

FASD and Aboriginal Peoples

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Context of this paper

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

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

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

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

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

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

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

Aboriginal cultural traits and FASD

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

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

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

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

The potential for misdiagnosis of FAS based on cultural traits, lack of confirmed consumption of alcohol, and association with the perception that FASD as an Aboriginal problem may contribute to the lack of recognition and diagnosis of FASD in non-Aboriginals who do not possess the same genetic phenotype and therefore exhibit different facial

appearances (pages 97, 102). This could mean rates are far higher in the non-Aboriginal population but remain undetected.

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

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

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