

**“Deconstructing Fetal Alcohol Syndrome:
A Critical Inquiry into the
Discourse Around Alcohol, Women, Ethnicity,
Aboriginals and Disease”**

by

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**A thesis submitted to
the Faculty of Graduate Studies and Research
in partial fulfillment of
the requirements for the degree of
Master of Arts**

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Ottawa, Ontario

April 21, 1997

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0-612-22077-X

ABSTRACT

An inductive methodology, known as grounded theory, was utilized in an attempt to inform, and challenge current theory and practice governing contemporary prevention efforts specifically targeting pregnant Native women. Various strands of the picture are filtered through a critical lens in an attempt to deconstruct the problematization of FAS within Aboriginal communities. The three primary strands identified were the relationships of alcohol to women; alcohol to ethnicity; and alcohol to Natives. The deconstruction of the problem of FAS yields implications on two levels: 1) epistemologically, the relationships between social control and language and discourse, and ideology, knowledge and power, are identified as being of concern, needing to be critically challenged and reconstructed ; and 2) on an applied level, it is argued that there is a need for a more comprehensive approach to prevention efforts, with clearly defined goals that are both culturally relevant and adopt a more holistic approach to prevention.

ACKNOWLEDGMENT

I am grateful to Flo Kellner and John Cove for their support, encouragement and sense of humour. Their insight into the various issues was invaluable, and their interest in the topic was extremely motivating.

To Carole Julien, at the Canadian Centre on Substance Abuse, for assisting me in my search for materials on FAS, making the research process considerably easier.

To my family for their continual support and assurance, and being there when I needed to take much needed 'study breaks'.

To Colin, for believing in me even when I did not believe in myself. Without you, this would have not been possible.

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INTRODUCTION

A drowning man is not separated from the lust for air by a bridge of thought - he is one with it - and my son, conceived and grown in an ethanol bath, lives each day in the act of drowning. For him there is no shore.
(Dorris, 1989:264)

For those individuals who have fetal alcohol syndrome [hereon referred to as FAS], or fetal alcohol effects [hereon referred to as FAE], every day can seem like an act of drowning. Reasoning is cloudy, as processes involving logic are disrupted. Behavior is aberrant and erratic, often resulting in condemnation on the part of bystanders. And for those less fortunate, physical abnormalities and deformities draw curious stares. For those individuals afflicted with FAS, a constant struggle is waged not only to understand, but to be understood. Life is an uphill battle, individuals with FAS never being afforded the luxury of coasting down the other side of the gradient.

Although FAS is being touted as a relatively recent 'discovery', in actuality it is more befitting to refer to the treatment of FAS in postmodernity as a 'rediscovery'. The negative effects of maternal alcohol consumption on the fetus have been recognized at least since the classical period, recognition of potentially adverse effects of alcohol on the developing fetus dating back to ancient Greek and Roman times (Abel, 1984). It is more accurate to say that FAS, a constellation of alcohol-related birth defects [hereon referred to as ARBD's], has been designated and so-named as a debilitating 'syndrome', for which there is no known cure. It is within the last twenty years that FAS has received much attention, the prevention of FAS becoming a timely issue.

The prevention of FAS within Native communities seems to address a very simple condition with a very simple, and straightforward cure: absolute abstention from the

consumption of alcohol on the part of pregnant Aboriginal women. FAS is clearly a permanent medical condition, caused by in utero exposure to alcohol via maternal drinking. But, because FAS is 100% preventable, through abstinence by pregnant mothers-to-be, there is concern, and bewilderment, as to why children are still being born afflicted with FAS despite the knowledge of how to prevent FAS in its entirety. In reality however, it is not that simple. There has been much debate over whether the prevention of FAS can be regarded as an economic, social, health, medical, or political problem. The ramifications of identifying FAS as belonging to one realm of concern versus another are of great significance. Current perceptions of FAS have adopted the notion that FAS is a health concern above all other interests. This has resulted in the medicalization of the discourse around FAS. However, the medicalization of the discourse around FAS can be construed as an attempt to depoliticize, and decontextualize a politically and morally sensitive issue. Despite such attempts, the prevention of FAS is still a problem with resounding political implications. As such, at the crux of this debate is the issue of social control of the less powerful by the more powerful, with practical implications for policies aligned around social control objectives.

There is growing concern, in particular, with respect to the incidence of FAS within many of Canada's Native communities. At the very best, the incidence of FAS appears to have plateaued; at the very worst, FAS rates are on the rise. Dorris (1989:158) states that "FAS is the most destructive thing to hit Indians since the European diseases five hundred years ago". Indeed, FAS has the potential to become a phenomenon that will have an extremely injurious, if not annihilative effect on Canada's Aboriginal population.

Accordingly, the prevention of FAS has been called for as a solution to high rates of FAS amongst Native children. However, the prevention of FAS within Canada's Aboriginal peoples is an extremely politically and morally volatile issue, which must be placed within a certain context: that of the historical and present-day oppressions and discriminations suffered by Canada's First Nations communities; and within the contemporary debate over maternal versus fetal rights. Such a contextualization results in an issue of monumental complexity, with subtle nuances. Many of these nuances lie hidden, yet to be explored and addressed. Other subtleties, already unearthed, appear to have been disregarded, having been dismissed as being of little importance. At worst, various aspects of the problem have simply been ignored. Regardless, the many complexities must be included and addressed, otherwise any efforts to prevent FAS will be rendered ineffective, and will be fundamentally discriminatory.

Logic would suggest that the legacy of FAS is a recurring phenomenon, heightening the gravity of the situation faced by many Native communities. A predominant pattern is the tendency for FAS children to grow up and have more FAS children. As expectant adult women with FAS, the connection between drinking during pregnancy and the possibility of harming the fetus, and consequently bearing a child afflicted with FAS is beyond the realm of understanding. Due to cognitive impairment, women with FAS are unable to relate the here-and-now with long-term consequences, making it that much more difficult to effectively educate and counsel FAS women who are at risk for bearing FAS children. And thus, FAS becomes chronic, the legacy of colonial introduction of alcohol to

Natives; Aboriginal children with FAS are “victims of victims in an endless linkage that’s been smithed by history, by racism, by economics, by bad luck” (Dorris, 1989:193).

However, it has been theorized that the prospect of a dismal future does not have to be written in stone. Prevention, as a means of breaking the cycle has been posed as a viable solution. Simply put, prevention revolves around the assumption that, if women *do not* drink alcohol while pregnant, *no* children will be born with FAS. Nonetheless, the potentiality of prevention has yet to be realized in actuality. Speculations might be raised as to why FAS remains problematic. On a practical level, the goals of prevention are unclear, being overridingly ambiguous in nature. On a more theoretical level, the conceptualization of prevention, in itself is problematic. What does prevention mean? It means different things to different people and different groups. For some, prevention entails advocating for total abstinence by pregnant women; while for others, moderation may be the intended goal. Finally, on an epistemological level, numerous coexisting discourses in circulation appear to converge at the discourse around FAS. This intersection of discourses has resulted in an ideologically racist, sexist and classist discourse, riddled with assumptions, myths and stereotypical images of the relationship between alcohol, Natives, women and pregnancy. Consequently, the notion of prevention as little more than an enigma resonates throughout this project, leaving little doubt as to why prevailing prevention efforts are sadly lacking. Prevention is supposed to circumvent an occurrence, acting as a hindrance before it has an opportunity to manifest itself. Indeed, “the very idea of primary prevention means getting there *before* the disease process starts” (Zola, 1994:196). Prevailing efforts aimed at the prevention of FAS within Canada’s

Aboriginal communities, then, cannot be regarded as prevention in its truest form. Such efforts are essentially addressing the occurrence of FAS after-the-fact, attempting to arrest the incidence of FAS before it grows to even larger proportions.

At this point, it might be useful to picture a funnel, around which the various aspects of the problems surrounding FAS and its prevention, alcohol, women, Natives, and disease, just to name a few, are circling. As we funnel through the various elements, the picture is clarified; at the extreme end of the funnel we arrive at FAS as a gendered issue, intensified in the case of Native women due to their status as members of a minority. It is through this funneling process, by which the plethora of ambiguities in existence with regard to drinking are examined, and the rhetoric and discourse around the prevention of FAS, are critiqued and challenged. This funneling process then, is to be the central focus of this project, where the issues around the prevention of FAS amongst First Nations peoples are raised and discussed at length.

In an attempt to address the various issues around FAS and prevention, they have been organized and presented within the following framework. In Chapter 1, an overview of the literature on FAS is performed, attempting to discern what is known and what is not known about the phenomenon of FAS, as presented in contemporary formal academic literature. Chapter 2 outlines the methodology utilized in this research project. *The Discovery of Grounded Theory: Strategies for Qualitative Analysis* (1967) by Barney G. Glaser and Anselm L. Strauss; and *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory* (1978) by Barney G. Glaser provide the basis for a qualitative analysis of the literature around FAS. Chapter 3 contains a review and evaluation of some

of the available pamphlets to professionals and laypersons about alcohol, pregnancy, and FAS. Bredemeier and Stephenson's *The Analysis of Social Systems* (1976) provides a classificatory system by which the pamphlets can be categorized as either cognitive, evaluative, or cathectic.

Chapters four through six report the results of the codification and categorization of the existing literature in the following manner: Chapter 4 examines the relationship portrayed within current literature between alcohol and women; Chapter 5 investigates the relationship between alcohol and ethnicity; and Chapter 6 narrows the focus of the previous chapter, centering on the relationship between alcohol and Natives found to exist in contemporary literature. Chapter 7 is an application of the ideas addressed in Chapters four through six, to the situation of pregnant, alcohol abusing Native women. It is in this chapter that the core variable is identified as being social control. Thus, the results of this research project are found to be informing theory on social control, and therefore, possess certain implications for future social control policies.

Chapter 8 is comprised of a theoretical overview of the predominant conceptualization of prevention. Using Toulmin's *The Uses of Arguments* (1958) as a framework for analysis, the claim that 'FAS is 100% preventable' is assessed and evaluated to be a socially constructed claim. Several key points made in the previous chapters are brought together in support of this argument. Finally, Chapter 9 addresses the implications of the deconstruction of FAS as a medicalized problem, for policies of social control in the name of prevention, in both epistemological, and practical spheres of consideration.

The value of an exploration of current efforts to prevent FAS within Aboriginal communities is of great significance, the contributions of this thesis being threefold. First, this dissertation serves to inform current policy and programs designed to prevent FAS within Canada's First Nations peoples. This thesis also serves to inspire and guide future considerations for the content of policy and programs with the goal of prevention. Finally, for sociology, the exploration into the prevention of FAS serves as a focal point which directs not only the examination of the position of women, minorities and Aboriginals, but further serves to criticize and challenge existent positioning, and consequential treatment of such groups.

CHAPTER ONE: WOMEN, ALCOHOL, PREGNANCY, AND FETAL ALCOHOL SYNDROME - FACT VERSUS FICTION

There has been massive literature published over the last quarter century on the relationship between alcohol, pregnancy, and FAS. Indeed, “since 1973 more than 2,000 scientific articles have appeared in the medical literature documenting the adverse effects of maternal alcohol consumption on the developing fetus” (Blaze-Temple et al., 1992:32). This number does not include the numerous books and articles about women, alcohol, and pregnancy written in the context of other fields of interest, including sociology, psychology, and social work, just to name a few. As well, numerous pamphlets, films, and videos have been created, dealing with the subject of maternal alcohol consumption and FAS. And, with the advent of modern technological advances, details about drinking, pregnancy, and FAS can be found on ‘the information highway’; a website dedicated solely to the topic of FAS is available on the Internet.

The information available to the public at large is problematic. It is extremely difficult to determine what information can be regarded as factual, and which information is merely epic in nature, fundamentally comprised of unsubstantiated ideas and claims, and informed by ideology rather than evidence. The content of this chapter is dedicated to distinguishing what is known from what is not known about the maternal consumption of alcohol during pregnancy; to discern fact from fiction.

The Known

Much content of the literature can be regarded as factual in nature. Thus, to begin, what is known about FAS, and effects of maternal consumption of alcohol during

pregnancy will be presented. The information contained within the literature will be discussed under the following headings: Alcohol as a Teratogen; Alcohol as a Cofactor of Birth Defects; What is FAS?; The Risk of FAS; Abstention as Prevention and The Universality of FAS.

Alcohol as a Teratogen

”Since Roman and Greek times, alcohol intoxication at the time of conception has been linked with skeletal and mental defects in offspring” (Graham-Clay, 1983:2). It is known that FAS is an alcohol-related birth defect (AADAC, 1994:1). ”FAS is due in some way to the effects of *in utero* ethanol exposure” (Graham-Clay, 1983:3). Thus, the consumption, absorption, and distribution of alcohol during pregnancy has an impact on not one, but two organisms: the mother, and the unborn fetus.

The principles of teratology may be extremely useful in understanding how FAS occurs as a result of maternal drinking. Teratology is “the study of congenital malformations induced in the fetus as a result of exposure to exogenous agents” (Cooper, 1978:322), such as chemicals, viruses, irradiation, and/or drugs. Alcohol is a known teratogen (Canada’s Drug Strategy, 1995:6; Schroeder, 1994:30; Michaelis and Michaelis, 1994:17; Loock, n.d.:1), which can best be defined as: “a substance which, when given to a pregnant woman, can produce a specific pattern of birth defects in her baby” (Canada’s Drug Strategy, 1995:6). Hence, there is a teratogenic risk to the fetus associated with alcohol use during pregnancy.

Cooper (1978:325) outlines some basic principles of teratology, stating that the possible occurrence of congenital malformations is dependent upon the interaction between four primary factors: 1) the nature of the teratogenic agent; 2) the time of the agent's action; 3) the level and duration of the agent's dosage; and 4) genetic constitution (of both the fetus and the mother). The teratogenic effects of alcohol on a developing fetus are dependent on nine identified factors (Canada's Drug Strategy, 1995:6; Michaelis and Michaelis, 1994:17): 1) the amount of alcohol consumed; 2) the frequency or pattern of consumption (i.e. daily versus bingeing); 3) when during the pregnancy the alcohol is consumed; 4) the genetic susceptibility of the fetus; 5) the age of the mother (the older the mother, the greater the risk of damage to the fetus); 6) maternal metabolism; 7) mother's general health; 8) mother's state of nutrition; and 9) maternal use of other drugs.

Cooper (1978:325) presents several factors which have a bearing upon the transfer of alcohol/drugs across the placenta, in conjunction with the kind and degrees of intake of alcohol by the mother. First, lipid solubility is a factor, as substances with a higher degree of fat permeate the placenta more readily. A second factor has to do with drug ionization, as there is a higher permeability if the substance is in an un-ionized state. Thirdly, placental blood flow plays a role in the transfer of substances across the placenta; the transfer of substances is proportional to the placental blood flow [fetal blood circulation is also a factor]. A fourth factor is the placental metabolism, as many therapeutic chemicals can be metabolized by placental enzymes. A fifth factor is the molecular weight of a given compound, as compounds with a molecular weight of less than 600 can easily cross the

placenta; those compounds exceeding 1000 do not. And finally, placental aging has direct bearing on the diffusion of substances across the placenta.

Most therapeutic drugs, including alcohol, weigh between 250-400. Consequently, because alcohol molecules weigh less than 600, they can easily pass across the placenta. Engelmann (1993:7) makes an important point, stating that all forms of alcohol are equally harmful to the fetus: spirits, beer, and wine (coolers). However, in relation to lipid solubility, if one were to consume foods with a higher concentration of fat than alcohol *before* the consumption of alcohol, this could, in theory, slow down the diffusion of alcohol across the placenta.

In relation to placental blood flow "the fetus eliminates alcohol at approximately 50% of the adult rate through passive diffusion back through the placenta" (Graham-Clay, 1983:3). Thus, alcohol could be in the fetus's system for up to twice as long as the alcohol is in the mother's system. Graham-Clay (1983:3) cites several studies (Abel, 1980; Hanson, Streissguth, and Smith, 1978; Randall and Blum, 1977), in which she suggests that "ethanol passes from mother to fetus through the placenta, and the fetal alcohol concentration is approximately equal to maternal concentration". Thus, not only is the alcohol in the fetus' system for twice as long as the mother's, but the alcohol concentration is at the same level as the mother's. Additionally, as the placenta matures, it decreases in thickness, which may lead to both faster and easier diffusion of alcohol molecules into fetal circulation.

Alcohol as a Cofactor of Birth Defects

Alcohol is one of the many “cofactors” (Abel and Sokol, n.d.:160; Graham-Clay, 1983:3) related to the possible risks of bearing a child with (a) birth defect(s); other factors identified include: social class/poverty, maternal illness, physical stress, genetic susceptibility, smoking, diet (undernutrition), past health history, pregnancy complications, use of drugs, and exposure to environmental pollutants. However, the specific degree of prenatal growth deficiency and pattern of malformation have not been previously recognized in offspring to mothers who were undernourished, but not consuming alcohol (“alcoholics”) during pregnancy (Jones et al., 1973:1270). Prenatal growth deficiency in the infant was more pronounced in terms of lack of height than weight, which is in direct contrast to typical results from maternal undernourishment, where the infant is usually underweight for their length (Jones et al., 1973:1270). Accordingly, “alcohol has been isolated as the cause of FAS” (Northwest Indian Child Welfare Association, 1993:21).

What is Fetal Alcohol Syndrome?

So what exactly is FAS? FAS consists of a set of symptoms in each of three areas (AADAC, 1994:1; Graham-Clay, 1983:2): 1) slowed growth: microencephaly (small head circumference) and pre-natal and post-natal weight and height are below average/normal; 2) craniofacial characteristics that are abnormal: short palpebral fissures (openings between eyelids), long mid-face, vertical groove between nose and upper lip is flattened, thin upper lip, cleft palate, and flattened upper jaw bone; 3) damage to the brain: retarded

psychomotor development and low intelligence; the child may not develop and /or behave as other children do.

The extent of prenatal damage to the unborn child is on a continuum (Graham-Clay, 1983:3; AADAC, 1994:1; Schroeder, 1994:31; Blaze-Temple et al., 1992:32). "Research clearly shows that heavier drinking increases both the likelihood and the severity of damage to the fetus" (AADAC, 1994:1). Graham-Clay (1983:4) states that "the degree of retardation varies from mild to severe, and a direct relationship exists between the degree of retardation and the severity of FAS". And finally, attention must be paid to the fact that the symptomology of FAS is not only, irreversible, but permanent as well (Engelmann, 1993:7). Indeed, the Northwest Indian Child Welfare Association (1993:3) suggests that when a mother ingests alcohol while pregnant, the result is permanent physical, emotional, and mental damage to the child.

The Risk of FAS

"Alcohol can damage the developing fetus during the entire pregnancy" (Schroeder, 1994:31). Michaelis and Michaelis (1994:32) outline the stages of fetal development, which is divided into two major periods: 1) the embryonic period - up to eight week of gestation; and 2) the fetal period - from eight weeks to delivery. In particular, "drinking during very early pregnancy increases the chance of having an infant with a birth defect from 2% to 19%, almost a one in five chance" (Schroeder, 1994:39). Michaelis and Michaelis (1994:32) support Schroeder's contention, stating that "it is during the embryonic period that malformations are readily produced by various drugs

introduced directly into the maternal bloodstream or administered through the maternal diet". Streissguth et al. (1990:663) have concluded that is during "organgogenesis" that the risk of teratogenic effects is most critical. Yet, this is often the point at which women are either unaware that they are indeed pregnant, or have yet to alter pre-pregnancy drinking patterns in light of being pregnant. However, Canada's Drug Strategy (1995:7) advocates that "a reduction in alcohol intake at any point during the pregnancy will reduce risk to the fetus" The Northwest Indian Child Welfare Association (1993:9) supports this notion, stating that if a pregnant woman drinks, a reduction in the amount of alcohol consumed will greatly reduce the risk of harm to the fetus.

Abstention as Prevention

It is a well-supported contention within the literature that ARBD's, FAS in particular, are completely preventable (Engelmann, 1993:9; Canada's Drug Strategy, 1995:7; Graham-Clay, 1983:5; Northwest Indian Child Welfare Association, 1993:4; May and Hymbaugh, 1989:508; Voutier, n.d.:ii). If a mother abstains from alcohol use during her entire pregnancy, she will not bear a child afflicted with a birth defect that can be attributed to in utero alcohol exposure. The Northwest Indian Child Welfare Association (1993:4) goes one step further on the road to abstinence, advocating for abstinence not only during pregnancy, but also during the period where the infant will be breast-fed.

The Universality of Fetal Alcohol Syndrome

Children born with FAS “come from all socioeconomic levels and ethnic groups and may live in any type of community” (Engelmann, 1993:8); regardless of age, race, ethnicity or social status, there is risk of harm to the fetus associated with alcohol consumption during pregnancy (Canada’s Drug Strategy, 1995:7). FAS knows no boundaries, and is not discriminating in whom it affects. However, “American Indian communities are especially affected [by FAS] due to the high rates of alcohol and drug abuse” (Northwest Indian Child Welfare Association, 1993:3).

The Unknown

Despite what is known to be the truth about FAS, there is still much information that is open for contentious debate among professionals and laypersons alike. This questionable information is presented as fact within the literature. However, it is fundamentally comprised of unproven, and often conflicting assertives, distorted to give the impression of truth. As such, the dubious information contained within the literature will be discussed under the following headings: Risk Perception; Safe Levels and Safe Times for Alcohol Consumption; ‘Light’ versus ‘Heavy’ Drinkers and FAS; Average versus Absolute Measures; The Incidence of FAS; Paternal Health and FAS; and Natives, Alcohol, and Fetal Alcohol Syndrome.

Risk Perception

Morris et al. (1994:135) refer to “risk literature”, from which useful notions about use of alcohol by pregnant women might be contextualized including: ‘perceived risk’; ‘uncertainty’; ‘consequences’; and ‘risk acceptability’. Perceived risk refers to the beliefs of an individual about the hazardous nature of a given product; risk acceptability is the interpretation of the given risks, leading a decision to use, or not use, the product. Both of these are subject to differential perceptions at the level of the individual, with respect to the uncertainty of the consequences of using a given product. However, Morris et al. (1994:135) state that ”risk perceptions do not necessarily forecast judgments about a product’s use”. Thus, even if there is a perceived risk of using a product, the risks being both recognized and understood, an individual may elect to use a product despite knowing the associated risks.

Morris et al. (1994:136) write that “several studies suggest that drinkers and abstainers may have different perceptions of the risks of consuming alcoholic beverages during pregnancy”. This may be due largely to the fact that theory does not necessarily coincide with reality; “drinkers may know that consuming alcohol is factually related to fetal alcohol syndrome or fetal alcohol effects. However, they may recall examples of women who consumed alcoholic beverages during pregnancy, yet gave birth to normal children” (Morris et al., 1994:142). Thus, FAS is seen only in some, not necessarily all, children born to women who consumed alcohol during their pregnancy (AADAC, 1994:1).

“It is very difficult to predict outcome or state why some children are more affected than others” (Canada’s Drug Strategy, 1995:6) as “the exact mechanism by which ethanol exposure produces its deleterious effects is still largely unknown, and is open to much speculation” (Graham-Clay, 1983:2). Abel and Hannigan (1995:455) hypothesize that the variability of alcohol’s teratogenic effect on the developing fetus is a result of external permissive factors, which in turn contribute to internal provocative changes. Permissive factors identified by Abel and Hannigan (1995:455) include behavioral patterns of alcohol consumption, low SES, ethnicity and cigarette smoking. These external conditions, it is hypothesized, result in internal conditions, such as high peak blood alcohol levels, poor nutrition, high levels of stress, and increased susceptibility to pollutants. These internal conditions are regarded as ‘provocative’ because they “provoke cellular changes which enhance alcohol’s toxic actions” (Abel and Hannigan, 1995:455). Consequently, Schroeder (1994:33) concludes that “like any teratogen, alcohol does not affect all exposed to it”; hence, maternal use of alcohol during pregnancy is only a risk, as the alcohol may not have had any effect on the unborn fetus (Northwest Indian Child Welfare Association, 1993:21).

The Northwest Indian Child Welfare Association (1993:9) states that “the more you drink, the greater chances you take with your baby’s health”. However, even women who are recognized to be severe alcohol misusers, bear children that are not afflicted with FAS. Graham-Clay (1983:3) asserts that “not all infants of chronically alcoholic mothers develop clinically recognizable FAS”; only 32% of alcoholic women bear children afflicted

with FAS. It must be heeded however, that it is only a *risk*, not a *certainty*, that in utero exposure to alcohol will result in a child being born with FAS.

Safe Levels and Safe Times for Alcohol Consumption

It is unknown what, if any, “safe” levels of consumption of alcohol during pregnancy exist (AADAC, 1994:1; Canada’s Drug Strategy, 1995:7; Northwest Indian Child Welfare Association, 1993:9; Loock, n.d.:1; Peterson and Lowe, 1992:613; Weiner et al., 1989:386). Schroeder (1994:30) affirms that “new research indicates that there is no “absolute” safe minimum dosage of alcohol”. This conclusion is largely based on the idea that “what might be a “safe” level (producing no birth defects) in one woman would not be a “safe” level for another woman” (Schroeder, 1994:30-31). As such, it is an extremely difficult, if not impossible task to estimate just how much alcohol is “too much” (Graham-Clay, 1983:3). Moreover, Koren et al. (1996:161) assert that “it is unknown whether a threshold effect exists or whether a dose-dependent relationship continues to very low amounts of drinking”.

In addition, there is no known “safe” time during a pregnancy which women can drink alcohol without harming the developing fetus (AADAC, 1994:1); “safe” periods for drinking during pregnancy have not yet been identified in any of the existing clinical literature (Graham-Clay, 1983:3). It is believed that “one occasion of “too much” alcohol at a *critical point* [emphasis added] in fetal development may cause damage” (Northwest Indian Child Welfare Association, 1993:21). Graham-Clay (1983:4) contends that binge-drinking may be equally as harmful as consistent alcohol consumption throughout the

pregnancy to the unborn fetus, depending on the stage of the pregnancy at which the binge occurs.

Consequently, most doctors tell women not to drink at all if they are pregnant (AADAC, 1994:1; Schroeder, 1994:30, Knupfer, 1991:1063). In adopting a “conservative stance concerning advice to both the public and professionals” (Blaze-Temple et al., 1992:32), prevention efforts err on the side of caution, just to be safe, in an attempt to alleviate the risk of potential, but not guaranteed, harm to the fetus. The assumption is made that “no amount is safe” (Engelmann, 1993:7; Schroeder, 1994:30), and the advice conveyed to society reflects this assumption. However, this message has been described by Koren et al. (1996:156-157) as being too ‘hard line’, criticized for being unduly alarming, as it implies that even one drink can cause harm to the developing fetus.

Knupfer (1991) states that within the health promotion field, ‘prevention’ has been taken one step further, the suggestion being made that pregnant women not consume alcohol for some time *before* they become pregnant. Blaze-Temple et al. (1992:33) refer to women’s drinking as “responsible drinking”; this notion embodies the idea that women are deemed to be responsible, within the bounds of the maternal role, for not only their welfare, but the welfare of the fetus as well. For that reason, women are expected to heed all warnings of potential harm, to err on the side of caution, and not to consume alcohol while pregnant. This advice is proffered to expectant mothers, despite the fact that harm to the fetus is only a potentiality, not a certainty.

'Light' versus 'Heavy' Drinkers and Fetal Alcohol Syndrome

An ongoing debate within the literature is whether FAS is solely a phenomenon attributable to women who either drink heavily, or are chemically dependent [alcoholics]. On the one hand, Cooper (1978:330) states that infants with FAS are born to mothers who are alcoholics. Cooper (1978:330) defines an 'alcoholic' as someone who "imbibes alcohol-containing drinks regularly and in large quantity". Cooper (1978:328) goes on to suggest that "the majority of infants born to mothers who use alcohol only moderately do not manifest the syndrome". However, "not all alcoholic women give birth to children with the syndrome" (Abel, 184:219). Contrary to the predominant presumption that only women who misuse alcohol bear children afflicted with FAS, is the notion that women who bear children afflicted with FAS are not necessarily chemically dependent (Engelmann, 1993:8). Apparently, "occasional" and/or "moderate" drinkers also run the risk of bearing children with FAS. Indeed, the Northwest Indian Child Welfare Association (1993:21) asserts that "it is dangerous to think that only alcoholic mothers place their unborn babies at risk". The findings of a study done by Streissguth et al. (1990:667) support the contention that moderate drinking can be harmful to the developing fetus, claiming that "the present study is the first to link learning problems in young school aged children with social drinking during pregnancy".

The notion that light drinking produces fetal damage is responded to, and denounced by Knupfer (1991), Abel (1996), and Abel and Sokol (n.d.). Knupfer (1991:1065) states that upon review of vast amounts of research, she had "not been able to find any good evidence showing that light drinking by the mother presents a risk to the

foetus”; ‘light’ drinking being circumscribed as two drinks per day (Knupfer, 1991:1064). Abel and Sokol (n.d.:161) support this contention, stating that “we know of no evidence to suggest that this amount consumed occasionally, e.g. once or twice a week, will cause bad things to happen to unborn babies”. To Abel and Sokol (n.d.:161), “social” drinking is equated to two drinks (containing 1 oz. of absolute alcohol), consumed by a 140 lb. individual, over a two hour period, resulting in a BAL of less than 0.04%. In defence of light/social drinking by women while pregnant, Knupfer (1991:1072) proposes that “should this pattern of drinking cause foetal damage, entire populations would be affected, which we suspect not to be the case”. Abel (1996:151-152) maintains that “studies reporting significant effects of levels of alcohol typically refer to biological effects so small as to be meaningless (e.g. a decrease in birth weight from 3500 to 3400 g)”. Another apparently meaningless difference might then, also be a decrease in a child’s IQ by one or two points, which are attributed to in utero exposure to alcohol.

What appears to be a root cause of the debate, is the lack of consistent, and use of sometimes conflicting, definitions and criteria by researchers when studying alcohol use. Problematic terms include the notions of “occasional”, “moderate”, “light”, and “social” drinking (Abel and Sokol, n.d.:161; Knupfer, 1991:1064; Streissguth et al., 1990:667). There appears to be a general lack of consensus with respect to the terminology utilized; indeed, definitions and/or criteria often arbitrary in nature. Such ambiguity might well be a principal cause of contention within the literature.

Average versus Absolute Measures

A major problem in alcohol studies appears to be the use of problematic measures. Knupfer (1991:1064) problematizes the results of studies where *average* amounts of alcohol consumed per day are used. She suggests that the notion of 'average' should be regarded as suspect, as it "does not provide a realistic description of a drinking pattern" (Knupfer, 1991:1064). There is no demarcation made between binge drinkers versus consistent [daily] drinkers, as the use of the term 'average' "does not differentiate between those who drink a little every day and those who drink a lot once a week" (Knupfer, 1991:1072). A more useful measure might perhaps be an 'absolute', rather than 'average' measure of alcohol consumed. Indeed, Abel (1996:153) addresses this issue, suggesting that "the evidence is clear that there is no apparent risk to a child from exposure to one drink per day - not an average, but a true single drink per day containing 13 g of alcohol".

Another problem identified within the literature is the validity of self-reports. "There is no practical objective way of knowing how much anyone drinks" (Abel and Sokol, n.d.:159), as alcohol is a self-prescribed drug. How much alcohol is in a "drink"? It is highly unlikely, that, unless an individual is imbibing alcohol in a bar setting, the alcoholic content of a beverage is being measured. The more likely scenario is the consumption of unknown amounts of alcohol. As such, self-reports are dubious at best, especially if the individual consuming the alcohol is abusing alcohol, in which case they are likely to under-estimate the amount of alcohol ingested. Abel and Sokol (n.d.:159) go one step further, and suggest that "self-reports of drinking during pregnancy are always suspect".

The Incidence of Fetal Alcohol Syndrome

Another 'unknown' is the frequency at which FAS occurs in children of mothers who consumed alcohol during pregnancy. The *exact* number of children afflicted with FAS in North America is unknown (AADAC, 1994:1). Only estimates of the incidence of FAS can be made, as many factors make the diagnosis of FAS extremely difficult. One such factor is the reluctance of professionals to diagnose an individual with FAS, and thus, placing a potentially stigmatizing label upon the individual. Another factor is the lack of knowledge about FAS, and therefore, the inability of professionals to recognize the manifestation of FAS. Accordingly, Blaze-Temple et al. (1992:32) conclude that there is "conflicting evidence concerning incidence of FAS/FAE" within the literature. This sentiment is echoed in an article published through Canada's Drug Strategy (1995:7) which advises that "statistical rates of FAS/E are, at best, educated guesswork and should not be considered an absolute".

Abel and Sokol (1991) advise that the way in which the incidence figures are derived has direct impact on the incidence numbers themselves. First, the use of retrospective and/or prospective studies will affect the incidence estimates; the figures from retrospective studies tend to be less controlled (Abel and Sokol, 1996:514), and more inclusive (Abel and Sokol, 1996:514), resulting in higher incidence rates than results yielded from prospective studies. Second, incidence rates will differ substantially depending on whether studies focus strictly on FAS, or whether they include other ARBD's in their estimates, ARBD's being a much broader category (Abel and Sokol, 1996:515). Finally, according to Abel and Sokol (1996:515), "the most critical

determinant of incidence rates appears to be the population characteristics of the study site”, socioeconomic status and racial background being identified as two characteristics that are directly related to study sites, and therefore, FAS incidence rates.

Paternal Health and Fetal Alcohol Syndrome

Paternal health has a potential effect on the well-being of the fetus, in addition to the health of the mother. However, this topic has been largely unaddressed until very recently, as “the effects of paternal health are only beginning to be studied” (Schroeder, 1994:42). The effects of paternal alcohol use are not clear at this point (Northwest Indian Child Welfare Association, 1993:21), but speculations regarding the potential impact of alcohol consumption by potential fathers, such as impotence, lowered sperm count, sterility, as well as the social role of supporting his partner are in need of further exploration.

Natives, Alcohol, and Fetal Alcohol Syndrome

FAS has been described as reaching epidemic proportions amongst Canada’s Aboriginal peoples (Scott, n.d.; Bray and Anderson, 1989; Burd and Moffatt, 1994). In an unpublished study, Wong, as cited in Abel and Sokol (1996:519) found that the rate of FAS among the Native population in a community in British Columbia was “about 10 times higher than among the rest of the population”. Indeed, Burd and Moffatt (1994:688) state that “American Indians and Aboriginal peoples of Canada are reported to be at very high risk for FAS”. However, much of the information about FAS within Native

communities is speculative in nature, and therefore the validity of such information is highly questionable. Habbick et al. (1996:206) state that “there are no published estimates of incidence for any province or territory in Canada”. In addition, several of the studies attempting to discern FAS incidence rates within Aboriginal communities “have significant restrictions which limit both the confidence in the rates reported and the generalizability of the results” (Burd and Moffatt, 1994:688).

There is also notable doubt about the role of genetic versus environmental factors in the incidence of FAS (Bray and Anderson, 1989:42). Finally, Scott (n.d.:12) outlines several theories that have been posited as explanations for the etiology of alcohol abuse amongst First Nations peoples, these theories competing for credence as being the correct theory. Such criticisms of the knowledge base around FAS and Natives is not to deny the fact that FAS is, indeed, a documented problem within several Aboriginal communities. However, it must be recognized that FAS is neither mainly, nor exclusively, a problem faced by Natives (May, 1991:240). Consequently, Bray and Anderson (1989:44) suggest that “the notion that there is more FAS among Native children than non-Native children is questionable”.

The diagnosis of FAS in Aboriginal children is problematic in itself; facial features, low birth weight, and a reluctance to make a diagnosis are confounding factors in making an accurate diagnosis. With respect to facial features, physicians making the diagnosis of FAS may be “less experienced in differentiating affected children among minorities from nonaffected children, or may even characterize minority features as “anomalous”, relative to a prevailing white standard” (Abel and Sokol, 1996:518). Indeed, one of the facial

characteristics used to diagnose a child with FAS is the presence of epicanthic folds, yet “Native Americans have a genetic trait for epicanthic folds” (Abel and Sokol, 1996:519). The presence of such genetically determined facial features may potentially result in an erroneous diagnosis of FAS among Native children. Additionally, low birth weight is another factor used in making a diagnosis of FAS. However, “low maternal age is a risk factor for LBW” (Abel and Sokol, 1996:520). Thus, rather than attributing low birth weight to the young age of the mother, many Aboriginal women bearing children at very young ages, a child’s low birth weight will be ascribed, wrongly so, to FAS. And finally, the reluctance of physicians to make a diagnosis of FAS is a factor in determining the true rate of FAS within Native communities. Indeed, “the variability in clinician’s willingness to label children with FAS will also have an important influence on rates” (Burd and Moffatt, 1994:693).

Despite the fact that much is unknown about FAS in First Nations communities, there are some findings that lend credibility to the notion that FAS is potentially problematic within Aboriginal communities. One such factor is the drinking patterns exhibited by pregnant Aboriginal women. Abel (1996:151) claims that “the difference in drinking patterns is a critical factor determining the potential dangers of alcohol”. Indeed, drinking one drink per day versus drinking five or six drinks at one sitting cannot be regarded as having the same impact on the developing fetus. Although the average number of drinks consumed is averaged out to be the same, peak blood alcohol levels would be very different (Abel, 1996:151), which in turn means two entirely different things for the fetus.

Streissguth et al. (1990:666) maintain that "mothers who reported BINGE drinking patterns were, on average, younger, less educated, and less likely to be married", BINGE drinking having been defined as "mothers who reported drinking five or more drinks on any occasion in the period in question" (Streissguth et al., 1990:663). Thus, other factors that have been determined to play a role in the creating conditions conducive to problematic drinking are social and economically based. However, these factors affect not only the potential mothers of FAS children, but the potential fathers as well.

Streissguth et al. (1990:667) have concluded that "in populations with larger numbers of more poorly educated fathers and more young children in the households, the effects of the same level of prenatal alcohol exposure would be expected to be exacerbated, with an even larger proportion of children falling into the subnormal IQ range". We will see in later discussions that the above noted description of conditions typically fit with the conditions under which Native children afflicted with FAS are born; Aboriginal babies with FAS are brought into the world by young, uneducated women and men, with several other children, who are typically binge drinkers. Consequently, the existing conditions within many Native communities possess the potential to substantially intensify the problem of FAS within Canada's Aboriginal peoples.

Conclusionary Remarks

The ambiguous nature of much of the current literature on FAS makes it extremely difficult to determine what information is indeed factual, and which is merely equivocation. The problematic nature of existing information available about FAS to the

public at large has profound implications. Knupfer (1991:1065) believes that “research results may be misunderstood in ways that can be important to policy decisions”. In Knupfer (1991:1063), Dr. Wells Shoemaker, a pediatrician, is quoted as saying “unscientific information is manipulated to meet the goals of anti-alcohol forces...Alcohol has replaced communism as the bogeyman in America, targeted for all that is evil”.

In the case of FAS, epidemiological evidence linking the maternal consumption of alcohol during pregnancy with harmful effects on the fetus, has had a monumental impact on women’s relationship with alcohol and pregnancy. Such evidence led to a governmental policy urging pregnant women to refrain wholly from alcohol consumption (Warren and Bast, 1988), in the name of ‘prevention’. The evidence has also resulted in the dominant public perception that “drinking alcohol during pregnancy is a form of child abuse” (Northwest Indian Child Welfare Association, 1993:4), resulting in the criminalization of such behavior by women who are with child.

CHAPTER TWO: METHODOLOGY

The method for my study is a qualitative analysis of the discourse around FAS. Through an inductive process, utilizing the prescribed methodology for the generation of grounded theory, I will develop a substantive theory with respect to suggest why, if FAS is theoretically preventable, current prevention efforts targeted at Canada's Aboriginal population, are not as successful as anticipated. To develop such a theory, I will be using two primary resources: *The Discovery of Grounded Theory: Strategies for Qualitative Analysis* (1967) by Barney G. Glaser and Anselm L. Strauss; and *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory* (1978) by Barney G. Glaser.

Why Grounded Theory?

"A theory should be able to explain what happened, predict what will happen and interpret what is happening in an area of substantive or formal inquiry" (Glaser, 1978:4). Current theory informing the prevention of FAS does not appear to be accurate, the reasons for which I hope to uncover in my investigation of the vast literature available on FAS. Indeed, the purpose of my research is to extend, and perhaps even transcend extant theory, rather than verification or replication of preexisting theoretical notions. As such, I will not rely upon preconceived notions and concepts around FAS. Thus, for the purpose of my study, my data will be comprised of the actual *text* contained within the current literature on FAS.

As such, the appropriateness of the generation of a grounded theory as the chosen methodology for my study is fourfold. First, given the type of data to be analyzed,

grounded theory is best suited for my research purposes. Also, the generation of a grounded theory, will yield answers to the various questions I have posed about the discourse around FAS. Grounded theory helps in the conceptualization, organization, and integration of non-theoretical knowledge: empirical, experiential, and descriptive knowledge (Glaser, 1978:13). Through an exploration and organization of existing “theory” around FAS, I will be able to examine the operation of discourse within the existing literature, and facilitate the process of myth-breaking in largely assumptive postulations.

Thirdly, the generation of grounded theory is an inductive process, theory emerging or being induced only after data collection has begun. Because the theory is rooted in the data, not pre-existing theories and concepts, there is little, if any, room for assumptions or myths in resultant tenets. Finally, grounded theory allows for a great deal of flexibility in its applicability to general situations, where a “finite social basis of knowledge can be flexibilized to apply to other general conditions” (Glaser, 1978:13). Due to the nature of grounded theory, the contrived philosophy will possess the potential to be applicable to not only Canada’s Aboriginal population, but to others as well. For Glaser (1978:13), “with substantive theory the man in the know can start transcending his finite grasp of things”. Thus, the generation of a grounded theory on FAS within Canada’s Native population will inform both current and future prevention efforts within the Aboriginal population. In addition, the resultant precepts can potentially move beyond applicability to First Nations peoples, and inform FAS prevention theory and practice for numerous groups in society.

The Generation of Grounded Theory as a Process

The generation of grounded theory can best be conceived of as an *a posteriori* process, the prescribed route to generating such theory being comprised of six primary steps. These steps are outlined by Glaser (1978:16) in the following manner: 1) the collection of research data; 2) the coding of the data; 3) the identification of categories; 4) the identification of the core variable; and 5) the generation of theoretical memos; and 6) the generation of substantive theory. A much more detailed description of each step in this process, can be found in Appendix A.

Theoretical Framework

My analysis of the relationship between the numerous codes and categories identified was influenced by varied notions around aspects of language, discourse, knowledge, power and social control. The ideas from numerous theorists and philosopher were utilized to comprise a theoretical framework around which the results of the coding and categorization process were assessed. Dorothy E. Smith's ideas in *The Conceptual Practices of Power* (1990) were useful in exploring the construction and subsequent deconstruction of social problems through the use of language. In addressing the relationship between power and knowledge, notions presented in Meghan Morris and Paul Patton's *Michel Foucault: Power, Truth and Strategy* (1979), Joseph Rouse's *Knowledge and Power: Toward a Political Philosophy of Science* (1987), and Michel Foucault's work in *Power/Knowledge* (1980) constituted the foundation upon which this relationship was contemplated. I also utilized Foucault's ideas about the body and social control as

discussed in *Power/Knowledge* (1980). Finally, Jurgen Habermas's ideas around the notion of ideology and hegemony were useful in tying together the workings of discourse and knowledge within the context of power relations.

Method for Classification of Pamphlets

In attempting to discern the known from the unknown within the literature on FAS, it became evident that some type of a classificatory system for the data was required. The system chosen for categorization of the data, was that outlined by Harry C. Bredemeier and Richard M. Stephenson in *The Analysis of Social Systems* (1976). The system entails three exhaustive categories of ideas that are evoked in response to an individual's environment, the three categories being: 1) cognitive ideas; 2) cathectic ideas; and 3) evaluative ideas (Bredemeier and Stephenson, 1962:11).

D) Cognitive Ideas

The first category, *cognitive* ideas was identified, being comprised of statements that tell people what to "see" in their environment. Cognitive ideas "tell people what *is*, (or was, or will be, or might be)" (Bredemeier and Stephenson, 1976:11). Thus, cognitive ideas are not only about what is, but also what the chances of something might be. It is of particular importance to this research project to note that cognitive ideas, are particularly concerned with cause and effect relationships. However, cognitive statements are not necessarily concerned with the correctness of the information they impart to their audience. Indeed, Bredemeier and Stephenson (1976:11) state that "there is no necessary

implication that cognitive ideas are “correct” or even that it is possible to ascertain whether or not they are correct”. Cognitive ideas operate in such a manner that “if people’s cognitive ideas tell them that something is so, they will *act* as if it were so” (Bredemeier and Stephenson, 1976:11).

II) Cathectic Ideas

The second type of response to situational perceptions identified by Bredemeier and Stephenson (1976:11), is the category of *cathectic* ideas. Cathectic ideas, according to Bredemeier and Stephenson (1976:27), are those statements which tell people both what is pleasant, as well as what is unpleasant about what they “see” in their environment. These ideas intervene between humans and their environment, as culturally bound notions “that define what is pleasurable and what is painful” (Bredemeier and Stephenson, 1976:11).

III) Evaluative Ideas

Finally, Bredemeier and Stephenson (1976:12) have identified a third form of perceptual response that can be utilized to classify information, the category of *evaluative* ideas. Evaluative ideas, for Bredemeier and Stephenson (1976:27), are those ideas which tell people what is morally good and bad about what they “see” in their environment. Evaluative ideas then, can be perceived of as ‘moral’ or ‘normative’ ideas about their perceived environment. Moral, or normative ideas, are an added dimension to human responses, which for the most part, are absent from other animal responses to their

environment (Bredemeier and Stephenson, 1976:12). Humans respond not only to cognitive ideas about situations, but also react to the “goodness” or “badness”, or more specifically, the right and wrong, imputed to things. One very important aspect of evaluative ideas brought forth by Bredemeier and Stephenson (1976:12), is that “evaluative ideas often take precedence over both cognitions and cathexes in determining action” (1976:12) taken by humans in response to given statements and/or situations. Perhaps this is due to the fact that evaluative statements appeal to issues revolving around one’s morality; issues encompassing such things as moral *obligations*, moral *prohibitions*, and/or moral *requirements*.

Application of the Classificatory System

I familiarized myself with each classificatory idea, and then proceeded to analyze the content of each of the thirteen pamphlets I had in my possession. I performed a sentence-by-sentence coding of each pamphlet, identifying each sentence as one of the three possible choices for classification. In some instances, a sentence could be perceived as possessing the characteristics of two of the categories, and was so identified. My analysis of the results of my classification yielded findings on two levels: 1) that of the individual pamphlet; and 2) that of overall patterns found within the pamphlets. Each individual pamphlet was identified as one of the three possible categories (cognitive, cathetic, or evaluative) on the basis of the frequency of occurrence of each type of idea, where the category of idea *most* frequently found within a given pamphlet was the deciding factor. My findings were then reported and discussed at greater length.

CHAPTER THREE: PAMPHLET CATEGORIZATION - COGNITIVE, CATHECTIC, OR EVALUATIVE?

Upon review of the current literature on FAS, attempting to discern the “known” from the “unknown”, it became apparent that some type of classificatory system needed to be developed for the information contained in the pamphlets about FAS, alcohol, Natives and women. As discussed in the previous chapter, an exhaustive system for classification of statements or ideas was found in *The Analysis of Social Systems* (1976) by Bredemeier and Stephenson, where three types of “ideas” were identified: cognitive, cathectic, and evaluative. An analogy can be drawn between Freudian theory and the statement typology outlined above to further exemplify the three categories identified earlier (see Appendix B).

The Pamphlets

Turning to the pamphlets, the results of the categorization of the pamphlets as cognitive, evaluative, or cathectic will be reported. My discussion of the findings will take place on three levels: 1) the individual pamphlet; 2) the larger, overall patterns found within all the pamphlets; and 3) each category of ideas. In total, the content of thirteen pamphlets were examined, classified, and analyzed. To begin, the content of each pamphlet will be briefly outlined and evaluated.

Table 1. Pamphlet Description and Categorization

Title	Description	Categorization
1. Pregnancy and Alcohol/Drug Use: A Professional's Guide to Identification and Care of Mother and Infant	-for professional use; a checklist of questions to ask in identifying 'at risk women'; 'advice' for professionals on how to provide care to 'at risk women'; more complex "medical" terminology used	cognitive
2. If You Are Pregnant and Drink, Your Baby Drinks Too	-question & answer format; very basic information about FAS, alcohol and pregnancy	cognitive
3. A Healthy Start: Alcohol and Other Drugs Before, During and After Pregnancy	-filled with information about substances (alcohol, marijuana, tobacco, cocaine) and their abuse in relation to pregnancy; utilizes repetition to make their point--"There is no known safe amount of --- a pregnant woman can --- --" (alcohol, drink; cocaine, use; marijuana, use).	cognitive
4. Fetal Alcohol Syndrome: A Preventable Birth Defect	-basic information about FAS and its prevention; uses repetition to make a point, repeating this sentence twice: "There is no known safe amount of alcohol a pregnant woman can drink."	cognitive
5. Fetal Alcohol Syndrome: Birth Defects You Can Prevent	-question and answer format; extremely basic information about alcohol and pregnancy	cognitive

6. Are You Chemically Dependent?	-question and answer format; checklist format; if individual answers 2 or more 'yes', it is suggested that a referral be made to a professional as it is concluded he/she may be chemically dependent	evaluative
7. Committed To Caring for People	-targeted for Native women specifically; information about FAS (lists 4 requirements for diagnosis) and FAE	cognitive
8. Advice for Indian Women for a Safer Pregnancy and Healthier Baby	- targeted for Native women specifically; very basic; a list of 'DO's' and 'DON'TS'	evaluative
9. Alcohol and Pregnancy (Health Canada)	-question - answer format; basic information about alcohol consumption during pregnancy; mentions FAS	cognitive
10. Fetal Alcohol Syndrome: FACTS	-very basic information about FAS; "Learn, Know, Act"	cognitive
11. Alcohol and Pregnancy: Know The Facts	-question and answer format; basic information about alcohol consumption during pregnancy; mentions FAS	cognitive
12. Alcohol and Pregnancy: Keeping Your Baby Sober	-largest pamphlet; filled with information about FAS/FAE, and alcohol and pregnancy; however, the choice of words/phrases sends a strong moral message against drinking while pregnant (mentions The Bible, works on mother's feelings of guilt and fear)	cognitive

13. Alcohol and Pregnancy (AADAC)	-question and answer format; cognitive basic information about FAS and FAE, and alcohol and pregnancy; looks at the “positives” of the situation-its never too late to stop drinking during pregnancy, or to cutback-women have drank socially in the past, and had healthy babies
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Existing Patterns Within the Pamphlets

If the larger, overall patterns found within the pamphlets are examined, some very engaging findings are revealed. First, the structuring of many of the pamphlets is similar. Most pamphlets begin first with a cognitive statement or two, declaring the need to be aware of the potentially harmful effects of alcohol consumption during pregnancy. However, these statements possess evaluative undertones, often prohibitive in nature, which play upon the reader’s feelings of guilt and/or fear. The pamphlet entitled *Fetal Alcohol Syndrome: FACTS* produced by Drug Dependency Services (n.d.b:1) begins with the question, “Did you know that alcohol can harm the unborn child and that the effects last a lifetime?”. In addition, the pamphlet entitled *Alcohol and Pregnancy: Keeping Your Baby Sober* by Spence (1993:2) begins to set the tone for the entire pamphlet in the second paragraph by stating that “Birth defects caused by drinking alcohol are completely preventable, so take care of your baby, and DON’T DRINK ALCOHOL”. Although both statements present information about the harmful relationship between alcohol consumption and pregnancy, which is a known fact, these statements attempt to evoke a

deeper, gut-level response from the reader based on feelings of guilt and/or fear. The first statement uses guilt as a motivating factor in suggesting that the effects of alcohol consumption during pregnancy can have negative effects on the developing fetus that *last a lifetime*. The second statement first uses guilt in stating that ARBD's are *completely preventable*, which sends the message to the reader that there really is no excuse for the occurrence of ARBD's if they are preventable. The second portion of the statement then proceeds to make an assertion that carries with it an extremely overt prohibitive message, instructing pregnant women, in no uncertain terms, not to consume any alcohol while pregnant. This message is emphasized even further by the writer utilizing capital letters to convey his message to the reader.

These types of statements are then typically followed by cognitive statements, presenting the "facts" about alcohol consumption during pregnancy, and its relationship to FAS/FAE. Such statements might include declarations made in the following manner: "Fetal Alcohol Syndrome is birth defects caused by a mother who drinks alcohol while she is pregnant. The more she drinks, the more likely her baby will have Fetal Alcohol Syndrome" (The Arc, n.d:1); and, "Research indicates the possibility of damage occurring during the first trimester when organs are formed" (The Addictions Foundation of Manitoba, n.d.b:2). These statements attempt to illustrate a 'causal' relationship between in utero maternal alcohol consumption and the incidence of ARBD's. These cognitive statements not only attempt to inform the reader of what is, but of what might be, with respect to the risks associated with maternal alcohol consumption during pregnancy.

Cathetic statements appear to be “thrown in” here and there, largely for effect. Cathetic statements are utilized to reinforce negative ideas about the relationship between women and alcohol, and the unpleasantness of the current situation around FAS. Two forms of cathetic statements have been identified within the pamphlets. First, are those statements that refer to either the unpleasantness, or the pleasantness of maternal alcohol consumption while pregnant, examples of which might include statements such as: “These toxic substances are difficult for the baby to clear from its system” (The Addictions Foundation of Manitoba, n.d.a:1); “Pregnancy can be a time when memories surface and become disturbing” (Infant Mental Health Promotion Project, n.d.:1); and, “It is never too late to stop drinking” (AADAC, 1993:5). The first two statements refer to negative, or unpleasant aspects of pregnancy and maternal alcohol consumption. The third statement, on the other hand, refers to a positive in the environment, where the ceasing of maternal drinking at any point in the pregnancy will have a positive impact on the fetus. It is interesting to note that the number of negative cathetic statements found within the pamphlets *far outweighs* the number of positive statements found in the pamphlets.

After much consideration, I decided that a second type of cathetic statement existed within the pamphlets. In most of the pamphlets, the symptoms, of FAS are listed in pamphlets, being characterized as the negative effects of in utero exposure to alcohol on the fetus. At first glance, I classified these statements as cognitive in nature, because they present the ‘facts’ about FAS. However, upon reflection, I recognized that these characteristics of FAS, being presented in a negative manner, were only negative if society

defines them as such. This notion will be explored in greater detail further on in the chapter.

Finally, many pamphlets appear to end with evaluative statements, outlining moral obligations, requirements and prohibitions that parents should heed if they want to have healthy babies. Obligatory statements within the pamphlets are directed at expectant mothers, fathers, as well as friends, outlining the responsibility each individual has to the fetus. The statement "to help your child be as healthy as possible eat a nutritious diet, get plenty of rest, have regular prenatal checkups" (The Addictions Foundation of Manitoba, n.d.a:1) is directed specifically at expectant mothers. Statements of requirement reiterate the necessary steps to ensure the health of the fetus; "If you need help to stop drinking, consult a doctor, clinic or addiction centre" (Health Canada, 1993:3). And finally, prohibitive statements forbid certain behavior, these statements being directed primarily at expectant mothers; "Don't drink any beer, wine or alcoholic beverages" (Fetal Alcohol Syndrome Project, n.d.a:2).

Another interesting pattern found within the structuring of the various pamphlets is that the "question and answer" format is frequently utilized to communicate information to the reader. Of the pamphlets analyzed, 46% of the pamphlets were in such a format. Six of the thirteen pamphlets inform the reader about issues around FAS by first posing a question, designed to communicate a certain set of ideas about alcohol, women, FAS and its prevention. Speculations about why such a format is chosen over others can be raised. First, the author has total control over what information is presented and considered. By constructing the questions in a certain way, a particular answer will be the result. Thus,

only that information that the author wants to communicate to the reader will be imparted in their answer to the question which they so carefully constructed.

Second, the question - answer format leaves little, if any, room for independent thought on the part of the reader. The reader is presented with a question and is given *the* answer. Thus, little room is left for discussion, as the answer is presented in such an authoritative manner, that for the reader to question the answer would be perceived of as impudent. Third, this form of presentation legitimizes the information presented - this is the question, and here is the answer. The question - answer format operates to give the information presented in the pamphlet the appearance of being both factual, and truthful in nature. Finally, the question - answer format places the reader in the role of questioner, creating the illusion that the reader is participating in a dialogue with the writer of the pamphlet.

Another noteworthy similarity between the various pamphlets assessed, are the *silences* found within the pamphlets. Two issues that are not addressed within the context of the pamphlets are central issues, yet appear to have been ignored. First, no concern is expressed about the welfare of the mother, and the toll that drinking is having on her life. All concern within the pamphlets is directed at the health and welfare of the fetus. The second silence noted in the pamphlets is that none of the reasons as to *why* the woman is drinking, before and during her pregnancy, and will probably continue to do so, are mentioned or addressed. The recommendation within the pamphlets is simply that the woman should seek treatment, regardless of the reasons behind her problematic usage of alcohol, or how she may feel about the pregnancy.

The Operation of Cognitive, Cathectic, and Evaluative Ideas

If the operation of each type of idea is explored, how the ideas convey their messages is quite engaging. From my analysis of the various pamphlets available on the subject of FAS, alcohol, Natives and women, what became apparent is that the different types of ideas often could not be separated, and indeed worked together *within* the same sentence or idea to achieve a certain response by the reader. Many of the cognitive statements found within the pamphlets were cause and effect statements, which may or may not be true. The difficulties in proving or disproving the accuracy of the statements lies in their vagueness, most of which are full of uncertainties. Many of the key words and phrases utilized in cognitive statements are not definitive in nature. To illustrate this point further, some of the words/phrases found in the cognitive statements include: often, risk, may (as opposed to 'will'), can, 'not well known', potential, likely, 'at times', possible, and some (as opposed to 'all').

But, as was mentioned in Chapter 2, cognitive statements are neither concerned with the correctness of the information they impart to the reader, nor are they concerned with the ability to discern fact from fiction. For the most part, this appears to be true of the statements in the pamphlets identified as being cognitive. This allows for cognitive ideas to operate in such a manner that if people's cognitive ideas tell them that something is the truth, they will act as if it were so, even if verity is in reality, misrepresentation.

It also becomes evident that cathectic statements found in the pamphlets are utilized to evoke a desired response in the reader, that of rousing particular sentiments within the reader. Cathectic ideas found in the pamphlets are primarily statements about

the “unpleasantness” associated with maternal alcohol consumption during pregnancy, outlining the negative effects of alcohol on the fetus. Indeed, such statements were intended to elicit unpleasant feelings in the reader, including guilt, fear, depression, and anger.

However, some pamphlets took into account the “pleasantries” of maternal alcohol consumption. Positive feelings associated with alcohol use, including feelings of power from alcohol use, as well as the escape from daily life that alcohol consumption offers some individuals, were outlined in some pamphlets, in order to offer some insight as to why pregnant mothers drink. As well, some of the pamphlets profiled the positive aspects of the situation around alcohol consumption during pregnancy. Such ideas included the realization that mothers can cease their consumption of alcohol at any point in the pregnancy, and as a result the baby will be that much healthier. As well, the idea that support for mothers is available, from professionals, spouses/partners, family and friends is presented in numerous pamphlets.

In many instances, ideas comprising the pamphlets could be conceived of, and therefore classified as *both* cognitive and cathectic in nature. Such a categorization might occur when the effects of alcohol consumption on the fetus in utero were outlined in the pamphlet, including physical deformity, mental retardation, hyperactivity, and behavioral and learning difficulties. Cognitively speaking, such lists present information about characteristics that allow for a diagnosis of FAS in an individual. However, such characteristics have been assigned negative definitions, based on modern societal values, including health, educational attainment, conformity, and physical beauty. Having been

culturally defined as “unpleasant”, the symptoms of FAS have been labeled as undesirable. Thus, such ideas might also be simultaneously categorized as cathectic in nature.

Finally, evaluative ideas included in the numerous pamphlets appeal to issues revolving around one’s morality; obligations, prohibitions, and requirements rooted in societal norms of right and wrong, good and bad. Moral obligations appear to be based upon those normative imperatives that imply that as a caring and responsible parent, “good” choices, ensuring the health of the baby need to be made. Moral requirements are identified in those statements that affirm the necessary steps to ensure the health of the baby, such as proper nutrition, adequate exercise, and cease/reduce alcohol intake. And, moral prohibitions are restrictive statements made ‘in the name of prevention’, forbidding certain behaviors such as the consumption of alcohol while pregnant, or in the case of the woman’s spouse/partner, drinking in her presence.

I have identified two goals of evaluative statements, which operate by appealing to one’s normatively based sense of goodness and badness. The first goal appears to be the creation of guilt within the reader. The ‘guilt factor’ operates via the arousal of feelings of guilt, shame, fault, blame, stigma, and dishonour, by making reference to such things as the maternal consumption of alcohol while pregnant while alone, and the reputation of the mother due to her use/abuse of alcohol. The second goal is to kindle fear within the reader. The ‘fear factor’ functions on the basis of the fear and anxiety experienced by many expecting parents - that their baby will be born healthy (i.e. ‘normal’).

Theoretical Evaluation

Of the thirteen pamphlets analyzed, eleven were classified as cognitive in nature, two as evaluative, and none as cathectic. One might speculate as to why cognitive ideas appear to be the method of preference for the transmission of information about FAS, alcohol and pregnancy. But, before any speculations are made, the relationship between culture and how situations occurring in society come to be defined must be addressed. A given culture is influenced, and influences, how individuals come to understand and adopt cognitive, cathectic, and evaluative definitions held by groups (Bredemeier and Stephenson, 1976:13). Group definitions are introduced to the individual during infancy, and are reinforced throughout one's lifetime via interaction with other group members. The expectations of situations are dependent upon the cognitive, cathectic, and evaluative definitions of a given situation. Variations in definitional perceptions of a given situation are related to three points raised by Bredemeier and Stephenson (1976). First, the precision of the definition is a factor, as some situations are defined more rigidly than others (Bredemeier and Stephenson, 1976:14). Second, behavior is placed on a positive - negative continuum, where expectations fall somewhere between 'required' and 'taboo'. Thus, behavior might be classified along these lines:

required	preferred	permitted	tolerated	disapproved	taboo (prohibited).
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And third, expectations of behavior differ with respect to the variables of time, the individual, and the situation.

With respect to women, pregnancy, and the consumption of alcohol, the situation where there is a potential risk of harm to the fetus as a result of maternal drinking, the situation has been defined in extremely rigid terms. From the content of the pamphlets reviewed, the situation is defined to depict the following scenario: if pregnant women drink, they run an *extremely high risk* of bearing children afflicted, on some level, with FAS/FAE; the only way to avoid this occurring is for the woman to *avoid* the consumption of alcohol at *any* point during the pregnancy. As well, a pregnant woman's behavior does appear to be placed at the extremes of the behavioral continuum. On the one hand, some behaviors are required of the mother, to ensure the present, and future, health and well-being of the fetus, such as following a healthy diet and attending prenatal checkups on a regular basis. And on the other hand, other behaviors are strictly prohibited, before, during, and after the baby is born, namely the consumption of alcohol. And finally, with respect to the variables of time, individual and situation, it appears that society is more concerned about the misuse of alcohol by its female membership during a woman's pregnancy, as opposed to when she is not pregnant, and therefore, not necessarily at immediate risk for bearing a child afflicted with FAS. Apparently, it is only when a woman becomes pregnant that her abuse of alcohol becomes of paramount concern. However, it must be recognized that the resultant definition of the above described situation is culturally based, and therefore, may be culturally biased against those who do not share the dominant (popular) culture.

Cognitive, cathectic, and evaluative definitions of a situation are of assistance to individuals and groups alike, who are concerned with the resolution of what Bredemeier

and Stephenson (1976:15) refer to as “action problems”. Dilemmas inherent in every ‘action problem’ are outlined by Bredemeier and Stephenson (1976:15), and in doing so make reference to the work of Talcott Parsons. Their discussion takes place under the context of the following headings: Qualities versus Performances; Universalism versus Particularism; Affectivity versus Neutrality; and Self-Orientation versus Collectivity Orientation. I would suggest that the occurrence of FAS, and its relationship to maternal drinking, has been defined as an ‘action problem’, a situation requiring swift response to prevent further incidences of FAS from occurring.

Qualities versus Performances

Bredemeier and Stephenson (1976:16) suggest that there are two institutionalized ways of defining people: on the basis of ability, or on the basis of certain qualities. Indeed, the majority of individual expectations and rights are structured, and thus, institutionalized on the basis of “qualities” in modern society. However, “most people think of the “quality” orientation as “discrimination”” (Bredemeier and Stephenson, 1976:16). Within the context of modern society, discrimination occurs on the basis of characteristics such as gender and race, lending itself to the perpetuation of both sexism and racism. Two key qualities that can be identified in the pamphlets reviewed earlier in the discussion, include *being pregnant*, and *being a woman*. On the basis of such qualities, if women do not respond appropriately, based upon a culturally derived definition of the situation, and thus, conforming to certain expectations, they are subjected to forms of oppression.

Universalism versus Particularism

In addressing the issue of morality, and how it becomes institutionalized in society, Bredemeier and Stephenson (1976:17) have identified two forms of morality: the “morality of principle”; and the “morality of loyalty”. The ‘morality of principle’ is defined as “the expectation that one should treat everyone according to the same abstract, general, *universal* principles” (Bredemeier and Stephenson, 1976:17). Conversely, the ‘morality of loyalty’ is defined as “the expectation that one should treat people differently, based on their particular relationship to one” (Bredemeier and Stephenson, 1976:17). Both of these expectations are rooted in deep emotions, often conflicting immovably with one another. As human beings, women are entitled to certain rights as members of modern society. However, as females, women are regarded as inherently different than men, on the basis of gender. This division between the genders becomes amplified when a woman becomes pregnant, and is misusing alcohol in such a manner as to potentially endanger the welfare of the fetus.

Affectivity versus Neutrality

A discussion around the notions of affectivity and neutrality will help to lend understanding about which type of statement, cathectic or evaluative, has priority in defining a situation and designating the appropriate responses to the situation. Such a discussion revolves around the issue of ‘immediate gratification’ (Bredemeier and Stephenson, 1976:18). In certain situations it is acceptable to choose the route to immediate gratification, one’s response expected to be affective in nature; while, in other

situations, the route to immediate gratification is deemed to be inappropriate, neutrality being one's expected response.

Bredemeier and Stephenson (1976:18) suggest that there is less indignation towards those individuals who act neutral in situations where affectivity is called for; however, there is a much harsher response to those individuals who act affectively when a neutral response is required. Why is this so? Bredemeier and Stephenson (1976:19) speculate that "neutrality is harder to learn than affectivity, which "comes naturally"". Affective behavior, thus, is based on immediate gratification, occurring naturally within the individual, and might be regarded as somewhat instinctive in nature. On the other hand, neutral behavior is controlled behavior that is learned by the individual through conditioning.

Hence, resentment is low if individuals are neutral in an affective situation, because the individuals appear to have mastered their instincts and seem to be in control of their behavior. Indignation is high, on the contrary, if an individual is affective in a neutral situation, as the individual appears to be allowing their instincts to rule in a situation that calls for their better judgment. In the case of women who consume alcohol during pregnancy, they appear to be letting their 'addictive' instincts to rule over their 'maternal' reason, and thus, are subjected to the acrimonious displeasure of society as a whole.

Self-Orientation versus Collectivity Orientation

In referring to self- versus collective-orientation, Bredemeier and Stephenson (1976:21) speak about the *kind* of motivation that is institutionalized. In particular, these

notions deal with expectations that can be classified as either shared or personal. A collective orientation is grounded in shared expectations, whereas a self-orientation is based on individual expectations. Expectations, within the context of 'culture', are clear, shared and complimentary (Bredemeier and Stephenson, 1976:25). It can be concluded that a majority of the expectations outlined in the pamphlets are of a collective orientation, as they speak about the welfare of the unborn child, which is a shared expectation by all members of society. "When expectations become institutionalized, people can predict how others will act, and believe they should behave that way" (Bredemeier and Stephenson, 1976:24). Such expectations can be overtly stated, but they also take on the form of implicit beliefs about how a woman should, and should not behave, especially while pregnant. These expectations are inferred within the pamphlets, primarily through the utilization of statements with an evaluative message, either overt, but usually covert in nature.

Certain words and /or phrases, used within the pamphlets, are used to communicate ideas, which in turn, elicit a response by the reader on a deeper level than cognitive statements can achieve. Thus, although the overall categorization of the statement might indeed, be cognitive, there is a definite evaluative component in the statement. One vivid image used in the pamphlets is that the fetus is, in essence, being poisoned by maternal alcohol consumption. Examples of such words and/or phrases portraying such an image include: "developing babies are being poisoned" (Spence, 1993:2); "alcohol is poison to the growing cells in the baby's body" (Anonymous, n.d.:2); and, The Addictions Foundation of Manitoba (n.d.a:1) refers to alcohol (and drugs) as

“toxic substances”. Words and phrases are also used to conjure up the image that the occurrence of FAS is a tragedy (The Addictions Foundation of Manitoba, n.d.b:2; Spence, 1993:13), the maternal consumption of alcohol being inflicted upon “unfortunate children” (Spence, 1993:7), with ‘effects that last a lifetime’ (Spence, 1993:7; Drug Dependency Services, n.d.b:1).

Thus, evaluative statements, under the guise of cognitive statements, are chosen to communicate clandestine messages to the reader. Evaluative ideas often take precedence over both cognitive and cathectic ideas in determining human response to given statements and/or situations. By appealing to one’s morality, it is the intention of the pamphlet authors to compel the reader to react in an intended way to what is being communicated. However, “in the case of *moral* judgments, which have no ultimate objective standards, it would appear that people are especially subject to group values” (Bredemeier and Stephenson, 1976:14). It would appear, then, that culture has a strong influence on how, and for that matter, whether at all, an individual responds to statements that are evaluative in nature. Intrinsicly, if the values and norms being enforced within the pamphlets are not shared by those individuals at which the pamphlets are targeted, the dogmatic messages contained within evaluative statements will be for naught.

CHAPTER FOUR: ALCOHOL AND WOMEN - A PRECARIOUS RELATIONSHIP

*One cup of wine is good for a woman;
Two are degrading;
Three induce her to act like an immoral woman;
And four cause her to lose all self-respect and sense of shame*
(Gomberg, 1982:16).

The first relationship to be introduced into the funnel is that between alcohol and women. Women's relationship to alcohol is, at best, one governed by ambiguities and uncertainties. At worst, it is a relationship dominated by myths, assumptions, and untruths. What becomes readily apparent on closer inspection of the literature about women and their relationship with alcohol is that "drug and alcohol abuse among women is a political issue, linked to gender roles, power, ambivalence, and hidden angers and fears" (Gomberg, 1982:21). As such, an overview and analysis of the precarious relationship between women and alcohol will be the primary objective of this chapter.

It is in this chapter that the coding process is commenced. To begin, an intensive exploration of the literature was performed, revealing the dominant themes within the literature, which were then coded using descriptive terms characterizing the various themes (see Appendix C). From the codes, eleven categories were derived (see Appendix D), under which the codes could be grouped together. An overview of these groups is presented below. It is important to recognize that the categories are inextricably intertwined, interacting with one another in a complex manner, so as to reflect the intricacies of the relationship between alcohol and women. However, for simplicity's sake, the categories are presented and discussed separately.

Gender Roles

At the center of the relationship between women and alcohol, are societally prescribed expectations of each gender, which become embodied in a *gender ideal*. For Holmila (1991:549), notions of masculinity' and 'femininity', and associated expectations of each are central in the construction of gender ideals. Abramovitz in Goldberg (1995:792) supports Holmila's contentions, suggesting that women are expected to be "elaborately dressed and made up, gentle, passive, dependent, and subordinate to men". Thus, the gender ideal orientation for women is what Hoar (1983:252) refers to as "feminine-passive". In direct contrast, males are expected to be 'manly', their gender ideal being organized around a "masculine-active" (Hoar, 1983:252) orientation.

Consequently, the socialization process of females in society focuses on the internalization of feminine ideals by women. In Gomberg (1982:21) Barry, Bacon, and Child suggest that "girls are socialized with greater pressure toward nurturance, obedience and responsibility". In particular, the socialization of women is geared toward preparing women for their maternal role; to be "a loving wife and good mother" (McCormack, 1986:56). The maternal role is the most important function a woman plays within the context of her role as a female member of society.

Indeed, Gomberg (1982:12) suggests that the stages in a woman's life are marked by physiological events; "menstruation, pregnancy, childbirth, lactation, menopause, are unmistakable markers of life stage and hormonal status". These monumental markers appear to be situated solely around a woman's capacity to bear children, the emphasis being placed almost entirely on woman as a 'mother'. McCormack (1986:45) goes on to

suggest that "the implication of this is that women have a unique responsibility for their social behavior based on their reproductive functions." This responsibility is so important, that a "higher moral standard" (El-Guebaly, 1995:74) is imposed upon women, as "service to the species is foremost" (McCormack, 1986:45).

Gomberg (1982:13) proffers that any "impairment in the nurturing, caretaker role--the work role--of women is anxiety provoking and threatening" to collective society. When a woman's behavior falls outside expectations it is deemed as being "unacceptable behavior" (Goldberg, 1995:790). Hence, when the (ab)use of substances, such as alcohol, either interferes with, or replaces altogether, important activities (i.e. a woman's duties and responsibilities as a mother), society as a whole feels obligated to respond. Much outrage is "directed toward women who produced sickly offspring in the first place, and neglected their children in the second" (Gomberg, 1982:16).

Women who do not conform to societal expectations of their ideal are frequently described as "bad" women. If you fail your primary function as a female, "you are a bad mother" (Gomberg, 1982:17). If you are the bearer of addicted babies" (Gomberg, 1982:15)", you are subject to become the target of stigmatization by the rest of society (Gomberg, 1982; McCormack, 1986; Hoar, 1983; Goldberg, 1995; El-Guebaly, 1995). Strong social disapproval is experienced by woman who assume characteristics associated with the masculine role (Hoar, 1983:256), such as the (ab)use of alcohol, which deviates from expectations associated with the female gender ideal.

This "self-achieving woman" (Hoar, 1983:258), is often portrayed within the literature as rebelling against societal "sexual taboos" (Gomberg, 1982:21), being overly

sexual or promiscuous (El-Guebaly, 1995; Gomberg, 1982; Holmila, 1991; Goldberg, 1995; Kagle, 1987; McCormack, 1986). Implicit within the literature are the notions that women who drink too much are “seen as tramps who deserve to be taken advantage of sexually” (Goldberg, 1995:792); are sadistic and lewd (McCormack, 1986:49); obnoxious and unfeminine (Kagle, 1987:22); and are easily seduced (McCormack, 1986:55), as alcohol “unlocks the sensuality of women” (McCormack, 1986:55) which is normally repressed through self-control. These “bad” women are depicted in direct contrast to “good” women as “women seated in cafes drinking absinthe” (McCormack, 1986:44) who are militant teetotalers (McCormack, 1986:47); the “family-oriented woman” (Hoar, 1983:258).

The prodigious amount of emotional stress inflicted upon women, largely due to conventional definitions of femininity is problematic because many women have great difficulty adjusting to, and accepting the expectations entailed in the traditional role as ‘female’. It has been suggested that due to pressures to conform to traditional gender ideals, women have turned to alcohol to assuage their doubts, fears, and guilt. Hoar (1983:265) states that “alcoholic women are concerned about their ability to fulfill tradition female roles”, and may turn to alcohol for one of two reasons.

McCormack (1986:52) and Hoar (1983:256) propose that women drink as a means of escape and solace from the expectations placed upon them within the confines of their role as ‘woman’ . Wilsnack in Hoar (1983:252), on the other hand, suggests that “women drink not to satisfy dependency or power needs, but rather their drinking may help them to feel more womanly”. Thus, if women should deviate from gender role

expectations, they are made to feel that they are less than 'real' women, and may turn to alcohol to make them feel more feminine. Doubts about a female's adequacy as a woman are raised if she does not conform to strict notions of her gender ideal, which include being feminine, and perhaps most importantly, being a good mother. For some, alcohol is seen as the answer to all the difficulties faced by females in society within the context of their gender role of 'woman'.

Social Control

"The social control of drinking is a very complex mixture of norms, attitudes, feelings, interaction and direct violence" (Holmila, 1991:569). Historically and presently, "people have sought to regulate the use of substances" (Gomberg, 1982:10), via mechanisms of control, which upon closer inspection, it becomes apparent are *gender specific* in nature. The social control experienced by women who drink, in particular when they are pregnant, is governed by societal values and norms, and ruled by intense feelings and beliefs.

The justifications proffered for social control, or management of women who misuse alcohol are the social costs of substance abuse. Goldberg (1995:790) reports that "their own behavior frequently puts other innocent people at risk and places a financial burden on society". Many arguments in support of social control place the focus on "the serious consequences of drug abuse for infants" (Goldberg, 1995:791), who are portrayed as innocent victims. Thus, the good of the collective is taken into consideration, and

compared to the rights of the individual in deciding which situations require intervention in the form of social control.

Holmila (1991:550) identifies two forms of control upon women who drink: *externalized* forms of control (other people's response to behavior such as actions or remarks), and *internalized* forms of control (self-reflection, or "private talks" about others perceptions of their behavior). Both forms of control act to shape a woman's existence through the actions of *agents of control*. I would suggest that external agents of control can be viewed as being either formal or informal, both of which possessing great influential power over a woman's behavior. Formal agents of control include those individuals in women's lives who act in authoritative roles. Authority figures identified in the literature include physicians (Gomberg, 1982; Goldberg, 1995; McCormack, 1986; Kagle, 1987); social workers (Goldberg, 1995; Kagle, 1987); the State (Goldberg, 1995); child protection services (Goldberg, 1995); therapists (Goldberg, 1995; McCormack, 1986); administrators (Goldberg, 1995); publicists (Goldberg, 1995); program designers (Goldberg, 1995); religious counselors (McCormack, 1986:53); police officers (McCormack, 1986:53); researchers (Hoar, 1983:251); and employers (Kagle, 1987). Informal agents of control possess less 'official', or State sanctioned power, but are equally, if not more so, influential in the lives of women. Holmila (1991:560) explains children and parents are significant agents of control, the impact of their responses to a woman's behavior being significant. Holmila (1991:560) attests "that partners are the most important agents of control". This notion will be explored in greater detail further on in the discussion under the category "Personal History".

It must however, be recognized that women themselves act as agents of control over their own behavior, utilizing internalized forms of control. Having internalized societal reactions, on both formal and informal levels, to their behavior women will respond to these reactions. Notwithstanding, "a lot of the social control imposed on women's behavior is so internalized that it is hard to see it or to question it" (Holmila, 1991:568), as we are not privy to the content of the "private talks" that occur within the woman's psyche. The internal aspect of social control makes the operation of such control that much more complex, and difficult to fully comprehend.

Turning now to the *means of control* utilized by agents of social control, the forms of regulation legitimizing the social control of women discussed within the literature are twofold: 1) criminalization through legislation; and 2) medicalization. The social control of women consuming alcohol while pregnant through medicalization, is of particular importance to this topic, and as such, will be developed as its category further on in the discussion. Thus, turning to regulation through legislative efforts, American legislation as a form of social control of women's drinking can be found dating back into the early twentieth century. In the United States, women's use of 'medicinal tonics', one of the primary ingredients being alcohol, became regulated first, in 1906, with the enactment of the *Pure Food and Drug Act* (Gomberg, 1982:11). The use of these 'tonics' came under further scrutiny, alcoholic tonics being outlawed by the *Harrison Act* in 1914 (Goldberg, 1995:791). Although neither act was specifically enacted to control women's consumption of alcohol, the content of these two acts had the effect, intended or otherwise, of placing limits on the consumption of alcohol by women.

The social control of women via the criminalization of drug use, including alcohol, during pregnancy is a timely point of contention within modern society. On the basis of the earlier discussion about the paramount importance deemed to a woman's role as mother, women "are subjected to intensive social control" (Goldberg, 1995:793) out of concern for the welfare of children. The family is the societal institution in which gender order is regulated (Holmila, 1991:548), however, when the family as an institution cannot control the woman, the State feels obligated to intervene. "A widespread legal presumption that any woman who abuses substances necessarily is guilty of child neglect and abuse" (Goldberg, 1995:793), this presumption providing the basis for the creation of legislated offenses such as "prenatal child abuse" or "delivery of a drug to a minor" (El-Guebaly, 1995:74).

The *mechanisms of control* utilized by agents of control discussed within the literature operate both to facilitate and legitimize the control of a woman's drinking behavior while pregnant. These mechanisms include oppression, denial, and being labeled as 'lacking control'. First, oppression can be defined as "systemic harm that people with more power do to people with less power" (Goldberg, 1995:791). Oppression can take on two different discriminatory forms, which Goldberg (1995:792) describes as 'direct' and 'indirect' discrimination. "Oppression appears to be a causal factor in creating and maintaining chemical dependency among women" (Goldberg, 1995:790), as women are subjected to varying forms of oppression in relation to their gender role as 'woman'.

A second mechanism of social control is through the *denial* of the existence of a problem with women and alcohol use. The approach of denial can take on many different

forms: one can “underestimate the magnitude of the problem” (McCormack, 1986:44); or one can “deny its salience” (Kagle, 1987:21); or, one can entirely “ignore the problem” (Kagle, 1987:24). This mechanism of control is not effective, as the social costs women abusing alcohol, whether pregnant or not, are rising. Finally, by labeling a woman as lacking control, characterized by her “loss of control of use, inability to cutback” (Goldberg, 1995:791) in her use of alcohol, frequently paired with “unsuccessful attempts to control its abuse” (Kagle, 1987:23), results in the legitimization of outside intervention. If “a woman who allows her body to overrule her duty as a mother” (McCormack, 1986:58), social control is deemed to be necessary for the sake of all concerned; the fetus, the collective, and lastly, and perhaps least important, the woman.

The “Problem”

The primary way in which women (mis)using alcohol can be socially controlled is to first define such behavior as problematic. “It is difficult to make simple definitions as to what kind of drinking is to be considered heavy or problematic” (Holmila, 1991:567). However, attempts have been made to construct a definition of “the problem”, which include such notions as “substance-abusing and substance-dependent women” (Goldberg, 1995:790) who are either pregnant, or ‘at risk’ for becoming pregnant. Within the literature, such women have been referred to as “a problematic population” (Goldberg, 1995:790).

Goldberg (1995:790-791) refers to the DSM-IV, 1994 edition, in defining *substance abuse* as:

(1) that a person uses a psychoactive substance when expected to perform significant tasks at home, at work, or school, or when it is physically hazardous and (2) that he or she continues to use a psychoactive substance despite awareness that such use is causing major problems in one or more aspects of life such as financial, legal, psychological, or marital.

Thus, if a woman fulfills these criteria, she is classified as being a “substance abuser”. It is noteworthy to point out that in the DSM- IV, the definition of ‘substance abuse’ specifies that an individual is a substance abuser if his/her use of a substance results “in a failure to fulfill major obligations at *work, school, or home* [emphasis added]” (The Task Force on DSM-IV, 1994:182). The ordering of the tasks/obligations should be noted here, as Goldberg (1995) appears to have modified the ordering of the tasks from the original definition found in the DSM-IV.

Upon closer inspection of Goldberg’s (1995) definition, two important aspects of the definition emerge: 1) the importance of gender/maternal role expectations; and 2) identifying women as lacking control. First, a woman is defined as being a “substance abuser” if her use of alcohol/drugs interferes with the responsibilities a woman is expected to perform in the capacity as a mother and wife. Indeed, the DSM-IV provides examples of failure to meet ‘home’ obligations, which include the neglect of children or the household (The Task Force on DSM-IV, 1994:182). A woman might also be labeled as a “substance abuser” if there is a potential risk of harm to the fetus as a result of her use of drugs/alcohol, which is also related to a woman’s maternal role. Second, if a woman is deemed to be lacking control over her own behavior, there is a perceived need to control the behavior of those who cannot on their own, especially if they are jeopardizing the health and/or safety of not only themselves, but others as well.

Within the literature, an extremely important point is made by Kagle (1987:27), stating that in the construction of women misusing alcohol, we have “ignored substance abuse as a *social* [emphasis added] problem”. Instead, the problem of inutero alcohol consumption has been ‘medicalized’, being conceptualized and defined in terms of medically-oriented discourse.

Medicalization

The relationship of women to alcohol has been ‘medicalized’ in much of the literature reviewed, being described in medical terms, and possessing medically-oriented implications. The response of the medical profession to the (mis)use of alcohol by women has been somewhat controversial in nature. The use of drugs by women, including alcohol, has typically been characterized as therapeutic in nature (Gomberg, 1982:11). Historical use of medical ‘tonics’ by women, which contained either alcohol or drugs, were viewed as an acceptable course of therapy. Today, “many women who drink heavily are treated by physicians and hospitalized” (Kagle, 1987:24), their abuse of alcohol being overlooked. Instead, they are treated for symptoms of their misuse of alcohol, rather than the actual problem, their dependency upon alcohol. Whether this is a conscious decision on the part of physicians to ignore existing problems, or merely an underestimation of the enormity of the problem has yet to be determined.

The notion of ‘disease’ governs the problematization of alcohol consumption by women. In particular, the notion of ‘disease’ plays a pivotal role in the construction of a response to the problematic misuse of alcohol by women, especially pregnant women. The

'disease model' has been set forth as an explanation for the phenomenon of alcoholism, in both men and women. Both Gomberg (1982:20) and Goldberg (1995:792) posit that viewing alcoholism as "a disease" has resulted in more sophisticated and sympathetic public attitudes about the misuse of alcohol. Because individuals cannot control whether or not they become the victim of a disease, such an explanation assuages all responsibility for the effects of the given disease. Thus, in the case of 'alcoholism', if the notion is accepted that it is a disease, all resultant behavior is deemed not to be the responsibility of the individual afflicted with the malady.

In support of the explanatory powers of the disease model, is the heredity argument, which is addressed in much of the literature. Arguments presented in Goldberg (1995:792) by Deren, and Wilsnack and Wilsnack (1991), suggest that having one or more alcoholic parent contributes to the development of alcohol misuse problems in women. Hoar (1983:253) also suggests that heredity has a role in developing alcoholism, as female alcoholics "are more likely to have alcoholism in their families than male alcoholics".

The concept of 'illness' has been "further extended to include unhappiness, loneliness, boredom and other psychic malaise" (Gomberg, 1982:12), resulting in women becoming the major consumers of psychoactive drugs (Gomberg, 1982:12). Indeed, "earlier psychiatric theories often accounted for alcoholism" (McCormack, 1986:44), carrying with them the notion that women who misuse alcohol are "more psychologically confused and conflicted" (Hoar, 1983:251). Implicit is the notion that the misuse of alcohol by women is, in some way, related to mental illness or infirmities. Goldberg (1995:796) refers to "dual-diagnosis patients", a medicalized term designating a

population of women who have both a substance abuse problem, as well as a psychological disorder.

Finally, in keeping with medical model explanations, if someone has a disease, there is also a cure (sometimes yet unknown) for the given illness. An unspoken assumptive message found within the literature is that treatment is regarded by many as a “cure”. Goldberg (1995:793) refers to “recovery after treatment”; and Hoar (1983:268) makes reference to “treating alcoholic women”, referring to participation in treatment as being “on the road to recovery” (1983:266). El-Guebaly (1995:76) also suggests that “treatment is critical” is restoring the woman’s health. Thus, for many, treatment programs addressing the abuse of alcohol are posited as solutions to problematic alcohol use by women.

Drinking as Deviant Behavior

Through the medicalization of problematic drinking behavior in women, the focus has been on women’s pathology, “suggesting that the alcoholic woman is somehow “sicker” than the alcoholic man” (Hoar, 1983:251), and is therefore, “doubly deviant” (Kagle, 1987:22). Not only is the woman stigmatized by being labeled as mentally infirm, she is further discredited by being marked as a ‘drunk’. It is important to note that there are distinct gender differences in the tolerance of intoxication, and non-conformity to norms governing the consumption of alcohol. In McCormack (1986:44), Karpman suggests that “alcoholic women are much more abnormal than alcoholic men”. Kagle

(1987:26) echoes this notion, suggesting that is a commonly held belief that “alcoholic women are more deviant and more difficult to treat than alcoholic men”.

Holmila (1991:548) suggests that “in comparison to men’s drinking, women’s drinking can be claimed to be so innocent that the slightest deviation from it will give rise to exaggerated interest”. Women’s drinking, excessive or otherwise, challenges conventional norms, such rebellious behavior being perceived of as a form of non-conformity. Deviation from expectations embodied by culturally defined and influenced gender ideals result in non-conforming behavior being labeled as ‘deviant’. Indeed, recognizing and negotiating deviance is a process whereby “decisions about future conduct turn on readings of the meaning of deviance and the acceptability of deviant identity” (Holmila, 1991:550). Three dominant public images or perceptions of the deviant woman are outlined by Heidensohn in Holmila (1991:553), which include: 1) the witch, the evil woman; 2) the whore; and 3) the non-woman, the masculine woman. Based on previous discussions, women who drink excessively, especially while pregnant, could potentially fit all three deviant personas.

Gender Bias (Sexism)

Several of the categories that have been described thus far are inherently biased on the basis of gender, such proclivity placing women within modern society at a distinct disadvantage. Despite public attitudes about alcoholism as a ‘disease’, “there still appears to be less tolerance for women alcoholics than for male alcoholics” (Gomberg, 1982:20). For Holmila (1991:556), “social attitudes are more negative toward female intoxication

and problem drinking than toward male intoxication and drinking problems". McCormack (1986:45) argues that the judgmental shelter offered to men through the medical model definition of alcoholism is not extended to females in modern society, evidence that "men are treated more tolerantly than women" (Goldberg, 1995:792).

Stemming from differential tolerance of female drunkenness are the issues of accountability and responsibility for one's behavior. Not only do women who misuse alcohol receive little sympathy, but they are also subjected to a rejection by the rest of society; "in the past and in the present, women substance abusers have received short shrift and little sympathy" (Gomberg, 1982:17). Gomberg (1982:13) suggests that "rules about substance use may be related to gender assignment of work". Due to "the ethics of motherhood" (Holmila, 1991:568), women cannot be excused from their responsibilities and duties as a mother. Thus, when their consumption of alcohol interferes, on any level, with the performance of the duties entailed within the maternal role, women are typically forgiven less than men for their misuse of alcohol (Holmila, 1991; Kagle, 1987). Even though these women are deemed by society to be defective, they are still held to be responsible and accountable for their behavior. Hence, a double standard (Gomberg, 1982; McCormack, 1986) appears to exist in levels of tolerance between the genders. The rationale which grounds such standards as necessity, are described by McCormack (1986:55) as "first, to protect the woman against herself; second, to protect the family honor". Thus, the regulation of substance use takes on paternalistic undertones, resulting in innate "differences in the regulations for men and women" (Gomberg, 1982:10).

Another problematic aspect revealed in the literature, with respect to gender bias, pertains to theory. Much of existing theory about the relationship of alcohol and women makes unfounded assumptions and generalizations. For example, dependency theorists “assume that their theory applies equally well to women” (Hoar, 1983:253). Power theorists are also biased against women, as the theory pertains exclusively to men’s experiences. The flaw in both theories “is that they draw their generalizations about all drinkers based only on studies of men” (Hoar, 1983:256).

Finally, women experience bias on the basis of their age, age acting as a marginalizer. “Greater age is clearly associated with having fewer drinks per day, fewer occasions of intoxication or heavy episodic drinking, and fewer drinking problems or symptoms of alcohol dependence” (Wilsnack et al., 1993:7). Therefore, based on previous discussions, heavy drinking in women is only problematic during younger ages; during the *child-bearing* years when the intake of alcohol has the potential to interfere with maternal responsibilities.

Cultural Influences

All mankind “has had an ambivalent, love-hate relationship with alcohol for centuries” (Gomberg, 1982:10). Alcohol holds great importance in society, alcohol being the oldest of the three “social” drugs (caffeine and nicotine being the others) (Gomberg, 1982:10). Unequivocally, “alcohol has a complicated history in that it has also been considered at certain times and places, as a beneficial *food*” (Gomberg, 1982:16). Also, alcohol has been, and still continues to be, used for medicinal purposes (Gomberg,

1982:15). But perhaps most importantly, "alcohol seems to have an important position in the ideological and practical bargaining that takes place between genders" (Holmila, 1991:548).

"The norms controlling the use of alcohol in our culture are curiously ambivalent" (Kagle, 1987:24); on the one hand they are permissive and tolerant in nature, but on the other hand they can also be very harsh in response to behavior that breaches accepted standards. Gomberg (1982:13) refers to "taboos about intoxication", which are gender specific, and therefore, gender biased. Drunkenness in women is perceived to be more threatening (Gomberg, 1982:13), and is responded to with "greater distaste and rejection" (Gomberg, 1982:13). The sanctions of heavy drinking involve a more punitive attitude toward females who abuse alcohol. Thus, the norms regulating drinking behavior are not necessarily concerned with women drinking moderately, but instead, with heavy drinking and intoxication.

The cultural relativity of "social norms" (Gomberg, 1982) governing drinking behavior is a key point to this category. Norms are defined collectively, and are culturally specific. Such norms are reflections of both cultural stereotypes (Kagle, 1987:27; Goldberg, 1995:792) and cultural ideals (Goldberg, 1995:792) of women. Kagle (1987:23) suggests that cultures do not share common norms, nor do they share common patterns of drinking behavior. In their article, Wilsnack et al., (1993:9) refer to a cohort effect; "a cohort may be at risk for alcohol problems if it grew up in a cultural context of increased tolerance for substance use, intoxication, and the use of alcohol or drugs to cope with problems, so that getting drunk would seem less abnormal and more excusable".

However, the notion of a period effect appears to be a more accurate description of the effect of alcohol on a specific group, occurring within a specified cultural context.

Such a discussion gives rise to the issue of *aboriginality* of alcohol in a given society, and the development of gender differentiated drinking norms. Gomberg (1982:10) states that "societies with definite sex differences in the use of alcohol were significantly more often those societies that had used alcohol aboriginally; among societies with no evidence of normative sex differences, postcontact introduction to alcohol was more likely than aboriginal use". Thus, those societies with more stringent norms governing drinking behavior, and a more punitive in nature with respect to female intoxication, tend to be those societies who utilized alcohol aboriginally. This point in particular, will prove to be of the utmost importance in future discussion.

The Drinking Context

The context in which the use of alcohol is important, as it illustrates the *differences* between the genders, with respect such factors as the location, the motivations, and the attitudes entailed in the consumption of alcohol. A review of the literature suggests that males typically consume alcohol in public, in groups, and are motivated by external forces. On the other hand, women usually consume alcohol in a secluded setting, perhaps even in secrecy, alone, being motivated by internal forces. Gomberg (1982:14) states that the typical patrons of saloons and bars are males, while habitual drinking by women is done alone, at home (Holmila, 1991:561; Kagle, 1987:23). McCormack (1986:44) suggests that the low visibility of female alcohol consumption in society has essentially resulted in

invisibility, and hence, has played a role in the historical invisibility of women's alcohol problems.

The motivations reported within the literature for use of alcohol also varied between the genders. For males, alcohol is typically consumed for recreation and pleasure (Gomberg, 1982:11) as a "social" drug (Gomberg, 1982:10). Women, on the other hand, used alcohol for medicinal purposes (Gomberg, 1982:11), in the capacity of a "medicinal" drug (Gomberg, 1982:10). "If women were to have alcohol, they were more likely to get it from the tonics" (Gomberg, 1982:14), as there were no negative connotations attached to the use of such products, even though they contained alcohol. Thus, tonics were a socially accepted form of alcohol consumption for females.

Both the drinking context itself, as well as attitudes about alcohol consumption, have undergone changes in recent years. The context in which women consume alcohol has been modified with the passage of time. According to Gomberg (1982:19), more women consume alcohol in public places in gender mixed company. However, increased acceptance still has limits placed upon it. Gomberg (1982:20) differentiates between more accepting attitudes towards women's *social drinking* and women's *heavy drinking*, stating that "there seems to be little change in the direction of greater tolerance for the latter". Holmila (1991:551) suggests that women are welcome in public places only on specific terms; bars and saloons are receptive to the presence of females only when accompanied by a male escort.

As well, important changes have been made in attitudes about the consumption of alcohol by females. "Attitudes toward women's smoking and drinking have undergone

much change in the last half century” (Gomberg, 1982:15), in the direction of greater acceptance in women’s usage of alcohol; it has become “more socially acceptable for women to drink alcoholic beverages” (Gomberg, 1982:19). Women no longer have to consume alcohol hidden in tonics, but instead can openly drink alcoholic beverages, such as cocktails, wine, and beer.

There is diversity among the population of women who misuse alcohol (Goldberg, 1995:790). However, certain factors, or elements of the situation seem to be present in many of the scenarios, that are utilized as explanatory tools for the justification of alcohol use by women which can be categorized in two groups: 1) their personal history; and 2) social factors.

Personal History

For many individuals, there is strong motivation to blame some situational factor for the onset of problematic drinking. El-Guebaly (1995:74) attests that a “vulnerability to traumatic events in women’s history” may predispose certain women to abuse alcohol. Very often, “women come into treatment due to interpersonal crisis” (Hoar, 1983:253), such a crisis having been precipitated by events in a woman’s life, including sexual violence, domestic violence, childhood sexual abuse, and/or childhood physical abuse by a father (Goldberg, 1995; Kagle, 1987; El-Guebaly, 1995).

Excessive drinking also has also been associated with difficulties in interpersonal relationships (Hoar, 1983; Holmila, 1991), such as marital and parental problems. In particular, the influence of a spouse on a woman’s drinking behavior has been recognized

within the literature. Spousal influence appears to have bearing on tolerance of substance abuse in women. Goldberg (1995:792) states that "men are less tolerant of the behavior of substance-abusing than non-substance-abusing women". Thus, perhaps it is the case that men of substance abusers are more likely to act as agents of social control, exerting external forms of control over their partner, resulting in the creation of tension within the marital relationship. Secondly, "having a spouse or romantic partner who abuses chemicals is more likely to generate substance abuse in women than men" (Goldberg, 1995:792). Holmila (1991:550) and Kagle (1987:23) refer to several studies done that indicate women often live with men who also misuse alcohol; El-Guebaly (1995:75) also mentions the potential impact of spousal influence on women's use of alcohol.

Social Factors/Influences

The dimensions of social structure need to be explored in looking at the relationship of women to alcohol. Drinking problems are typically portrayed within the literature as a class specific problem, one's social class having bearing on the perception of an individual's consumption of alcohol. Divisions between the classes in drinking patterns (upper-class, middle-class and lower-class) have been identified within the existing literature. In particular, the lower classes are the subject of scrutiny, McCormack (1986:43) describing "drink is the curse of the working classes".

In relation to women and class, there appears to be bias in the assignment of stigma to those women who drink excessively, on the basis of social class standing. In Goldberg (1995:791), Calahan, Cisin and Crossley state that "of lower-class women who

drink, a higher proportion are heavy drinkers.” Despite the fact that “some studies have indicated that there are more abstainers among lower-class women than among middle- or upper-class women” (Goldberg, 1995:791), the predominant perception of lower class women as heavy drinkers persists. For upper-class women who drink problematically, McCormack (1986:51) suggests that they “drink to retain an illusion about their status” as they slip down the social ladder. Somehow, this motive seems to be more acceptable to the palate than lower-class women drinking as a coping mechanism, or perhaps ‘just because’.

Ideology

In attempting to assess and interpret the relationships between the various categories, and then decode the messages being delivered to the reader within the content of the literature, the eleventh category derived from the coding process, “Ideology”, is extremely useful. The notion of ‘ideology’ will prove to be an extremely important factor in not only the relationship between women and alcohol, but the larger picture overall. Thus, I will briefly outline the conceptualization of ideology I will be utilizing, drawing primarily upon Habermas’s thoughts, as I will be referring to the notion of ideology throughout various discussions.

Ideology can be characterized as ‘the science of ideas’. However, this is far too simplistic a definition for a concept with many complexities and nuances. A more comprehensive definition can be provided utilizing Habermas’s thoughts. For Habermas (1973:237), ideology emerges as a product of the conflict between various interests within

the capitalist process of production. Resultant from these conflicts is the derivation of both political actions and institutions.

The principles used to make politically-oriented decisions, Habermas (1973:266) suggests, “are not accessible to rational comprehension: their acceptance is based solely on a decision, a commitment”. Apparently, ideology operates to intervene in the relationship between rationality and the decision-making process. Thus, decisions become based upon habitual responses, rather than rationalization processes. Referring back to previous discussions about the nature of responses, habitual decisions can best be characterized as evaluative in nature, based on morality rather than rationality.

Another functional aspect of ideology is the role of ideology in political legitimation. Hoover (1994:5) contends that “ideology is a crucial part of political life”, ideology serving to justify and sanction the policies and practices of government in the administration of State affairs. Consequently, the operation of ideology possesses political implications for societal members. However, ideology also operates in such a manner as to have social consequences. Contained within ideologies are assumptions about both individual and community life, and ideas about the nature of power in society. These assumptions and ideas, which are intended to reinforce group boundaries, serve to inform social action. Socially speaking, ideology can be conceived of as the basis of individual and group relations (Kinloch, 1981:14).

Returning back to the literature, Holmila (1991:549) refers to the existence of a “family ideology”. This family ideology operates in such a manner as to create certain images, perceptions and expectations for female members of society. Holmila (1991:549)

suggests that "strong ideological forces bind women" to the expectations entailed within the maternal role. Thus, women who drink excessively are depicted in certain ways, which elicit negative public perceptions of these women. The resultant imagery of alcoholic women both devalues and degrades these women as being less than "women". The functional basis of family ideology, I would suggest then, is to facilitate both the retention and the preservation of the subordinate structure of a social and political system organized under the guise of patriarchy.

As mentioned earlier, the operation of ideology is reliant upon both *assumptions* and *stereotypes*. Prevalent within the literature are assumptions about the nature of the relationship between alcohol and women. Holmila (1991:547) suggests that culturally situated rules of behavior are internalized "to the point where they cease to be felt as assumptions of beliefs but are more like "facts of life", which do not change and are not questioned". Ideology then, operates to transform the appearance of beliefs based on assumptions, into 'knowledge' based on 'facts'. Much of the 'information' contained within the literature is based on myth, general beliefs and common opinions (Goldberg, 1995:791), speculation (Hoar, 1983:251), and "hunches" (Hoar, 1983:256), which are inherently subjective rather than objective in nature.

To illustrate this point, Gomberg (1982:10) refers to historical legends and myths about the aphrodisiac nature of alcohol, which resulted in the restriction of alcohol consumption for women. Such myths serve to legitimate, both historically and presently, the restrictions placed upon the consumption of alcohol by women. As well, Hoar (1983:253) states that "even though hard statistics are lacking, informed observers agree

that alcoholism among women is becoming more prevalent”. Such conclusions must be based on opinion rather than fact, as empirical evidence supporting such conclusions is absent.

The various stereotypes about women who abuse alcohol found within the literature, Kagle (1987:22) suggests, are largely ”inaccurate and simplistic” in nature. Such stereotypes include the presentation of women as “unreliable, illogical, emotionally unstable and incapable” (Goldberg, 1995:792). Often, these stereotypes are grounded in morality issues (El-Guebaly, 1995:73), based on ”cultural stereotypes that justify exploitation” (Goldberg, 1995:792). These stereotypes are frequently communicated in *evaluative* statements about women, which are grounded in beliefs about the virtuous nature of the maternal role.

Abramovitz in Goldberg (1995:792) proposes that ”both the stereotypes and the ideals are strongly reinforced by the media”. The media serves as a powerful communicative agent for the transmission of the dominant ideology, the ideology of the family. Many of the norms being imparted in the media are not articulated in words. The nature of such norms makes it extremely difficult to question their validity. Gomberg (1982:16) refers to *messages* [emphasis added] to women about the acceptability of alcohol use. These messages are unspoken, being implicit rather than explicit in nature.

Theoretical Memos

During the coding process, many ideas about the relationships between the various codes and categories emerge. This section of the chapter will be devoted to reporting

those ideas, which fall under several themes pertaining to the codes and categories discussed earlier: The Maternal Role; Social Control; Conformity versus Non-Conformity; Autonomy; Medicalization; and Gender Bias.

The Maternal Role

What became evident to me during the coding process, is the paramount importance of the maternal role to understanding the relationship between women and alcohol. When drinking interferes with a woman's ability to fulfill her obligations and responsibilities entailed within the "maternal role", she is labeled a "bad" woman, and is she is made to feel guilty. Thus, the maternal role appears to be one, if not the most important gender role expectation placed upon females; it is a foretold conclusion that women are not only to be a mother, but to be a *good* mother.

When a woman's drinking behavior falls outside socially prescribed norms regulating drinking behavior, such behavior brings into question her *competency* as a mother. If a woman is deemed incompetent in her capacity within the maternal role, social control is levied upon such a woman, agents of control utilizing means such as sanctions of drinking to evoke desired responses by those women. Externalized forms of control are utilized by agents of control, which may in turn, evoke internalized forms of control over a woman's consumption of alcohol. Three points for discussion that stem from the maternal role are 1) social control; 2) conformity versus non-conformity; and 3) the issue of autonomy.

Social Control

With respect to social control, the issue of a woman's competence is brought into question, to cast doubt on her ability to perform her maternal duties. The doubt raised serves to reinforce the perceived need for someone to first, step in and take care of the woman, and in the case of pregnant women, the child she is expecting as well. And second, the conclusion is drawn that someone needs to provide the woman with guidance. By bringing into question a woman's competence, the intervention of agents of social control are both justified and legitimized.

Words such as 'administration' and 'intervention', in reference to addressing problems associated with women and excessive use of alcohol implicitly mean *control* of the women's behavior. Thus, intervention/administration can be conceived of as being comprised of the interaction between three elements: the means of control; mechanisms of control; and institutions of control. Legislative policies and agents of control, utilize mechanisms of control, which include exclusion, discrimination, inequality, and oppression. These mechanisms create and perpetuate bias, on the basis of gender differences, almost solely to the benefit of male members of society. Both State operated institutions of control, such as 'child welfare', as well as privately run agencies, are the vehicles by which the means of control gain the power to intervene. But even more importantly, the means of control gain legitimacy by acting in the name of these institutions of control.

Nonetheless, vehicles of social support, including family members, friends, support groups, as well as the more formalized institutions, could potentially be perceived of in a

positive light. However, they are more frequently than not, perceived in a negative manner, as agents of social control, who employ externalized forms of control to women who abuse alcohol. Social support, in reality may be nothing more than the rubric of social control under the guise of 'well-meaning intentions'. Which perspective is adopted is largely dependent upon how the woman perceives the aims of the 'agents'; whether their intentions are viewed as something positive or something negative. I would suggest that, at best, the nature of social control can best be characterized as unwavering, intrusive, and repressive; at worst, social control inflicted upon women who drink, especially while pregnant, is malicious, obtrusive, and bigoted.

Conformity versus Non-Conformity

Turning now to the issue of conformity versus non-conformity, when women conform, they are in compliance with gender role expectations and gender role ideals. However, limits are placed on women by 'buying into' gender ideals of women, as these expectations are informed by culturally designated values and norms. Historically, women could covertly consume alcohol through the consumption of "medicinal" drugs such as tonics, presenting the facade of conformity. With alcohol no longer available in covert forms, women's consumption of alcohol is now subject to more stringent public scrutiny, and any deviation from gendered expectations is interpreted as non-conformity. However, it must be recognized that non-conformity means different things for each gender; higher expectations are placed upon women to conform to societal norms with respect to gender role expectations.

Both women's behavior and appearance, when intoxicated, are described as at the very least, 'unpleasant', as such behavior conflicts with expectations of women to "behave nice and look nice" at all times. When women are described as 'heavily drinking women', there is a connotation that *heavily* is a bad thing; by consuming excessive amounts of alcohol, women are judged to be going against traditional perceptions and expectations of how women should, and should not behave. I would suggest that by conforming, this is perceived as implicit acceptance of the differences between gender role expectations by women. As a result of such conformity, the boundaries between the genders become even more firmly entrenched. Thus, non-conformity, in the form of 'rebellious drinking' behavior may not be such a negative thing after all.

Autonomy

A predominant notion within the literature is that women's autonomy in society is not genuine. It is not just mere semantics when words are chosen for defining what constitutes alcohol abuse. Women can be described as 'substance abusing' or 'substance dependent', but these are not the same thing. On the one hand, connotations associated with the word 'abusing' imply that there is an conscious choice made by the woman to (ab)use alcohol/drugs; on the other hand, 'dependent' insinuates that there is no choice in the (ab)use of alcohol/drugs, and that the woman is helpless. The notion of dependence then, appears to support the medical model definition of alcoholism.

As well, the issue of autonomy arises with reference to the relationship between fetal and maternal rights, where the potential harm to the fetus is weighed against a

woman's right over her body. A woman "automatically comes under the control of the state" (Goldberg, 1995:793) if she is pregnant and abusing illicit substances. Thus, there are no difficult choices offered to women, there are simply *no* choices. Goldberg (1995:791) states in studies of drugs present at delivery, urine tests were administered to women to determine if alcohol and/or drugs had been used recently; but more importantly, these tests "were administered to everyone *and not just willing respondents*" [emphasis added].

Medicalization

What I found particularly problematic with the disease model as an explanatory tool for the occurrence of alcoholism, is that if a woman is defined as an "alcoholic", how can she be blamed, even held accountable for her behavior? If a medical explanation of alcoholism is accepted as definitive, alcoholism having been medically ascertained to be a 'disease', how can women be held accountable for being alcoholics, and the ensuing results of their behavior? An analogy can be drawn, through a comparison of alcoholism as a disease, to another disease, such as cancer for example. We do not necessarily *blame* people for getting cancer, yet we somehow lay blame on those women who have a problem with excessive use of alcohol.

Also, denial within the medical profession is rampant, which I believe to be indicative of general situation in society. By using blinders, one being the medicalization of women's alcohol problems, we allow members of society to avoid seeing the 'real' picture; problems do exist, with respect to women's use of alcohol. However, I would

suggest that these problems are merely symptomatic of problems at a much deeper level, in both individual and systemic spheres. On an individual level, women may drink to deal with past and present abuses, poverty, and boredom, just to name a few factors. In the systemic domain, women may drink to deal with sexism, racism, and classism inherent within modern societal institutions and practices.

Gender Bias

Finally, with regard to gender bias, research in the past has been performed primarily by male researchers on male populations. This research has come to be regarded as biased in nature. However, research is being done solely by female researchers, and with tools specifically designed to be utilized on female populations, as was a study referred to in Hoar (1983:265). My concern is that is could this type of research not also be regarded as a form of gender bias, even if it is in the opposite direction? It becomes apparent that the problematic relationship between women and alcohol is constructed around the gender-oriented expectations of women entailed in maternal role, and non-conformity to these expectations evokes a negative response by collective society. These expectations are culturally relative, defined on the basis of collective norms and values. Thus, the "problem" is formulated as a need for social control of women who misuse alcohol, in such a manner that a politically-oriented problem is re-defined as a medical problem via the medicalization process. However, I do not believe that the adoption of the medical model explanation of alcoholism is necessarily beneficial for women. The misuse of alcohol by women is a problem with historical longevity that continues to grow in

complexity due to the enigmatic nature of modern society. The current construction of this problematic relationship does little to resolve the issues contributing to, and perpetuating the misuse of alcohol by the female membership of society.

CHAPTER FIVE: ALCOHOL AND ETHNICITY - BIOLOGY OR A SOCIAL CONSTRUCT?

The next aspect to be funneled into the picture is the connection between alcohol and ethnicity. A filtration of the affinity between alcohol and ethnicity will prove to have bearing on current efforts in the prevention of FAS. Again, as in the previous chapter, a extensive review of the literature pertaining to alcohol and ethnicity (pertaining to various subgroups within society) was performed, and the content of such literature was coded (see Appendix E) and then categorized. The resulting six categories can be best characterized as: the “problem”; biological factors; social factors; the influence of culture; power considerations; and dependency (see Appendix F). Each category will be discussed separately, keeping in mind that the categories interact with one another in such a manner as to create the complex dynamics of the relationship between alcohol and ethnicity.

To begin first, however, a very brief introduction to this discussion will help to contextualize the subsequent discussion. “For a long time, it was thought that beverage alcohol, ethanol, had the same effect on people all over the world, regardless of its particular form and despite variation in cultural context” (Everett et al., 1976:6). Nonetheless, despite the fact that customs involving drinking alcohol are virtually universal, the uses of alcohol vary widely (Everett et al, 1976:2) from culture to culture. Uses of alcohol within a given society can take on many different forms, alcohol use being employed in nutrition, health, religion, and/or entertainment. Thus, there appears to be cross-cultural variation with regard to drinking behavior.

This variation occurs on two levels: 1) on the basis of human biology; and 2) on the basis of sociocultural systems. The possibility of non-uniform physiological effects of alcohol, on the basis of racial/ethnic differences may exist, resulting in variation in the effects of ethanol across cultures. Furthermore, the norms and values governing drinking behavior may vary from culture to culture; “the social rules and the regulation of drinking behavior, and the cultural norms and meanings of alcohol use that are operative in particular societies” (Everett et al., 1976:5) need to be addressed. However, differentiation on the basis of ethnicity may be perceived of as biased, even racist in nature, and thus, notions of cultural variation may be subject to great controversy.

The “Problem”

Once again, the use of alcohol by a specific subpopulation of a society is defined as being problematic. In the previous chapter, the relationship between alcohol and women was problematized within the literature. In the literature on alcohol and ethnicity, the relationship between alcohol and ethnocultural groups in society is construed to be enigmatic. The various problems surrounding the use of alcohol, referring to circumstances such as undesirable alcohol induced behavior, compulsive consumption of alcohol to one’s physical and social detriment, and alcoholism (Hanna, 1976; Fenna et al., 1976; Barry, 1976) by ethnic minorities in society are deemed to be problematic.

”It has long been hypothesized that ethnic differences in alcohol tolerance exist” (Hanna, 1976:235), and that “significant ethnic differences may exist in the physiology of alcohol use” (Hanna, 1976:236). The conflict between knowledge and beliefs rears its

head once again, as the relationship between alcohol and ethnicity is riddled by assumptions and myths. "It is assumed that physiological or morphological factors which could produce variation in brain alcohol concentration could also produce variation in the resulting behavior" (Hanna, 1976:235). The belief in variations between ethnic groups has been referred to within the literature as "alleged differences" (Fenna et al., 1976:227), "unverified medical and law enforcement reports" (Fenna et al., 1976:227). Fenna et al. (1976:234) proceed to speculate that the difference in apparent metabolism rates is attributed to *probable* [emphasis added] differences in diet over many generations.

In addition, myths about the effects of alcohol on minorities inform perceptions of the relationship between alcohol and ethnocultural groups in society. "American Indians, for example, have a long-standing reputation for a weakness for alcohol" (Hanna, 1976:235). Thus, dominant perceptions of the relationship between Natives and alcohol has been contrived around mythological conceptions; "the effect of "firewater" on the native Americans have, since the days of the early explorers and traders, been described as unusually severe" (Fenna et al., 1976:227). This phenomenon will be explored at greater length further on in the next chapter.

Notwithstanding, to dismiss the possibility of differences between ethnocultural groups in society in their encounters with alcohol would be untimely. Problems associated with alcohol consumption involve both biological and social parameters (Hanna, 1976:235). In the past, it has often been an 'either-or' situation with respect to studies done on cross-cultural drinking behavior, the focal point being either biological factors, or social factors. Writings and/or research address either biological or cultural factors, but

never conjointly. Hanna (1976:240) suggests that in exploring the relationship between alcohol and ethnicity, "the relative importance of biological and social factors in the determination of drinking behavior" needs to be assessed, as "evidence relevant to a biological hypothesis of alcohol and cultural variation has become available" (Hanna, 1976:236).

There have been concerns raised within the literature regarding the problematic concept of 'ethnicity'. Adrian et al. (1996:116) take note of these concerns about recent criticisms of the concepts and typologies of race, ethnicity and culture. The issue at hand is the apparent interchangeability in the terminology used within the literature; the concepts of 'race', 'culture', and 'ethnicity' are understood to assume the same meaning. I would suggest that it is misleading to presume that these concepts are necessarily the same thing.

Biological Factors

There has been "little recognition of the underlying biological differences which could modify behavior" (Hanna, 1976:235). However, Hanna (1976:236) suggests that since alcohol use "involves biological processes, some organic basis should also be considered". Two key areas with regard to biological concerns identified within literature are 1) the metabolism of alcohol; and 2) the existence of differential thresholds. The rate of alcohol metabolism, the "rate of blood alcohol clearance - is known to involve some genetic component" (Hanna, 1976:236). At the group level, the differences between ethnic groups are discussed. In particular, comparisons are made between Caucasian and Natives.

Apparently, "natives metabolize alcohol at a significantly slower rate than the whites" (Fenna et al., 1976:234). Fenna et al. (1976:229), in reference to study results, posit that "the decline of blood alcohol level was much higher in the whites than in the natives", the rates of metabolism of alcohol as follows: whites at 0.370 mg/min; Natives at 0.259 mg/min; and Eskimos at 0.264 mg/min. "Indeed, the rate of metabolism for each category of whites is higher than that for any group of Indians or Eskimos" (Fenna et al., 1976:231), the individuals having been categorized as either light, moderate or heavy drinkers as defined in the study.

At the individual level, "the rate of disappearance in the same individual at different times is constant, and suggests that people have a characteristic burning rate" (Fenna et al., 1976:232). There is a general tendency for individuals to adapt to higher levels of intake of alcohol, by metabolizing alcohol at a faster rate; however, "even the subgroups of heavy drinkers among natives had lower rates of metabolism than the subgroup of light-drinker whites" (Fenna et al., 1976:233). Conversely, "the whites showed little metabolic adaptation to alcohol ingestion" (Fenna et al., 1976:230). As such, "in each ethnic group a tendency to adaptation to alcohol was indicated, but only among the Indians was this significant" (Fenna et al., 1976:233).

Hanna (1976:237) refers to the existence of a differential threshold in response to alcohol. Anatomical factors identified by Hanna (1976:238), including body mass, mass composition, and internal architecture play significant roles in how an individual's threshold to alcohol operates. Body mass differs between individuals, the composition of such mass comprised of a ratio of adipose (fat) tissue to muscle tissue being variable as

well. Also, internal architecture, especially differences in the small intestine, play a role in how an individual reacts to alcohol, as “the greatest alcohol absorption takes place in the small intestine” (Hanna, 1976:238). As such, the implications are as follows: if two individuals ingest the same amount of alcohol, the individual with a lighter body mass will have a higher concentration of alcohol in the system, as will the individual with a higher concentration of adipose tissue. In addition, the individual with a longer small intestine will have a higher concentration of alcohol in the system than someone with a small intestine that is shorter in length.

Gender and age are also related to threshold differences, as “women are smaller and tend to be fatter” (Hanna, 1976:239), resulting in higher concentrations of alcohol in women than in men who consume the same amount of alcohol. With respect to age, “as men and women age, there is a general increase in body fat content” (Hanna, 1976:240), typically resulting in higher alcohol concentrations in older individuals than younger individuals, despite having consumed identical amounts of alcohol. Thus, there appears to be a biological proof of the existence of a genetic propensity towards variations in alcohol metabolism and tolerance. Hanna (1976:240) asserts that some of the biological parameters discussed above also follow major ethnic lines. Nonetheless, it must be taken into consideration that variation occurs not only between ethnic groups, but *within* ethnic groups as well. This is an especially important consideration when referring to Canada’s Aboriginal population, as each tribe has unique background and characteristics.

Social Factors

The tendency persists, of ethnocultural groups in society to maintain, on some level, their cultural identity. Thus, cultural factors must be taken under serious consideration in exploring differences in the relationship between ethnic groups and alcohol. Several societal factors identified within the literature appear to have bearing upon how a particular group in society regards and relates to alcohol. A key determinant, identified by Boyatzis (1976:278), 'socioeconomic simplicity', encompasses both the economic and social organization of a society. Measures of insobriety are "negatively correlated with several measures of highly organized, hierarchical or stratified social structure" (Barry, 1976:258), as those societies with high levels of organization utilize social disapproval as a restraint against drunkenness (Barry, 1976:259). Typically, those societies with high levels of organization are oriented around capitalist notions, and are patriarchal in nature, the social structure of these societies being predominantly comprised of strong male-based institutions.

Another key factor is the aboriginality of alcohol to a given society. Barry (1976:258) states that in many societies with aboriginal use of alcohol, religious or ceremonial contexts are the principal, or only settings for drinking. As discussed in the previous chapter, this is not necessarily the case for those societies to whom alcohol is non-aboriginal, as such societies usually have very few, if any, rules or customs governing the consumption of alcohol. Community size has also been identified as a determinant in drinking behavior, where "small community size shows a significant positive correlation to drinking" (Boyatzis, 1976:277). A final social factor identified as having influence over

drinking behavior is that of male solidarity; "low male solidarity correlates significantly with drinking" (Boyatzis, 1976:275). As such, those societies with low levels of organization, are small in size, have low solidarity among its male membership, and to which alcohol is non-aboriginal, drinking is most likely high, perhaps even reaching levels that could be defined as problematic.

The Influence of Culture

Barry (1976:253) affirms that "drinking has a universal appeal which is indicated by its widespread popularity". The importance of alcohol to any given culture is significant, as alcohol serves a cultural function. Drinking involves specific patterns of social behavior, the social usefulness of alcohol illustrated in the adaptive function of drinking (Barry, 1976:260) within different societies. "Evidence of the social value of alcohol is the fact that substitute drugs are used in most societies without alcohol" (Barry, 1976:260); tobacco and gambling are identified as other forms of 'drugs', as they "are equivalent but alternative expressions of the same motivations" (Barry, 1976:260).

It must be remembered, however, that "alcohol is used in a cultural context" (Barry, 1976:249), differences in the usage of alcohol are "due to the cultural diffusion of ideas" (Adrian et al., 1996:104). Adrian et al. (1996:113) support the contention that there are cultural differences with respect to the meaning, and subsequent use of alcohol, as "perceptions of the social meaning of alcohol also differ for different ethnic groups in Canada". Hanna (1976:240) notes the existence of predispositions to "differing drinking habits and would behave differently while under the influence of alcohol", an explanation

for these differences being offered by Barry (1976). Barry (1976) discusses the use of alcohol within the context of the notions 'dependency' and 'self-reliance', suggesting that "variations in conflict over dependency may account for cultural variations in alcohol use" (Barry, 1976:250). Barry (1976:252) goes on to suggest that "rewards and punishments for self-reliance show large cultural variations which are related to other important cultural attributes", which in turn, are related to the drinking behavior of a given culture.

Each culture possess its "own different traditions of alcohol and drug use" (Adrian et al., 1996:104), with regard to the frequency of drunkenness and general consumption (Boyatzis, 1976:271). Adrian et al. (1996:112) suggest that the pattern of alcohol consumption is specific to a culture, this notion being illustrated by the drinking habits of various cultural groups in society. In particular, the "classification of the native according to drinking habits revealed a preponderance of heavy and moderate drinkers among our Indian population when compared to the whites and Eskimos" (Fenna et al., 1976:233). These traditions and customs are steeped in culturally based norms and values, which in turn are reflected in the variations in drinking behavior between different cultural groups, each culture possessing "varying beliefs, customs, mores, norms and behaviors" (Adrian et al., 1996:105).

Differences between the genders with respect to the acceptability of use of alcohol and other drugs are related to cultural belief systems. These gender divisions are evidenced as Adrian et al. (1996:113) report that "drinking and intoxication are less acceptable and less common among women than men in a number of ethnic or cultural groups". Adrian et al. (1996:115) refer to 'old-world' belief systems regarding the

divisions between the genders with respect to drinking behavior; these beliefs in turn, are reflected in varying “attitudes, opinions and behaviors regarding sexual roles and the use of alcohol, tobacco and drugs” (Adrian et al., 1996:105).

Boyatzis (1976:284) and Barry (1976:252) concur with Adrian et al., respectively stating that “the psychological effects and determinants of drinking behavior are linked to cultural sex roles”, as “in most societies, girls are trained more strongly in compliance and boys more strongly in assertion”. Discussions in the previous chapter, around the notions of ‘masculinity’ and ‘femininity’ in relation to gender role expectations must be considered here, as they have bearing on the ideals and expectations that are placed on males and females in any given society. Differences in the usage of alcohol between the genders might also have to do with the accessibility of alcohol to women, Hanna (1976:240) declaring the existence of “social factors which limit access to alcohol may also differ between the sexes”.

The level of acculturation is also an important factor in gender differences in the social acceptability of alcohol consumption. Differences in acceptability levels has to do with the level of acculturation of a given group (Adrian et al., 1996:104). Adrian et al. (1996:105) refer to ‘mainstream’ and ‘non-mainstream’ cultural norms, beliefs, and behaviors within the context of the discussion. What becomes apparent is that the differences in acceptability lie in whether a cultural group’s belief system can be regarded as ‘mainstream’ or ‘non-mainstream’.

The motivations for use of alcohol appear to be, to a certain extent, culturally based, as motivational patterns differ between, and within societies, resulting in variation

in the use of alcohol. Six motivational factors found within the literature (Adrian et al., 1996:117; Barry, 1976:249) can be characterized in the following manner: 1) to be sociable; 2) to add enjoyment to meals; 3) to feel good; 4) to help in relaxation; 5) to forget worries; and 6) to feel less inhibited. An additional motivation identified by Barry (1976:249) is to alleviate the conflict over one's dependency, alcohol meeting the individual's dependency needs by making them feel affectionate and nurtured, while simultaneously meeting their self-reliance needs, by making the individual feel both independent and assertive (Barry, 1976:253). Boyatzis (1976:281) suggests that intoxication is also a response to the boredom associated with powerlessness, this notion being of particular relevance to later discussions about the relationship between natives and alcohol. Finally, Adrian et al. (1996:112) suggest that "women's drinking served as a means of coping with stress and managing tensions resulting from discontinuities in social values". Again, this notion will prove useful in later discussions.

The use of alcohol is explained in terms of the pharmacological actions of the drug in the satisfaction of certain needs (Barry, 1976:249), alcohol serving to loosen the bond of reality (Barry, 1976:253). When discussing motivations for use, we must consider the characteristic features of alcohol, namely two: 1) as a sedative; and 2) as a disinhibitor (Barry, 1976:252). In high doses alcohol acts as a sedative, the principal action being depression of mental and physical activity. In low doses, alcohol behaves as a disinhibitor, with a stimulant effect on the individual consumer.

Power Considerations

The issue of political, economic, and social power, appears to be a significant factor in the drinking behavior of cultural groups within society, the degree of societal influence possessed by a given ethnic group within society being of at the crux of the power concerns. Boyatzis (1976) suggests two possibilities of relevance to this discussion, regarding the relationship between the consumption of alcohol and concerns about power. First, "drinking may be related to a particular form of power concerns" (Boyatzis, 1976:268); indeed, Boyatzis (1976:275) states that a "certain type of power concern is a critical determinant of cultural drinking levels". Alternatively, drinking may be related to the *arousal* of power concerns (Boyatzis, 1976:268) by certain circumstances within the environment.

Two dominant hypotheses, found within Boyatzis' (1976:270) power theory of drinking, suggest that the relationship between power and drinking is influenced strongly by cultural values. "First, cultures with high levels of concern about power should have high levels of drinking behavior and *vice versa*, second, cultures high in drinking should have structural characteristics which arouse power concerns" (Boyatzis, 1976:270). This theory will prove to have powerful implications in further discussions, when the context in which Native drinking typically occurs is explored at greater length. For now, the second hypothesis is of particular relevance to our discussion about the relationship between alcohol and ethnicity. When the characteristics of a society are such that there is a discrepancy between the impact of the individual on the environment and the impact of the environment on the individual, tension results. Tension can also result when an individual

fails to meet behavioral expectations, and thus, feelings of incompetence arise. This tension gives rise to feelings of powerlessness, at both the group and individual levels. Boyatzis (1976:283) suggests that powerlessness can be conceived of as an experience of 'alienation', the tension of feelings of powerlessness being compounded by boredom (Boyatzis, 1976:280).

"Alcohol can help the individual by making him FEEL more powerful" (Boyatzis, 1976:278), the state of intoxication changing the individual's power perceptions on a non-permanent basis. Boyatzis (1976:267) suggests that "the process of thinking he is powerful may provide the sensation of having risen above and become more powerful than his environment", if even for only a brief time. However, "heavy drinking is primarily associated with impulsive rather than controlled power concerns" (Boyatzis, 1976:268), illustrated by the use of socially unaccepted means of attaining power satisfaction. Barry (1976:253) makes a distinction between 'personalized' power and 'socialized' power that is useful to this discussion. On the one hand, personalized power, for Barry (1976:253), induced by higher amounts of alcohol, is grounded in aggressive, individualistic fantasies; conversely, socialized power, produced by lower amounts of alcohol, is grounded in fantasies about dependency motivations (Barry, 1976:253). Thus, it appears that drinking rooted in feelings of powerlessness is based on a need for personalized power. Typically then, behavior rooted in feelings of powerlessness is heavy drinking, resulting in aggressive behavioral tendencies.

As such, "restraints against drinking are needed, both for the individual and for the society" (Barry, 1976:258). Within the context of power, the issue of social control arises

once again. However, in this instance, social control is directed at ethnocultural groups in society. Such controls include limitations on the availability of alcohol (Barry, 1976:253), the establishment of a religious or ceremonial context within which drinking can take place (Barry, 1976:258), social disapproval (Barry, 1976:259), and self-control (Barry, 1976:259). Abstinence, at the individual and/or group level, is regarded as a severe form of restraint against drunkenness (Barry, 1976:259), but nonetheless, an effective form of social control.

Dependency

The final category, dependency, has been alluded to in earlier discussions, which will now be explained in greater detail. At the crux of this discussion is the notion of a conflict, referred to as the 'dependency conflict', where motivations of self-reliance and dependency are in opposition with one another (Barry, 1976:250). This conflict is a result of either greater rewards or greater punishments for one behavior over the other. This conflict is created whilst personality development is taking place; it is during infancy and childhood, when the child is rewarded or punished for self-reliance and/or dependency (Barry, 1976:254).

There is a low degree of reward for self-reliance in early stages of life in societies with high drunkenness (Barry, 1976:256). This results in individuals who adopt and utilize inactive, rather than active problem-solving strategies. Active problem-solving is characterized by constructive efforts to change oneself, or the offending environment. However, because the individual is not taught to be self-reliant during childhood, they

choose to use inactive problem-solving tactics, a passive response pattern of behavior (Barry, 1976:258). One such tactic is drinking alcohol, in many instances in excessive quantities. Intoxication provides a temporary escape, at best, from life conflicts and anxieties. Inebriation however, does nothing to assist in the resolution of the various conflicts or establishing new methods for alleviating the anxieties (Barry, 1976:257; Boyatzis, 1976:281); thus, repetition of intoxicated state is the predominant method.

Theoretical Memos

During the process of coding the literature pertaining to the relationship between alcohol and ethnicity many ideas were generated about the various relationships between the identified codes and ensuing categories. These ideas were recorded in the form of theoretical memos. A discussion of these ideas is warranted at this point, as such a discussion will provide the basis for analysis of the categories discussed above, on a deeper, more theoretical level.

Power Concerns: The Influence of Ethnicity on Gender Expectations

There are cultural differences with respect to acceptability of alcohol consumption by the genders. Values and norms, which are culturally relative, define the boundaries delegating what is, and is not acceptable behavior for women and men. Thus, gender differences are also culturally relative, with respect to perceptions of acceptability and tolerance of alcohol consumption and intoxication. As such, culturally relative perceptions of masculinity and femininity are inherently embedded in the structural organization of

society, and are reflected in the relationship between gender role expectations and drinking practices. In many cultures explored in the literature, there is pressure on males to be masculine and support their families, which in turn, is designated as a reason for the consumption of alcohol. Most theories about alcohol and ethnicity are predominantly male-oriented, studies about the relationship between ethnicity and alcohol, operating from a fundamentally male perspective. However, I would suggest that females also experience pressure and anxiety from the numerous expectations placed upon them as women, especially within the context of maternal role expectations.

It is true that women might drink to address pressures associated with the inequality and bias they experience in society. However, in the case of women who belong to ethnic minority groups, in addition to being women, the question arises as to which, if any, form of discrimination, racism or sexism, is first, more predominant, and second, of more relevance to the situation of these women? Because these women experience 'double bias', on the basis of gender and ethnicity, both forms of bias must be taken into consideration. However, the question of which form of bias, sexism or racism, seems to be an overriding factor in the inequality these women experience, will provide a strong clue in addressing the relationship between Canadian Native women and the incidence of FAS within the Aboriginal population.

The Cultural Influences on Drinking Patterns

Two relationships between drinking and behavior are apparent within the literature (Boyatzis, 1976:275): a positive relationship between impulsive power and level of

drinking; and a negative (inverse) relationship between self-control and level of drinking. These relationships are reflective of the culturally based values, norms, and mores informing and regulating drinking behavior. However, belief systems are not static, being subject to influences of various ethnocultural groups, new and old, resulting in a belief system reflective of the cultural diversity in society; a mosaic of norms, values, mores, and beliefs. Those beliefs systems, once regarded as "old-world" systems, from the immigrant populations of many years ago, are now reflected, to different degrees, in the dominant belief system in modern Canadian society. Yet, a presiding division made within the literature, is between 'mainstream' and 'non-mainstream' drinking patterns. Implicit is the assumption that those patterns of behavior regarded as mainstream are of Caucasian drinkers, placed in opposition to the drinking patterns of the many different ethnic groups in society, old and new.

The Precariousness of Dependency and Self-Reliance

As mentioned earlier, Barry (1976:256) suggests that in those societies with high levels of drunkenness there is low reward for self-reliance. As such, there is much ambiguity in such situations. On the one hand, the self-reliance motivation is predominant in childhood when parents are alcoholics, involved in criminal activity, and/or the children come from a broken home. Would it not be then, out of necessity, that children placed in such situations become self-reliant for mere survival, as such parents are absent, incapacitated, or just do not care? To allow dependency needs to rule would not be in the child's best interests. However, the cultivation of self-reliance is heavily frowned upon in

such societies, self-reliance being punished. As adults, these individuals consume alcohol excessively to fulfill *manifest* self-reliance needs, overt in nature, and *latent* dependency needs, covert in nature.

Reflections on Social Control

Abstinence by Natives, as a form of social control, was recommended as an option, when all other forms of control have been largely ineffective or absent. There are two problematic areas of concern with respect to abstention. First, it is assumed that abstinence, as a form of social control, is effective in the alleviation and prevention of alcohol misuse. The validity of such an assumption, however, is suspect, and should be challenged to provide proof to substantiate such a claim. One example that is brought to mind is 'dry' reserves, where the presumption is that the absence of alcohol on Native reserves will both alleviate current problems of alcohol misuses, and prevent future generations from abusing alcohol. The second area of concern pertains to the notion of self-control as a form of social control. Self-control operates through cultural norms and values. Pressure to conform to dominant perceptions of acceptable behavior, via self-control, may or may not be exerted upon an individual, largely being dependent upon those values and norms that govern a given society. Thus, dominant values and norms may conflict with culturally specific beliefs, resulting in disharmony between varying ethnocultural groups.

“Alcohol, tobacco and drug use behavior was found to differ among women of various ethnocultural groups” (Adrian et al., 1996:123). Such a finding, may indeed, be of

great significance, and carry with it resounding implications. In particular, differences in the behavior and attitudes towards alcohol and drug use has serious implications regarding public policy. "A general program developed to reduce the consumption of alcohol, tobacco and drugs may be inapplicable or inappropriate for women of specific ethnocultural groups" (Adrian et al., 1996:124). As such, attention to differences in ethnicity must be heeded in addressing perceived misuses of alcohol of one member of society by another, as misconceptions about the nature of sub-groups in society result in the making of unenlightened assumptions. "Racial variations in drinking settings, preferences, practices and consequences" (Dawkins and Harper, 1983:347) must be given credence. Erroneous or premature judgments, on the basis of cultural bias, would be costly in nature, in terms of financial costs, and perhaps even more importantly, in terms of damage to social relations.

CHAPTER SIX: ALCOHOL AND NATIVES - 'TIL DEATH DO US PART

We gave them corn and meat.

They gave us poison (liquor) in return

Red Jacket, a Seneca Chief (Price, 1975:23).

It is at this point that we insert the final key relationship into the funnel, allowing the connections between alcohol and Canada's First Nations peoples to percolate with the other elements previously introduced and combined in the funnel. The nature of the relationship between alcohol and Natives is an extremely sensitive and potentially volatile subject. For Scott (n.d.:10), "in the past, Indigenous groups epitomized the state of human health and harmony with the environment". However, in modern society, many Aboriginal communities today are struggling for day-to-day survival. The prevailing hypothesis in not only the literature, but society as a whole, is that this strife can be attributed largely to alcohol-related problems. As such, this chapter will be devoted to the exploration of the relationship between a particular ethnic minority in Canadian society, the Indigenous population, and their relationship to alcohol.

Alcohol and Natives

To begin, from the coding of the existing literature on alcohol and Natives, seven main themes within the codes (see Appendix G) were identified: The "Problem"; Social Control; Drinking as Deviance; Native Identity; The Drinking Context; Societal Factors; and Ideology (see Appendix H). The categorical organization of these codes will be explored singularly, rather than together, as such a depiction will lend some clarity to a very convoluted picture. The many elements involved in a relationship filled with vagaries

and complexities will be distinguished in an attempt to interpret the current relationship between alcohol and Canada's Indigenous population.

The Problem

The "problem" identified in this chapter is merely an extension of the problem outlined in the previous chapter, where the relationship between alcohol and ethnocultural groups in society was problematized. Only in this instance, the "problem" has been construed around a specific target, Canada's Aboriginal population. In very simple terms, the "problem" identified within the literature are the destructive and dysfunctional patterns of drinking among Indians (Price, 1975:18; Watts and Lewis, 1988:80), and the associated consequences of this dysfunction (Scott, n.d.:10). Alcohol appears to be the substance of choice among Aboriginals (Scott, n.d.:9). Indeed, "native Americans showed the greatest disruption because of alcohol" (Watts and Lewis, 1988:70), and thus there is an apparent need "to control excessive drinking" (Price, 1975:18). In doing so, the intended result is the reduction of alcohol-related problems, and the maintenance of local social controls on drinking behavior (Price, 1975:18).

However, within the literature, it became evident that there is some indecision as to what exactly constitutes the "problem"; Native alcoholism, Native health, Native youth, or Native youth and alcohol (Watts and Lewis, 1988:74). In addition, criticisms have been levied within the literature suggesting that "few serious efforts to ascertain the underlying reasons for alcohol abuse" (French and Hornbuckle, 1980:276) have been made. Indeed, the notion of alcohol abuse as a symptom of deeper social, cultural and personal problems

(French and Hornbuckle, 1980:275; Watts and Lewis, 1988:77) resonates below the surface of a simple definition of the “problem”, alluding to an interplay of sociological, psychological, and physiological causes (French and Hornbuckle, 1980:277) at the root of the problematic relationship between alcohol and Natives. Both Duran and Duran (1995:106-107) and Watts and Lewis (1988:76) contend that all but few authors maintain a definition of the problem that masks the issues of domination and subjugation, the complex interaction of cultural, economic and environmental elements best understood in a historical context.

There appears to be a historical progression to the current level of concern about Natives and alcohol, the nature of the relationship evolving into a problematic state over time. Initially, liquor was given as a gift to Natives, almost having to be forced upon them (Price, 1975:23); MacAndrew and Egerton in Duran and Duran (1995:123) state that “initially Indians were distrustful of the effects of alcohol but soon learned to enjoy the experience”, drinking progressing to become a practice associated with trading (Price, 1975:23). Consequently, alcohol became a desired object for trade (Price, 1975:23; Watts and Lewis, 1988:71). For many Aboriginal communities, it is at this point that the numerous obstacles yet unseen, in their association with alcohol, commenced. In the modern societal context, alcohol is seen as a pivotal factor in the many pitfalls faced by the Aboriginal population; “the Canadian Indigenous context is described as heterogeneous, oppressed, colonized states with high rates of poverty, and physical and social distress” (Scott, n.d.:9).

The 'problem' with alcohol and Natives has been largely constructed in the literature on the basis of legal terms, with the creation of a class of drinking/alcohol-related offences (Price, 1975:21; Watts and Lewis, 1991:70; French and Hornbuckle, 1980:275). These liquor crimes are comprised to include behaviors such as public drunkenness, drunk driving, and liquor law violations (Price, 1975:18). Prohibitions placed on the use, possession and/or sale of alcohol have "created an unnecessary class of legal offenses" (Price, 1975:22), resulting in Native drinking being characterized as one of the most extreme forms of deviant behavior, and in many instances a criminal act. Indeed, "Indian troubles with the law in both the U.S. and Canada are highly correlated with drinking" (Price, 1975:22). The arrest rate of Aboriginals for alcohol-related crimes is extremely high, liquor crimes constituting the basis for 75 percent of all Indian arrests (Price, 1975:18). Liquor crimes are particularly problematic for some tribes, as "the majority of the population of some Indian societies eventually serve jail or prison sentences for drinking-related behavior" (Price, 1975:25).

Several problems with the "problem" are identified within the literature. First is the issue of cultural diversity, both between and within Aboriginal communities. Differences persist with respect to language, folk medicines, ceremonial practices, and world-views (Weisner et al., 1984:239), these inter-tribal variations evidence of the heterogeneity of Canada's Indigenous population (Scott, n.d.:10). Since Native culture cannot be viewed as a single entity (Duran and Duran, 1995:104), "surely there are differences in the percentage of the population directly involved in substance abuse from one community to another" (Storm, n.d.:61). Variations in drinking styles and patterns need to be questioned

and examined on the basis of tribal affiliation (Weisner et al., 1984:237), and "cultural differences between native Americans and the larger society must be acknowledged" (Watts and Lewis, 1988:70) and paid respect. Watts and Lewis (1988:70) extend the notion of difference further yet, suggesting that "there is also a tremendous diversity of cultural and social traditions among different tribes", and that these intra-tribal differences must also be heeded in the conception of the "problem".

A second problem identified within the literature is founded on the composition of 'mainstream' society. The "problem" is constructed on the basis of comparisons made between Aboriginals and mainstream individuals (Scott, n.d.:24), "despite non-comparability on several demographic variables" (Scott, n.d.:31). Such a construction is inherently problematic in nature, the validity of current conceptualizations of the "problem" being somewhat suspect. A third enigma within the literature is the use of the word 'Indian' as a signifier. Duran and Duran (1995:108) acquaint us with the notion of "'Indian" as a signifier of ethnicity, cultural traditions, a similar historical experience"; they go on to suggest that "'Indian", in its popular cultural meaning, is not an ethnicity, but a stage in a social evolutionary ladder" (Duran and Duran, 1995:136). Thus, the notion of 'Indian' is inherently convoluted with negative undertones, suggesting that Aboriginals as 'Indians' are somehow lesser human beings than other ethnic groups, Caucasians in the context of this particular issue. Finally, within the literature, the issue of cultural specificity arises in framing potential responses to the "problem". Price (1975:24) asserts that "Indian societies need programs that work through Indian cultural patterns", there being an emphatic need for Indigenous-specific substance abuse and prevention programs (Scott,

n.d.:30). Watts and Lewis (1988:75) expand on the above ideas, recommending that such programs work on not only individual, but group concerns as well; alcoholism is still often looked at as an individual problem, rather than as a societal problem having implications for not only the individual, but the community as a whole.

Finally, in ascertaining the “problem”, although “the interplay of Western and Native cultures thus gives drinking both positive and negative meanings for Indian people” (Savishinsky, 1991:82), the focus is placed not on the positives of drinking, but solely on the negatives. In the literature, many positive functions of drinking are discussed.

Savishinsky (1991:82) affirms that “many Indian people experience drinking as pleasurable and meaningful”. Moreover, “there is evidence that drinking has positive social functions for various Indian societies” (Price, 1975:19) which include facilitating both social and communal integration, easy attainment of dream-like states, acting as an outlet for individualistic behavior, and breaking down emotional isolation between people (Price, 1975:19).

However, the negative functions of drinking overshadow the positives, appearing to far outweigh any potential value the consumption of alcohol might possess. Price (1975:20) suggests that the negatives of drinking can be classified in terms of the nature of the adversity resultant of the ingestion of alcohol: primary; secondary; or tertiary. For Price (1975:20), primary negatives are “what the drinker does to himself in the process of drinking”, an example being the development of alcoholism. Secondary negatives are “what the drinker actively does to himself and others” (Price, 1975:20), examples including suicide, murder, accidental injury/death, assault, and theft. And third, tertiary

negatives are identified as contributing factors to problems associated with the misuse of alcohol (Price, 1975:20), examples including social discord, unemployment, and divorce (Price, 1975:20).

In the construction of the “problem”, secondary negatives are monumental in creating a dubious image of the relationship between alcohol and Natives, focusing in particular on the relationship between drinking and death. Evidence connecting drinking and death is resounding, Duran and Duran (1995:94) citing nine studies that have illustrated alcohol as a contributing factor to deaths within numerous Native communities. “A study of sudden deaths in British Columbia in 1969 showed that an unusually high proportion of them were Indians who had been drinking” (Price, 1975:21), many of these deaths being violent in nature. Statistics on violent deaths have a strong statistical correlation with substance abuse (Scott, n.d.:14), death as a consequence of addiction evidenced in high mortality rates among Aboriginals, especially severe for youths in particular (Scott, n.d.:9).

Social Control

“Alcohol as a polysemic cultural artifact has played a profound role in the production, colonization, and subjection of native people both materially and symbolically” (Duran and Duran, 1995:121), both historically and presently. Social control is endemic to the association between Natives and alcohol, as “the dominant society requires that the negative functions of excessive drinking that influence it be kept in check” (Price, 1975:21). Hence, alcohol can be perceived of as “a tool of domination” (Duran and

Duran, 1995:103), Canada's Indigenous peoples being the "intervention target" (Watts and Lewis, 1988:76; Duran and Duran, 1995:101). As such, the membership of dominant society feels not only obligated, but justified in meddling in Native affairs, due to either an apparent ineffectiveness, or a gross lack of, traditional Aboriginal controls over drinking behavior that is perceived as being out of check.

"Internal social controls of drinking" (Price, 1975:18) govern the behavior of not only oneself, but others as well, while drinking; "cultural norms of control not only apply to how one dealt with others but also how one dealt with oneself" (Savishinsky, 1991:85). Indeed, "there are societies where social inhibitions remain largely intact even during periods of extreme intoxication because of the maintenance of traditional controls" (Price, 1975:19). Consequently, the presence or absence of traditional controls has an effect on drinking rates (Price, 1975:18). For many Native communities, there is an apparent lack of these traditional controls, both historically and in the present. Prohibitive efforts, on the part of not only dominant society, but Natives themselves, have "prevented the development of internal controls" (Price, 1975:22) while drinking.

Historically, "in Canada the possession and use of alcoholic beverages by Indians has generally been prohibited by the various Indian Acts" (Price, 1975:22); abstinence by the Indigenous population was legislated via the prohibition of possession and use of liquor by Natives, and the sale of liquor to Natives (Scott, n.d.:28; Price, 1975:22; Duran and Duran, 1995:101; Watts and Lewis, 1988:72). Restrictions on the use of alcohol by Natives was first addressed in 1880, when the *Indian Act* was amended to include S. 90-94 (Hinge, 1981a:44-46). These sections prohibited the sale, exchange, barter or giving of

alcohol to any Native individual, in addition to the possession of alcohol by any Native individual at any place and at any time. Thus, the prohibitions governing the use of alcohol by Aboriginals, as set forth in the *Indian Act*, were status offences, the use of, sale to, or mere possession of alcohol by Natives being a punishable offence due to their status as 'Native'.

It was not until 1951, that the *Indian Act* was amended once again, to include S. 95 (Hinge, 1981b:33). This section revoked certain prohibitions placed on the use of alcohol by Natives, to permit the sale to, and consumption of alcohol by Aboriginals in a *public place*. However, the possession of, and use of liquor by Natives, was still prohibited on the numerous reserves. Thus, until quite recently, the learning of drunken comportment by Natives occurred under deviant conditions due to these restrictive conditions placed upon their possession and consumption of alcohol. The learning of drinking patterns and behavior under deviant conditions may have bearing on how drinking is perceived within Native communities in modern times. Indeed, the residual effects of the various restrictions under the *Indian Act*, may still being evidenced in current alcohol-related problems within many Native communities.

Native self-prohibition has also been a prevalent solution to alcohol misuse among Aboriginals. Price (1975:23) and Duran and Duran (1995:101) refer to the "Code of Handsome Lake", the code of self-prohibition embodied within this 'Code' being adopted by many tribes even today. One of the downfalls of restrictive efforts is that they have "focused on prohibition, rather than on teaching positive functional drinking patterns" (Price, 1975:24). Alternatively, the literature suggests that some Native tribes possess

traditional controls over drinking behavior. Descriptions of aboriginal means of controls by French Jesuits outlined in Price (1975:23) include tying the intoxicated person down, taking the individual's weapons, penalties such as exclusion from the tribe, as well as leaders speaking out against the use of alcohol by Indians. In addition, other social mechanisms utilized to maintain societal order, outlined by Savishinsky (1991:92) include: gossip, public opinion, family pressure, physical repression, and aggressive displacement. Savishinsky (1991:90) refers to physical withdrawal as a means of dealing with stressful situations. Two traditionally powerful institutions of control within Native communities are the family and the church (Price, 1975:18). However, "Indian drinkers - even the most chronic and disruptive ones - were not labeled by their peers. Nor were they placed in institutions" (Savishinsky, 1991:90).

Traditional controls that are ineffective do not accomplish their intended goals because, either they are no longer effective, or they were never very effective in the first place. Price (1975:24) suggests that "traditional sanctions do not work on the more acculturated Indians", as "one result of colonization has been the weakening of traditional methods of social control" (Duran and Duran, 1995:105). Aboriginal methods of control that have never been very successful in controlling drinking behavior include violent and prohibitive behaviors. "The violence and social problems that come out of heavy drinking were not very effective in controlling excessive drinking" (Price, 1975:22); nor was the retention of restrictions on liquor sales, distribution and use (Watts and Lewis, 1988:72). Prohibition has not worked very well in the past, and does equally poorly in the present, as it merely serves to push drinking problems below the surface, and serves as an impetus in

the creation of additional problems, such as bootlegging. Several authors referred to a code or ethic of 'non-interference' in the lives of tribe members (Price, 1975:24; Savishinsky, 1991:83; Scott, n.d.:32), this code, I would suspect, being largely responsible for the failure of traditional controls which require community involvement in other's personal affairs.

Within the literature, it becomes evident that social control operates on the basis of three primary mechanisms: oppression; discrimination; and prejudice. Oppression can take on many forms, and operates most effectively at the institutional level. Weisner et al. (1984:239) suggest that oppression occurs in both the economic and political realms. Legal oppression operates in the forms of discriminatory practices and policies, as "in ethnically mixed communities, cultural differences in drinking patterns have been a seedbed for misjudgment and misunderstanding" (Savishinsky, 1991:93). Racial discrimination and exploitation (Price, 1975:25; Watts and Lewis, 1988:75) is evidenced in the arrest rates of Natives for alcohol-related offences; "there are many documented cases of legal discrimination behind these high arrest rates" (Price, 1975:22). Indeed, "many native Americans resented the legislation, viewing it as discriminatory" (Watts and Lewis, 1988:72). Finally, Price (1975:21) proffers that "if the contextual society is prejudiced these controls can be very harsh", and perceived of as being remarkably biased.

The mechanisms of control operate through their indoctrination in both the means and institutions of control in dominant society. The means of control, whether they be under the guise of treaties, legislation, administrative measures, or federal policy (Price, 1975; Duran and Duran, 1995; Watts and Lewis, 1988; French and Hornbuckle, 1980;

Scott, n.d.), in conjunction with the institutions of control, both formal forms, including government and social agencies (Price, 1975:25; Watts and Lewis, 1988:73; Storm, n.d.:61; French and Hornbuckle, 1980:277; Duran and Duran, 1995:95), and informal forms, such as the family and community institutions (Watts and Lewis, 1988:78), operate with the assistance of agents of social control. Agents of social control, defined by Price (1975:25) are comprised by those individuals identified as authority figures whose membership includes: the police, the courts, missionaries, social workers, employers, parole officers (Price, 1975), the medical profession, politicians, religious leaders, and members of the scientific community (French and Hornbuckle, 1980:276), and health and social science professionals (Duran and Duran, 1995:99).

As it stands presently, "for every problem there is a program" (Watts and Lewis, 1988:78); the "problem" in this instance, identified by dominant society, is the misuse of alcohol by Natives, the programs geared towards controlling what has been defined as excessive and destructive drinking styles. However, if programs are to be truly effective, the literature suggests that two key elements for success must be given due recognition: agency and autonomy. The issue of who has public voice, and advocacy arises in attempting to define and control drinking behavior. Watts and Lewis (1988:75) suggest that while "middle-class, white alcoholics have more public voices, more advocates", "youth (and the aged and handicapped) have had less of a voice in respect to alcohol problems" (Watts and Lewis, 1988:75). I think it would also be safe to place minority groups, Natives in this particular case, in the membership of society that has less agency in modern society. The second criterion for success, autonomy for Indigenous people, has

been the topic of ongoing debate. Duran and Duran (1995:106) assert that Aboriginals have a "need for self-determination and control", in both the definitional process, and in the response to community problems. The need exists for autonomy in Indian communities to deal with alcohol-related issues that have become problematic (Watts and Lewis, 1988:80); in particular, "problems must be identified with the goal of empowering the addicted" (Scott, n.d.:10).

However, societal agencies have been "historically somewhat myopic in their realization of the problem, and their willingness to do something about it" (Watts and Lewis, 1988:73). Denial of the problem, as a means of social control can be extremely effective. "Another aspect of this is the denial that there can be any such thing as a full-blown teen or youth "alcoholic"" (Watts and Lewis, 1988:75). In defining the "problem" and devising a response to the prescribed "problem", such a process is an exercise in pragmatics. Agents of control only problematize those aspects of the "problem" that are beneficial to define as being problematic, and those aspects that have the potential to be effectively controlled.

Drinking as Deviance

Savishinsky (1991:84) suggests that the perception of drinking as deviant is partly a function of time and place; thus deviance is a phenomenon based on relativity. Some forms of behavior are seen by both Natives and Whites as both deviant and disturbing (Savishinsky, 1991:82). However, the existence of double standards becomes evident within the literature, with respect to tolerance of drunkenness. The question as to by

whose standards to we measure deviance arises, and may result in conflicting perceptions of drunkenness as deviance.

Alcohol-related deviance is situated around several cultural ideals (Savishinsky, 1991:83). If we judge deviance on the basis of the mainstream culture, deviance is measured based upon the standard of normality in the dominant white population (Duran and Duran, 1995:99). Duran and Duran (1995:101-102) proceed to suggest that "Native American drinking patterns have been historically labeled as deviant whereas white middle-class norms and behaviors have served as the validation criteria", where "inappropriate cultural values, beliefs, and behaviors may become the focus of intervention" (Duran and Duran, 1995:101).

If, on the other hand, deviance comes to be appreciated on the basis of non-mainstream, Native culture, drinking becomes deviant when it challenges or threatens the basic values of a given community (Savishinsky, 1991:88). "Drinking did set the stage, however, for certain forms of behavior that deviated from what Indian people regarded as proper and acceptable" (Savishinsky, 1991:86). Those values held in esteem by a community are pivotal factors in determining if a behavior can be regarded as deviant. For example, deviation from normally restrained standards of conduct within the community (Savishinsky, 1991:83), in such forms as violence, sexual flirtation, and emotionality were looked upon with derision. Also, "the man who goes into town and "drinks up the seed money" is clearly deviant" (Weisner et al., 1984:247).

For Savishinsky (1991:84-85), there are five "Indian cultural values" pertinent to understanding the ambiguous nature of the relationship between alcohol and Natives:

interdependence; generosity and reciprocity; non-intervention; self-restraint; and responsibility. These values are embodied in several cultural ideals: the maintenance of emotional control; the spirit of generosity; a sense of responsibility and autonomy; and an ethic of non-intervention (Savishinsky, 1991:83). In addition, certain gender expectations are implicitly resultant; "females had to exercise more control over their own drinking in order to play the roles of monitor and mediator effectively" (Savishinsky, 1991:88). Thus, women were expected to remain responsible, and accountable for their behavior, and the behavior of others, at all times.

The notion of cultural influence on a community's relations to alcohol is prevalent in the literature. "Whether alcohol's effects are seen as being primarily physiological or psychological in nature, the cultural responses to drinking are rarely neutral" (Savishinsky, 1991:81). Indeed, French and Hornbuckle (1980:278) suggest that "the use and abuse of alcohol is [sic] strongly linked to cultural environments". In addition, cultural differences "shape people's perception of deviance, but also affect their willingness to indulge in it, and their ability to tolerate it" (Savishinsky, 1991:91).

Returning to this notion once again, the aboriginality of alcohol to a given culture appears to have paramount importance in their ensuing relationship with alcohol. As discussed in previous chapters, "among Native American people in Northern Canada, alcohol was unknown in pre-contact times" (Savishinsky, 1991:82). As such, many Aboriginals had little experience with alcohol, and alcohol-related behaviors prior to contact (Watts and Lewis, 1988:71). Because colonialists introduced alcohol to Indians in only what can be regarded as relatively recent times, they were neither prepared to deal

with the impact of alcohol, nor have they had the opportunity to develop effective social controls governing drinking behavior (Price, 1975:18; French and Hornbuckle, 1980:277; Scott, n.d.:10). However, Price (1975:23) asserts that "the initial reaction of those Indians who had no previous experience with alcohol was generally a quiet and restrained drunken comportment".

So how did Natives get from this perception of alcohol, to behavior consequent of excessive drinking patterns? "Indians learned from these Whites that drunkenness excused excessive and irresponsible behavior, especially when binge drinking to complete drunkenness" (Price, 1975:23). "Whites, who introduced alcohol, also presented certain models for drinking behavior which are not fully consistent with Native norms of conduct" (Savishinsky, 1991:82). Under the influence of colonialism, Aboriginal drinking behavior was modeled after those who introduced them to alcohol in the first place (Weisner et al., 1984:240), apparently excusing Natives from all behavioral accountability and responsibility while under the influence. However, a double standard was imposed on Natives; "in reality, then, alcohol re-defined and suspended responsibility, but did not erase it" (Savishinsky, 1991:86).

Although it is possible for people to develop new patterns of behavior when drinking, to enhance the more positive functions of drinking, and abate the negative functions of drinking via the development of internal social controls, the dominant cultural context must be explored, as "the inequities in broad cultural relationships change very slowly" (Price, 1975:25). French and Hornbuckle (1980:275) advise that "cultural sanctions and socially acceptable drinking patterns are factors relevant to individual

alcohol abuse and alcoholism". In adopting mainstream perceptions measures of deviance, and imposing double standards on the drinking behavior of Natives, the construction of Aboriginal drunkenness as deviant can only be perceived of as an exercise in legitimating the social control of Canada's Indigenous peoples; "the labeling of Native American drinking behavior as deviant was a method of social control" (Duran and Duran, 1995:103-104).

Native Identity

The problematic nature of Native identity is rooted in colonialist efforts to assimilate Canada's Indigenous population, acculturation policies originating in the colonial era (French and Hornbuckle, 1980:277). Both the enterprises of assimilation, and cultural genocide, can be regarded as "policies designed to destroy the "aboriginal" or tribal culture" (French and Hornbuckle, 1980:277), as explicit policies with implicit implications, one such implication being the "devaluation of cultural identity" (Storm, n.d.:61). This devaluation was accomplished through an negative association of Aboriginal identity with alcohol; the use of alcohol became a symbol of the deterioration of traditional culture" (Price, 1975:23) within colonial discourse. With acculturation, "the native American community is being pushed to accelerate the assimilation process" (Watts and Lewis, 1988:78), a process where traditional forms of control were destroyed (Price, 1975:18). With a "history of loss or threatened loss of culture" (Storm, n.d.:61), most Native communities resist acculturation, in varying degrees, as they "do not want to be

mainstreamed or otherwise assimilated” (French and Hornbuckle, 1980:278) any more than they already have.

”Indian societies appear to react [to the contact situation] in ways that are determined by their own culture and values” (Weisner et al., 1984:247). As such, acculturation occurs on a continuum (French and Hornbuckle, 1980:279), with three predominant levels of assimilation: traditionalists, middle-class Indians, and marginalists. Very briefly, traditionalists are those Aboriginals whose dominant cultural orientation remains within the realm of Aboriginal traditionalism. Middle-class Indians are predominantly regarded as “sell-outs” (Weisner et al., 1984:244) to the dominant culture; they are frequently referred to by their Aboriginal counterparts in derogatory terms, including: ”apples” [red on the outside-white on the inside], and “Uncle Tomahawks” (French and Hornbuckle, 1980:279). An finally, marginalists are those Natives ”pushed out to the fringe of their traditional culture” (French and Hornbuckle, 1980:278), being caught in betwixt mainstream and non-mainstream culture. Alcohol takes on different symbolic meaning for these groups, Weisner et al. (1984:244) suggest that drinking levels are indicative of acculturation stress. For traditionalists, “alcohol has come to represent a convenient method of ritualistic escapism for traditionalists” (French and Hornbuckle, 1980:279); for middle-class Indians, “those who have drinking problems usually manifest symptoms similar to those of their white counterparts” (French and Hornbuckle, 1980:279); and in the case of marginalists, “alcohol provides an convenient, yet unacceptable, method of escape” (French and Hornbuckle, 1980:279). Speaking more generally, Duran and Duran (1995:105) submit for consideration the notion that those

"tribes with high traditional integration and low acculturation stress experience much lower levels of alcohol- and drug-related problems than tribes with high acculturation stress and low traditional integration". Thus, patterns of usage differ between the different groups, one primary example being binge versus steady consumption patterns.

In the name of protecting and securing "Indian communities against the debasing influence of spirituous liquors" (Duran and Duran, 1995:124), a "paternalistic framework" (Duran and Duran, 1995:101) has been adopted in response to the ostensible problem between alcohol and Natives. The relationship between alcohol and Aboriginals has been construed in such a manner as to give the appearance of being deviant, which in turn, facilitates the "justification for paternalistic policies" (Duran and Duran, 1995:104) oriented around social control. However, "federal paternalism creates a dangerous dependency" (French and Hornbuckle, 1980:277), resulting in a dilemma between an individual's self-reliance and dependency needs, referred to, and discussed in the previous chapter as the 'dependency conflict'; "conflict that is internalized and concealed through alcohol abuse" (French and Hornbuckle, 1980:278).

The Drinking Context

As was the case with the relationship between alcohol and women, the context within which drinking occurs is portrayed within the literature as being of great importance. The drinking context, according to Weisner et al. (1984:244) encompasses "where, with whom, and on what occasions one drinks, drinking patterns over time, the reasons for drinking and the types of behavior associated with drinking". The drinking

context is an important factor in the determination of whether, or not, drinking is regarded as deviant; it is the context of drinking, not just the alcohol content of people's blood, that defines such behavior (Storm, n.d.:61; Savishinsky, 1991:86). Some of the contexts in which Aboriginals consume alcohol appear to contribute to the perception of their consumption of alcohol as deviant, including skid row, the urban bar culture, and in cars or outdoors (Price, 1975:20). Price (1975:20) also states that drinking typically occurs in a group setting, with friends. An individual's family also has great potential to influence both perceptions of alcohol, as well as their drunken comportment.

In addition to the context in which drinking occurs, the pattern which predominates contributes to the perception of drinking as deviant. "The pattern of abusive drinking appears to be different" (Storm, n.d.:61) between different societal groups, the prevailing pattern for Aboriginals being binge rather than steady drinking (Price, 1975:20; Scott, n.d.:13); "the incidence of binge drinking is much higher among Indians than among Whites" (Price, 1975:23). Price offers an explanation as to why such a pattern prevails, its roots in historical legislative efforts to control Native drinking, prohibitive controls having "reinforced binge drinking patterns" (Price, 1975:22). There also appears to be a common pattern of drinking to capacity (Price, 1975:21) within the Indigenous population.

Intrinsically, the differentiation between private versus public, and steadily versus binges changes perceptions as to the degree of the drinking being problematic (Price, 1975:22).

Descriptions to differentiate drinking pattern variations are offered by Weisner et al.

(1984:242): "serious drinking"; "White man's drinking"; "teetotaling"; and "on the

wagon". Each description carries with it certain connotations, some positive, but for the

most part, negative. Most terms utilized to describe Native drinking possess associations with negative imagery, a point which will be addressed further on the chapter, under the category 'Ideology'.

Within the drinking context, the role of the family is significant as a socializing agent, and thus, a potential agent of social control. "People learn most of their drinking patterns and how to behave when drunk" (Price, 1975:24), family being the means by which individuals are socialized to associate behaviors and images with the notion of drunken comportment (Savishinsky, 1991:87). As such, drug socialization and role modeling within the context of the home has an impact on future drinking patterns (Watts and Lewis, 1988:76; Weisner et al., 1984:237; Weisner et al., 1984:243).

One such impact on future drinking behavior is the use of alcohol as a means of inactive problem-solving. While "many groups have obviously developed ways of coping with the pains of life in a nonalcoholic manner" (French and Hornbuckle, 1980:277), many Native individuals use alcohol as a coping strategy (Scott, n.d.:12), albeit a largely ineffective one. Scott (n.d.:26) suggests that boredom is a factor in the misuse of alcohol. Referring back to the discussion on powerlessness in the previous chapter about the relationship between powerlessness and boredom, it may be speculated that the consumption of alcohol may be a response to powerlessness in one of two ways: as either an "escape" (Watts and Lewis, 1988:76; French and Hornbuckle, 1980:278; Scott, n.d.:33); or as an act of aggression to feel powerful. Duran and Duran (1995:103) posit that "alcohol use and even suicide may be functional behavioral adaptations within a hostile and hopeless social context"; in essence, a passive form of resistance.

Within the literature, there are two presiding options available for dealing with drinking: abstinence or moderation. "The philosophy of abstinence still dominates relations between whites and Native Americans" (French and Hornbuckle, 1980:278), echoes of prohibitive legislation of the past heard today in efforts to control Aboriginal drinking. "Most reservations are dry, and yet alcoholism runs rampant in these communities" (Duran and Duran, 1995:137). As such, one might speculate that prohibitions, in the form of self-imposed abstinence is not as effective as intended. Litman in Price (1975:24) states that "we must free ourselves from thinking in terms of abstinence as the exclusive criterion for improvement", and that the relationship between alcohol and Natives is not necessarily an all-or-nothing situation. Conversely, Price (1975:24) pronounces that "Indians can learn to drink in moderation", such patterns being emphasized in Indian religion (Price, 1975:25). "When asked what is the most significant thing you should do to improve your health, only Indigenous respondents answered reduce drinking" (Scott, n.d.:24). Thus, a harm reduction perspective might be useful in approaching the excessive drinking by Natives. For Price (1975:25), "moderate social drinking is much more functional than heavy binge drinking". As such, Lewis in Watts and Lewis (1988:80) declares the need to develop policies and programs to encourage communities to "develop mores that govern the appropriate use of alcohol", focusing perhaps instead on moderation as opposed to out-and-out abstention.

Societal Factors

Within the literature, the importance several societal factors becomes readily apparent, with respect to how alcohol is perceived, utilized, and invariably controlled. These identified factors include social structure, economic access, life stress, and spirituality. The social structures of mainstream versus Native culture differ, and tend to oppose one another. According to Watts and Lewis (1988:78-79), on the one hand the structure of Native society is traditionally based on the circle, the fundamental of circular based on equality of importance in operation of society, changing and moving on the basis of collective consensus. Antithetically, the structuring of dominant society is based on corporate structure, the pyramid. The fundamentals of the pyramid, are based on hierarchical associations of inequality, a top-down system of power relations, where organization is key.

In addition, "the village's size, isolation and economy embody a number of distinctive characteristics which shape its drinking patterns" (Savishinsky, 1991:92). Thus, the issue of economic access, or inaccessibility, must be recognized, looking at socioeconomic status as a factor (Weisner et al., 1984:239). "Economic development programs on reservations to some may, at first glance, seem to be somewhat distant from alcoholism prevention. Indeed, the opposite is true" (Watts and Lewis, 1988:76). Those individuals and communities with less economic marginality were more likely to be regarded as abstainers or moderate drinkers.

As such, economic access appears to have bearing on the amount of life stress experienced at both the level of the individual, as well as at the community level.

For Weisner et al. (1984:244) both life stress and family modeling effects are intrinsically imbedded in an environmental, social and cultural context. Consequently, the social context differs for Aboriginals, from the mainstream, and well as in terms of comparisons made between tribes, on the basis of poverty, isolation, child and spousal abuse, violence, and suicide (Storm, n.d.:61), the aforementioned factors contributing to, and indicative of life stress. The relationship between stress levels and drinking levels appears to be positively related. Weisner et al. (1984:243) support this contention, suggesting that "highly stressed individuals drink more than those reporting less stress".

Finally, "alcohol also has had an effect on the way spiritual power and traditional medicine are used in a community" (Duran and Duran, 1995:140). Native spirituality, Watts and Lewis (1988:80) advise, needs to be oriented towards "preserving cultural values and traditions, and most importantly to developing and fostering spiritual and religious values". However, this may be difficult, given the residual effects of colonial discourse, where "their spiritual strengths were decried as pagan" (French and Hornbuckle, 1980:275), the ideology of such discourse becoming a critical element in future discourses pertaining to the relationship between alcohol and Natives.

Ideology

For Hoover (1994:5), ideology is a crucial component of political life, behaving as a legitimizing agent, both justifying and sanctioning the policies and practices of government in the administration of affairs. The ideological discourse which operates in governance of the relationship between alcohol and Natives, thus, performs at two levels,

conveying both manifest and latent messages to society; ideology serves to "to promote the welfare of Indians, as well as our political interests" (Duran and Duran, 1995:124), the interests of dominant postcolonial society. On the surface, the manifest messages are comprised of "generalizations about the behavior of native peoples" (Watts and Lewis, 1988:77), such ideational notions embodying "the nineteenth century attitude that it is necessary to contain Indian "excesses"" (Price, 1975:25). For Duran and Duran (1995:118), these representations of Indigenous peoples are regarded as social commentaries, edicts on the state-of-the-day. Hassrick in Watts and Lewis (1988:72) suggests that that such representations illustrate "the motive among whites of protecting themselves from "drunken Indians"".

However, beneath the manifest content of ideological discourse, lies the latent messages, a clandestine, more covert directive. French and Hornbuckle (1980:278) assert that "a small, elite group of regulators determines federal policy according to its cultural perspective", such policies required to "maintain rigid physical and social distance between themselves and the individuals they regulate" (French and Hornbuckle, 1980:278). Thus, for Edgerton in Savishinsky (1991:94), "the White image of native drinking as deviant is thus partly a consequence of a 'sub-cultural conflict' between minority and majority populations". Colonial based discourse operates to ignite, and perpetuate domination, ideology being "used to promote and maintain a system of domination" (Duran and Duran, 1995:104). Duran and Duran (1995:104) proceed to suggest that ideological assertions of cultural inferiority serve to promote cultural hegemony. As such, ideology is founded

primarily on the basis of a myths and stereotypical images, perceptions and assumptions about Native people.

”Myths are powerful influences in human affairs: they condition situations, their preconceptions create consequences” (Leland, 1976:123). Myths about the relationship between alcohol and Natives, found within the literature, come in two prevailing forms: 1) myths about Native drinking; and 2) myths about alcoholism. To begin, there is an abundance of allegorical notions about Native drinking; it is speculated that drinking did not flourish in some Indigenous societies because of their great continuity in religion and social structure (Price, 1975:23). Consequently, excessive drinking has been attributed to “a combination of weak internal controls, loose social structure and inadequate or discriminatory agencies working to regulate drunken emotional comportment” (Savishinsky, 1991:92).

There appear to be two dominant epilogues, based either on the “firewater myths” (Leland, 1976) or the myth of the “drunken Indian” (Duran and Duran, 1995). According to “the firewater myths”, “Indians are constitutionally prone to develop an inordinate craving for liquor and to lose control over their behavior when they drink” (Leland, 1976:1). Weisner et al. (1984:243) refer to the belief in the existence of an Indian genetic propensity to drink heavily, and react differently to alcohol; “natives turned into beasts when they drank and that debauchery, murder, and interfamily and intertribal feuds resulted” (Duran and Duran, 1995:123). This apparent inability to handle alcohol, has resulted in the presumption that alcohol “was poisonous and bad for native peoples” (Watts and Lewis, 1988:71). The myth of the drunken Indian (Duran and Duran,

1995:95), is merely a misconception that Aboriginals cannot hold their liquor, excessive binge drinking patterns having been "labeled as the unique style of native drinking" (Duran and Duran, 1995:107).

As well, myths about the nature of alcoholism exist, which comprise the footing for many assumptions made about the nature of the relationship between alcohol and Aboriginals. French and Hornbuckle (1980:276) respond to the various myths which predominate about alcoholism, proposing that: 1) alcohol by itself does not cause alcoholism; 2) alcoholism does not result from drinking a particular beverage; 3) alcoholism is not an allergic manifestation; and 4) alcoholism is not the result of an alcoholic personality. However, ideological notions about Natives and alcohol have stretched, manipulated and contorted both the "firewater myths" and the myth of the "drunken Indian" to suit a certain purpose, resulting in an "alleged connection between racial differences and susceptibility to alcohol" (French and Hornbuckle, 1980:277).

Equally powerful are the stereotypes which serve to legitimate and perpetuate pejorative images of Natives in relation to alcohol, such stereotypes being based in their entirety on Eurocentric notions (Duran and Duran, 1995:136). The stereotype which resonates throughout the literature is that of the "drunken Indian" (Savishinsky, 1991:94; Watts and Lewis, 1988:75; French and Hornbuckle, 1980:277; Duran and Duran, 1995:109). The image of Natives as wild men, unruly, foreign, uncultured, and savage (Duran and Duran, 1995:117) reigns, resulting in "the appearance of volatility" (Savishinsky, 1991:91). Accordingly, Natives are perceived, stereotypically so, as being irrational, instinctive, operating solely on the basis of intuition, rather than reason (Duran

and Duran, 1995:108). Drinking then, becomes central to Native identity, as in essence, drinking is 'Indian' (Scott, n.d.:13). In addition, the image of Aboriginals as being 'toughminded' is found within the literature, suggestive of "the tendency for both female and male Native American alcoholics to exhibit a high level of "toughmindedness" (Duran and Duran, 1995:97). Scott (n.d.:25) refers to this as the "tough-mindedness dimension".

Several authors make note of the existence of a self-fulfilling prophecy (Watts and Lewis, 1988:75; French and Hornbuckle, 1980:277; Scott, n.d.:13), where these stereotypes and myths are "internalized by many Natives, some of whom have become sensitive to the self-fulfilling nature of the concept" (Savishinsky, 1991:94). Thus, myths and stereotypes about Natives and drinking appear to serve in both the creation, and the perpetuation of the problematic relationship between alcohol and Indigenous peoples. These ideological considerations, in turn, precipitate the social control measures exerted on the Native population.

However, the legitimacy of the need for social control is at best, questionable, as the 'information' about the relationship between alcohol and Natives appears to be largely based on beliefs and opinions, influenced by mythical and stereotypical images of Aboriginals, rather than knowledgeable and factual data. Scott (n.d.:13) affirms that "little clear, direct data exist on the rate of Indigenous Canadian substance abuse"; she proceeds to suggest that "very little information available is published or rigorously scientific" (Scott, n.d.:33), resulting in a non-generalizability of 'findings' about the relationship between alcohol and Aboriginals. For Price (1975:18), Indians are not 'true' alcoholics- because *addiction* [emphasis added] rates are low among the Native population); indeed,

“a number of experienced observers in several fields share the opinion that alcohol addiction may be absent or rare in the Indian groups they report on” (Leland, 1976:8). As such, “gathering adequate data among Indian populations is extremely difficult with the result that the interpretation of findings becomes largely a matter of theoretical taste” (Levy, 1976:xi).

Several authors make reference to Jellinick’s ‘disease’ concept of alcoholism (Watts and Lewis, 1988:73; French and Hornbuckle, 1980:276; Duran and Duran, 1995:101), attempting to medicalize the relationship between alcohol and Natives. The medicalization of the “problem” then, attempts to lend credibility to the seemingly problematic relationship between alcohol and Indigenous peoples. “Alcoholism has become the single most serious *health problem* [emphasis added] accounting for the three leading causes of death among Native Americans: cirrhosis of the liver, suicide and homicide” (French and Hornbuckle, 1980:275). Thus, “alcohol abuse and alcoholism is one of the nation’s most serious health problems and one of the most difficult *illnesses* [emphasis added] to cure” (French and Hornbuckle, 1980:276). Watts and Lewis (1988) and French and Hornbuckle (1980) refer to the pathological nature of alcohol misuse within the aboriginal population, which can potentially induce the condition of an “alcoholic psychosis” (Watts and Lewis, 1988:70).

The process of medicalization serves to bring a societal problem down to the level of the individual (Duran and Duran, 1995:101). Thus, medicalization is an attempt to gain “acceptance of alcoholism as something that needed scientific, medical and societal handling” (Watts and Lewis, 1988:73); “calling for alcoholism to be treated as a health

problem rather than as a criminal justice problem” (Watts and Lewis, 1988:73). It is noteworthy, that attempts to reconstruct the “problem” in medical terms occur despite the notion that there are extremely low addiction rates among the Indigenous population; the rate of physiological addiction to alcohol among Indians is low (Price, 1975:18), Savishinsky (1991:90) suggesting that there are “no clinical alcoholics” to be found in the Aboriginal population. One implicit implication of medicalization of alcohol-related problems in relation to the Indigenous population is the assumption that treatment is a ‘cure’. The need to treat alcohol and drug-related problems (Watts and Lewis, 1988:75; French and Hornbuckle, 1980:278; Duran and Duran, 1995:101) is echoed throughout the literature, the implicit assumption being that treatment is the be-all, end-all ‘cure’ for alcohol-related problems. However, Scott (n.d.:19) suggests that the most effective “Indigenous treatment centres are residential facilities with intensive, *non-medical* [emphasis added], culturally-sensitive programs”.

The ideological discourse around alcohol and Natives, which serves to inform society about the “problem” and govern social control measures to deal with the “problem”, is steeped in hypocrisy. “Admonishing words came from individuals whose ancestors had introduced alcohol to Indian people and who, in Native eyes, therefore had to bear at least some of the responsibility for dealing with its consequences” (Savishinsky, 1991:89). Indeed, there is no one truth, but there are many judgments (Savishinsky, 1991:94). However, current truths, and according judgments are based on deceptive myths and stereotypes, sodden with insincerity.

Theoretical Memos

During the coding and categorization process, many ideas occurred to me about the relationship between alcohol and Canada's Indigenous population. The complexity of the various issues is striking. This section is devoted to the sorting out and exploring of these ideas. The presentation of these thoughts will occur under the following headings: Social Control; Deviance and Drinking; Ideological Considerations; The Symptomatic Nature of Alcohol Misuse; and Applicability of Current Theory.

Social Control

The social control of Natives, as was the case with women and alcohol, operates via the use of authority figures as agents of social control. However, social control in this instance is conducted within the context of ethnicity rather than gender; social control then, in the case of Aboriginals and their relationship with alcohol, is based on racism rather than sexism. The resultant social control is a product of the combination of policies of control, which are then utilized by institutions of control and agents of control, oriented around an essentially racist dogma. Regardless, social control, in whatever form it takes, and by whom it is employed, is viewed as a necessity to order, at the level of the individual, community and society as a whole. If Aboriginals cannot control the misuse of alcohol by their counterparts, then formal control such as the police and government, in addition to informal controls, such as family and friends, feel obligated to intervene. And thus, the social control of the Indigenous population is seen to be legitimately justified.

The failure, and in some case the absence of, traditional Aboriginal controls is seen to be at the root of the misuse of alcohol by many Natives. The code of non-interference, mentioned several times in the literature, may be at the root of the problem with respect to ineffective Aboriginal controls over drinking within Native communities. Non-interference is highly valued within most Aboriginal communities, and thus, conflicts directly with the need for Aboriginally-based social control of drinking behavior deemed to be problematic in nature. Those societies who did not succumb to the perils of alcohol were assumed to be very strong in terms of their religious and social structure. By comparison, were all those who have a high incidence of alcohol-related problems weak in nature? I find this hard to believe, and would instead, suggest that perhaps it is the case that those societies with low incidences of alcohol-related problems, in essence, sacrificed the code of non-interference for the welfare and preservation of other traditions, customs, and values. 'Culture' then, becomes yet another medium through which social control operates, via culturally based and prescribed norms, values and mores that place restrictions upon behavior, and exert pressure upon individuals to conform.

Another notion for consideration is the idea that Natives are buying into the myths about their relationship with alcohol, and are assisting dominant society in their control. In the adoption of aboriginal controls based on self-prohibition (abstinence), are Natives not also buying into the myth that 'Indians cannot drink'? A distinction is made within the literature between two types of abstainers: lifetime, and former drinkers (Weisner et al., 1984:244). I would question the extremity of self-prohibition as a form of Aboriginal control, and its overall effectiveness. It appears that rather than attempting moderation,

abstention is the perceived route to success. However, in embracing this trajectory, are Natives not accepting the ascendant perception that it is an all-or-nothing situation for them with respect to alcohol?

In addition, the effectiveness of abstention, in the form of prohibition must be taken under solemn regard. The issue of abstinence versus moderation is especially relevant to issue of pregnant Native women and the prevention of FAS in their children. Under the guise of 'moderation', social control is not as effective as social control in the form of 'prohibition'. Under prohibition, it is simply a matter of essentially banning the consumption of alcohol; a very simple solution to the "problem" it would seem. The complexities of such a solution will be discussed in more depth in the following chapter, which deals specifically with the relationship between alcohol and Native women.

Although drinking has taken on different meanings for different 'types' of Natives: traditionalists; middle-class; and marginalists, the implications for each group are reasonably similar. Adopting a harm reduction perspective, moderation, as opposed to abstinence, may be more realistic for all 'categories' of Aboriginals. Abstinence need not be the imminent goal. Thus, although these differentiations may be somewhat useful, in labeling an individual as either a traditionalist, middle-class, or a marginalist, such labels primarily serve to divide the Native population. Such divisions may assist in further controlling Indigenous peoples, and controlling them that much more effectively; the epitome of the notion 'divide and conquer'. Finally, the notion of "toughmindedness", I would suggest, is perhaps just another stereotypical image of Natives, serving in the legitimization in administrative efforts of social control. Since Natives are resistant, are

outside forces not justified in using force, if necessary, to control behavior that is both destructive and costly, on not only an individual level, but at the collective level as well?

Deviance and Drinking

Within Native communities, belief systems are not oriented around just one isolated norm or value; five predominant values within Native communities were discussed earlier, around which deviance, within the context of Native communities is constructed. Therefore, the definition of drinking as deviance is culturally specific, defined around culturally prescriptive values, mores, norms, beliefs and ideals. It is when drinking as deviance goes beyond private violations directed at the individual, harm, potential or actual, is perceived to be elevated to the level of the collective. It is at this point when society feels justified in stepping in to control drinking behavior deemed to be problematic; one example being in the case of pregnant women consuming alcohol, bearing the risk of producing children afflicted with FAS. In addition, the motivations to use alcohol are culturally specific; for Natives 'escapism', as a coping mechanism, is touted as a primary motivational factor.

The notion of drinking as a deviant behavior is also subject to the influence of mainstream versus non-mainstream notions about drinking. Such comparisons are inherently biased in nature, yet seem to govern the decision as to whether certain behaviors and patterns resulting from the consumption of alcohol are deviant, and therefore, problematic. Finally, the aboriginality of alcohol to a group plays a pivotal role in the construction of drinking as a deviant behavior. Thus, part of the definition of the

“problem” is due to the issue of aboriginality; due to a lack of norms regulating drinking behavior, alcohol becomes a problem for many Natives. Initially, at the time of colonial contact, Natives possess few, if any, incipient controls to regulate drinking behavior. For many Native communities there have been continued difficulties in developing these norms, which can be copiously attributed to both historic, and current prohibitions of alcohol use, external and self-inflicted in nature.

Ideological Considerations

The ideological discourse around alcohol and Natives is based on the dubious debate between fact and opinion, such conflict fueled by the myths, assumptions, and stereotypes governing the relationship between alcohol and Natives. Hence, ideology is essentially a combination of myths, assumptions, and stereotypes, working in synchronicity to present a manifest agenda of treatment and prevention, with a latent connivance; the preservation of hegemony by dominant society. As such, ideology can be perceived of as a frame of reference, conflict resultant of the clash betwixt differing frames of reference adopted by cultural groups in society; in this particular case, conflict in the relations between Whites and Indians.

The Symptomatic Nature of Alcohol Misuse

To protect Natives from the harms of alcohol, and from themselves, both historically, as well as in the context of current society, prohibitive controls have been levied against Natives. These controls as discussed earlier, are inherently paternalistic in

nature. Paternalism, in turn, creates conflicts between self-reliance and dependency; these conflicts are first internalized, and then externalized, evidenced not only in alcohol consumption, but also the ensuing problems associated with the consumption of alcohol. Thus, problems occur *before* the consumption of alcohol, and problems occur *because of* alcohol consumption, alcohol misuse being largely symptomatic rather than causal in nature. The numerous alcohol-related problems faced by Natives are a manifestation of the systemic and structural inadequacies of current societal conditions within Aboriginal communities. The notion of alcohol use as a symptom of underlying hindrances should be taken into esteemed regard when interpreting the use of alcohol by Native communities. However, this is not to dismiss the fact that alcohol can, and does, exacerbate the numerous problems faced by the Aboriginal population.

The Applicability of Current Theory

Although the existing theory about the relationship between ethnicity and alcohol does lend some insight into the use, sometimes problematic in nature, by ethnocultural groups in society, such theoretical notions leave much room for speculation and uncertainty in the case of Canada's Indigenous population and their use of alcohol. Adrian et al. (1996) discuss a theory pertaining to immigrants and alcohol consumption within the context of postcolonial multicultural society. However, this theory does not really apply to Natives, for four reasons. First, Canada's Aboriginal peoples are not immigrants, as they were inhabitants of the land we have come to regard as Canada prior to colonial contact.

The second issue pertains to the non-aboriginality of alcohol to the Native population, as in the case of many immigrants, alcohol is aboriginal to their cultural group.

Third, the role of the notion 'mainstream' in definition the "problem" is somewhat problematic in nature, as the belief system of dominant society serves as a basis for comparison of the belief systems extant within the Aboriginal population. Consequently, the behavior and beliefs of the Native population are placed in direct antithesis to those of the mainstream. However, the use of mainstream society as a measuring rod is not necessarily a valid, constructive, or informative comparison. A final point for consideration revolves around the notions of cultural diversity and tribal affiliation. Both differences *between* tribes, inter-tribal differences, and distinctions *within* tribes, intra-tribal differences, are worthy of consideration theoretically. In assuming that 'one-solution-fits-all', a sweeping generalization is made. Such generalizations do little to reduce the incidence of alcohol-related problems faced by Aboriginal communities, one such problem being FAS.

To deny the saliency of the "problem", the misuse of alcohol within the Canada's Indigenous population would be a great injustice. Nonetheless, the reality in which such problems occur and are constructed must be taken into account, and the uniqueness of the situation of the Native population taken unto its own accord. Within the context of inebriated behavior, there are culturally patterned variations (Price, 1975:24) of behavior. However, "externally imposed solutions, at a minimum, will not work and probably will only add to the sense of failure experienced by Indian people" (Watts and Lewis, 1988:79). Current administrative efforts, under the rubric of social control, must be

recognized for what they truly are; as oppressive restraints motivated by an underlying hegemonic desire of preservation, cloaked beneath the ideological guises of treatment and prevention.

CHAPTER SEVEN: ALCOHOL AND NATIVE WOMEN - A CASE OF 'TRIPLE- JEOPARDY'

Although there is almost no reliable research data about Indian women and alcoholism, it is assumed that Indian women exhibit higher alcohol-related problem rates than the larger society. This assumption may be derived from the prevalence of the stereotypical portrayal of some Indian males as drunken Indians", and the belief that "Indians can't "hold their liquor""

(New Breast et al., 1986:3).

In the funneling process, we have reached the point at which all elements related to the issue of FAS and its prevention within Native communities have been combined. These elements have had the opportunity to intermingle with one another, their passage through the funnel resulting in a derisive perception of Aboriginal women's connection to alcohol and pregnancy. In addressing the vexatious relationship between alcohol and Native women, there is at best, scanty literature dealing specifically with the relationship between *Native* women and alcohol. Most of the literature addresses the topic either within the context of gender or ethnicity, even then, just barely skims the surface of this grievously complex relationship. Hence, the relationship of Indigenous women to alcohol will be explored and evaluated based on discussions in Chapters 4 through 6, drawing upon key points and categories contemplated in each chapter. As such, this chapter will trace the evolution of a phenomenon, alcohol use by Native women, from the status of a 'problem', to the prescribed solution, the social control of Native female substance (ab)users, and ensuing implications of the decreed solution.

The Phenomenon

The phenomenon in question, in this instance, is the use of alcohol by Native women. The use of alcohol by this particular group must be looked upon from the societal and cultural context in which drinking occurs, taking into consideration both past and present attendant conditions. In addition to the influence of culture, societal conditions, have bearing upon ensuing behavior at the individual, community, and even societal level. For Native women, drinking is related to the combined effects of social factors such as community size, social organization and spirituality, and elements of a woman's personal history. Two primary motivations for use of alcohol by pregnant women cited by Scott (n.d.:30) include social motivation, or in relation to coping. According to Kellner et al. (1996:1620), "alcohol is not a socially neutral substance"; indeed, the consumption of alcohol by women is often perceived of as a class-related issue. The dominant societal perception of the relationship between alcohol and women from the membership of the lower classes, erroneous or otherwise, is often regarded as problematic. And thus, the consumption of alcohol by lower class women, be it problematic or merely recreational in nature, is frequently looked upon with much scorn and stigma. In addition, the role of the family as a socializing agent, is significant. The context within which an individual learns to drink, will have bearing on his/her future use and perceptions of alcohol. One's peer group is also a factor in how an individual utilizes alcohol, and perceives alcohol-induced behavior. Within many Native communities, "there is a noted social acceptance of excessive alcohol use, and often peer pressure encourages it" (Scott, 1996:136).

An individual's personal history also has considerable impact on his/her use of alcohol, as personal experiences give rise to life stress. For women, circumstances such as past and present abuse, and spousal influence are of significance. Considering Aboriginal peoples, one's identity as 'Native', subjected to the effects of acculturation, and issues of economic inaccessibility are of particular relevance. Regarding Aboriginal women, their personal histories are frequently an aggregate of these conditions. Native women are subject to violence in the home, both personally and as witnesses; "it is claimed that the lives of virtually all Indian females in Ontario are affected in some way by family violence" (Scott, 1996:131). Moreover, "lower-income people are more vulnerable to alcohol use-related harm" (Kellner et al., 1996:1634), a great number Native women belonging to this income category. Consequently, binge drinking serves as an inactive means of problem-solving for many Aboriginal women, the use of alcohol functioning as coping mechanism to deal with life stresses. The amount of alcohol that many Native women imbibe might be explained by Barry (1976:252-253), who suggests that the consumption of alcohol serves two primary functions: 1) to fulfill dependency needs; or 2) to fulfill self-reliance needs. High doses of alcohol act as a sedative, relieving anxiety, and dulling awareness, which satisfies an individual's dependency needs; the need for affection and the need to be nurtured. Inversely, low doses of alcohol, which have a disinhibitive effect, appease the need for self-reliance, by making an individual feel more aggressive and powerful.

The tendency for Aboriginal women to drink heavily, ingesting high doses of alcohol, is illustrative of a compulsion to deal then, with dependency issues. The consumption of alcohol is motivated by a need to alleviate anxiety and dull awareness of

their life situation, past, present and future: *past* childhood abuse and/or neglect; *present* domestic abuse and poverty; and *future* hopelessness and powerlessness. Indeed, "Indigenous women cited low self-esteem as an important factor in chemical dependency, as well as a lack of control over their situation and poor coping skills" (Scott, 1996:140).

The Problematization of the Phenomenon

Certain expectations are placed on women and ethnic minorities in society, these expectations defined by collective society, and governed by norms and values. Culturally based variations in the norms, values and beliefs that govern behavior result in significant differences between cultures in proscribed ideals and expectations. The influence of culture on normative structured ideals is depicted in the matter of gender role expectations and traditionally based Native values. Gender role expectations are informed by cultural values, and measured against the ideals entailed within such expectations. For women the maternal role, and the responsibilities and obligations demanded within this role, are of paramount importance, in all societies, but even more so in Native society. According to Scott (1996:131), for Native women, traditionally, "their roles as the carriers of life and primary educators of their children made them critical to their group's cultural survival". Moreover, the prominence of women in society was evidenced in the fact that "before Euro-Christian contact, many indigenous groups were matrilineal and matrifocal" (Scott, 1996:130). Presently, according to the Native Women's Association of Canada [NWAC], cited in Scott (1996:139), Indigenous women are expected to act as "baby-maker, child-rearer, and husband-nurturer".

Indubitably, the capacity of women to bear *healthy* children is of the utmost importance to Aboriginal society, more so than perhaps all other concerns, including a woman's abuse of illicit substances, such as alcohol; "indigenous women must choose between fulfilling their responsibilities as child rearers and obtaining chemical dependency treatment" (Scott, 1996:139). I would surmise that the emphasis would be placed on choosing the former rather than the latter, much to the detriment of both the woman and her child(ren), especially those yet to be born. In addition, Native values central to the operation of Aboriginal society, which include non-interference, self-restraint, responsibility, generosity/reciprocity, and interdependence, are the basis upon which expectations for behavior, of both men and women, within Aboriginal communities are founded.

It is around those culturally defined expectations and ideals that the notion of 'deviance' is formulated. These normatively based guidelines serve as the basis for the justification of the social control of behavior that falls outside these culturally sanctioned boundaries. When the behavior of an individual challenges conventional normative ideals and expectations, their behavior is categorized as non-conformity. However, it must be remembered that judicious reasoning is culturally relative, being based on culturally specific standards. One such behavior susceptible to judgment is drinking behavior, subject to be perceived and labeled as deviant. For the most part, "drunken abuses were usually private violations directed against persons and their property rather than the public at large" (Savishinsky, 1991:90) within Native communities. Such behavior, although going against one or more of the traditional Native values, is not perceived as being a threat to

the dominant order of collective society. However, it appears that a great leap has been made in the case of Natives, and in particular Native women, in characterizing drinking and drunkenness as deviant. The drinking behavior of Native women is subject to microscopic scrutiny, especially when pregnant. Not only are such women violating the expectation of responsibility and self-control, placed on them by traditional Native values; more importantly, Aboriginal women who consume alcohol while pregnant are breaching their maternal obligations, risking the bearing of children afflicted with FAS. This aberrant behavior is a transgression that is neither easily forgotten, nor forgiven.

Such infringements are measured against 'normality'; in the in the case of Natives, the measuring rod of normalcy is dominant, White culture, whereas in the case of women, the standard of normality is their male counterparts. Thus, Native women's behavior is gauged on the basis of two standards; one on the basis of gender, and the other on the grounds of ethnicity. With respect to ethnicity considerations, "Indigenous men outrank Indigenous women who outrank mainstream women. These data suggest a greater polarization of drinking in the Indigenous communities" (Scott, n.d.:24). Scott (1996:133) also submits that "Indigenous women were more similar to their male counterparts than to Canadian women with respect to substance use and to social reinforcement of opportunities for substance use". The reasons behind the apparent lack of difference will be addressed further on in the discussion, seemingly contingent upon the aboriginality of alcohol to a group.

However, differences, both between and within the genders, has great explanatory capacity. There appear to be inter-gender differences in the use of alcohol; "Indigenous

women were more likely to have irregular/infrequent drinking patterns than their male counterparts” (Scott, 1996:134). Moreover, intra-gender differences are equally worthy of consideration, Scott (n.d.:25) positing that ”Indigenous women have more social opportunities for substance abuse than Euro-Canadian women”. Regardless of the bedrock upon which deviance is evaluated and consequently judged, American Indian women have an unusually high prevalence of drinking problems (Wilsnack and Wilsnack, 1991); ”virtually all indigenous women are affected by substance-abusing lifestyles” (Scott, 1996: 139), a fact that cannot be ignored.

In the case of deviant behavior, however, the need persists to identify someone to be accountable for the behavior, and perhaps deflect culpability onto those individuals who are behaving in a deviant manner, even when the circumstances in the imputation of censure is not justified. It is apparent that double standards are imposed for Natives and for women in the judgment of their drunken comportment; clearly, both women and Aboriginal peoples must be above reproach. Women are always to be accountable and responsible for behavior, even when imputed with the status of ‘intoxicated’, or ‘alcoholic’, such expectations contingent upon the bounds of the maternal role. Neither is liability erased for Natives, even when labeled as ‘intoxicated’ or diagnosed as ‘alcoholic’, the limitations for reprieve grounded in the steadfast values of responsibility and self-restraint.

Once a behavior has been identified as deviant, the next step in problematizing the phenomenon is to define such behavior as being inherently problematic in nature. For both women and Natives, the primary concern identified is the *misuse* of alcohol, the drinking

styles, patterns and behavior being characterized as arduous in nature. For women, the focus is placed on the paramount importance of their role as mother in constructing the 'problem', a woman being identified as a problematic substance abuser if she fulfills two criteria: 1) her use of alcohol interferes with the performance of daily tasks; and 2) she continues to use despite an awareness of serious difficulties resultant of her use of alcohol. Thus, the use of alcohol becomes a "problem" when such use interferes with a woman's capacity to fulfill the obligations of maternal role, in addition to a lack of self-control over her use alcohol, where she may jeopardize the health and welfare of not only herself, but others as well.

For Natives, in defining drinking as problematic, the locus of concentration is on the excessive, and sometimes destructive consumption of alcohol. Traditionally, the "problem", for Natives, has primarily been defined in legal terms, the emphasis of such definitions exacted around the negative aspects, rather than the positive consequences of drinking, the relationship between death and drinking repeatedly cited as a result of the misuse of alcohol, especially the deaths of innocent others as a result of drinking. Thus, in both definitions of the "problem", 'secondary' negatives, classified as harm done to oneself and to others, as a result of drinking, are of the utmost importance. The implicit implication for the problematization of drinking by Aboriginal women, especially if pregnant, is that their drinking is doubly problematic; their drinking becomes an issue dependent upon both their gender, as well as their ethnicity. As Natives, and as women, their drinking is deemed to be not only harming themselves, but potentially harming their unborn children as well.

Biological factors also come into play in the construction of the “problem”, the ethnic origin of an individual, it is argued, having bearing upon how an individual responds to alcohol. This ethnicity-based argument is grounded on two premises: 1) metabolic rates differ between ethnicities, Natives metabolizing alcohol at slower rates in comparison to Caucasians; and 2) the existence of differential thresholds to alcohol, on the basis of physiological differences, the biological parameters upon which differential thresholds are determined by following major ethnic lines.

Thus, variations between ethnic groups in their drinking behavior are accounted for, based on the presumption in the existence of a genetic propensity towards variations in alcohol metabolism and tolerance. However, the biological factors must also be considered on the basis of gender; women tend to have a higher percentage of fat, and consequently, alcohol remains in their systems longer than those with lower percentages of body fat, typically males. As such, the consumption of alcohol by Aboriginal women is construed as being deviant, and then problematized on the basis of two key elements; gender and ethnicity.

A third factor inherently intertwined with the prevarication of drinking as deviant and therefore, problematic, is related to the aboriginality of alcohol to a given society. Drunken comportment of a group or individual is based on several factors, one such factor being the presence or absence of rules, gender specific in nature, governing drinking behavior. As previously discussed, alcohol is non-aboriginal to Canada’s Indigenous population, which in turn, has a significant impact the relationship between alcohol and Natives, in particular, the subsequent usage and alcohol use-related conduct of Aboriginal

people. In most societies, there are usage expectations for each gender prior to contact with alcohol; however, for Natives, this is not the case. The non-existence of such rules have sparked a debate within the literature as to the existence of differences between the genders in Aboriginal communities with respect to drinking. For some authors, the belief is held that “men drink more than women” (Weisner et al. 1984:243; Scott, n.d.:13), and “men are more likely to abuse than women” (Scott, 1996:136).

Contrarily, some authors allude to the notion of the non-existence of differences in the amount of alcohol used between the genders. Kendall in Adrian et al. (1996:113) states that “however, in the native Canadian community, substance abuse was reported in young indigents, both male and female”, Storm (n.d.:61) noting that the “the usual difference of rate between the genders is absent”. If this is true, then the absence of differences between the genders might be attributed to a lack of rules governing female consumption of alcohol. However, the traditional Native values of self-restraint and responsibility in particular, would also play a role in determining drunken comportment, especially for women in their role as procreators. As such, the paucity of traditional controls over drinking behavior has fueled the fire in the debate over the existence, or non-existence of differences in gender use of alcohol. This has contributed to the problematization of the use, and misuse, of alcohol by Aboriginal women.

Another aspect of the “problem” is related to age; “younger people were also particularly vulnerable” (Kellner et al., 1996:1634) to alcohol use-related harms in the Aboriginal population. Alcohol misuse by Indigenous people is a youthful phenomenon; for Natives, “alcohol abusers are over-represented in the 25 to 44 year old age group”

(Scott, 1996:135). Coincidentally, this is the time at which women are most likely to become pregnant and have children. This is particularly problematic for Natives, as the collective concern with female drinking is stressed primarily during the child-bearing years, those very same years during which Native individuals, both men and women, are most at risk for being alcohol misusers. And finally, FAS may appear to be much more problematic for the Aboriginal population due to the fact that Natives typically have higher numbers of children than do non-Natives. Thus, the potential exists for the incidence of children afflicted with FAS to be higher in the Native population. Larger families, comprised of a higher number of children, may have a direct impact upon the predominating perception of the severity of the problem of FAS within Canada's First Nations peoples.

The Prescribed Solution

The construction of drinking by Indigenous women as problematic is both gender-based and ethnicity-based. Although it is a fact that many Aboriginal women drink alcohol, some excessively so, several of the components of the "problem" are based on conjecture, rather than fact. The "problem" as it presently stands, then, is merely fabricated, as an exercise for oppression, prejudice, and discrimination, steeped in sexist and racist discourse. The prescription for cure is based on the construction of the 'problem', based on a paternalistic framework of control of women and Natives who drink. Paternalistic policies, based on fundamentally prohibitive controls, are presented under the facade of concern and caring for those individuals who are incapacitated as a result of their misuse of alcohol. It is noteworthy that many of agents of control in the case of Natives, are the

very same agents which are involved in the lives of women who drink: social workers; the police and the courts; the State; religious counselors; physicians; researchers; family members; and friends.

Denial has been used as a means of social control, negation and dismissal occurring in two degrees. In its entirety, the misuse of alcohol, especially by women was a taboo subject. The tendency was to treat the symptoms of alcohol abuse, rather than the abuse itself. To a certain extent, this notion rings true in the case of the Aboriginal population, the misuse of alcohol merely being a symptom, rather than *the* problem. Partially, denial is used in the manufacture of the “problem”. For those members of dominant society who ascertain what the “problem” is, they see only certain aspects of the situation as being problematic. By de-contextualizing the misuse of alcohol by women, and by Natives, their abuse of alcohol is seen in a distorted light, resulting in a depiction of their life situations that is largely incomplete and copiously inaccurate.

The way in which the “problem” has been defined, has facilitated the transformation of a social problem into a medical problem. Accordingly, the medicalization of the misuse of alcohol by both women and Aboriginals has resulted in a re-orientation of social control efforts in two ways. First, the required response to the misuse of alcohol as a medical problem, has resulted in the level of control being lowered from a need to respond to a concern at a community or group level, to the level of the individual. Not only are measures of control less visible at this level, but it is easier to intimidate, and thus, control individuals. And second, the primary agents of control have become physicians, in an effort to prevent FAS, accomplished via the pamphlets

distributed in their offices, and the advice proffered to pregnant women, prohibiting the use of alcohol, in any amount, and at any time during pregnancy. Apparently, the disease model as an explanatory tool, has been co-opted as means by which to control the consumption of alcohol by women and Natives. This has occurred despite the fact that it has been suggested that Natives are not 'true' alcoholics, as discussed previously, because alcohol addiction may be a rarity, or absent altogether, in Indigenous communities. Regardless, the use of the medical profession, its terminology, its prestige, and its power, is effective in legitimizing, and lending some credibility to social control levied at the female and Aboriginal membership of society.

The operation of ideological discourse, via myths, assumptions, and stereotypes is extremely effective in creating and perpetuating perceptions about certain individuals and groups in society. Indeed, beliefs about Natives and women, and their relationship with alcohol, are ridden with, and regulated by deprecatory and censorious assumptions, stereotypes and myths. Ideology as a key factor in the preservation of the hegemonic order of society, has been discussed at great length, and the ensuing implications of the potency of ideological discourse are of great significance.

Ensuing Implications of the Solution

Perhaps the single most detrimental impact of the evolution of the use of alcohol from the status of a "problem" to a socially regulated behavior, is the impact of social control on the autonomy of both individuals and groups in society. If one's autonomy is imperiled, or in the worst case scenario, eradicated, feelings of powerlessness emerge. For

women, the debate over fetal versus maternal rights is bedrock upon which the struggle for autonomy, and agency is waged. In the case of Aboriginals, the issues of agency and autonomy arise in the context of the fight for self-government and self-determination. In addressing concerns over power, the power theory of drinking, discussed earlier is useful in contextualizing the struggle for autonomy waged by Natives, women and men alike. This theory is comprised of two posits: 1) cultures with high levels of power concerns tend to have high drinking levels; and 2) cultures with high levels of drinking tend to have structural characteristics which arouse power concerns. Given these ideas, it is not surprising that the Indigenous population has high levels of alcohol (mis)use. First, a deficit in autonomy and agency within Native communities contributes to feelings of inadequacy and powerlessness, which in turn are alleviated, albeit temporarily, by intoxication. And, the current societal context within which many Natives live is a state of 'anomie', due to a combined effect of the imprint of acculturation on Aboriginal societies, in conjunction with the non-existence of norms regulating drunken comportment. For many Native women then, drinking to the point of intoxication might be perceived of as not only a coping mechanism to deal with their dismal life situations, but also as an assertion of their autonomy, even to the detriment of themselves and to others; in the case of pregnant women, their unborn child.

Synopsis

The relationship of Native women to alcohol is distressing, especially when the use of alcohol represents harm to not only the women of the present generation, but the

children of future generations. However, most pregnant Aboriginal women who misuse alcohol are facing a situation of 'triple jeopardy': they are females, they are members of an ethnic minority, and they are young; they are "citizen minus" (Scott, 1996:130). Both attitudinal and institutional barriers (Scott, 1996:141) contribute to fatalistic perceptions of young, Native women who drink, and intercede with addressing those issues which impel these women to drink. As discussed earlier, deprecatory attitudes about women lead to paternalistic solutions; "if a woman's body leads her astray, her mind may not be a better compass" (McCormack, 1986:60). Furthermore, "First Nations people have a reputation for having trouble with alcohol" (Kellner et al., 1996:1620), assumptive notions about Natives are equally injurious and debilitating. Institutionally, the assumption of homogeneity in the population of substance abusers serves as a barrier to effective resolutions.

Although there may be some similarities in the causes and consequences of alcohol abuse among women identified as belonging to various sub-groups in society, there are important differences as well. According to Scott (1996:129), "members of Canada's indigenous groups are diverse, speaking 10 major languages and 58 different dialects". Indeed, "many people recognized by the federal government as "Indian" are of various racial and ethnic origins" (Scott, 1996:141). Thereupon, there are "large differences among rates of drug use by women of several racial and ethnic categories" (Goldberg, 1995:791), female substance abusers being a heterogeneous groups by nature.

Despite the fact that "a substance abusing life-style is the most significant health problem among indigenous groups serviced by the Indian and Inuit Health Services"

(Scott, 1996:132), and that "alcohol abuse among women has been known since antiquity" (Goldberg, 1995:791), the combination of being a Native and a woman who misuses alcohol, "our knowledge of how to empower and heal the addicted indigenous woman is pathetically limited" (Scott, 1996:142). However, dominant society has not only great knowledge, but extensive experience in socially controlling Native women, in their gendered capacity as women, and in their ethnic capacity as a ethnocultural minority.

Core Category/Variable

In concluding this chapter, on the basis of the above discussion, I am confident in proceeding to the next step in the generation of grounded theory; the identification of a core category. Ideas about the relationships between alcohol, women, and ethnocultural groups, Natives in particular, have been scrutinized at length, such an exploration resulting in the integration of such notions. Upon reflection, it becomes apparent that a key concept in all group relations with alcohol is the *social control* of drinking behavior. Briefly, social control will be evaluated on the basis of the criteria previously discussed in the chapter one, used in the determination of the core variable. To begin, social control is a central category, reoccurring frequently in the data. In addition, it took more time to saturate the category of social control in comparison with other categories. Not only does social control relate easily and meaningfully to the other categories resulting from the coding process, the category of social control possesses clear, and resolute implications for formal theory on social control. Notions with regard to social control possess considerable carry-through, pointing to many avenues of analysis, and there is complete flexibility in social

control as a variable. As we have seen, social control is a dimension of the problem, being a theoretical code identified within the literature. An finally, the element of social control is seen in all relations between the numerous codes and categories, its tenacity preventing all other categories from establishing themselves as core.

The social control of both women and ethnocultural minorities in society, in this particular instance, Natives, is a central theoretical factor, indicated by its resounding pervasiveness within the literature. Indeed, the relationship between alcohol and Native women is inherently garnered under the rhetoric of social control. The prevention of FAS in the Canada's Indigenous population, under the ideological rubric of 'prevention', although somewhat successful, appears to be yet another effort to socially control both women and a particular minority group in society, our Aboriginal population.

CHAPTER EIGHT: THE SOCIAL CONSTRUCTION OF FETAL ALCOHOL SYNDROME AS A PROBLEM

At this point in the funneling process, the final product of the mixing and filtration of the various elements around the prevention of FAS within Native communities requires evaluation. This evaluation will attempt to deconstruct and assess the many elements of which the problem around FAS and its prevention within Aboriginal communities has been construed. For some, a social problem is believed to be an entity unto itself, a dilemma based on objectively occurring environmental conditions and social arrangements deemed to be harmful to collective society. However, Schneider (1985:210) submits that "concepts such as "deviance," "dysfunction," and "structural strain" have been "impotent" as guides for research to identify social problems". Alternatively, a social problem can be perceived of as being socially constructed, which by contrast, is largely subjective in nature. This is the approach I will adopt in my analysis of FAS as a social problem.

Toulmin's *The Uses of Arguments* (1958) serves as a framework for analysis as to how claims are made, interpreted into a social problem, and transformed into social action. Elements from Best's article "Rhetoric in Claims-Making: Constructing the Missing Children Problem" (1987) are also useful in constructing a framework for analysis of the current treatment of FAS as problem. As such, the specific elements of the problem of FAS will be theoretically explored and analyzed from a social constructionist perspective, on the basis of: 1) medicalization; 2) drinking as deviance; 3) 'prevention'; 4) ideology; and 5) social control.

The Elocution of Claims-Making

Briefly, it might be useful to provide a succinct overview of the social constructionist perspective. From a social constructionist perspective, it has been argued that social problems are “*the activities of groups making assertions of grievances and claims with respect to some putative conditions*” (Kituse and Spector, 1975:415). Accordingly, Kituse and Spector (1975:415) state that social problems should “account for *the emergence and maintenance of claim-making and responding activities*”. Such a perspective would acknowledge the inherently selective quality of the construction of social problems (Schneider, 1985:214).

Toulmin (1958) explores the nature of problems, and addresses problems about logic, expressing concern about the way in which conclusions are derived and established. For Toulmin (1958:166), “logicians have taken analytic arguments as a paradigm; they have built up their system of formal logic entirely on this foundation”. The success or failure of an argument then, is overridingly dependent upon the adherence of the claim-maker to the rhetoric of logical claims. For Toulmin then, claims are made about the nature of a societal condition; “a man who makes an assertion puts forward a claim - a claim on our attention and to our belief” (Toulmin, 1958:11). Toulmin (1958:11) proceeds to suggest that “the claim implicit in an assertion is like a claim to a right or to a title”; essentially, a claim to knowledge. Arguments are then made to justify the legitimacy of a claim or assertion, the type of argument produced dependent upon the nature of the claim (Toulmin, 1958:13).

According to Toulmin (1958:17), there are certain basic patterns and procedures that an argument follows, the cogency of an argument dependent upon the structure of the proffered explanation. For Toulmin (1958:94) “an argument is like an organism”, there being similar anatomical structures and physiological processes in all arguments.

Accordingly, there are four basic elements to any argument: 1) the *claim*; 2) the *grounds* upon which the claim is based; 3) the *warrants* supporting the claim; and 4) the ensuing *conclusions* (for a more detailed description of each component see Appendix I).

On a deeper level, there is a need to assess the broader role of rhetoric on the construction of social problems. Toulmin inquires into the theory of knowledge, epistemology, which he suggests “has comprised a set of logical-looking answers to psychological-looking questions” (Toulmin, 1958:211). The use and function of language in the production and transference of knowledge is central to the construction of social problems. “Language as we know it consists, not of timeless propositions, but of utterances dependent in all sorts of ways on the context or occasion on which they are uttered” (Toulmin, 1958:180). Thus, arguments are not ‘context-free’, and must take under regard both the past and present contexts within which a problem is constructed and the ensuing argument is made. And finally, “the scope and relevance of the notions were too often exaggerated” (Toulmin, 1958:205). The prescribed solution to a problem is often generalized to particular environments, groups, and relations, when there are no apparent justifications for doing so. As such, the science of logic appears to govern the construction of epistemological notions, in the form of claims of knowledge about a

phenomenon, which are socially constructed to be perceived of as being inherently problematic.

The Argument of Fetal Alcohol Syndrome as a Problem

In looking at the perception of FAS as a problem, Toulmin's (1958) ideas about arguments are useful tools in explaining how FAS is constructed as a problem by claim-makers, with a specific agenda in mind. Overtly, the objective of identifying FAS as a problem is to increase the awareness of FAS as a problem, and the need for its prevention; covertly, the hidden agenda in the construction of FAS as a problem, is the social control of pregnant, Native women.

The Claim

To begin, the claim is made that 'FAS is 100% preventable', based on the hypothesis that if pregnant women do not drink, no children will be born afflicted with FAS. Such a claim is based on ground statements, and warrants justifying the making of such a claim. The grounds upon which such a claim is made, is based on statements of fact that have been decided, on the basis of previous discussions, as being cognitive in nature. The information about FAS then, can be regarded as socially constructed in nature, cognitive statements being concerned neither with the correctness of such statements, nor the implications of causality inherent in such statements.

The Grounds

D) Domain Statements

In defining FAS as a problem, domain statements play a role in characterizing dominant perceptions of the problem, and the bounds within which the problem can be regarded. Best (1987:104) suggests that “domain statements are particularly important when claims-makers hope to call attention to a previously unacknowledged social problem”. The occurrence of FAS within society has been treated as a relatively new discovery, however, in reality, the recognition of FAS is more appropriately referred to as a rediscovery of the adverse effects of alcohol on a developing fetus. Indeed, historical perspectives on alcohol consumption during pregnancy alluded to the presence of FAS. Beliefs about the dangers of drinking during pregnancy have persisted throughout history (Blume, 1992:3; Canada’s Drug Strategy, 1995:4; Abel, 1984; Graham-Clay, 1983:2, Plant, 1985:5), dating back to the times of Plato and Aristotle, and even to Biblical times. In more recent times, Blume (1992:5) and Abel (1984:24) refer to FAS as the modern ‘rediscovery’ of fetal damage resulting from in utero exposure of the fetus to alcohol due to maternal drinking. ”The condition known as fetal alcohol syndrome (FAS) was first described in the late 1960’s” (Michaelis and Michaelis, 1994:17), the phrase ‘fetal alcohol syndrome’ officially coined in 1973, by Jones and Smith (Blume, 1992:5; Graham-Clay, 1983:2; Canada’s Drug Strategy, 1995:4; Tenbrinck and Buchin, 1975:1144; Streissguth, 1994:74; Plant, 1985:7). Thus, although claims-makers would like to have society acknowledge FAS as a new problem, it has been recognized in centuries past, merely existing as an untitled entity.

II) Orientation Statements

In addition to domain statements, orientation statements play a paramount role in shaping the dominant perception of the problem. In the case of orientation statements, “in addition to specifying a problem’s domain, there is some assessment of the sort of problem it is” (Best, 1987:105). The medicalization of FAS, within in the context of the relationships between alcohol, women and ethnocultural groups, Natives in particular, has provided a basis around which ideas about the causes and remedies of FAS are produced. The medicalization, we will see, is of preeminent importance in facilitating the social control of pregnant, Aboriginal women. The importance of the process of medicalizing FAS will be explored under the following headings: What is Medicalization?; Medicalization: Disease versus Illness; Medicalization as a Gender Issue; The Medicalization of Deviance; and The Implications of the Medicalization Process.

a) What Is Medicalization?

Medicalization can be described as the process of “the defining of aspects of everyday experience as medical issues” (Clarke, 1996:14), where social matters, alcoholism for one, are re-defined as medical problems. Thus, the medicalization process relies upon the medical model as an explanatory tool, “focusing on individual organic pathology and positing physiological etiologies and biomedical interventions” (Conrad and Kern, 1994:390), which is then applied to a wide range of human phenomena. According to Clarke (1996:15), under the medical model, “medicalization is the understanding of human social relations according to a rather narrow medical paradigm”. As such, Conrad

and Kern (1994:390) propose that medicalization occurs on three levels: 1) the conceptual level, where medical vocabulary is used to define a problem; 2) the institutional level, where medical personnel are supervisors of treatment; and 3) the interactional level, where physician's actually treat patient's difficulties as medical problems. Two important aspects of medicalization according to Clarke (1996:15) are one, the increasing power of the medical profession; and two, the subsequent growth of the medical profession's control over areas formerly outside of the medical realm.

b) Medicalization: Disease versus Illness

An ensuing proposition from the medical model of relevance to this discussion is the "proposition of the form "*X* is a disease"" (Seeley, 1962:586), where alcoholism is substituted in place of *X*. For Seeley (1962:591), "the decision as to whether or not to call something a "disease" seems to therefore turn on an evaluation of the foreseen consequences of so designating it". The ensuing consequences can be perceived of as either being positive or negative, largely dependent upon cultural interpretations and perceptions of disease and illness; "disease is the biophysiological phenomenon that affects the body, while illness is a social phenomenon that accompanies or surrounds the disease" (Conrad and Kern, 1994:106).

On the one hand, in regarding alcoholism as a disease, "such a view clearly opens the door to more humane, physician-like treatment of many sequences or conditions" (Seeley, 1962:592). Since "disease falls into a naturalistic matrix; sin, into a moral one; crime, into a legal one" (Seeley, 1962:588), individuals afflicted with alcoholism then, are

perceived of as ill due to naturally occurring circumstances largely beyond their control, and therefore are not responsible for their misuse of alcohol. Conversely, the notion of illness possess negative imputations, “the again-inescapable notion of culpability” (Seeley, 1962:588) associated with illness, as opposed to disease. Although “disease is something that is undesirable” (Seeley, 1962:587), based on a moral judgment by warranted judges, one such judge being physicians, the notion of illness implies that the host of the disease is, in some way, to blame for becoming afflicted with a given malady. On the basis of previous discussions, although males may be offered sanctuary under the notion of alcoholism as a disease, women and Natives, they are not offered the full shelter of the umbrella of alcoholism being so designated as a ‘disease’. For the latter two groups, their membership is still largely held accountable for their behavior under the influence of alcohol, despite being labeled as an alcoholic. In this instance, it appears that alcoholism is construed, and thus, perceived of as an illness rather than a disease; “in this perspective, we view illness as a social construction” (Conrad and Kern, 1994:106).

c) Medicalization as a Gender Issue

It becomes readily apparent that “medicalization has affected women differently than men” (Clarke, 1996:15), to what appears to be the detriment of women. Historically, “women were viewed as naturally sickly” (Clarke, 1996:16), expected to be unhealthy due to their biologically based inadequacies. Thus, ‘woman’ became synonymous with ‘illness’. In addition, Clarke (1996:16) suggests that the historically based belief among medical practitioners, that the sole purpose in life for women “was believed to be

reproduction". We are still feeling the residual effects the belief that "a woman's biology is her destiny" (Clarke, 1996:17), in the ideals and expectations placed on the female membership of society in their capacity as a woman second, and a mother first. Indeed, "women's life cycles have been redefined as medical crises that women must overcome with the expert assistance of medical professionals" (Clarke, 1996:16), one such crisis of particular relevance to FAS, pregnancy.

However, for many women, reliance on the medical profession is a ludicrous thought, due to rampant sexism, and racism, within the medical profession; "while physicians did not invent sexism, they reflected common sexist attitudes which they then reinforced in their definition and treatment of women" (Conrad and Kern, 1994:107). Clarke (1996:17) believes that "doctors are trained in an environment dominated by male values and perspectives, which reflects male-centered views of "normal" female behavior". The influence of such values results in extremely confining limits being placed upon women within the bounds of gender role expectations and ideals. However, "the effects of gender bias on the meanings of illness are now subtler and more complex" (Conrad and Kern, 1994:107).

Hence, there is a unequivocal need to contextualize the medicalization process. When the social problem of alcohol misuse by women is medicalized, the focus is displaced onto women, when in fact, it should address much larger, systemic issues and inadequacies, as "the importance of the social causes of women's health problems is neglected" (Clarke, 1996:17). The medicalization process then, essentially denies the social, economic, and political realities in which Aboriginal women live, both those who

do and those who do not drink, serving to de-contextualize the high incidence of FAS within Native communities.

d) The Medicalization of Deviance

Schneider (1985:219) offers that "much recent research on the medicalization of deviance draws on the constructionist perspective". The misuse of alcohol by women, and by Natives, as discussed earlier, is predominantly construed as being deviant by dominant society, being further 'deviantized' by regarding alcoholism as an illness. According to Conrad and Kern (1994:106), "illnesses may reflect deeply rooted cultural values and assumptions. This is perhaps particularly evident in the medical definition and treatment of women and women's maladies". As a form of culturally ascribed discrimination, "illness can reflect cultural assumptions and biases about a particular group or groups of people, or it can become a cultural metaphor for extant societal problems" (Conrad and Kern, 1994:106). Indeed, "certain illnesses may engender social meanings that affect our perception and treatment of those who suffer the illness" (Conrad and Kern, 1994:108). In turn, morally based meanings are attributed to an illness, resulting in the stigmatization of those afflicted with the malady.

e) Implications of the Medicalization Process

The implications of medicalization of a problem, alcohol misuse by (Native) women in this case, are of great significance, with respect to the issues of power, autonomy, and social control. "The trend toward medicalization has had a direct impact

on the control that women exercise over their bodies and their lives” (Clarke, 1996:14). The medicalization of women’s abuse of alcohol may be perceived of by dominant society as liberating, as “the imputation carries with it the legitimation of claims to “outside” help” (Seeley, 1962:590). However, this is not the case for Native women, who are expected to choose fulfilling their obligations within the bounds of the maternal role above *all* other concerns, including the woman’s need to address her substance abuse problem. In addition, “as with women’s abuse of alcohol, their misuse of drugs is generally viewed as being far more pathological than substance abuse by men” (Clarke, 1996:19). Thus, women who abuse alcohol are regarded as either requiring intervention from the outside to control their aberrant behavior, or being beyond all help.

”There is nothing to prevent such a dangerous extension of the view” (Seeley, 1962:592) of alcoholism as a disease, to include coercive forms of control over women’s behavior. ”Indeed, it may go further - toward an implicit moral injunction to seek outside help or all the way to coercion in accepting “help”” (Seeley, 1962:590). Such coercive techniques were evidenced in the evaluative statements found within the pamphlets about the prevention of FAS . Such statements informed women of their obligation to seek treatment, often in the form of covert, morally imperative messages, designed to target a woman’s fear and/or guilt over her drinking while pregnant. Indeed, Seeley’s worst fears have apparently come true, the disease concept of alcoholism being used against, rather than for, pregnant, Aboriginal women.

III) Examples

The next type of grounds often presented in an argument, in support of a claim are examples, the focus of such examples frequently being placed upon atrocities. Best (1987:106) advises that tales of an extreme nature are used by claim-makers because "atrocious tales do not merely attract attention; they also shape the perception of the problem". In the case of alcohol, women, Natives and pregnancy, in relation to FAS as a problem, severe cases of FAS are often referred to in the literature, as opposed to less extreme instances of ARBD's, such as FAE. In addition, those stories about FAS to hit the media tend to be more sensational in nature. In particular, a woman in Manitoba in the fall of 1996, was placed under arrest and later released, because she was pregnant, a substance abuser, had previously borne children afflicted with FAS, and not to mention, Aboriginal. The portrayal of cases such as this, in giving them attention, have the potential to create several erroneous perceptions in dominant society: 1) that all women who abuse substances, alcohol in particular, will bear children afflicted with FAS; 2) all Native women who drink are misusers of alcohol; 3) the incidence of FAS in Native communities is extremely high in comparison with the incidence of FAS in dominant society; 4) FAS is exclusively problematic for the Aboriginal population; et cetera. The result of using sensational cases to shape the perception of the problem as grievously problematic, serves to support the arguments of claim-makers, both legitimize, and perpetuate the social control of specific groups within society.

IV) Numeric Estimates

The use of numeric estimates, in the form of incidence estimates, growth estimates, and range claims assists claims-makers in confirming and validating their perception of the problem. Incidence estimates are numerical figures that attempt to depict how many individuals are indeed, afflicted with FAS. As discussed in Chapter 2, the exact numbers of people, adults and children, afflicted with FAS are not known, and that only estimates of the incidence of FAS can be made. Difficulties in obtaining accurate numbers with regard to the incidence of FAS are a result of many factors, which include: the reluctance of professionals to diagnose an individual with FAS; a lack of knowledge about FAS, resulting the inability of professionals to recognize the manifestation of FAS; and the inaccessibility of populations, especially Native, due to the remote nature of their geographical location. Indeed, statistical rates of FAS are questionable, Best (1987:106) accurately stating that when attempting to discern the incidence of FAS in society, it must be taken into consideration that “social phenomena are often difficult to measure”.

If growth estimates are explored, the claim is frequently made that things are getting worse, and will continue to do so unless appropriate action is taken to remedy the situation” (Best, 1987:107). Habbick et al. (1996) maintain that the incidence of FAS in Saskatchewan, despite prevention efforts, has not decreased in a twenty-year period. Best (1987:107-108) suggests claims-makers will go so far as to “often describe problems as epidemic” in nature, such a description appearing to be true in the case of FAS, particularly when the incidence of FAS is examined in the Aboriginal population. Indeed, the incidence of FAS within Canada’s Indigenous population has been alluded to having

reached epidemic proportions, the 'epidemiology' of FAS in the Aboriginal population (Bray and Anderson, 1989; Burd and Moffatt, 1994; Scott, n.d.) being a topic of study among researchers.

Finally, claims-makers will often use range claims in their arguments, suggesting that due to epidemic nature, "the problem extends throughout the social structure" (Best, 1987:108), knowing no bounds. Indeed, this is the case with FAS, as discussed in Chapter 2, FAS is a universal phenomenon, born to women who drink during pregnancy, regardless of age, race, ethnicity or social status. FAS is described as non-discriminating in whom it affects, such a depiction attempting to "make everyone in the audience feel that they have a vested interest in the problem's solution" (Best, 1987:108). However, certain populations appear to have a higher incidence of FAS, Canada's Aboriginal peoples being one such population, due to a high rate of heavy drinking.

The Warrants

Warrants, according to Best (1987:108), "have a special place in Toulmin's scheme", as they are the basis for the justification of drawing conclusions from the facts, the examples and the numbers, regarding the severity of the problem. However, warrants are typically value-laden, and implicit in nature (Best, 1987:108), being unspoken, normatively-based canons upon which an argument is based. I would suggest that warrants are also posited within an argument to deal with the conflict between rationality and morality. Toulmin (1958:41) poses the question, "what sort of priority in logic, if any, can matters of fact (say) claim over such things as matters of morals?", recognizing the

influence of morality within an argument, often taking precedence over rationality. We have seen power of morality illustrated in the use of statements in the pamphlets in Chapter 3, such statements although appearing to be cognitively based, are actually evaluative in nature, appealing to the reader's values and mores. Thus, although arguments are presented in a manner so as to appear to be appealing to one's logic, it seems that there is a heavy reliance upon an individual's morality to persuade them to support the claim-maker's perception of the problem.

A number of specific warrants presented by Best (1987) would be useful in framing how warrants are used to justify a claim and support the claim-makers' arguments: I) the value of children; II) blameless victims; III) associated evils; and IV) rights and freedoms. Each warrant will be addressed, particular attention being paid to the perception of women and Natives as deviants under the warrant of 'associated evils', and the debate between maternal and fetal rights under the warrant of 'rights and freedoms'.

D) The Value of Children

The value of children in modern society can be perceived of as existing on two levels: one the practical level; and two, the sentimental level. Speaking in practical terms, children are valued in terms of their political and economic potentiality. The potential value of future generations is touted under the notion that today's children are this society's future leaders. However, alcohol consumption during pregnancy is a leading cause of ARBD's, "physical, mental and behavioral abnormalities" (The Addictions Foundation of Manitoba, n.d.b:1), such as mental retardation and physical deformity,

resultant of maternal consumption of alcohol while pregnant. Thus, the symptoms of FAS essentially devalue the potential of children as the future. On a more sentimental note, children are valued by society because they are viewed as a precious gift, deserving of, at a bare minimum, a healthy start at life.

II) Blameless Victims

Unborn children are viewed as the blameless victims of FAS as a result of maternal ingestion of alcohol while pregnant; "too many developing babies are being poisoned where they should be safe" (Spence, 1993:2). Claims-makers are concerned about the unborn child, implicit is the assumption that the fetus is helpless and therefore, dependent upon the mother for their well-being. Essentially, the fetus is portrayed as a defenseless victim, whose fate is at the mercy of the mother. Although some mothers do not always act in the best interests of the child; in the case of FAS, it is the child, nonetheless, that is left to deal with the consequences of maternal drinking prior to their birth.

III) Associated Evils

With regard to the evils associated with a given claim, Best (1987:110) maintains that "claims-makers made little effort to locate causes in complex social conditions, preferring to assign responsibility to criminal or perverted individuals". In the case of FAS, as discussed in previous chapters, the drunken comportment of women and Indigenous peoples is construed in such a manner as to suggest that their behavior is in some way deviant, and possibly, even criminal in nature. Indeed, the organizational ownership and

management of social problems parallels work done the organizational processing of deviants and deviance (Schneider, 1985:215). Many ideas that are derived from the study of deviance within the Indigenous population, can be extended to the situation of women in society, without dismissing the inherent uniqueness of each group. Many parallels exist in the designation, and ensuing treatment of women and Aboriginals as deviants.

Within the realm of functionalist thought, deviance has been perceived of as being invaluable to the ordering and regulation of society. Indeed, "the common view of Natives as deviants is *positively functional* for the maintenance of Canadian society as it is presently structured" (Thatcher, 1986:272). For Schneider (1985:216), deviance permits the "routinizing and managing people's problems is the essence of the "public interest state"". The imputation of deviant status to certain groups in society is essential to immortalization of the status quo; thus, deviance preserves the hegemonic relations currently governing society, to the copious benefit of dominant society. "Native deviance, real or perceived, benefits specific segments of Canadians" (Thatcher, 1986:275), typically those segments with power. As such, the disrepute of such populations serves to legitimize and reinforce the need for involvement of societal agencies in the affairs of women and Natives.

Consequently, several public agencies have been created, and continue to exist "charged with the identification, constraint and change of deviant behavior" (Thatcher, 1986:272), exhibited by both Aboriginals and women alike. Such agencies have been identified, in earlier discussions, as institutions of social control, employing agents of social control. Undoubtedly, the deviance of certain memberships of society is reflective of

some real phenomenon. However, we must look at the context in which the deviation occurs, and who is labeling the behavior as deviant, before the causality of such aberrant behavior can be attributed to one variable over another. Agents of social control have thusly, targeted specific groups in society, to be identified as deviant, and constrained as a result of this label. In the case of FAS, the primary aggregate targeted is women, more specifically, Aboriginal women. "Natives are singled out as a group which confronts the system with "special problems"" (Thatcher, 1986:275); in the case of FAS, Native women in particular.

Institutions and agents of social control have a great deal of power, as "all of them directly or indirectly shape - "make or break" - the reputations of their clientele" (Thatcher, 1986:274), since according to Thatcher (1986:275), "reputations are by definition discriminating". Canada's Indigenous population has been ascribed with a reputation as a "problem population" (Thatcher, 1986:275) by officials in society. Such reputations tend "intentionally or unintentionally to entrench negative stereotypes of the Native population in the minds of other Canadians" (Thatcher, 1986:275). We have seen, in previous chapters, the deleterious impact erroneous stereotypes, myths, and assumptions about not only Aboriginals, but women as well can have on dominant perceptions and images of certain groups within society. It is upon the basis of such stereotypes that one's status as 'deviant' lies; the characterization of Natives and women as disreputable, in terms of a moral, and even biological sense, is premised on assumptions and myths about gender and cultural inferiority

The institutional production of deviance, although beneficial for certain groups in society, is intrinsically dysfunctional for those groups labeled as deviant. The residual effects of what Thatcher (1986:287) refers to as "deviancy-processing" are twofold: 1) the internalization of negative self-concepts by the 'problem population'; and 2) the discrediting of any legitimate claims the problem population might make. By virtue of "being relatively powerless as a group, Natives can be identified and punished as alleged or real deviants in order to uphold the legitimacy of dominant norms" (Thatcher, 1986:284). Ironically, the social reality of many Canadian Natives lies at the bottom of the social ladder, a position that results in paltry latitude to voice and incorporate their norms, values and beliefs into the dominant order of society. Aboriginals then, "have little say in making Canada's social rules" (Thatcher, 1986:274), which they are nonetheless, subject to adhere to. Much of what has just been said can be extended to the female membership of society today. Deviance then, is essentially a social construction, which in the case of Aboriginal females, is based on racist and sexist postulations. "Racism, once established, functions to the advantage of the dominant groups" (Thatcher, 1986:277). I would suggest that the same can be said for the efficacy of sexism in the prevarication of women's deviance.

IV) Rights and Freedoms

Schneider (1985:217-218) suggests that "people, groups, and institutions, including the state, attempt to transform various troubles into legal issues"; indeed, this has what has transpired in relation to the issue of maternal versus fetal rights. The debate

surrounding this issues is framed on “either - or terms, emphasizing either the woman’s rights to privacy or the fetus’s right to a sound mind and body” (Blank, 1993:85). On the one hand, in the case of maternal rights, the basic issue is ”women’s right to self-sovereignty” (Daniels, 1993:1); while on the other hand, the basis for fetal rights is premised on the notion that the fetus is ”a free-floating being temporarily housed in the womb, but with interests and needs of its own” (Daniels, 1993:1). As such, Daniels (1993:4) attests that ”the rhetoric of protectionism has fundamentally shifted from maternal rights to fetal health”, where, according to Blank (1993:74), the state’s interest in protecting fetal health appears to have taken precedence over the maternal right to privacy. Consequently, ”women’s rights as citizens are potentially made contingent by fetal rights. They can be revoked or qualified by the state’s higher interest in the fetus” (Daniels, 1993:2).

The rationale behind such state action lies in the perceived societal function of women; motherhood above all else. Historically, such a belief was explicitly expressed; in modernity this belief I would suggest, is implicitly omni-present, still possessing monumental influence over societal perceptions of women. Two predominant notions are derived from this premise: 1) the notion of “the pregnant woman’s body as public property” (Daniels, 1993:3); and 2) the notion of not only ‘bad’ mothers, but “anti-mothers” (Daniels, 1993:3). The focus of fetal rights places the emphasis on women as a “natural resource” (Daniels, 1993:4), as ‘baby-carriers’ or mere ‘hosts’ during the gestation period prior to birth. In addition, stringent expectations are placed upon women, in the capacity of “selfless motherhood” (Daniels, 1993:2). Women who “violated not only

their most fundamental natural instincts and who threatened to destroy the institution of motherhood altogether” (Daniels, 1993:3) are perceived of as not only “anti-mothers” I would suggest, but somehow also *less than female*.

The development of technology has had a colossal impact on the development of fetal rights. The discovery of causal links between fetal exposure to certain elements, and subsequent fetal damage, is compelling evidence in support of fetal rights. However, these advancements have essentially created a rift between the mother and the fetus; “technological, social, political, and economic developments in the second half of the twentieth century have challenged the “organic unity” of the pregnant woman and the fetus” (Daniels, 1993:1). Consequently, “in law and in popular culture, the fetus was treated as physically separate from the pregnant woman and was personified, granted interests, concerns, and needs which may conflict with the pregnant woman’s” (Daniels, 1993:9).

The ensuing conflict has been politicized, coming to be regarded as “the politics of fetal rights” (Daniels, 1993:2). Blank (1993:80) accurately and succinctly poses the question upon which the conflict between maternal and fetal rights is entrenched: “within the context of the growing knowledge of these hazards, the question reemerges as to what right a child has to a safe fetal environment and as normal as possible start in life?”. The final result of the conflict between maternal and fetal rights has been the creation of an adversarial relationship between mother and unborn child, keeping in mind that “the specter of the abortion debate underlies any discussion of this conflict” (Blank, 1993:85). One such aspect of the abortion debate that carries over into the conflict between maternal

and fetal rights is the notion of the procreative choice of women; in a word, autonomy. In placing conditions on women's choices, "women's autonomy is traded against (and often traded away) by women's right to reproductive choice" (Daniels, 1993:26). The implication of such conditions is that if then, a woman chooses to reproduce, she loses her autonomy in varying degrees. However, especially in the case where a woman has made the conscious decision to carry the child to term, Blank (1993:88) posits that "it is unlikely that any mother consciously behaves in a manner designed to cause harm to future baby".

In the face of the debate over maternal and fetal rights, "the power of the pregnant woman to nourish and contain the fetus became a power that could be appropriated by others and used against her" (Daniels, 1993:28). As a result, gender relations are in deep crisis as the issue of gender power relations surfaces yet again, the crux of the crisis being "masculine control over the female body through the power of the state" (Daniels, 1993:4). The state and its institutions then, become mediators between the woman and the fetus, managing and controlling the ensuing events of the pregnancy. Thus, the power concerns in relation to maternal versus fetal rights are, according to Daniels (1993:5-6), threefold: 1) the power of self-sovereignty; 2) the power of political agency; and 3) the power of moral discourse.

What becomes clear is that "just as the concept of fetal rights is flawed, so the argument for a pregnant woman's absolute right to privacy is unwarranted in light of current knowledge of fetal development" (Blank, 1993:87). Because "the well-being of the fetus is inextricably bound to the actions of the mother" (Blank, 1993:74), it is neither reasonable, nor logical to suggest that the rights of both the fetus and the mother can be

absolute. Certain qualifications must be placed on both sets of rights. Indeed, "the courts have played and will continue to play a central role in redefining the maternal - fetal relationship" (Blank, 1993:91). A reinterpretation of the maternal - fetal relationship will serve in "redefining responsible maternal behavior and the standard of care owed to the unborn" (Blank, 1993:75). One key point open for debate within such a redefinition, which has yet to be ascertained, is who will be deemed to be ultimately responsible for the welfare of the fetus - the mother or the State?

In the current treatment of the conflict between maternal and fetal rights, "as the fetus emerged as a person, the pregnant woman began literally to disappear from view" (Daniels, 1993:21). Daniels (1993:17) proceeds to suggest that "once this very private, internal process became publicly visible the possibility arose for the public control of pregnancy", as "in order to publicly display the fetus in photographic and video images, the pregnant woman had to become transparent" (Daniels, 1993:16). However, I would suggest that a woman's rights have also become transparent in the conflict between maternal versus fetal rights, largely at the hands of state interventions in an incessant need for control.

However, on an optimistic note, "the potential governmental role in suppressing reproductive rights can take many routes depending on how these rights are defined by prevailing societal values" (Blank, 1993:78). Blank (1993:82) correctly suggests that "the relationship between the pregnant women and the developing fetus is a special one that is culturally as well as biologically unique", which will hopefully be recognized as such, allowing for the achievement of a delicate balance between the rights of the fetus and the

rights of the mother. To achieve such a balance, I would suggest that society needs to understand the conflict between maternal and fetal rights on two levels: 1) the macro level, since the problems in the mother-fetus relationship "cannot be separated from the broader social context" (Blank, 1993:82); and 2) the micro level, as "one cannot explain an individual pregnant woman's behavior without knowledge of her personal experiences" (Blank, 1993:82). As we will see, this approach to understanding social phenomenon will prove to be key in the design and integration of effective preventative measures against FAS.

The Conclusions

The conclusion to any claim-based argument suggests demands for either the assuagement or extermination of a given social problem, claims-makers acting on behalf of an agenda with definite goals. The goals of claims-makers addressing the issue of FAS appear to exist on two levels: explicitly, increasing public awareness about the effects of maternal drinking while pregnant in the name of 'prevention'; implicitly, the goal of current solutions is the social control of pregnant, Aboriginal women, under the rhetoric of 'prevention'.

I) The Prevention of FAS

On the categorical level, the prevention of FAS is concluded by claims-makers to be both a logical necessity and a realistic possibility. Because "fetal alcohol exposure continues to be an important preventable public health concern" (Peterson and Lowe,

1992:614), the need exists for efforts to be made to prevent what has been referred to in the literature as a 'tragedy', such efforts being based on the notion that FAS is a *health* concern above all else. Prevention efforts can be placed on a three-phase continuum (Voutier, n.d.:ii; Weiner et al., 1989:390; New Breast et al., 1986:1) comprised of: 1) primary prevention; 2) secondary prevention; and 3) tertiary prevention. Primary preventative efforts seek to prevent a health problem before it occurs" (Voutier, n.d.:ii), and increase awareness of the health issue of FAS (Clarke and Davies, 1992:68). This awareness, it is believed can be created through education (May and Hymbaugh, 1989:508; New Breast et al., 1986:1;).

The question then, is *who* is the target of these educational efforts? There are several target groups, including: the public at large (May and Hymbaugh, 1989:508; Clarke and Davies, 1992:68; Abel, 1984:220; Weiner et al., 1989:387); "medical gatekeepers", including physicians and other medical personnel (May and Hymbaugh, 1989:508; Clarke and Davies, 1992:68; Abel, 1984); and of course, pregnant women (Clarke and Davies, 1992:68; Weiner et al., 1989:387). The information is disseminated to the various memberships of society primarily via information and education packages (Clarke and Davies, 1992:68; Habbick et al., 1996:206), comprised of pamphlets, fact sheets, posters (May and Hymbaugh, 1989:511; Abel, 1984:228; Weiner et al., 1989:387) and bumper stickers and buttons (Abel, 1984:229). In addition, warning labels on alcoholic beverages (Peterson and Lowe, 1992:614; Abel, 1984; Hankin, 1994:64); and public service announcements (Peterson and Lowe, 1992:614; Abel, 1984:228; Weiner et al., 1989:387) are utilized to increase awareness about FAS. Finally, the information is

dispersed in places that *might* reach high risk individuals, such as schools, bathrooms, eating establishments, bars (May and Hymbaugh, 1989:511; Weiner et al., 1989:387), physicians' offices (Abel, 1984:225; Weiner et al., 1989:387), supermarkets (Abel, 1984:225), and liquor stores (Weiner et al., 1989:387).

At the level of secondary prevention, efforts aim "to identify persons in the early stage of substance misuse and intervene before the condition progresses and negative consequences ensue" (Voutier, n.d.:ii). Upon identification of a problem population (smokers, drinkers), subsequent efforts are made to reduce drinking/smoking levels of the individuals belonging to the problem population (May and Hymbaugh, 1989:508; Clarke and Davies, 1992:69). The use of alcoholism treatment programs (Peterson and Lowe, 1992:614) are a key element in secondary prevention efforts, as was education in primary prevention attempts. However, current treatment programs are problematic in many ways, there being three main problems with existing services: 1) barriers to referrals and to treatment itself; 2) a lack of gender sensitive treatment programs; and 3) heavy reliance on the disease concept of alcoholism. Barriers to referral include no local services, no awareness of existing treatment services, a lack of 'woman-focused' treatment resources, a desire to 'protect' the woman, no training to recognize signs and symptoms of substance abuse, and the denial of existence of a problem (Colorado Department of Health, 1993), just to name a few. Identified barriers to treatment itself include a lack of finances, lack of child care, stigmatization of women who drink, denial of problem, fear of incarceration, fear of losing children, illiteracy, limited space in services, role of woman as provider and

nurturer of others, and a lack of treatment resources sensitive to women (Colorado Department of Health, 1993).

From the above list, it becomes evident that many barriers to treatment faced by women are gender specific (Copeland and Hall, 1992:884). Thus, there is a dire need for treatment, referred to by Copeland and Hall (1992:884), that is “gender-sensitive”. If treatment for women is going to be effective it must deal with issues relating to the woman’s personal history (past sexual abuse, present domestic abuse, et cetera), and dynamics of treatment setting (mixed-groups versus only-women groups). And finally, there is heavy reliance on disease conceptualization of alcoholism in treatment resources (Caetano, 1987:153). The inherent implication is that “the most frequently recommended treatment by subjects who agree that alcoholism is an illness is A.A.” (Caetano, 1987:157), which may not be the most effective course of treatment for everyone.

The final phase of prevention is comprised of tertiary efforts, which aim “to prevent reoccurrence of the condition” (Voutier, n.d.:ii). In this stage of prevention, there appears to be an increasing level of reliance upon the criminal justice system to deal with women who drink while pregnant. The use of legal system as a preventative measure, however, is questionable at best, the prosecution and indictment of substance-abusing women not being the best answer. The prosecution of these women does nothing to rectify the problem, and may even exacerbate the problem (Norton Hawk, 1994:517). There is a chance that by criminalizing substance abuse during pregnancy, pregnant women will not make the effort to receive *any* prenatal care for fear of their alcohol misuse problem being detected by a physician. In addition, the incarceration of substance-abusing pregnant

females as a means of prevention is based on an erroneous assumption on the part of officials in the judicial system that "view prisons as prenatal care in a drug-free environment" (Fralick, 1994:12). The reality of prison-life is such that "drugs are probably as, if not more, available in jails" (Norton Hawk, 1994:520). Indeed, Norton Hawk (1994:519) refers to use of criminal justice system as a "regressive intervention", which is working under the paradigm of offender punishment and/or control, as opposed to offender reform (Byrne and Taxman, 1994:228). This mind-set, can in no way, assist in the prevention of FAS.

As such, the failures of current prevention efforts are threefold, based on the notions of 1) awareness, 2) moderation versus abstinence, and 3) active versus passive preventative measures. Although "awareness of the problem of drinking during pregnancy was clearly related to the seriousness with which people rated the issue" (Abel, 1984:236), there is no insurance that a change in attitude will result in modifications in behavior; "awareness does not necessarily indicate changes in behavior" (Abel, 1984:238). Such a premise is based on the assumption that awareness is a catalyst for change, however this is not necessarily a true or accurate assumption. It appears that education as a means of prevention does little to reach those populations most at risk for bearing FAS children.

Those individuals least likely to change their opinions towards abstinence while pregnant were younger, low socioeconomic persons who misuse alcohol. Moreover, "there are few prevention programs specifically targeted toward pregnant women who drink frequently (e.g., consume alcohol daily) or who periodically drink excessively" (Peterson and Lowe, 1992:614). Informational prevention programs may not be successful

with these women, as drinking is an important, and for some, frequent behavior. In addition, a "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 behavior" (Weiner et al., 1989:388), such prevention efforts working on the woman's 'fear factor' and 'guilt factor'.

The second element in the failure of current prevention efforts is related to two founding notions grounding current prevention efforts (Abel, 1984:219): 1) that there is little doubt that alcohol has a teratogenic effect on the fetus; 2) that there is no way to identify women at risk for bearing children with FAS *a priori*. On the basis of these two posits, the most simple course of action "would appear to be abstinence, or at the very least, a reduction in drinking during pregnancy" (Abel, 1984:219). However, the routes to abstinence versus moderation are very different, and have very distinctive implications in reality. Fralick (1994:7) asserts that harm reduction perspectives allow for more flexibility and compassion in their approach to intervention measures.

The third aspect associated with the failure of current prevention measures is based on the notion of active versus passive measures (Hankin, 1994). In the case of passive measures, such as warning labels and pamphlets, the onus is placed upon the woman to read and internalize the message being sent to her specific situation. However, this may not always occur. Active measures, on the other hand, such as prenatal counseling and involvement in self-help groups may be more effective, as the woman has to take an active role in making changes to prevent the occurrence of FAS.

It was alluded to earlier that current prevention efforts were, in essence, missing their intended target, those women most at risk for bearing children afflicted with FAS. Weiner et al. (1989:386) suggest that "it is time to take the next step in prevention and to develop strategies which focus on the population at highest risk". But who exactly comprises this 'at risk' population? Women of child-bearing age are at high risk to develop alcohol-related problems (New Breast et al., 1986:3; Hankin, 1994:62), in particular young women, as "the later adolescent and early adult years are frequently considered the ages of greatest risk for substance use and abuse" (Abma and Mott, 1991:117). Substance misuse is particularly problematic during youth, because the risk of unplanned/unwanted pregnancy is also highest during this time " (Abma and Mott, 1991:117). Consequently, prevention needs "to target people before dangerous or destructive drinking patterns developed" (May and Hymbaugh, 1989:510).

On a slightly more abstract level, prevention efforts can be perceived of as existing on one of two levels; either the micro level, looking at the individual, or the macro level, focusing on the community or society as a whole. Currently, it seems that prevention is an 'either-or approach', focusing attention on either the individual, or the community, but not both. More often, attention is paid to the individual, focusing on treatment as a preventative measure. However, as discussed earlier, there are many problems with current treatment resources. "Little attention is paid to psychosocial processes which govern drinking behavior among women generally, and thus may be relevant to continued drinking during pregnancy" (Peterson and Lowe, 1992:614). Thus, it has been proposed that the use of cognitive behavioral principles with this group of women may be more

effective in the prevention of FAS (Peterson and Lowe, 1992:614; Hankin, 1994:65). Weiner et al. (1989:393) suggest that “direct interventions focused on changing the drinking behavior have an excellent chance of succeeding”.

In adopting such a perspective, the problematic alcohol expectancies, “the cognitions, attitudes, and beliefs about the effects of alcohol” (Peterson and Lowe, 1992:619) of substance misusing women are being identified, and challenged. Because “drinking has a strong learned component” (Peterson and Lowe, 1992:617), the “unlearning” of these life-long cognitive patterns can be a complex and arduous process. “Cognitive behavioral interventions do not rely on defining oneself as sick or addicted, and thus are not inherently stigmatizing. Rather, they focus on behavioral self-management, emphasizing motivation, learned patterns that underlie behavior, and the development of skills to facilitate change” (Peterson and Lowe, 1992:617). By placing the locus of attention on the development of more adaptive alternative behaviors and cognitions for these women, women are taught alternative methods to deal with their abuse of alcohol, such as keeping a diary, goal setting, and coping techniques (Hankin, 1994:65). In addition, women would be prepared for the possibility of ‘slipping’ (Peterson and Lowe, 1992:620), which may lead to abandoning further attempts for sobriety if not prepared for such possibilities.

At the macro level, much of the preventative effort at this point is left to speculation about what should be done at the community level. Clarke and Davies (1992:69) suggest that “FAS, the third leading known cause of mental retardation, is a health problem that must be managed at the community level - by the community”. Thus,

”maternal child health programs for high-risk women, infants, and children (both prenatal and postnatal) must be available at the community level” (Loock, n.d.:2). It appears that in reality, little focus has been heeded to prevention at the level of the community.

In sum, Habbick et al. (1996:206) suggest that ”in retrospect, we were probably over-optimistic in assuming that public and professional education would substantially alter the incidence of FAS”. Weiner et al. (1989:392) propose that ”the use of broad-based educational campaigns to prevent alcohol-related birth defects is based on an improper formulation of the problem”. Indeed, ”viewing the drinking behavior as a moral or volitional issue has given rise to simplistic solutions manifesting as the slogan therapy of “just say no” and to injunctions that a drinker stop lest she “harm her baby”” (Weiner et al., 1989:390). The reality of the situation is that ”women notice health promotion and prevention information only when they are actually pregnant, not before” (Reynolds et al., 1994:20). As such, this fact must be taken into regard when developing prevention strategies. Furthermore, there appears to be a tendency to search for extraordinary cultural factors to explain a phenomenon. However, in searching for exotic answers, practical elements of the circumstances are ignored. With respect to the Aboriginal population, the inherent assumption within the rhetoric of prevention programs “is that the only way out of alcohol-related health problems is Native American assimilation and adaptation to the dominant culture” (Duran and Duran, 1995:104).

II) The Social Control of FAS

On a more theoretical level, the implicit goal of claims-makers, in the name of prevention of FAS, can be conceived of as the social control of pregnant, Aboriginal women. "Social control theorists identify two forms of control: inner and outer" (Davis and Stasz, 1990:42). Within the context of this discussion, I will be primarily addressing external forms of social control, as the foremost goal of prevention efforts is to control the drinking behavior of pregnant women through using measures outside the women.

The Tenets of Social Control

To begin, there are basic tenets upon which social control is based, regardless of the perspective one takes with respect to social control. Davis and Stasz (1990:49-50) contend that social control is: *ambiguous*, deviance and normality being subjective notions, where deviance is the result of successfully labeling someone as a deviant; *selective*, where in the name of social control, emphasis is placed upon agency programs as opposed to client needs; *arbitrary*, agents of social control are subjective in their enforcement, targeting particular subgroups within society contingent upon class, power and current societal conditions; *routinized*, everyday routines keeping the system running in a smooth manner; *deceptive*, jargon disguising the detrimental impact of the labeling process; and finally, social control is *coercive*, agents on control using threats of force, or actual violence when attempting to control the lower classes. These basic notions will framing the discussion, and argument that current prevention efforts, can indeed, be interpreted as measures of social control.

The Operation of Social Control

The class, the race, and the gender of an individual appear to have strong bearing on whether oneself will be labeled as deviant, and therefore, need to be controlled.

According to societal reaction theorists, "in defining and applying rules, control agents can be influenced by the class, ethnicity, occupation, sex, and age of an individual" (Davis and Stasz, 1990:45). Concerns about power appear to be the central issue, where according to conflict theories, "what is considered proper at a particular period depends upon the interest groups and the powerful individuals that reign at the time" (Davis and Stasz, 1990:47). Thus, deviance is indeed, arbitrary, selective and ambiguous, attention being focused principally on the powerless within a situation, community, or society as a whole. The oppressive operation of sexism, racism, and classism in society, by placing an emphasis on the individual acts of those labeled as deviant, essentially blinds us to the larger picture; the systemic inadequacies of a hierarchically organized society, and the breakdown of the society as we know it.

Two marginalized groups within society of particular concern to this discussion, that have been detrimentally affected by racist and sexist measures of social control are Canada's Indigenous population, and women. Thatcher (1986:273) asserts that "public intervention in the social problems of Natives peoples has been primarily oriented towards social control rather than towards positive social development". Such policies of social control have been informed by a racist ideology, based on largely erroneous assumptions, myths and stereotypes about Natives and their relationship with alcohol. Women have been affected by social control methods that are inherently biased against women, sexism

serving “as a powerful mechanism of social control that reinforces subordination and deprives otherwise competent adults from realizing their full potential as human beings” (Davis and Stasz, 1990:239).

The Location of Current Prevention Strategies

Current prevention efforts, informed by essentially racist and sexist ideologies, appear to fall under the category of conservative social policy. This claim is based on the following reasons (Davis and Stasz, 1990:76): 1) conservatives postulate the need for more repressive state, school, and family intervention; 2) conservatives invariably beseech the theme of insidious moral decline; 3) conservatives offer an individualistic, sometimes biological approach to social control; 4) conservatives maintain that social control is effective only through quashing all forms of tolerance; 5) conservatives want social benefits for the ruling classes, proposing an increase in the repression of the economically and politically marginal classes to achieve this goal; and 6) deterrence is the primary strategy to reduce deviance, assuming that intervention and punishment will prevent deviance. All of these elements are present in current policies intended to prevent FAS, prevention efforts based on implicitly moral perceptions of the problem, focusing on the individual as the root source of the problem, covertly calling for the repression of a economically, socially and politically marginalized membership of society; pregnant, Aboriginal women.

Lemert’s (1962) models of social control assist us in further locating the position of current prevention measures; the second model in particular, is of the utmost value in

placing the current stance of prevention. The second model is based on education, grounded by the assumption that “a causative relationship holds between controlled presentation of information and change in attitudes and values” (1962:562), leading to is not abstinence, then moderation in drinking behavior. As described earlier, primary prevention measures are educationally based, with the goal of raising awareness about the problem of FAS. It is believed that by changing predominant attitudes about drinking, consequent behavior will be modified.

The Role of Medicalization in Social Control

The medicalization of all issues pertaining to FAS, pregnancy, alcoholism, and FAS itself, has served to essentially neutralize a potentially politically volatile subject; indeed, “the labels of health and illness are remarkable “depoliticizers” of an issue” (Zola, 1994:400). In defining a problem in seemingly neutral terms, and assigning outwardly impartial actors to design a solution to the problem, the involvement of the medical profession was supposed to be viewed as a positive by society as a whole. However, Clarke (1996:15) points out that “as more problems are defined in medical terms, the opportunities increase for medicine to provide the only solutions to those problems.

This power to define reality constitutes a significant component of social control”. Doctors are seen as “*the* legitimate, scientifically trained medical practitioners” (Clarke, 1996:15), not as traditional oppressors, agents of social control. This makes the role of the physician, and the medical profession as a whole, in social control almost invisible. Nevertheless, “medicine is becoming a major institution of social control” (Zola,

1994:392) in modern society. Today the prestige of any claim is tremendously enhanced, legitimized, and perhaps even justified, when it is expressed in the idiom of medical science, and supported by medical practitioners.

A considerable consequence in the castigation of 'illness' upon an individual is a shift in responsibility for care of the diseased. In the case of FAS, a shift in control from one set of professions to another has resulted in a shift "from the defenders of the society to the defenders of the individual" (Seeley, 1962:589). The medicalization of a problem brings it down from the societal level, to the level of the individual. Such a process has significant implications; medicalization facilitates social control, as discussed in previous chapters, it is easier to control individuals, as opposed to subgroups or communities. Consequently, "by locating the source and the treatment of problems in an individual, other levels of intervention are effectively closed" (Zola, 1994:400). Thus, the medicalization of a social problem, FAS in this particular instance, might be construed as being somewhat deceptive, medical jargon concealing the exercise of social control implicit within the rhetoric of prevention.

The Influence of Values in the Practice of Social Control

Best (1987:115) believes that "rhetoric is central, not peripheral to claims-making", the discourse around a claim is central to its success or failure. Within a claim, the rhetoric of rectitude is posed against the rhetoric of rationality (Best, 1987:116), morality being pitted against logic. The relationship between medicine and alcohol use is governed by social values and norms, which for Zola (1994:395), means that "a *moral*

rhetoric is needed to describe a supposedly moral phenomenon - illness" (Zola, 1994:395). For Lemert (1962:553), "values are crucial factors in the social control of alcohol use"; moreover, "often the physician is guided not by his technical knowledge but by his values" (Zola, 1994:398). The valuation of alcohol within any given society has the potential to become polarized; in the case of FAS, the locus of attention has been placed entirely upon the negatives associated with alcohol use and drunken comportment. This focus has resulted in the call for social control of the less powerful over the more powerful; the social control of pregnant, Native women via the practices of the medical profession. For Zola (1994:395), "medicine is not devoid of potential for moralizing and social control".

Deviance Amplification

Davis and Stasz (1990:62) state that deviance is amplified when coercive control is used to increase deviance, which in turn enhances and strengthens the power of the agents of social control. Deviance amplification can be achieved through the use of different means, including: publicity of a 'crisis' in the media; reduced tolerance and increased punishment; and increased incarceration rates (Davis and Stasz, 1990:62). In the case of FAS, the use of the media has been particularly effective in gaining the attention of the public at large about the issue. In addition, more coercive means of prevention have been used, as within the realm of tertiary prevention looms the potential for an expectant, substance-abusing woman, to be prosecuted, and consequently incarcerated for her drinking.

The Role of Ideology in Social Control

The role of ideology in contemporary capitalist society, is central in the social control of certain subgroups within society. Two notions pertaining to ideology are of relevance here: 1) the notion of manipulated consensus; and 2) Cohen's notion of controltalk (Davis and Stasz, 1990:65). First, manipulated consensus occurs "when power groups deceive the public and otherwise deliberately misrepresent their actions" (Davis and Stasz, 1990:65). Such manipulation is facilitated by a well-planned message strategy, usually implicit, with the production of certain behavior by specified subgroups within society, as a desired goal. Second, Cohen in Davis and Stasz (1990:65) suggests that "controltalk", as a form of language, replaces everyday speech with such things as jargon and euphemisms. Controltalk serves to keep the reality of societal conditions from being fully recognized and understood by the public. Thus, "despite its apparent authenticity, controltalk is political doublespeak, which aims to obscure the real intention and meaning of social control" (Davis and Stasz, 1990:66); the preservation of the hegemonic ordering of society.

Ideology then, "helps to explain why people often report feeling so helpless, apathetic, or fatalistic about the state of the world" (Davis and Stasz, 1990:67), power and ideology being inextricably related to one another. Consequently, ideology serves to sublimate, legitimize and perpetuate the domination of one group over another. However, power cannot be separated from knowledge, as "the power/knowledge unity implies that rather than through genuine consensus, based on citizens' real interests and needs, modern society often operates by stifling opposition at its roots" (Davis and Stasz, 1990:66-67).

The domain of knowledge found within the medical profession, bestows medical personnel with power over subgroups in society, in laying claims about certain social phenomenon, defining and arguing the merit of the problem, and devising solutions to the prescribed problem. The medicalization of FAS, in addition to the drinking behavior of women and Aboriginals, has had resounding implications for not only current measures devised and implemented to prevent FAS, but future endeavors to prevent FAS as well.

CHAPTER NINE: IMPLICATIONS AND CONCLUSIONS

The implications of current constructions and resultant efforts in preventing FAS will be explored on two levels: 1) the epistemological level, considering the relationship between language and discourse first, and knowledge and power second; and 2) on a more practical, grounded level, look at implications in relation to social control and prevention policies.

Epistemological Considerations

On a deeper, more epistemological level, consideration must be given to the relationships between 1) language and discourse; and 2) knowledge and power. The claim that FAS is a social problem must be conceived of as being socially constructed upon discursive practices of power, based on oppression and exclusion. The discourse around FAS has situated itself around the body; the control of one's body being opposition of the safekeeping of the larger social body. Foucault (1980:55) suggests that the protection of the social body, is constructed in a quasi-medical sense, "the materiality of power operating on the very bodies of individuals". The body itself, and one's autonomy over his/her body, becomes an issue of conflict. Thus, "the body takes on a certain idealistic - even mythic - dimension as extra-discursive site in truth and resistance" (Hennessy, 1993:45).

Language and Discourse

The language of claims is important, setting the milieu of the claim. Latour in Schneider (1985:216) suggests that when bureaucracies receive complaints, these claims are transformed by a language that is both created and controlled by experts or bureaucrats. Experts then, have the power to define, and therefore modify the problem to best suit their agendas. "The import of language and how it shapes interpretations and conduct is here enormous" (Schneider, 1985:224), as language is a key in the clockwork of social construction, assisting in the fabrication of intersubjective realities. In using medically-based language to construct the problem around FAS, claims-makers "make moral judgments both in the technical language of the profession and in the popular moral meanings so far as this language often incorporates popular moral meanings" (Schneider, 1985:220). Thus, the use of medical language contributes to the perpetuation of inequality, and the preservation of the hegemonic order of dominant society.

The language used by the medical profession reveals codes that mark differential levels of understanding and knowledge and different beliefs about illness. More importantly, the use of medical terminology illustrates "the attempts by doctor and patient to control and direct the discourse" (Cicourel, 1985:193). For Anspach (1994:321), medical language conveys the message that observations in an authoritative voice, and are therefore, not only factual, but unequivocal. However, "doctor language" (Cicourel, 1985:195) is little more than a medically-based form of jargon, especially the slang terminology utilized in case presentation. This doctor language serves two purposes, as it first serves to separate the patient from biological process of the body; and second, it

serves as “a linguistic ritual in which physicians learn and enact fundamental beliefs and values of the medical world” (Anspach, 1994:313). ‘Doctor language’ can be conceived of as the element of *deception* in social control, the use of *jargon* disguising the detrimental impact of the labeling process. For Anspach (1994:326), “the language of case presentation approaches rhetoric or the art of persuasion”, the rhetoric of prevention being based on medical terminology that is innately dehumanizing and depersonalizing.

Moreover, the discourse around FAS, is inherently biased against certain individuals in society, on the basis of gender and/or ethnicity. On the one hand, the use of terminologies are merely tools of the trade to certain professional groups, physicians being one such group; on the other hand, to ‘outsiders’, such terminologies are hurdles in the comprehension of the problem and its prescribed solution. With respect to language and gender, Kress (1985:39) asserts that “the language used about women differs from that used about men”. This is due to the fact that the language utilized in the fabrication of claims, what Gail Scott refers to as the “father tongue” (Smith, 1990:3), was created, and then used by men, from a male standpoint, not a female standpoint.

With respect to ethnicity, “culture and language strongly influence the understanding of each participant” (Cicourel, 1985:194). An individual’s cultural background must be a consideration with respect to language, especially in the instance that cultural differences prove to be a barrier to effective comprehension and communication. Linguistic systems are the basis for discursive exchange, these systems regulated by the symbols we use to express our thoughts, feelings, and ideas, and are “the means whereby they are ordered” (West and Zimmerman, 1985:103-104). Understanding

then, of the problem of FAS, and the ensuing solutions, is affected by an interaction between ethnic and gender differences.

Such an understanding is construed via the use of hegemonic discursive practices, where individual life experience is transposed “into the conceptual currency with which they can be governed” (Smith, 1990:14). Discourse, then, is a political commodity (Gordon, 1980:245), the core of many discourses being controlling schemata. As such, the medically-oriented discourse around the prevention of FAS can be conceived of as being based on two areas of discursive exchange: 1) the discourse around gender and alcohol; and 2) the discourse around Natives and alcohol. Gender-based claims about drinking are defined, explained, and subjected to social control based on socially constructed knowledge and facts, which in turn, inform current discourse. “Within and through sexist discourse, both sexes have been assigned and conventionalized, stereotyped sex roles that have certain language uses associated with them” (Kress, 1985:39). Indeed, current discursive practices in the arena of women, drinking, drinking problems and alcoholism, are reflexive and supportive of gender relations of power (Morrissey, 1986:160). Moreover, the discourse around women and alcohol is grounded on innately paternalistic and patronizing assumptions, this discovery being made in Chapter 4. It can be concluded then, that the discourse around FAS is concerned with gender power relations, power relations which are established and consolidated via the production and utilization of discriminatory discourse about the nature of the relationship between alcohol and women.

The relationship between ethnicity and discourse is equally discriminatory in nature, riddled with pejorative notions about Aboriginals and their relationship with

alcohol. The origins of such notions can be traced back to colonial discourse, the point of origination for the negative association of alcohol with Natives. Homi Bhabha in Duran and Duran (1995:117) suggests that colonial discourse can be conceived of as an “apparatus of power”, where knowledge is produced by the colonizer about the colonized, that is stereotypical in nature, based on myths and assumptions. As was the case with the discourse around alcohol and women, the discourse around alcohol and Natives is rooted in concerns over power relations.

It can be conceived of that, the discourses around gender and alcohol, and ethnicity and alcohol, intersect at the current discourse around the prevention of FAS. It is at this locus that the “voice of medicine” and “voice of the lifeworld” (Mishler, 1994:290) clash, where the voice of the lifeworld is typically silenced by the voice of medicine. Medical discourse “objectifies patients and devalues their subjective experience” (Anspach, 1994:327), serving to not only to minimize the lifeworld of the patient, but also to simultaneously decontextualize and depoliticize the issues around FAS. This is possible because the disease model conceptualization of alcohol-related problems is both ahistorical and acultural. Within the medical paradigm, causal responsibilities for a problem are created within a scientific discourse, and are then transformed into social, and political responsibility. The genesis of FAS in this manner, concurrently reinforces existing power relations, while providing the justification and legitimization for social control.

Discursive practices are based on the assumed truth of discourse, which is a function of the relationship between knowledge and power. The “truth effects are produced inside discourses which are not in themselves, either true or false” (Morris and

Patton, 1979:36). Thus, discourse may, or may not, be reflective of reality. Indeed, there may be real, and significant discrepancies between discursive practice and reality. The need then, to contextualize what has been decontextualized through the use of discourses is omni-present, McCormack (1986:46) inciting the need to locate the communicative act, and contextualize it in terms of culture, social structure, and I would add, gender experience.

It is through discursive practices that the exercise of domination is facilitated; domination via “the assertion of universality and neutrality, and by the disavowal of all other cultural forms or interpretations” (Duran and Duran, 1995:110). Consequently, an alternative framework for the codification of problem, and the prescription for a solution is required. It is within the realm of subjugated knowledges, that critical discourse emerges, and counterhegemonic discourse is thus, born; “it is really against the effects of the power of a discourse that is considered to be scientific that the genealogy must wage its struggle” (Foucault, 1980:84). Such a discourse can only be construed around a new language, an alternative to the ‘fathertongue’. Indeed, Smith (1990:11) calls for the creation of a new language, that gives women “speech, ways of knowing, ways of working politically”. This new language will form the basis of a new political, counterhegemonic discourse, that runs in opposition to hegemonic discourses, advocating and perpetuating the domination of subgroups in society.

Knowledge and Power

The operation of ideology is central in understanding the relationship between knowledge and power, as power and ideology, for Davis and Stasz (1990:66) “form an interrelated whole”. Dominance, under the influence of ideology, becomes both assumed and natural, based on such things as biological reality, gender and ethnicity. Thus, ideology can be envisioned as a term that covers concerns with forms of knowledge, and their relation to class structure, class interest, economic structure, and with forms of knowledge in specific social practices (Kress, 1985:29); ideology then, is concerned with how power in society ought to be organized. Moreover, there are three elements of which an ideology is commonly comprised: 1) a critique of existing society; 2) a vision of a better future; and 3) a strategy for getting from here to there (Love, 1991:xix). The claim for the need for prevention of FAS, and in some ways prevention efforts themselves, then, appears to be ideological in nature. Claim-makers base their claim on medical knowledge, the maintenance of their relation to class and economic structures, at the forefront of their agenda. And, prevention efforts themselves have been oriented around the three elements of ideology: prevention has been organized around critique of existing Aboriginal society and the high incidence of FAS within Native communities; prevention has offered what has been conceived of as a vision of a better future; and, prevention has designated a strategy for getting from here to there by increasing awareness via education about FAS and its prevention.

The power of ideology is derived from the use of binary relationships. Toulmin (1958:33) attests that “the force of commending something ‘good’ or condemning it as

'bad'" is a powerful one, the definition of alcohol centered around related terms and their binary opposites. Binary relationships are inherently antagonistic, the antagonism awash with value-laden condemnations; one half of the binary pair enjoys positive connotations, while the other half possesses negative nuances. Levi-Strauss in McCormack (1986:46) suggests that dialectical tension is created through the use of oppositional imagery, some of the imagery found within the literature to describe subgroups' relation with alcohol including: wets/drys, good/bad, saints/sinners, autonomy/dependency, tradition/assimilation, and public/private. Ideology then, is about the power to define, and disseminate meaning about a given claim to knowledge.

The perception of our world has been reconstructed due to advances in the realm of scientific knowledge; indeed, there is a great deal of power invested, and therefore intrinsic, to scientific discourse. Science, an externalized body of knowledge, is based on an organization of life experience that essentially excludes the reality of the individuals it addresses, which is then imposed upon the less powerful as their 'reality'. A woman's status is defined in abstract terms, determined by her relation to modes of *re*production, rather than modes of production. And, one of the primary elements involved in the conceptualization of the status of Aboriginal peoples is their relationship to alcohol. In essence, "the concept becomes a substitute for reality" (Smith, 1990:42).

Not only is this reality imposed on certain subgroups within society, but is also assumed that this reality is universal across the group for which concept becomes reality. The scientific paradigm utilizes jargon specific to given set of doctrines, which are believed to have universal applicability. Indeed, shared concepts, symbolic generalizations,

specific techniques, and theoretical claims are the constituent elements of scientifically discursive practices. “The standard model of scientific knowledge takes it to be knowledge of universal laws, valid at all times and places” (Rouse, 1987:21). However, Foucault (1980:81) claims that “the attempt to think in terms of a totality has in fact proved a hindrance to research”, this notion being addressed further on in the discussion.

Foucault (1980:93) contends that “we cannot exercise power except through the production of truth”, knowledge being accepted as the embodiment of truth. Indeed, the subjective interpretation of knowledge is best understood within the context of the relationship between power and knowledge. The application of power can be construed “as a practice which establishes certain relationships between heterogeneous elements” (Gordon, 1980:245) in society, that have tacitly come to be regarded as homogeneous in nature via universalistic notions about such groups. Thus, the usage of power is a repressive exercise; “power represses nature, the instincts, a class, individuals” (Foucault, 1980:90). In the case of FAS and prevention, “as relations of power become problematic, so does the use of alcohol by the subordinate group” (Morrissey, 1986:167). This is best illustrated in the power-play which occurs within the context of the doctor-patient relationship. According to Morris and Patton (1979:53), “the manifestation of power takes on the pure form of “thou shalt not”, doctors dictating what the patient can and cannot do. Referring back to the content of the pamphlets on the prevention of FAS, many of the evaluative statements in pamphlets take on a prohibitive tone, demanding that a woman not do certain things while pregnant, the number one prohibition being the consumption of

alcohol. Such prescriptions are taken to be based on scientifically proven, factually-based knowledge.

However, “the connection between what counts as knowledge and the ability to manipulate and control the things known, is culture bound and gender bound” (Rouse, 1987:256). Accordingly, there are three main interactions between knowledge and power (Rouse, 1987:13): 1) knowledge can be applied to achieve power; 2) power can be used to impede or distort the acquisition of knowledge; and 3) knowledge can liberate us from the repressive effects of power. First, knowing gives one power over another, creating opportunities for those who possess knowledge to manipulate and control those who do not. Knowers treat their knowledge as if it can be known, and is accessible to everyone; in reality, this is not always the case. The power advantage enjoyed by the professional classes is linguistically managed (Fowler, 1985:67), via the use of medical discourse. Second, false beliefs can be imposed, and true beliefs can be repressed through the use of knowledge-based discursive exchange. And third, knowledge can uncover distortions in power relations, and challenge those mechanisms facilitating the operation of inequality. However, the operation of ideology serves to circumvent such an occurrence, Shaw in Kinloch (1981:8) claiming that ideology has the potential to prevent individuals from understanding the society in which they live, this lack of understanding also preventing individuals from *changing* [emphasis added] society.

Epistemological Implications

The current discourse around FAS is an intersection of existing discourses: medical, classist, racist, and sexist discourses. The result is an ideology of prevention that is rendered ineffective, as knowledge cannot be neither universalized, nor decontextualized, without rendering it inept as a guide for intervention. "The objectified forms, the rational procedures, and the abstracted conceptual organization create an appearance of neutrality and impersonality that conceals class, gender, and racial subtexts" (Smith, 1990:65). The inherently androcentric nature of scientific knowledge fails to maintain the supposed objectivity of scientifically-based epistemologies. Accordingly, the conceptualization of the prevention of FAS, based on medically-oriented discursive practices, must be critically examined, and challenged, to bring to light the actuality of existing social relations. Otherwise, subgroups at which such discursive practiced is levied, will continue to be oppressed and confined.

The current treatment of women and Native peoples as homogenous, serves to universalize and totalize 'woman' and 'Aboriginal' as concepts. Although taken to be obvious categories, 'woman' and 'Aboriginal' are merely social constructs, with garbled meanings, and implicitly attached, pejorative assumptions. This is especially apparent in the case of Natives, where the term 'ethnicity' can be conceived of as merely "the jargon of bureaucratic categorization" (Heath, 1990:615). As discussed earlier, the use of jargon is a deceptive mechanism of social control. Ethnicity then, can refer to such aspects as phenotypic characteristics, national heritage, religious affiliation, and bureaucratic classification (Heath, 1990). The aspect to be focused upon is simply a matter of choice;

which conceptualization best serves the interests of those who are in a position to control those with less power? The notion of 'Aboriginal' then, becomes a signifier of something other than mere phenotypic characteristics; it becomes as label that justifies and legitimizes the social control of those individuals, and groups who can be categorized as Aboriginal.

Thus, there is a need for a counterhegemonic discourse around FAS, based on alternative knowledge bases, the "genealogies" (Foucault, 1980:83), of both women and Natives. Genealogies can be perceived of as 'anti-sciences', "concerned with a *historical knowledge of struggles*" (Foucault, 1980:83). Within the realm of traditional knowledge, the historical contents have been buried and disguised, resulting in the creation of what Foucault (1980:81) refers to as "subjugated knowledges". Knowledge is comprised of logic systems of signification, power, resource allocation, and divisions of labour, that are hierarchically organized on the basis of difference (Hennessy, 1993:73). Genealogies have essentially been "disqualified from the hierarchy of knowledges and sciences" (Foucault, 1980:82), not having been afforded with the same privileges as more formal, acceptable epistemologies.

It becomes apparent that there is a need to create autonomous, non-centralized bodies of thought about those areas of discourse which have bearing on the perception of FAS as problematic; alcohol, pregnancy, women and Natives. For Foucault (1980:81), the validity of such bodies of thought would not be dependent on the approval of the established regimes of thought. Instead, the validity of the genealogy would come from lived experience. For Natives, Indigenous theory (Duran and Duran, 1995:125), which "utilizes knowledges and idioms produced by native people from within native culture",

would be central to the conceptualization of FAS as a problem. And for women, reproduction, and motherhood would be merely one aspect of a woman's lived experience, as the establishment, and the theories they produce, deny women any functions other than reproduction (Clark, 1976:54).

Grounded Implications

The Faulty Conceptualization of 'Prevention'

The laying of criminal charges against women with substance abuse problems, due to the personal harm inflicted upon her unborn child, "is indicative of a failure of society to address the problem of high-risk behavior before the damage is done" (Blank, 1993:83). Prevention is intended to forestall an event *prior* to its occurrence. With current efforts to prevent FAS, this does not appear to be the case. Norton Hawk (1994:521) declares that "social policies have the potential to provoke a counterproductive emotional response in the group targeted by this intervention". In the case of Canada's Native population, perhaps drinking is an expression of protest, albeit a destructive one, to the many repressive social policies they have had to deal with, beginning with assimilationist policies dating back to colonial times.

Perhaps then, drunken comportment might be esteemed as a discursive form of communication for Aboriginal peoples. Drinking as discourse, for Native peoples, may be a communicative behavior, in response to the biased norms governing drunken comportment, non-conformity aimed as a direct challenge at dominant norms and values. Thus, drinking may be being utilized, either consciously, or perhaps unconsciously, as a

form of resistance against the many attempts at acculturation by dominant society, serving a purpose at not only at the individual level, but as a broader, more collective forum for expression. "Alcohol consumption was and continues to be the salve of wounded warriors as well as the vehicle of protest" (Weiner et al., 1984:248). Thus, prevention as a policy must address the root of the problem, rather than the mere symptoms, of the predicament of Canada's Indigenous peoples.

Social Policy Implications

The reality of the situation around FAS is that prevention will continue to be perceived, on some level, as a form of social control. However, social control does not necessarily have to carry with it negative imputations. Cohen's "realistic critical policy" (Davis and Stasz, 1990:78) is useful here; such an approach designed to (1) cultivate a sensitivity to success, and (2) be an experimental and inductive method, testing new and different solutions to a problem. This form of social policy works under a more modest set of goals, is more humane, and less repressive than traditional forms of social control. In addition, such policy is realistic, advocating for involvement from ordinary people within the community, "to avoid the mistake of turning over the regulatory task to licensed functionaries of the central state" (Davis and Stasz, 1990:78).

This form of social policy can be identified as being founded on the "strengths perspective" (Chapin, 1995:507), as opposed to the problem-centered approach. According to Chapin (1995:507), strengths-based policies are rooted in the belief that all people have the potential to change, and are entitled to equal access to resources. The

success of future prevention policies is dependent upon four factors: one, a complete and concise definition of the problem of FAS within Native communities; two, the mitigation of labeling individuals and/or groups as deviant or dysfunctional; three, getting past the perception of Native communities as inherently dysfunctional; and four, dispelling colonialist notions of Aboriginal tradition and culture as toxic.

The Goals of Prevention

In defining the problem, and prescribing a policy-based resolution, the key elements in success are the goals of prevention. The identification of overriding goals will guide the course of action taken to prevent FAS. The following goals are required if prevention is to be successful: the determination of abstinence versus moderation; personal accountability; the empowerment of women and Natives; and healthy babies. First, the decision must be made whether to focus efforts on advocating for maternal abstinence during pregnancy, or to espouse moderation. Kellner et al. (1996:1635) assert that "programs which aim to reduce the number of drinks consumed on particular occasions should have substantial effect upon reducing alcohol use-involved harm". In adopting a harm reduction perspective, moderation appears to be a more realistic, and less controlling approach to dealing with the severity of alcohol misuse and dependency amongst Canada's Aboriginal peoples.

A second goal of prevention is that of personal accountability. Prevention should promote responsibility to not only to others, but also to oneself. "Messages concerning the possibility of controlling behavior while drinking should be set forth with some force to

convince the drinker and others, that, drunk or sober, the actor is responsible for his/her own conduct” (Kellner et al., 1996:1635), and the resultant consequences of their behavior while intoxicated. A third aim of prevention is empowerment; the empowerment of both Natives and women. Power is regularly interpreted in purely negative terms (Morris and Patton, 1979:54). However, power can also be conceived in a positive light. If pregnant women are equipped with the knowledge about the effects of maternal consumption during pregnancy, and the skills to assist them in staying sober, they have the ability to make responsible choices. However, the autonomy to make such choices is not enough. There is also a need to *respect* those choices; “to respect that ultimate decision, even if it challenges our beliefs” (Fralick, 1994:10). Thus, prevention must aim to motivate women, and those close to her, to make wise lifestyle choices, placing an emphasis on why *not* consuming alcohol to excess, especially during pregnancy, gives you power. Finally, the overriding goal of prevention should be to maximize the birth of healthy children.

Community, Family and Peer Group Influence

Effective prevention policies will also take into consideration the powerful effect of an individual’s family and peer group. Lemert (1962:563) suggests that the serious flaw within the second model of social control, education as prevention, lies in the assumption that attitudes and values are strongly influenced by formal educational agencies, when in actuality, they are shaped by family and peer group associations. Often, there is great pressure on individuals to drink at the family and peer-group levels. Thus, prevention of FAS should be tackled at these levels, as a community development program. In adopting

a family-oriented approach, with the support and participation of tribal members, Native communities should be provided with comprehensive knowledge about FAS, and the necessary skills and resources to carry out prevention and intervention *in their own way*. Indeed, Habbick et al. (1996:207) suggest that "the main impact is likely to come from the efforts of communities most at risk" for producing children afflicted with FAS.

Cultural Sensitivity in Prevention

Effective prevention strategies would also recognize a need for culturally-sensitive efforts. Current prevention efforts rely "heavily on the written word - a grossly inefficient form of communication in the indigenous community" (Scott, 1996:139). However, even in verbal exchanges, between professionals, such as physicians and social workers, and pregnant Aboriginal women, cross-cultural misinterpretation is a very real possibility. Elements of mutual understanding, when speaking with one another, play a role in discursive exchanges. Indirectness can result in misunderstanding and misinterpretations, and are even more likely when discursive participants come from different cultural backgrounds. Tannen (1985:205) contends that "there are cultural differences with respect to how much and what type of indirectness is expected in particular settings". Furthermore, certain aspects of conversation may vary between cultures, such aspects including: pacing, tone of voice, pitch, and loudness (Tannen, 1985:210). If these differences are ignored "discrimination of another sort" (Tannen, 1985:212) is perpetrated against Natives, in this instance, Native women in particular.

A Comprehensive Approach to Prevention

The recommendation could be made to include both micro- and macro-level approaches to prevention. Prevention must be considered not only at the level of the individual, as is the current medically-based trend. It must also look at systemic inadequacies that result in the misuse of alcohol. However, change is a much more complex and arduous task; “in prevention, efforts, particularly on the macro level, one must be positive and optimistic, but also realistic” (May and Hymbaugh, 1989:516). Thus, one must not be guided by unrealistic expectations, and contrive insurmountable goals to be attained by those at whom the policy is directed. Another aspect of a complete prevention plan is the focus of such policies; an effective policy will concentrate on long-term goals rather than short-term ‘quick fixes’. Although policies with long-term benefits and results may be more expensive in terms of monetary value, and the expenditure of effort in the present, such policy directives will be much more cost-effective in the long-run. “If the damage associated with only one FAS child has been prevented and the special needs and costs associated with the problems of such a child have been eliminated, the program has more than paid for itself” (May and Hymbaugh, 1989:517). However, the approach with which most agencies are currently addressing the issue of prevention of FAS within Aboriginal communities, illustrates just how out of touch bureaucracies are with the reality of Canada’s Indigenous population.

The Role of Tradition within Prevention

Brady (1995) cautions us to be aware of use of 'culture as treatment' as opposed to 'culture in treatment'; "culture is beginning to be mooted as the answer to addiction - panacea for all ills" (Brady, 1995:1488). Cultural affiliation, in and of itself, cannot necessarily be seen as a cure. However, this is not to dismiss the paramount role traditional customs can play in addressing the misuse of alcohol among Canada's Indigenous peoples. Traditional notions of healing embrace the symbolic, ritual, and myth, attempting to deal with the misuse of alcohol on a more spiritual level. Duran and Duran (1995:146) suggest that an individual can learn to deal with, and appease alcohol spirits, by making offerings to them, the making of offerings an integral part of custom. In addition, individuals are taught to understand the dual nature of alcohol, where the good or evil consequences of alcohol are left entirely up to the individual (Duran and Duran, 1995:148). Such notions afford individuals autonomy, while addressing their responsibility to be accountable for their choices.

A Cognitive Behavioral Approach to Prevention

Duran and Duran (1995:151) advocate for a combination of tradition "in addition to other sound clinical therapeutic strategies", recognizing that the strength of prevention lies in a comprehensive, 'holistic' strategy. One such school of thought that might prove to be a viable option is the cognitive behavioral approach. The rationale behind choosing to advocate for such an approach lies in Lemert's (1962) fourth model of social control, where the proposition is made that "the costs of intoxication and drunkenness can be

reduced by substitution of functional equivalents of drinking” (1962:566). Thus, if Aboriginal women are given the opportunity to learn the skills required to engage in non-drinking behaviors, such as coping mechanisms for negative moods and stress relief, and the ability to avoid high-risk situations, where drinking will take place, the potential exists for a reduction in the incidence of FAS amongst Native children.

Conclusionary Remarks

”The idea that intoxication impairs women’s primary responsibility, her nurturing role, reaches its current expression in campaigns of fear about “neonatal addiction” and “the fetal alcohol syndrome”” (Gomberg, 1982:22). Unfortunately, the residual effects of fetal alcohol syndrome are permanent; as such, future generations are going to be affected by actions from generations past. However, this does not have to continue to be the case; prevention can work. But, the prevailing discourse and practice around the prevention of FAS impedes effective prevention, displacing the focus from a community and even, societal locus. Daniels (1993:7) proposes that ”social anxiety and resentment are most easily projected onto those women who are perceived as most distant from white, middle-class norms”; in two words - Native women. Until prevention efforts are contextualized, and are purged of racist and sexist assumptions, attitudes, beliefs, and practices, bias will continue to be perpetrated against females in society. This bias has been “sustained by a recent emphasis in the literature on the “fetal alcohol syndrome”” (McCormack, 1986:45).

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APPENDIX A

The Process of Grounded Theory Generation

D) Data Collection

The first step in my research process was comprised of a comprehensive collection and review of the literature pertaining to alcohol, women, and Natives. Three primary searches were performed to construct a sample of literature for my analysis. First, a search on Sociofile, Social Work abstracts and Current Periodical Indexes were performed. Searches included various combinations of the following “local concepts” (Glaser, 1978:45): *alcohol, women, aboriginal, Native, fetal, alcohol, and syndrome*. An initial review of the results obtained from the various searches was performed, and those articles that would comprise my primary bibliography were identified and collected. A secondary review of the remaining articles was performed, selecting an additional 20 articles for inclusion in the sample to literature to be reviewed through a simple random sample of the remaining articles. The selection of numbers was facilitated by using a table of random numbers in B. H. Erickson and T. A. Nosanchuk’s *Understanding Data* (1979:377).

I then performed a search of Carleton’s collection of books and government documents on the topic of FAS. Using the terms *fetal alcohol syndrome*, a boolean search was performed, resulting in the identification of several governmental reports on the topic of FAS. As well, using the term *fetal* to perform a keyword search, several books were identified for inclusion in the literature sample. Finally, I visited the Canadian Centre for Substance Abuse [hereon referred to as the CCSA]. My visit resulted in the selection of a variety of literature for review, both academic and non-academic in nature, including such

items as pamphlets, articles, educational kits, newsletters and journal articles. It is at the CCSA that I obtained the sample of my pamphlets that were analyzed in Chapter 3. I informed the person assisting me in my search that I needed as many pamphlets as she could find for my research. Her search of available pamphlets yielded me a sample of 13 pamphlets to be coded and assessed.

Briefly, the literature yielded by the various searches performed can be classified as either 'academic' or 'practical' in nature. This differentiation is significant, as the two types of literature were utilized within this project in a different manner. In the case of academic literature, primarily comprised of journal articles, was coded in a non-critical manner, in an attempt to generate the numerous themes existing within formal academic literature. The more practical literature, comprised of pamphlets, was approached much more critically, and evaluated with a more discriminating mind-set.

II) Coding

The next specified step is the coding of the collected data. Coding can be perceived of as two 'types' of reading. The analyst is first, reading for "ideas" (Glaser, 1978:32), in an attempt to identify conceptualizations made by the authors. Second, the analyst is reading for "style" (Glaser, 1978:32), looking at the construction of the written work, attempting to discern what the author is doing when writing. In grounded theory, the derived categories will "fit" the data, because they are derived *from* the data itself. Rather than attempting to fit the data into preconceived categories, the categories are a product of the data (text, in this case) being coded. Therefore, the categories and the

relationships between them, are expected to be more reflective of reality than current depictions of these relationships.

The decision was made to code the content of three main areas of literature: 1) that pertaining to alcohol and women; 2) that regarding alcohol and ethnicity; and 3) that referring to alcohol and Natives. Each main area of literature was coded separately, five articles being randomly selected to be read and coded from collection of articles on each of the topics. After reviewing the five articles selected for coding, I concluded that the search for codes had exhausted all major possibilities, and thus, the decision was made to discontinue further coding. This decision was justified on the basis that I was not keeping a numerical count of the occurrence each code as they appeared in the literature.

III) Identification of Categories

The next step was to examine the codes, and attempt to make some sense out of them. Thus, I began by exploring the codes for the existence of larger categories within the codes. I then grouped the codes together on the basis of commonalties between the theme of each code. The resulting groups of codes were then named, the headings being comprised of descriptive terms intended to illustrate a common theme running through various codes. In each of the respective chapters dealing with a given topic, each category was briefly outlined. Additional articles from each main topic area were read to obtain ancillary information on each category.

IV) Identification of Core Category/Variable

"The generation of theory occurs around a *core category*" (Glaser, 1978:93"), the variable identified as being most central to the development of a substantive theory, around which all other variables are organized. Glaser (1978:95-96) has outlined eleven criteria as guidelines in the selection of the core category: 1) the core variable must be central; 2) the core variable must reoccur frequently in the data; 3) the core variable takes more time to saturate than other categories; 4) the core variable relates easily and meaningfully with other categories; 5) the core variable has clear and grabbing implications for formal theory; 6) the core variable possesses considerable carry-through (does not lead to dead-ends in the analysis); 7) the core variable is completely variable; 8) the core variable is a dimension of the problem; 9) the core variable prevents other categories from establishing themselves as core; 10) the core variable can be seen in all relations, whether grounded or not; and 11) the core variable can be any kind of theoretical code. The identification of a core variable was presented in Chapter 7, the category deemed to be most befitting of the label as 'core variable' identified as *social control*. It was concluded that the category of social control fulfilled the requirements of a core variable resoundingly. The variable of social control appears to be the most logical and informative choice, as social control is the nucleus of the connection between alcohol, women, Natives and pregnancy.

V) Theoretical Memos

The generation of theoretical memos occurs *during* the coding process, being recorded *as they strike* the researcher during the coding process. For Glaser (1978:83), memos are comprised of theorizing write-ups “of ideas about codes and their relationships”. Via comparisons between the identified categories, an assessment and analysis of the relationships between the various categories can be performed. According to Glaser (1978:42) “comparing on the basis of properties of groups has the purpose of generating theory”. Consequently, the numerous theoretical memos generated during the coding process were compiled for each of the three main areas of literature. The memos were reviewed and subsequently arranged according to commonalities in the ideas. These ideas were then reported as the conclusion to each of the three chapters, in an attempt to shed some light on the key conceptual, and practical relationships between the various codes and categories.

VI) Generation of Substantive Theory

Analysis occurs at *various* stages in the generation process; coding, generation of theoretical memos, and sorting of the codes and memos. Through a comparison of the core category to other identified categories, such a process will result in the generation, the writing of, a substantive theory. Theoretically speaking, my analysis of the relationship between the codes/categories identified was influenced by diverse notions around aspects of language, discourse, knowledge, power and social control.

APPENDIX B

A Freudian Analogy: Ego/Cognitive, Id/Cathectic, and Superego/Evaluative

From Freud's ideas about the human personality, a structural model of the human personality was devised, which described the personality in terms of three constructs: the *ego*, the *id*, and the *superego* (Ewen, 1984:20). Although each portion of the personality blends into the other, being inextricably interrelated to one another (Ewen, 1984:20), it is most beneficial to address each component of human personality individually. For Freud, the ego is logical, problem-solving oriented, motivated by reality, resultant of an individual's experience with the outside world (Ewen, 1984:27). A comparison can be made between the ego and *cognitive* ideas, as cognitive ideas are responses based upon what appear to be logical perceptions of the environment.

The id, on the other hand, is described by Freud as being motivated by innate human instinct. Thus the id has the potential to be irrational, possesses little or no sense of logic, and can be perceived of as being amoral (Ewen, 1984:27). In many ways, the id is similar to *cathectic* ideas, as these ideas can be strongly subject to cultural influences, which define what is, and is not, "pleasant" [positive] within a given situation. Such definitions may not appear to have a logical basis, and may be construed as being irrational by other cultures. And finally, Freud has described the superego as the aspect of an individual's personality which operates on the basis of moral imperatives, which may or may not be realistic, these imperatives being enforced utilizing feelings guilt or pride (Ewen, 1984:27). Similar to the superego, *evaluative* ideas appeal to issues of morality, making essential statements about moral obligations, requirements, and prohibitions.

Evaluative ideas typically operate via the evoking of guilt or fear in the individual, which in turn, results elicits the desired response to a given statement.

APPENDIX C

Codes - Alcohol and Women Literature

gender roles	public	use of support
operation of ideology	group	anxiety
social control	external	stigma
defining the “problem”	solitary	sexism
knowledge vs. beliefs	internal	permissive
authority figures	assumption	tolerance of drunkenness
conflict betw. knowledge and beliefs	“truth”	sanctions of drinking
issue of control	racism	double deviant
authority	denial	avoidance
binary relationships	culture	gender bias
norms regulating drinking behavior	social support	control
medicalization	oppression	treatment as “cure”
gender bond	deviant label	no support
treatment barriers	“bad” women	mental illness
operation of gender roles	gender expectations	self-recognition
indirect barrier	patriarchal	depression
direct barrier	maternal role	lack of control
paternalistic	victims	ideology
responsibility and accountability	secondary alcoholism	primary alcoholism
competence	gender differences	polydrug abuse
self-esteem	personal history	overmedication

bias	social drugs	patronizing
social factors	quantity	seclusion
defn. as a social problem	frequency	pain
spousal influence	duration	life stress
social costs of subst. abuse	sexuality	risky behavior
diversity among subst. abusers	relationship problems	ethnicity
social class	stereotype	addiction
longevity of the "problem"	direct discrimination	indirect discrimination
physical abuse	sexual abuse	heredity
compliance	exclusion	lack of services
criminalization	fetal rights	maternal rights
discrimination	"at risk" group	means of control
institutions of control	intervention	birth control
child welfare	feminist theory	"good" women
redefinition of the "problem"	social status	secrecy
prevention of subst. abuse	physical factors	non-conformity
trauma as a cause	inequality	devaluation of women
discourse	autonomy	social structure
justifications for drinking	individual	collective
masculinity	symbolism	age as a marginalizer
independent	self-destructive	promiscuity
perceptions of drinking	morality	inclusion
imp. of alcohol in society	gender relations	culturally defined values

femininity	drinking as discourse	apathy
internalized forms of control	self-reflection	culturally defined norms
subordinate	agents of control	mental health
gender identity conflict	hypocrisy	medicinal drugs
externalized forms of control	power	interpersonal crisis
educational attainment	gender ideal	submissive
aboriginal use of alcohol	non-aboriginal use of alcohol	binary images
degradation of women	perceptions of women	

APPENDIX D

Categories - Alcohol and Women

THE PROBLEM

defining the "problem"
 definition as a social problem
 primary alcoholism
 secondary alcoholism
 polydrug abuse
 diversity among subst. abusers
 longevity of the "problem"
 prevention of subst. abuse
 redefinition of the "problem"

SOCIAL CONTROL

social control
 authority figures
 issue of control
 oppression
 control
 means of control
 institutions of control
 agents of control
 power
 internalized forms of control
 externalized forms of control
 autonomy
 lack of control
 social costs of subst. abuse
 criminalization
 fetal rights
 maternal rights
 intervention
 birth control
 independent
 (denial avoidance, resistance, apathy)

DRINKING AS DEVIANT BEHAVIOR

risky behavior
 deviant label
 non-conformity
 "at-risk" group
 double deviant

MEDICALIZATION

mental illness
 depression
 overmedication
 heredity
 addiction
 mental health
 competence
 physical factors
 medicinal drugs
 social drugs
 treatment as "cure"

SOCIAL FACTORS/INFLUENCES

educational attainment
 social status
 social class
 social structure

GENDER BIAS (SEXISM)

sexism
 gender differences
 inequality
 discrimination
 exclusion
 direct discrimination
 indirect discrimination
 subordinate
 inclusion
 age as a marginalizer

GENDER ROLES

operation of gender roles
 stigma
 maternal role
 gender expectations
 gender bond
 "bad" women
 "good" women
 compliance
 gender ideal
 femininity
 gender relations
 responsibility and accountability
 gender identity conflict
 sexuality/promiscuity

CULTURAL INFLUENCES

permissive
 tolerance of drunkenness
 sanctions of drinking
 ethnicity
 perceptions of drinking
 norms regulating drinking behavior
 culturally defined values
 culturally defined norms
 aboriginal use of alcohol
 non-aboriginal use of alcohol
 importance of alcohol in society
 morality
 perceptions of women

EXTRA CODES

pain
 empathy
 binary relationships
 treatment barriers
 indirect barrier
 direct barrier
 drinking as discourse
 lack of services
 use of social support
 social support
 no support
 binary images

THE DRINKING CONTEXT

public
 group
 external
 solitary
 internal
 seclusion
 secrecy
 duration
 frequency
 quantity

IDEOLOGY

hypocrisy
 patronizing
 degradation of women
 devaluation of women
 patriarchal
 paternalistic
 operation of ideology
 discourse
 knowledge vs. beliefs
 assumption(s)
 conflict between knowledge and beliefs
 symbolism
 "truth"
 stereotype

JUSTIFICATIONS FOR DRINKING

personal history
 physical abuse
 sexual abuse
 spousal influence
 life stress
 relationship problems
 victims
 trauma as a cause
 interpersonal crisis

EXTRA CODES

self-recognition
 self-esteem
 self-destructive
 self-reflection

APPENDIX E
Codes - Alcohol and Ethnicity Literature

definition of the "problem"	biological vs. social factors	social factors
biological factors	assumptions	hypothesis
ethnic differences	myths about Native drinking	body mass
knowledge vs. beliefs	cultural influences	drinking habits
alcohol metabolism	genetic propensity	age differences
differential threshold	mass composition	socialized power
gender differences	alcohol adaptation	medicalization
internal architecture	inter-differences	intra-differences
importance of alcohol	motivations for use	social control
cultural differences	dependency conflict	life stress
personality development	dependency motivation	cultural concerns
subsistence economy	personalized power	power concerns
characteristics of alcohol (high vs. low doses)	active problem-solving	impulsive power
self-reliance motivation	inactive problem-solving	power motive
sanctions of drinking	social organization	conformity
power satisfaction	patriarchal organization	power factor
aboriginality of alcohol	influence of social setting	masculinity
power perceptions	power theory of drinking	powerlessness
cultural norms and values	cultural factors of drinking	community size
inhibition factor	male solidarity	economic factors
socioeconomic simplicity	high power needs	low power needs
expectations	level of acculturation	boredom

APPENDIX F
Categories - Alcohol and Ethnicity

THE "PROBLEM"

definition of the "problem"
 biological vs. social factors
 medicalization
 problematic concept of 'ethnicity'
 ethnic differences
 inter-differences
 intra-differences
 assumptions
 hypothesis
 myths about Native drinking
 knowledge vs. beliefs
 social control

SOCIAL FACTORS

patriarchal organization
 community size
 economic factors
 socioeconomic simplicity
 subsistence economy
 social organization
 aboriginality of alcohol
 influence of social setting
 life stress
 boredom
 male solidarity

DEPENDENCY

dependency conflict
 dependency motivation
 self-reliance motivation
 active problem-solving
 inactive problem-solving
 personality development

THE INFLUENCE OF CULTURE

cultural influences
 cultural differences
 sanctions of drinking
 cultural concerns
 cultural norms and values
 cultural factors of drinking
 importance of alcohol
 drinking habits
 gender differences
 age differences
 motivations for drinking
 characteristics of alcohol
 (high vs. low doses)
 masculinity
 conformity
 expectations
 level of acculturation

BIOLOGICAL FACTORS

alcohol metabolism
 genetic propensity
 differential threshold
 body mass
 mass composition
 internal architecture
 alcohol adaptation

POWER CONSIDERATIONS

personalized power
 socialized power
 power concerns
 power perceptions
 impulsive power
 power motive
 power satisfaction
 power theory of drinking
 power factor
 inhibition factor
 powerlessness
 high power needs
 low power needs

APPENDIX G
Codes - Alcohol and Natives Literature

low addiction rates	high arrest rate	liquor crimes
not "true" alcoholics	definition of the "problem"	personal action
personal inaction	traditional controls	acculturation
economic access	anxiety drinkers	drinking context
recreation drinkers	aboriginal controls	drinking patterns
drunkenness/drinking as deviance	aboriginality of alcohol	social control
negative functions of drinking	primary negatives	authority figures
positive functions of drinking	secondary negatives	self-control
drinking and death	tertiary negatives	means of control
formal external controls	informal external controls	prejudice
prohibitive controls	discrimination	lack of control
accountability/responsibility	evolution of alcohol	self-prohibition
myths about Native drinking	cultural influence	culturally specific
individual vs. group concerns	abstinence	moderation
institutions of social control	ideology	spirituality
medicalization	myths about alcoholism	double standards
stereotypes	self-fulfilling prophecy	cultural genocide
colonialism	paternalism	self-reliance
motivations to use alcohol	treatment as "cure"	dependency
dependency conflict	traditionalists	denial
middle-class Indians	marginalists	Native values

drinking as discourse	gender expectations	hypocrisy
inactive problem-solving	agent of social control	agency
triple jeopardy	autonomy	resistance
“toughmindedness”	oppression	cultural bias
cultural diversity	Native identity	“Indian” as a signifier
binary relationships	societal context	knowledge vs. beliefs
gender differences	harm reduction	intra-tribal differences
powerlessness	mainstream	life stress
importance of social structure	familial influence	

APPENDIX H

Categories - Alcohol and Natives

THE "PROBLEM"

liquor crimes
 definition of the "problem"
 mainstream
 high arrest rate
 gender differences
 evolution of alcohol
 individual vs. groups concerns
 drinking and death
 societal context
 cultural diversity
 intra-tribal differences
 "Indian" as a signifier
 culturally specific
 personal action
 personal inaction
 positive functions of drinking
 negative functions of drinking
 primary negatives
 secondary negatives
 tertiary negatives

IDEOLOGY

knowledge vs. beliefs
 low addiction rates
 myths about Native drinking
 myths about alcoholism
 stereotypes
 medicalization
 treatment as "cure"
 self-fulfilling prophecy
 not "true" alcoholics
 hypocrisy
 "toughmindedness"

SOCIETAL FACTORS

importance of social structure
 economic access
 spirituality
 life stress

SOCIAL CONTROL

aboriginal controls
 traditional controls
 prejudice
 discrimination
 means of control
 prohibitive controls
 self-control
 lack of control
 formal external controls
 informal external controls
 self-prohibition
 institutions of social control
 agent of social control
 authority figures
 resistance
 autonomy
 oppression
 denial
 agency

DRINKING AS DEVIANCE

drunkenness/drinking as deviance
 cultural influence
 double standards
 Native values
 gender expectations
 cultural bias
 accountability/responsibility
 aboriginality of alcohol

NATIVE IDENTITY

paternalism
 self-reliance
 dependency
 dependency conflict
 acculturation/cultural genocide
 traditionalists
 middle-class Indians
 marginalists
 colonialism

THE DRINKING CONTEXT

drinking patterns
powerlessness
familial influence
inactive problem-solving
abstinence
moderation
harm reduction
motivations to use alcohol
anxiety drinkers
recreation drinkers

EXTRA CODES

drinking as discourse
binary relationships

APPENDIX I

The Structure of an Argument

In the beginning stages of an argument, there are several possibilities for solution open to consideration; “more often than in most, the answers to questions remain matters of opinion or taste” (Toulmin, 1958:20). Thus, the need exists to rule out all other possible arguments; “we are entitled to say that some possibility has to be ruled out only if we can produce grounds or reasons to justify this claim” (Toulmin, 1958:30).

I) The Claim

The origination of an argument begins when claim-makers “make an assertion, and commit ourselves thereby to the claim which any assertion necessarily involves” (Toulmin, 1958:97). In making such an assertion, claims-makers “want to convince others that X is a problem, that Y offers a solution to that problem, to that policy Z should be adopted to bring the solution to bear” (Best, 1987:102). Thus, claim-makers pose a hypothesis, which has certain implications for the ensuing processes, and for the resultant solutions to the problematized phenomenon. Inevitably, the intent behind such claims is to persuade the audience (Best, 1987:102).

II) The Grounds

The next phase of the argument is the presentation of the basic facts, which Toulmin (1958:97) refers to as datum. Datum then, is comprised of the facts upon which support for the original assertion is grounded, which may be based on personal knowledge

(Toulmin, 1958:97). In addition to the datum, propositions, in the form of rules, principles, and inference-licenses (Toulmin, 1958:98), are used to illustrate that based on the facts, “the step to the original claim or conclusion is an appropriate and legitimate one” (Toulmin, 1958:98). However, Best (1987:104) cautions that there is a need to recognize that “facts are themselves socially constructed knowledge”, and therefore, must not be taken as the unequivocal ‘truth’. Facts can be manipulated, and distorted to suit the intentions of claim-makers, to support their position, and to persuade the audience in the validity and legitimacy of their claim.

Nevertheless, Best (1987:104) identifies three types of grounds statements: definitions; examples; and numeric estimates. The first type of statement is definitional in nature, serving to establish two objectives: the domain of the claim; and the orientation of the claim. “Perhaps the most fundamental form of claims-making is to define a problem - to give it a name” (Best, 1987:104). Examples are then used to illustrate the validity of the claim, with the frequent utilization of “atrocious tales” (Best, 1987:106); “the atrocity - usually selected for its extreme nature - becomes the referent for discussions of the problem in general” (Best, 1987:106). Finally, numeric estimates are made in an attempt to depict the severity of the problem, and the need for immediate action on the part of society. Numeric estimates customarily take on one of three forms: incidence estimates; growth estimates; or range claims. In many instances, claims-maker will use multiple forms of numeric estimates to support their claim, the numbers exemplifying the pervasiveness of the problem.

III) The Warrants

Next, warrants are made, the task of such statements being simply to register explicitly the legitimacy of the step involved (Toulmin, 1958:98), from the perception of the facts to the making of a claim. Warrants then, can be characterized as "statements which justify drawing conclusions from the grounds" (Best, 1987:108). Statements of warrant can be perceived of as "practical standards or canons of argument" (Toulmin, 1958:98), being both implicit and general in nature, "certifying the soundness of all arguments of the appropriate type" (Toulmin, 1958:100). Thus, warrants are not necessarily specific to the given claim, but to all claims about a given phenomenon. For Toulmin (1958:105), "the backing for warrants can be expressed in the form of categorical statements of fact quite as well as can the data appealed to in direct support of our conclusions". However, Best (1987:109) proposes, that "it is in the warrant that values most often come into play". We have seen the interaction between morality and rationality in chapter three, where the nature of cognitive versus evaluative statements was discussed. Cognitive statements of 'fact', it was determined, are often steeped in evaluative messages about morality issues of right and wrong, good and bad, communicated to the audience as prohibitions, imperatives and obligations. The effectiveness of evaluative messages lies in their covert nature, messages of morality implicit within what appears to be a cognitive statement based on factual information. However, as pointed out earlier, cognitive statements may not in actuality be factual, as cognitive ideas are not only about what is, but also what the chances of something might be, and as such, are not necessarily concerned with the accuracy of the information contained within such statements.

IV) The Conclusions

Finally, the conclusions that are derived within claims call “for action to alleviate or eradicate the social problem” (Best, 1987:112). Logical deduction, based on the grounds and warrants, results in a specific prescriptive remedy for the problem. However, Best (1987:112) appries that we, as the audience, must be aware that ”claims-makers may have an agenda with several goals” in recommending a certain solution over other available options. “By qualifying our conclusions and assertions in the ways we do, we authorize our hearers to put more or less faith in the assertions or conclusions” (Toulmin, 1958:90-91).