** - Answers to the first phase of questions should provide me with the information necessary to ask more focussed questions (i.e. more specific to the research).

If the participant is or was a drinker.

- When did you first start drinking?



- What influences led you to begin drinking?
- Why did you continue to drink?
- Has alcohol always been a part of your family? your life? Did your siblings drink? uncles, aunts, etc.? Did your friends, acquaintances drink? Was peer pressure a factor?
- When did you stop drinking? Why?
- Do you feel there is a higher than average rate of excessive drinking on your reserve? If yes, why do you think this is so?

**iii) The participant's attitude toward Fetal Alcohol Syndrome/Effects.**

- What do you know about FAS/E? What causes it? Prevention? Intervention? Signs?
- Do you feel there is a higher than average rate of FAS/E on your reserve? If yes, why?
- What do you feel needs to be done to help diminish or eliminate FAS/E in your community?