

**IDEOLOGY IN A BOTTLE: WESTERN THEORIES ON ALCOHOL AND  
INDIGENOUS PEOPLES**

by

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## **ABSTRACT**

### **Ideology in a Bottle: Western Theories of Alcohol and Indigenous Peoples**

This thesis presents an Historical Materialist critique of current explanations of alcohol abuse and the implications of these models on policies and interventions imposed on Aboriginal peoples of North America. An Historical Materialist approach provides an alternative conceptual framework for understanding the impact of alcohol among these populations. It stands in opposition to current positivistic and Eurocentric explanations rooted in a methodological individualistic framework. Historical Materialism can help alcohol researchers and policy makers develop an integrated understanding of the relationship between society and individuals within an historical context, and thereby begin to develop insights and recommendations for reducing alcohol through its prevention.

## Table of Contents

ABSTRACT .....	ii
PREFACE .....	v
ACKNOWLEDGEMENTS .....	vii
CHAPTER ONE: INTRODUCTION .....	1
Methodology .....	3
CHAPTER TWO: ALCOHOL AND HEALTH POLICY .....	7
Historical Context of Programs and Policies .....	7
The Genocidal Policy of Indian Residential Schooling .....	10
Residential School Syndrome .....	12
Healing Fund .....	12
Friendly Genocide .....	13
The Indian Health Transfer Policy .....	15
First Nations Alcohol and Drug Policy Today .....	19
Summary .....	24
CHAPTER THREE: THE CLASH OF TWO WORLDS .....	26
Capitalism and the Oppression of Indigenous Peoples .....	27
The Political Economy of Native Alcohol Policy .....	33
Summary .....	34
CHAPTER FOUR: QUESTIONS UNANSWERED .....	36
Ideology: Methodological Individualism .....	36
Literature Review of Alcohol Studies and Aboriginal Peoples .....	40
Definitions .....	41
Prevalence .....	43
Aetiology and Risk Factors .....	45
Evaluation of Alcohol Treatment Programs .....	54
Summary .....	54
CHAPTER FIVE: THE BIOLOGICALLY DISEASED INDIAN .....	56
The Biologically Susceptible Indian .....	56
The Disease Model .....	59
More Racist Fictions .....	63
Nechi Institute and Poundmaker's Lodge .....	67
Summary .....	74

CHAPTER SIX: TOWARD AN ALTERNATIVE UNDERSTANDING.....	76
Western Capitalism and the Objective Circumstances of Alienation .....	78
“Ordinary” Genocide by Assimilation.....	82
Alcohol and Related Social and Health Problems Among First Nations in Canada ....	84
CHAPTER SEVEN: SOME POSSIBLE DIRECTIONS .....	89
Conceptual Clarification .....	90
Historical Materialism.....	95
Summary .....	97
CHAPTER EIGHT: IDEOLOGY IN A BOTTLE .....	98
Recommendations .....	101
REFERENCES.....	104
CURRICULUM VITAE	

## Preface

I had to overcome a great deal of resistance in writing this thesis. It was a continuous struggle to keep from falling into the ideology of Methodological Individualism I criticize throughout this work. However, as Ryan (1981) stated “Even those of us who consciously set out toward the goal of equality must be expected to get mired down in the swamps of our mistaken assumptions and to lose our way” (p. 200). Yet another reason was the concern this work might be dismissed on the grounds of being too extreme. As a professor once said mockingly, “What are you calling for - a complete restructuring of Canadian society?” implying I was taking an *extreme* position rather than a *practical* one. However, I must agree with Chrisjohn (1997): “If we are less than honest in what we think it will take to undo what has been done, what right of complaint do we have if they [we] fail to undertake effective measures” (p.112)? In other words, anything less than this extreme position fails to properly represent the issues at hand and is yet another form of capitulation. To critique particular aspects of existing alcohol policies and interventions aimed at First Nations in Canada (e.g. the amount of funding provided for health and social services, the lack of health research, the presence of under qualified workers, and so forth), whether administered by First Nations or non-First Nations is one thing; but to claim these programs in their entirety are irrelevant to the task of effectively intervening in issues of alcohol use in Aboriginal communities is quite another. I begin from the position despite the stated intent of these programs (i.e., curing Aboriginal

individuals of the supposed "disease" of alcoholism), the purpose of Canadian policies and initiatives has been (and remains) the enforcement of a latent agenda of assimilation serving to bolster mainstream political and economic structures. I also claim this system of assimilation is more accurately termed genocide.

Before beginning I must forestall a potential criticism. In analyzing the current situation, the reader may be curious about what I would do instead, and even insist I have no right of complaint about *what is* without offering a program of *what should be*. But as I was once told, one does not have to be a firefighter to pull an alarm and yell "fire!" Since very few people have pulled the alarm and the fire continues to spread, in this thesis, I am focused on pulling the alarm, not putting out the fire. Perhaps most importantly I will have the bad taste to point out many of those who have responded to the alarm are not putting out the fire.

As a matter of style, since I am of Aboriginal descent, at times I will include myself when referring to Aboriginal peoples. In addition, the opinions in this paper may not necessarily be shared by other Aboriginal peoples. In fact, many may disagree with what is written. However, as Aboriginal peoples know, it is precisely this diversity of opinion among our groups that makes us stronger. And as an Aboriginal person, I have a responsibility to pull the alarm and yell "fire!"

## **Acknowledgements**

This thesis is a culmination of the support and guidance from my family, friends, colleagues and teachers, who have intellectually challenged my thinking and helped me better understand the world in which we live. Since my second year as an undergraduate student, I have been fortunate to study, argue and learn with the most thoughtful and brilliant individuals. Over the years, it has often been difficult to sustain this opportunity. I am very grateful to all those who have helped me along the way.

It was Professors Dr. Roland Chrisjohn and Andrea Bear Nicholas at St. Thomas University who first introduced me to a radically different way of understanding indigenous peoples' struggles and have greatly influenced me in writing this thesis. I am grateful for their intellectual and emotional support and for reminding me that revolutionaries do not speak in passive voices.

I also want to extend my sincere appreciation to Dr. Linda Eyre at the University of New Brunswick for allowing me unimpeded space for developing my ideas and for creating an environment to ensure this takes place. I am grateful for the encouragement and the generous comments which were consistently positive and most helpful in giving concrete guidance and direction.

I especially want to thank Karen Stote, who spent many hours carefully correcting and helping me to clarify my thoughts; she brought a kind of literacy to this work I could not have achieved on my own. Writing this thesis was a shared



collaboration, with many nights of stimulating and, at times, heated discussion.

What started out as an academic exercise has become unabashedly political.

## **CHAPTER ONE**

### **Introduction**

Alcohol problems are considered one of the most persistent and pervasive afflictions within Aboriginal communities in Canada (Health & Welfare Canada, n.d.; RCAP, 1996; Statistics Canada, 1993). Early mortalities, violent deaths, homicides, injuries, and poisoning deaths, for instance, are regarded to be direct and/or indirect consequences of alcohol problems (Kirmayer, 1993; NNADAP, n.d.). Alcohol is also considered a direct cause of family violence and spousal abuse (Koss, et al., 2003) and attempted and successful suicide (Kirmayer, 1993; RCAP, 1996) while indirectly related to other problems such as Fetal Alcohol Syndrome, Fetal Alcohol Effects, and Fetal Alcohol Spectrum Disorder (Grace, 2003; Masotti et al., 2006). Furthermore, alcohol is considered a risk factor for various health problems such as hypertension, obesity, diabetes, heart disease, as well as other conditions including, cardiomyopathy, gastritis, hepatitis, AIDS, and cirrhosis of the liver (Young, 1994).

There is no lack of documentation that alcohol has a major social and health impact on the quality of life of Aboriginal peoples and requires attention. Yet most prescriptions for addressing alcohol use among indigenous peoples of North America are woefully inadequate. They amount to little more than calls for more research, for the modification of personal behaviour through life skills training, counselling and education, and the “indigenizing” drug and alcohol treatment programs for Aboriginal peoples. And, despite the purported success of

Native-run alcohol and drug treatment programs, no evidence has been produced to substantiate any long-term positive impact on individuals -- if the purpose is to off-set alcohol problems within First Nations communities. In this thesis, I argue existing programs addressing indigenous peoples' problems with alcohol are neither effective nor neutral; rather they constitute another assimilationist attack on the people they are supposed to be helping.

Approaches for understanding the impact of alcohol among North American indigenous peoples typically involve the imputation of a disease to Aboriginal individuals. As expressed in psychological and social terms, these approaches presume alcohol problems inhere within indigenous peoples. Existing policies and interventions reflect this convention elaborating models which reinforce a "defective Indian" stereotype and dictate (explicitly or implicitly) the individual Aboriginal person (and his or her mental and/or biological state) is the appropriate site of intervention.

To presume alcohol problems are the outcome of personal and internal forces located within Aboriginal individuals is erroneous. Social and economic realities are ignored, or brought into explanatory models only as secondary causal factors reified within indigenous individuals (either as elements in their genetic make-up or their disordered personal histories). The cumulative impact is that psychiatric and psychosocial explanations for the conditions of Aboriginal peoples "blame the victim" (Ryan, 1971). To posit alcohol problems as failures of Aboriginal peoples' mental states or biological make-ups fundamentally misunderstand the issues and begs the question of the efficacy of existing

interventions within the Canadian context.

In what follows, I argue the symptoms of alcohol problems within First Nations communities are inextricably tied to the existing oppressive political, economic, and social conditions of Canadian society. The primary causes of alcohol and related social and health problems currently existing in First Nations communities are not biological; they are social and historical, rooted in colonialism, racism and exploitation (Fisher, 1987; Saggars & Gray, 1998). Yet these oppressive material circumstances forced upon First Nations are either ignored or downplayed in mainstream alcohol policies and interventions. As long as these material conditions remain unexamined, those who are concerned with the state of First Nations communities are left with few (if any) alternatives other than more victim blaming intervention strategies.

Throughout this thesis, I demonstrate how and why existing alcohol policies and programs aimed at Aboriginal peoples are part and parcel of Canada's latent policy of assimilation. In order to show this, I examine the political, economic and ideological context out of which these policies arise. My point is, without a fundamental understanding of this framework, approaches to alcohol problems in First Nation communities will remain superficial and will continue to perpetuate (by default) the oppressive circumstances under which First Nations live.

### **Methodology**

My primary interest in this work is to provide an Historical Materialist critique of current explanations of alcohol abuse and the implications of these

causal models on existing policies and intervention programs imposed on Aboriginal peoples of North America. An Historical Materialist approach provides an alternative conceptual framework locating the causes of alcohol problems not in individuals but in the broader social conditions in which people live. It stands in opposition to the current positivistic and Eurocentric explanations rooted in a methodological individualist framework; that is, the assumption alcohol and related problems are a reflection of individual agentive properties (social, biological, and/or psychological). With an Historical Materialist approach a completely different picture of the dynamics of alcohol abuse emerges. Rather than research taking for granted models of micro-level (personal) causation, this approach considers the broader social and cultural context. I consider Historical Materialism an improvement over present ways of understanding issues facing indigenous peoples of North America. At the very least, this approach can help elaborate aspects unaddressed in standard methodologies.

In Chapter Two I review the various Indian policies in Canada. I begin with a brief description of Canada's legal obligation for providing health and education services to First Nations. Next, by outlining how Canada has interpreted these legal obligations in regard to residential schooling and the 1969 White Paper and Indian Health Transfer Policy, I demonstrate how these policies serve to enforce First Nations assimilation into Canadian society. Finally, I consider the assimilationist agenda behind the National Native Alcohol and Drug Abuse Program (NNADAP) and the consequences of this program for Aboriginal

peoples. By drawing parallels between the various Indian policies and the NNADAP, I substantiate the case that current alcohol policy is simply a continuance and extension of the genocidal attack deployed by the Canadian government since time of Confederation.

In order to bring into sharper focus the conflict between Aboriginal peoples and Canadian society, in Chapter Three I examine the political economy of Canada and demonstrate why alcohol policy furthers the assimilationist attack against Aboriginal peoples.

In Chapter Four I provide a description of Western capitalist ideology of Methodological Individualism and how this ideology gives rise to a particular form of analysis guiding alcohol studies. I claim that an adherence to this ideology serves to further perpetuate the ideological attack against Aboriginal Peoples. Next, I critically examine the limitations of existing literature on alcohol and Aboriginal peoples. In Chapter Five I critically examine models commonly used to explain alcohol abuse and their implications for First Nations in Canada. I aim to demonstrate the limited understanding provided by these models and their failure to consider the objective material circumstances giving rise to these problems.

In Chapter Six I work toward providing an alternative understanding of alcohol abuse in Aboriginal communities. By utilizing Marx's Historical Materialism I challenge the view of Methodological Individualism and demonstrate how alcohol abuse arises from the objective material conditions. In doing so, I aim to expose the irrelevancy of these programs and policies. Rather

than addressing the problems, I claim existing interventions further the genocide machine currently operating in Aboriginal communities.

In Chapter Seven, by making use of Wittgenstein's approach to conceptual clarification and Marx's Historical Materialist framework, I provide an alternative method of investigating alcohol issues in First Nations communities.

## **CHAPTER TWO**

### **Alcohol and Health Policy**

In this chapter, I demonstrate how the NNADAP is an assimilationist policy which maintains the status quo of Canadian society. First, I begin with a brief description of Canada's treaty obligations to Aboriginal peoples. Next, I focus on how these legal and moral obligations, particularly in the area of health and education, have continually been interpreted by federal governments as a way of making Aboriginal peoples into another kind of Canadian rather than allowing us to pursue our own forms of life. Finally, I consider the assimilationist agenda behind the NNADAP and its consequences for Aboriginal peoples. In drawing parallels between the various Indian policies and the NNADAP, I substantiate my case that current alcohol policy simply continues and extends the genocidal attack deployed by the Canadian government since the time of Confederation.

#### **Historical Context of Current Programs and Policies**

Any discussion of First Nations health services (including Native alcohol and drug programs) must begin with the premise that health care is a treaty right (Favel-King, 1993; Lux, 2001). Although the issue has been settled through court rulings affirming this interpretation (Cumming & Mickenberg, 1972), the federal government views its involvement in the provision of these services as flowing simply from humanitarian principles (Flavel-King, 1993; Frideres & Gadacz, 2001; Waldram, Herring & Young, 1995).

Despite federal claims of good will, this line of thinking reinforces



Canada's assimilation of Aboriginal peoples into mainstream society. This policy of assimilation was given impetus in 1867 when Canada broke away from the British Empire and became an independent political entity. Great Britain had acknowledged (at least in theory) indigenous nations as long-standing allies in the wars for control of North America, and the Crown formalized its obligations through nation-to-nation treaties. As a newly independent political entity, indigenous peoples became impediments to the expansionist project envisioned by Canada (Wasacase, 2003).

No longer seeing a need to foster political alliances, Canada was more interested in the development of its political economy. Consequently, its problem was to find a way to terminate the legal line of Aboriginal descendants (and thus establish legal property rights to territory and resources it did not own) without violating the letter of British policy inherited in the Acts of Confederation. Hence, the implementation of the Indian Act served Canada's bureaucratic objective of eliminating the "Indian Problem" without physically killing Indians. This point was illustrated by Duncan Campbell Scott during his tenure as Deputy Superintendent General of Indian Affairs in the early 1900s:

I want to get rid of the Indian problem. I do not think as a matter of fact, that this country ought to continuously protect a class of people who are able to stand alone. That is my whole point. Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic, and there is no Indian question, and no Indian department and that is the whole object of this Bill. (Titley, 1988, p. 50)

From 1876 to 1911, Canada embarked upon a campaign of treaty making with various indigenous peoples establishing its legal obligation to provide services, treaty payments and compensation to Aboriginal peoples. These documents acknowledge the sovereignty of First Nations and establish their right to receive health care services as minimal and partial compensation for the appropriation and exploitation of their land and resources.

Despite the federal government interpreting the provision of medical services to First Nations as a matter of policy (which can be altered as it wishes), treaties are formal agreements between sovereign nations. By entering into these agreements, Canada agreed to provide health care to the Nations involved without limitation on form, duration, or circumstance.

In addition, as international agreements treaties supersede the Canadian constitution, statutes, case law and policy, despite historical and present day rulings, Canadian courts have no jurisdiction over international agreements. That Aboriginal peoples are forced to pursue their claims through the Canadian court system represents but another attempt to “confine, constrain, demarcate and delimit those [treaty] rights and consequently [is] part of the process of confining, constraining, demarcating, and delimiting Aboriginal peoples” (Kulchyski, 1994, p. 4).

Canada must uphold the fiction it provides health care to First Nations based on humanitarian principles rather than legal obligations because its political economy depends on the exploitation and appropriation of Aboriginal Peoples lands and resources. Furthermore, assimilating First Nations into Canadian

society allows for the elimination of differences between Aboriginal title holders and Euro-Canadians. Once First Nations are indistinguishable from the Canadian populace, the fiction that Aboriginal peoples are not real nations but internal minorities will be maintained. Canada will be able to continue under the pretence of having no legal obligations to First Nations and will successfully evade responsibility for the provision of health services.

### **The Genocidal Policy of Indian Residential Schooling**

A further example of how the Canadian government unilaterally interprets its treaty obligations is in the area of education and the creation of the residential school system for Indian children. Residential schools operated in Canada from the 1870s to the mid-1980s. First Nations parents and families were forced by law to send their children to residential schools, and threatened with fines or jail sentences for failure to comply. In an attempt to reduce costs related to their agreements, the federal government contracted its responsibility for education (as established in a number of treaties) to religious denominations (primarily Catholic and Anglican churches) who were given virtual dictatorial power over First Nations children (Chrisjohn & Young, 1997; Frideres & Gadacz, 2003).

While many forms of abuse occurred within residential schools, the fact these schools existed at all was an act of genocide (as detailed by The United Nations Genocide Convention, 1948; cited in Chrisjohn & Young, 1997, p. 41-48). The practice of taking First Nations children away from their parents and communities and placing them under the control of the churches (intent on obliterating their forms of life by imposing non-Indian religions, languages and

forms of life) is well documented by Chrisjohn & Young (1997). Education had nothing to do with the operation of the schools; rather, the aim was to indoctrinate First Nations into mainstream religious ideologies and vocations in hopes of them becoming a subservient class of people (Bear Nicholas, 2003). This imposition, it was hoped, would break First Nations people's connection with what rightfully and legally belonged to them: their lives, lands, and resources.

As already mentioned, since Confederation, the Canadian government had a political and economic interests in the extinguishment of Aboriginal legal title to North America. Since it was too costly to uphold and acknowledge Aboriginal title, a means was created to systematically reduce the number of people able to legally claim Aboriginal title. The *Indian Acts* (1876, 1880 and 1886), the *Indian Advancement Act* (1884) and the residential school attendance provisions (under the *Indian Act* of 1886) served to terminate Indian status by prohibiting Aboriginal cultural and spiritual practices (including languages), and by obliterating their political, legal, social and economic systems.

The phasing out of Indian residential schools and the introduction of public schooling did not depart from the Canadian government's agenda of genocide by assimilation. Indeed, Chrisjohn (1998) argues, "residential schools' in the most meaningful sense of the phrase never ceased operation; they merely changed their clothes and went back to work" (p. 5). The transition (in 1973) to Indian Control of Indian Education is misleading since the government remains in control of finances, curriculum and certification requirements.

*Residential School Syndrome.* Many First Nations individuals forced to attend residential schools are now said to suffering from “Residential School Syndrome” (Chrisjohn & Young, 1997). By reducing residential schooling to a pathology of First Nations individuals who are treated by mainstream specialists, the economic, social, legal and moral aspects of the Canadian genocide are obscured. There is no evidence for this syndrome; understanding the experiences of individuals who attended residential schools within the medical model is not based on science. Rather, it is a rhetorical and ideological move which changes the subject of conversation from holding the perpetrators of this genocide criminally liable to the pathologizing of the victims who attended these institutions (Chrisjohn & Young, 1997).

*The healing fund.* The federal government’s response to the program of genocide came in the form of a healing fund, consisting of \$350 million for individuals suffering from the traumatizing effects (i.e., Residential School Syndrome) of attending the schools. One must ask who is being served by the denial of genocide and the pathologizing of victims of Indian residential schooling. The offices of the healing fund function as a mainstream bureaucracy regardless of whether the functionaries are Aboriginal or non-Aboriginal persons. To qualify for any portion of the healing fund, First Nations must demonstrate a willingness to accept themselves as sick individuals in need of therapy. As Smith et al. (2001) point out, the Canadian government is of the view that First Nations “will be cured when they no longer complain about or even remember what specific experiences of genocide they were forced to undergo” (p. 7). The healing

fund and therapists simply continue and extend the genocidal attack on First Nations.

It must be understood: residential schools were designed, in the words of Duncan Campbell Scott, to take the “Indianness out of the Indian” (Titley, 1988) by destroying First Nations spiritual/cultural practices, obliterating Native languages, and indoctrinating Indian children into mainstream ideologies (religious and otherwise), as the designated operatives benefited monetarily. In the end, the humanitarian response to this outrage has served to cover up Canada’s crime of genocide.

### **Friendly Genocide**

With the rise of the American Civil Rights movement, the publication of various studies (e.g. the Hawthorne Report, 1966) and bad press reports (MacLeans Magazine’s (1967) account of the “The Lonely Death of Charlie Wenjack”), alternatives to the increasingly embarrassing policy of gross mistreatment of First Nations had to be developed. Also at this time, many Aboriginal organizations and advocacy groups began to demand recognition and implementation of treaty rights, and redress of past grievances. For the first time for many ordinary Canadians the social and economic realities of First Nations communities were exposed. However, rather than addressing First Nations oppressive material conditions, a new assimilationist policy was introduced by the Canadian government -- the White Paper Policy of 1969, advanced by former Prime Minister Jean Chrétien during his time as Minister of Indian Affairs under Prime Minister Trudeau’s tenure.

The White Paper proposed the eventual repeal of the Indian Act, the phasing out of the Department of Indian Affairs, the abolition of Indian reserves, and the provincial takeover of federal services to Indians (including education and health care). According to the Canadian government (Canada, 1969 cited in Neu & Therrien, 2003), only with a policy based on First Nations full participation into Canadian society would First Nations realize their needs and aspirations; “To argue against this right is to argue for discrimination, isolation, and separation” (p. 129 ). However, to begin from the liberal assumption of equality for First Nations is to turn back the clock and ignore history, erasing in a stroke the whole question of nation-to-nation relationships and avoiding the issue of treaty obligations (Neu & Therrien, 2003).

The full participation of First Nations in mainstream society under the auspices of liberation and equality obscures the political, economic, social and ideological relations between Euro-Canadians and First Nations. It reinforces the genocidal, racist, and exploitive practices of the Canadian government while at the same time denying these practices exist. First Nations across Canada vehemently rejected the White Paper, recognizing it for the genocidal policy that it was.

Although the assimilationist vision articulated in the White Paper policy was officially withdrawn, the federal government has continued to gradually implement the recommendations. This is reflected in the Indian Health Transfer Policy, established to promote the transfer of health services to First Nations under the guise of self governance, self determination, and Aboriginal control.

## **The Indian Health Transfer Policy**

In 1986, First Nations across Canada received notice of a new federal initiative: the Indian Health Transfer Policy. The basic premise of this policy is to allow First Nations to incrementally obtain control of the delivery of health services. Government spokespersons stated the Indian Health Transfer Policy was drafted in close consultation with First Nations representatives and reflected a positive response by the government to long-standing demands for increased First Nations autonomy and community control of health care services (Speck, 1989).

Since its publication, the Indian Health Transfer Policy has been the subject of a good deal of controversy. Even the Assembly of First Nations (1988) has argued the Transfer Policy is designed to achieve the federal government's goals of reducing spending on health and social services, abdicating legal and fiduciary responsibility for the delivery of health care services to First Nations, denying treaty rights or rights flowing from Aboriginal title, and ultimately assimilating First Nations.

Speck (1989), in her critical analysis of the Transfer Policy, argues this policy does not represent a positive departure from the past or a fundamental change in position by the federal government with respect to First Nations health and health care. Particularly problematic is the government's refusal to accept legal responsibility for First Nations health by transferring the responsibility to the provincial governments. Furthermore, by denying First Nations legal rights to health care and favouring the integration of Native with non-Native consumers of services, Speck argues the Transfer Policy is inherently assimilationist and



“government simply parrots the rhetoric of self-determination and self-government while unilaterally diverging from the Indian meaning of the concept” (p. 243).

Furthermore, Speck (1989) identifies a number of major flaws in the transfer process. For example, the Medical Services Branch representatives claim the policy has evolved from consultations with First Nations communities, but First Nations reject this claim, stating no such consultations have taken place.

In addition, the inclusion of a "no-enrichment" clause in the Transfer Policy means no additional funding is to be provided for communities taking control of health services: budgets are effectively frozen as of the date of the transfer. Bands are left to introduce new programs to combat health problems on reserves, but must do so by reallocating existing resources while maintaining the current level of health services, which leaves First Nations communities to compete over scarce resources. In other words, First Nations are required to run these services with less money than those made available to Medical Services Branch for the same purpose. This problem is further compounded by the fact that non-reserve members and newly reinstated Indians (under Bill C-31) are not accounted for in the allocation of funding.

Moreover, in order to receive funding various steps are required. With each step, First Nation must submit a written proposal to the Medical Services Branch, a process which often requires the hiring of consulting firms at First Nations expense. The proposals for each step are to be reviewed by the government bureaucracy, first at the Zone level of the Medical Services Branch,

then at the Regional level and finally at the National level. More often than not, First Nations' involvement in the review process is almost non-existent. In addition, despite the identification of specific needs within a community the government ultimately determines how and if these needs are met. In other words needs are primarily determined by federal fiscal policy.

Speck also points out, although the Transfer Policy states First Nations will not be pressured or coerced to enter into transfer agreements, this begs the question of what will happen to First Nations who decline to engage in the process. Given the federal government's refusal to uphold its treaty obligations to provide health services to First Nations, there is no guarantee First Nations without transfer agreements will not be forced to accept provincial or municipal services. By the same token, there is no guarantee for those who enter into transfer agreements that such agreements will be re-negotiated after three to five years. In other words, as the government does not accept a legal or fiduciary responsibility to provide health care to First Nations, future funding is always vulnerable to fiscal restraints. Since the state of Indian Health is notoriously poor, establishing limited structures of control within the confines of the *status quo* results in First Nations being restructured into self-administering enclaves of poor health. First Nations are effectively "assigned the task of administering their own misery" (Speck, 1989, p. 208).

Although the Indian Health Transfer Policy has been portrayed as a positive step toward indigenous control of indigenous affairs, it is an agenda set by the federal government. Communities having signed transfer agreements are

required to provide increasingly expensive, though steadily narrowing, health care services from a shrinking health care budget, and are forced to provide services in accordance with and under the supervision of federal and provincial legislation.

Smith et al., (2001) state the consequences of this situation:

This off-loading of the federal responsibility to the provinces has the further result of producing jurisdictional disputes between federal, provincial and municipal governments. In coming to understand the provision of health services to indigenous peoples, Canada's continuing abrogation of the fiscal responsibility is not just of matter of "coffers being empty." Rather, the budgets are driven by an ideological policy of termination of the "special" status of indigenous peoples, so that they become an indistinguishable part of Canada's citizenry. (p. 4)

The move to incorporate First Nations health services within the Canadian health care system is but one example of the federal government's continuous attempt to abrogate its responsibilities to First Nations. That successive governments of Canada have chosen to conceal these obligations and instead pretend its involvement with indigenous Nations arises from charitable and humanitarian impulses is nothing less than another example of the lengths to which it will go to eliminate the "Indian problem" by eliminating Indians (Chrisjohn & Young, 1997).

Such is the end result of Canada's policy and treatment of indigenous people; the manner in which modern health care services are delivered to indigenous peoples in Canada continues to reflect the 1969 White Paper, which

sought to eliminate the “Indian problem” by eliminating Indians. It is within this context that I now turn to an examination of the operations of the NNADAP.

### **First Nations Alcohol and Drug Policy Today**

The NNADAP, which came into effect in the 1980s, is heralded as an example of a Health Canada program now largely controlled by First Nations communities and organizations (Health Canada, n.d; RCAP, 1996). It is promoted and described by government agencies as helping First Nations and Inuit communities set up and operate programs aimed at reducing high levels of alcohol, drug, and solvent abuse among on-reserve populations (NNADAP, 1998). Indeed, as a program controlled by First Nations for First Nations, the NNADAP was initially viewed as providing First Nations the opportunity to design and implement health and alcohol initiatives to meet community needs previously unaddressed by governmental agencies. The NNADAP has contributed to the emergence of some of the most significant Aboriginal health initiatives, including the Four Worlds Development Project, the Nechi Institute, and the Alkali Lake prohibition strategy (O’Neil, 1993).

However, despite the purported success of some of these initiatives, frustration remains with the extent to which the NNADAP is truly responsive to community needs (O’Neil, 1993). First Nations organizations have expressed concern that funding is insufficient, services are inappropriate, control is lacking over personnel training, and First Nations are involved less than optimally in service delivery (NNADAP, 1998; RCAP, 1996; Sagers & Gray, 1998; Thatcher, 2004). In the following discussion, I illustrate despite the government’s

assurances that control of the NNADAP has been transferred to First Nations, ultimate decision making remains in the hands of the federal government. It is able to set the terms and conditions of the programs set out by the NNADAP by (1) mandating that mainstream standards, regulations and protocols be followed, (2) maintaining complete control over budget allocation and transfers, (3) demanding priority for mainstream accreditation of alcohol programs, and (4) refusing resources for the development of alternative initiatives. In short, despite the NNADAP's positive depiction, First Nations' control over alcohol and drug initiatives remains non-existent.

Government control is particularly noticeable when First Nations enter into agreements and are required to abide by the regulations and standards unilaterally set by the Medical Services Branch (Saggers & Gray, 1998). The majority of the agreements for Native alcohol and drug programs are negotiated through Contribution Agreements and funding is provided through multi-year agreements which stipulate matters such as what services are to be provided, to whom and at what expense (DIAND, 1993, p. 12). Having to accept such standards rather than changing to suit particular community needs and cultures, most alcohol programs simply emulate mainstream programs. Moreover, when "cultural" aspects are incorporated into alcohol treatment programs, they look "suspiciously like conventional programs with some feathers and beads attached" (Waldram, 2004, p. 286).

Since the federal government maintains complete control over budget allocation and transfers, all financial decision making is retained by the Medical

Services Branch. Agreements typically supply funds for a set time period and for specific program purposes, and attach various conditions, including reporting requirements and the Minister's right to intervene (Auditor General of Canada, 2002). Moreover, rather than funding being negotiated with First Nations, the Medical Services Branch uses resourcing formulas based on information collected by communities. First Nations are required (dictated) to collect data on what was spent ("resource inputs"), what was done ("activities") and what was produced ("outputs") to be submitted to the Medical Services Branch. Information collected by First Nations generally does not reflect their priorities for meeting community needs. However, if reports are not filed according to the terms and conditions of the agreements, the community is at risk of not receiving funds for the next period. Furthermore, the reporting has no importance or consequence for program delivery; instead it encourages the practice of filing reports for the sole purpose of ensuring continued funding. In other words, data for dollars rather than data for improving programs (Auditor General of Canada, 2002).

Many obstacles are faced while compiling these reports (Auditor General of Canada, 2000); requirements are often poorly explained, data is often difficult to gather, and funding for report preparation is often inconsistent. Many communities state the development of new strategies is greatly impeded due to the amount of time required to meet reporting obligations, often leaving them unable to address the most pressing needs of their communities. Most importantly, despite First Nations being held accountable for monies spent, communities are left unaware of the purposes of reporting practices.

Once First Nations enter into transfer agreements, the accreditation of Native alcohol and drug treatment programs is mandatory (NNAPF, 2000). Consequently, First Nations are required to abide by mainstream professional industry standards rather than their own. Accreditation requires workers to be certified by mainstream institutions. The result is the programs implemented by First Nations are inculcated with the same ideological biases as mainstream Euro-Canadian programs (e.g., meritocracy, victim blaming and Methodological Individualism).

Should First Nations want to develop their own programs, train their own workers based on their own ideological principles, and evaluate standards according to their own terms, they must do so at their own expense. Consequently, Indian controlled drug and alcohol programs merely replicate mainstream standards, regulations and protocols, and are a far cry from First Nations political autonomy and local control.

By structuring the terms and conditions so First Nations are given little or no role in the development of programs, in decision making responsibilities, or in financial administration, the federal government remains effectively in control of program initiatives stemming from the NNADAP. The sole difference from past federal policy is in the area of accountability and responsibility. Since the NNADAP is primarily a funding agency, reflecting the “evolution” in the “government-to-government” relationship with First Nations, the intent is to share accountability and responsibility for health and health services (Neu & Therrien, 2003, p. 133). In other words, a larger share of the responsibility previously

allocated to the federal government is shouldered by First Nations, without a larger share of power or decision-making being similarly transferred. Local band authorities and First Nations organizations are held responsible for the delivery of health services in their communities, while remaining accountable to the federal government.

By establishing limited structures of self-administration, First Nations are assigned the task of administering the cycle of their own destruction: the federal government continues to deny its treaty obligations and by doing so successfully off-loads its responsibilities for health and service delivery onto First Nations communities. These communities have limited resources, thereby inclining them to failure. The terms and conditions of the NNADAP allow First Nations limited flexibility in determining how to best respond to community health needs; funding of alcohol treatment programs is delivered based on formulas and specific practices set out by the Medical Services Branch; and the programs are required to operate with fewer funds than those allocated to the Medical Services Branch for the same purposes.

Federal priorities, clarified by the terms and conditions of such agreements, are consistent with those advanced in the White Paper. Where the White Paper called for the political, economic and social integration of all "Status Indians" as full and equal citizens of Canada through the termination of treaties and the transference of responsibility for "Indians" from federal to provincial governments, the NNADAP promotes the transference of bureaucracy from the Canadian government to First Nations in the form of delivery systems and grant



funding, thereby insinuating mainstream ideological precepts. Thus, it is only when First Nations follow the full implementation of the assimilationist agenda of the NNADAP (and the adoption of Canadian standards, practices, and protocols within a bureaucratic framework) they will be recognized as full and equal citizens of Canadian society. This does not represent a positive step toward First Nations control of First Nations affairs: it is a further attempt to implicate First Nations in the process of their own demise.

The underlying ideology giving rise to the Indian Act, residential schooling, and the White Paper is the same ideology behind the NNADAP: the elimination of grievances, title claims, and legal obligations to various indigenous nations. Indeed, while the NNADAP is promoted as a Health Canada Program largely controlled by First Nations communities, it merely provides the appearance of control while the Canadian government continues its long-term program of assimilating First Nations into mainstream Canada. Once First Nations come to accept the workings of the Canadian bureaucracy they will have “come to see the ‘common Canadian interests’ as [their] own and the treaties will become mere scraps of paper, of historic and nostalgic interests, but otherwise insubstantial” (Chrisjohn, 1999, p. 7).

### **Summary**

Canada was founded upon (and continues to depend upon) the outright theft of indigenous lives, lands and resources. If our physical genocide was unattainable, the bureaucratic genocide would accomplish the task of assimilating First Nations into mainstream society through various policies. My review has

established the NNADAP works toward this goal of assimilation. Against this background, any criticisms of the NNADAP fail to address the fundamental concessions demanded. Very seldom do we try to grapple with issues in their totality, preferring to concentrate narrowly on issues of insufficient funding, inappropriate services, lack of training resources, resources used less than optimally, and so forth. As a result, the NNADAP is understood as not meeting community needs based on a combination of these factors. Though indeed relevant, these criticisms make no mention of the way in which these assimilationist program-related activities insinuate mainstream ideology and practices, and therefore remain superficial. Hence, this is the topic of the next chapter, where I discuss the functioning of Canadian society and its implications on First Nations peoples.

## **CHAPTER THREE**

### **The Clash of Two Worlds**

Thus far I have shown that, historically (through the residential school policy and the White Paper) and presently (through the Indian Health Transfer agreements and the NNADAP), the intent behind Canadian Indian policy has been to assimilate First Nations peoples into mainstream society. Separate bureaucratic systems of Indian administration and separate bodies of law were created to better control and manage First Nations. I have stressed the overriding motive for the implementation and enforcement of Canada's assimilative program (in various guises) was (and still is) borne out of the material requirement of expropriating the wealth of First Nation peoples. To this point, however, I have not discussed the kind of society within which Canada demands First Nations participation. I address this in the present chapter. By examining the systematic structure of Canada's political economy, the fundamental conflict between First Nations and Canadian society will be brought into sharper focus and will allow for a deeper understanding of why alcohol policy (including guidelines, funding decisions and service delivery) furthers the assimilationist attack against Aboriginal peoples of North America. I use Marx's description of the Western capitalist structural conditions as the foundation for my analysis of the unequal relations between First Nations and Canadian society. I then critically reassess the political economy of alcohol policy aimed at First Nations in Canada and demonstrate how capitalism is being imposed upon us.

## **Capitalism and the Oppression of Indigenous Peoples**

Although Karl Marx did not write directly about the indigenous peoples of North America, he provides the insights necessary to grapple with the social, political, economic, historical and ideological context of the relations between Aboriginal and non-Aboriginal peoples and the implication these relations have for First Nations in Canada. Indeed, Marx's Historical Materialism provides an important contribution for understanding why history is unfolding as it is:

In the social production of their life, men [sic] enter into definite relations that are indispensable and independent of their will, relations of production which correspond to a definite stage of development of their material productive forces. The sum total of these relations of production constitute the economic structure of society, the real foundation, on which rises a legal and political superstructure and to which correspond definite forms of social consciousness. The mode of production of material life determines the social, political and spiritual life processes in general. It is not the consciousness of men [sic] that determines their being, but, on the contrary, their social being that determines their consciousness. (in McLellan, 1977, p. 389)

Marx's Materialist conception of history is a complex observation not to be interpreted as economic determinism (Tesh, 1988), for what Marx called mode of production was characterized by two other elaborate concepts: the means of production (material, skills, techniques, and the populations available to use them) and the relations of production (social classes and institutions of power). In

addition, Marx challenges the Idealist perspective which views society as the way it is because people are the way they are. In Marx's view, people are the way they are because society is the way it is.

Marx links society to the economic and social relations within an historical context – Historical Materialism. From this perspective, our conception of society, including our institutions, practices and ideas are born out of a particular form of life rooted in an objective material reality. Marx was not making a scientific discovery; rather he was describing the systematic workings of Western capitalism and the implications of this form of life on human existence. Marx derived these consequences not as empirical assertions but as particularized elaborations of his original observation of the separation of ownership from labour. Traditional empiricism reifies and objectifies social phenomena, removing them from the historical and material conditions. As an alternative, Marx offered an “historical and sociological account [of the social relations], alien to empiricism” (Easton, 1983, p. 6).

How does Marx's perspective inform us about the fundamental conflict between Canadian society and First Nations? He alerts us to the important sociological role of economic relations in Western capitalist society, i.e., the division of labour, the distribution of economic wealth and power, and the creation of particular forms of control in a capitalist political economy. Among the features of capitalism are racism, sexism, and classism. While these inequalities are not unique to Western capitalism, they are integral to its functioning and must be understood as expressions of the larger social

organization of a capitalist economy. This broader framework allows us to see the consequences of capitalism on indigenous peoples and shapes the relations between Canadian society and First Nations.

Marx argued almost everyone engaged in economic activity under the mode of production of capitalism falls into one of two major groups. There are some who own and control factors necessary for productive activity (like land, raw materials, factories, machinery, administrative structures and so forth), and others who do not (their economic survival depending upon their ability to sell their labour in exchange for a wage). The wealth of the first group (the capitalists) is dependent upon the exploitation of the second group (the workers) such that the goods and services produced are more valuable than the wages received by the workers for their labour, creating profit for the capitalists. Thus, owners and workers are primary distinctions under the mode of production of capitalism.

For Marx, however, capitalism is not only a system in which workers are exploited through their labour; it is also a system in which workers are forced to provide their labour to the capitalists. Capitalism is a coercive relation by the very fact that capitalists own the means of production – the means necessary for human subsistence (i.e., land and resources) – and workers do not. An implication of this distinction is an alienated society (Marx, 1988); as a necessary consequence of this division of labour, individuals born into this particular mode of production (regardless of whether one is an owner or worker) are alienated in their productive activities, from their “human essence” (according to Marx, 1988),

from themselves, from their community and social relationships, and from the natural world.

Marx's exposition of the necessity of human alienation under capitalism is widely known and need not be recounted here. Schaff (1980) sums it up neatly when he describes alienation as the human condition under capitalism. It must be emphasized, however, Marx was making no point about the consciousness or unconsciousness of alienation; he was not talking about a human psychological condition. The divorce of ownership of a product or commodity from the labour needed to produce it was how Marx defined alienation and, as such, it made no difference to him or his theorizing whether the people engaged in this mode of production liked the division or indeed even noticed it; people living under such a mode of production were alienated, regardless of what was happening in their minds.

Western Idealist philosophers and social scientists have found it impossible to grasp the point of alienation as an objective material circumstance (Wallimann, 1981). As a result, many reify and idealize his insight. For example, Durkheim transmutes alienation into his notion of anomie which is its own kind of emotional experience. For Marx, even those who do not experience alienation as an emotional state are still alienated, just as women who do not experience sexism as a personal emotion still live in a sexist society, or as a people can be oppressed without having a visible boot on their necks (Baldwin & Lorde, 1984; Chrisjohn & Young, 1997). It is into this alienated form of life the political and economic forces of Canadian society are attempting to assimilate Aboriginal

peoples. Whatever the forms of life Aboriginal peoples of North America were engaged in prior to 1492, they were not capitalism; whatever the peoples of North America were before Columbus, they were not capitalists; whatever the human condition was in North America prior to “discovery,” it was not alienated. Capitalism, capitalists, and alienation all are predicated on a mode of production simply not present in Aboriginal forms of life.

Thus, the fundamental conflict between Canada and First Nations remains a clash between a capitalist form of life and non-capitalist forms. As Aboriginal peoples, we do not fit anywhere within Canada’s political economy; as Aboriginal peoples, we did not operate social systems fundamental to the capitalist mode of production. It is precisely because Aboriginal forms of life fall outside Canada’s structural system that First Nations peoples have become a “costly burden” to Canada. Indeed, if Aboriginal peoples had gone along with the expansionist plan there would be no need for Canada to implement its various assimilationist policies. However, since we are not capitalists and have completely different ways of organizing ourselves and relating to each other, antithetical to the capitalist mode of production (and therefore detrimental to the development of Canada’s political economy), we must be brought into the workings of this economic system either by force or coercion. At this point, we will no longer be Aboriginal peoples, but participants in a capitalist mode of production. That is, by being absorbed into the capitalist mode of production, they will begin to accept unquestioningly Western capitalist hierarchical structures, values, ideologies and practices, and necessarily become divorced/alienated from our own forms of life.



As Andrea Bear Nicholas (2003) points out, in the long history of the suppression of indigenous political, economic and religious customs there has always been a more insidious intent than just the obliteration of these institutions. She writes: “the real intent has been the subordination of Native nations to colonial powers with the two-fold purpose of 1) absorbing and obliterating Native people and nations altogether and 2) appropriating their lands” (p. 15). Indian residential schooling and public education (indoctrination of capitalist values, ideologies and practices) has been “the chief means of achieving these ends” (Bear Nicholas, 2003, p. 15).

If Canada’s economic system were to respect indigenous societies and allow Aboriginal peoples to pursue their own forms of life, its very structural integrity would be undermined if not obliterated. For example, to respect existing treaty obligations would require the recognition of First Nations as nations with certain legal, proprietarial, political, and economic statuses (which would overrule Canada’s). Moreover, compensation would be required for stolen lives, lands, and resources since Confederation. It is for these costly reasons Canada’s economic system demands First Nations participation. Consequently, the drive to assimilate First Nations is a drive to enforce the ideological system of capitalism itself. When First Nations agree to play by capitalism’s rules (offering us a marginal existence within Canadian society), we by default accept the predomination of an “alien form of life” and become our own enemy.

## **The Political Economy of Native Alcohol Policy**

Capitalist ideology and practices are reflected in the NNADAP and the health transfer agreements through program guidelines, funding decisions, education, and training programs. For example, the tenets of bureaucracy are insinuated: the hierarchical authority structures, decision-making based on formalistic rationality and means-end calculation, the division of labour and so forth. From Canada's perspective, First Nations must not be allowed full control and operation of health systems on their own terms, as manifested by unwavering governmental control over allocation and management of funds. These funds must be constrained in particular ways without a charge of racism being levelled. This is achieved through control over budgets, reporting practices, and funding allocations, memorialized in contribution and health transfer agreements, and thus establishing how alcohol policy is to be designed and implemented (Bear Nicholas, 2003; Neu & Therrien, 2003; Saggars & Gray, 1998).

Moreover, distributed monies benefit mainstream institutions, not Aboriginal ones. For example, we report to the bureaucrats, who, while being paid comparatively enormous salaries, provide no services while directing our activities and our operatives; we attend and pay tuition to Canadian colleges and universities. If First Nations were to have complete control over finances, not only might we pursue intervention strategies antithetical to capitalism, but mainstream institutions would be excluded from the money. Like the healing fund, the NNADAP operates to benefit Canadian society.

Furthermore, despite the purported success of various programs (e.g., Four

Worlds Development Project, the Nechi Institute, and the Alkali Lake prohibition strategy), these remain inundated with Western ideological assumptions.

Personnel trained to intervene are seldom educated about the oppressive circumstances impinging on First Nations; the ideological underpinnings of focused intervention strategies and models are not part of their basic education.

Smith et al. (2003) state:

Such 'professionals' will never come to grips with the way in which their unexamined assumptions give rise to a never-ending cycle of health crisis, useful, perhaps, as a make-works project for them, but dehumanizing, overwhelming, and genocidal to their hapless 'clientele'. (p. 8)

In sum, alcohol and drug treatment programs are nothing more than another battleground for the war between indigenous and alienated forms of life.

Alternatively, if we are to create alcohol strategies that are not destructive to Aboriginal forms of life, among the many steps required is to turn the appearance of control into real control. This requires recognition of First Nations as nations with the sovereign right to be in full control over financial planning and decision-making and to develop and operate their own health systems. As long as Canada remains in control of alcohol policy and programs, First Nations will continue to take up capitalist ideologies, practices and values which are in direct conflict with and detrimental to Aboriginal forms of life.

### **Summary**

An Aboriginal person who acts and thinks like an Aboriginal person cannot be contained within a capitalist mode of production. To hold, implicitly or

explicitly, that we can “still be Indians,” while accepting the imposition of capitalism is a dangerous myth. Furthermore, to believe that alcohol policy is in place to help First Nations address the issues of drug and alcohol abuse is misguided. Standing behind these policies and programs is the hidden agenda of assimilating First Nations into Canadian society. Beyond a minimal level of existence under this alienated form of life, Canada must exert financial power against First Nations such that the manner, amount, and direction of the monies spent conform to Western capitalist ideological precepts. It is at this point I will examine this capitalist ideology which continues the assimilationist attack against First Nations.

## CHAPTER FOUR

### Questions Unanswered

I have demonstrated thus far that alcohol policy aimed at First Nations serves to further the assimilationist attack upon us, formalized through the implementation of a worldview and practices arising from Western capitalism. It is therefore important to grasp the world view being imposed. In this chapter I begin with a description of this capitalist ideology, Methodological Individualism. It is this world view which goes unrecognized in current explanations for alcohol problems and ultimately leads to indigenous emulations of mainstream alcohol policy and programs.

#### **Ideology: Methodological Individualism**

Methodological Individualism is the view that “all social phenomena must be accounted for [that is, ultimately understood] in terms of what individuals think, choose, and do” (Bhargava, 1992, p. 2). It institutionalizes preference to putative internal, personal, individual processes -- processes which are supposed to explain (provide a causal account for) why things happen the way they do. A complete description of Methodological Individualism and its refutation is beyond the scope of this thesis, but straightforward refutations of the topic are detailed elsewhere (Bhargava, 1992; Bhaskar, 1989; Chrisjohn & Young, 1997).

However popular this worldview, Methodological Individualism is certainly not fact; it is an opinion, a preference, an ideology, or a belief system (Bauman, 2000; Bhargava, 1992; Chrisjohn & Young, 1997; Tesh, 1988).

Methodological Individualism has more to do with our immersion in Western civilization than with any force of logic or science. As the concrete foundation of Western capitalist ideology, it is reflected in notions of personal guilt or innocence under law, individual salvation or damnation in religion, internal responsibility for success or failure, and so on *ad infinitum*. Methodological Individualism presents one with the pre-established rules of: “(a) how much (or how little) should be allowed to be considered contestable at all; (b) from what point of view, and (c) to which end in mind” (Meszaros, 1989, p. 4) in any discussion or analysis. Although Methodological Individualism is usually accepted unquestioningly in the modern Western world, there are countless alternatives.

The ideology of Methodological Individualism is implicit in the very structure of investigation and explanation of the social sciences. It serves as a powerful mode of explaining unequal relations of status, power and wealth in Western capitalist society and of defining human “universals” of behaviour as natural and inevitable characteristics of that society (Lewontin, Rose, & Kamin, 1984, p. 7). Despite claims to scientific status by purporting neutrality and objectivity, social scientists are not and cannot be immune to ideological, political and economic biases of Western capitalist society. Indeed, what we choose to study, the questions asked and how we go about investigating and analysing our data all reflect ideological, political and economic interests influencing the outcome of our investigations. To assume otherwise is symptomatic of the ideological assumptions taken for granted in the social sciences (Waterston,

1993).

As an ideology, Methodological Individualism defines and limits what constitutes evidence within the social sciences. The prevailing methodology guiding scientific research is empiricism, positing scientific knowledge is subject to and derived from individual experience and observation. Methodological Individualism, as a concomitant of scientific empiricism, is reductionistic, in that, by fiat, it accords primacy to individual agency. As well, explanations of more complex phenomena are treated as if arising, in principle, exclusively from simpler components; when explanations are sought for complex activities of people, Methodological Individualism limits empiricists' (purported) thoughts, choices and actions. In formal language, reductionism is the claim "that the compositional units of a whole are ontologically prior to the whole that the units comprise. That is, there is a chain of causation that runs from the units to the whole" (Lewontin, Rose, & Kamin, 1984, pp. 5-6).

For example, when existing mainstream approaches for understanding drinking behaviour among First Nations concern themselves with latent personal, internal and individual explanations, they do so ideologically (or preferentially), not because such variables present themselves for examination. What results are models of causes and effects of drinking behaviour expressed solely in terms of what individuals think, choose, and do. However, the absence of any empirical support for the supposedly latent, unobservable, internal, and personal explanatory variables evades, rather than answers, questions about Indians and alcohol.

Without revisiting all critiques of Methodological Individualism, I would like to call attention to a particular deficit that informs the whole of my argument against existing accounts of indigenous alcohol abuse: the Fallacy of Composition (Copi, 1986). Simply, it is a fallacy to posit the properties of a “whole” are reducible to the properties of its parts. A car built of light components can be extremely heavy; knowledge of the properties of chlorine and sodium do not lead one to believe the composite would taste good on French Fries. There may be relations between a whole and its parts, but these cannot be taken for granted.

Methodologically individualistic researchers fall into the compositional fallacy as soon as they start looking for the “parts” that “stand behind” the more complex “wholes.” For example, methodologically individualistic sociologists have argued the properties of a human society are reducible to the behaviours of its individual constituents. Alcohol theorists begin by situating the cause of alcohol abuse among First Nations within environmental and social conditions, including cultural loss, family breakdown, crime, violence, poverty, unemployment, acculturation, rapid cultural change, and so forth. However, rather than investigating the systematic aspects, they turn to explanations of how these factors produce negative emotions (i.e., stress) inside the indigenous individual. In turn, this causes individuals to act out in their communities. This is not to dispute the potentially negative impact these factors may have on First Nations. However, the systematic aspects giving rise to these factors in the first place are not contained within a discussion of the properties of individuals. The broader social, economic, political and historical context in which individuals live



cannot be accounted for within methodologically individualistic models. What is required is a different level of analysis, i.e., Historical Materialism.

A fundamental shortcoming of Methodological Individualism and empiricism is the commitment to understanding social phenomenon in terms of personal causation. This necessarily leaves out the broader social, political, economic, and historical aspects of alcohol abuse among First Nations. Indeed, within a methodologically individualistic framework, questions of genocide, economic oppression, systematic racism, exploitation, and the hegemony of the mainstream (Gramsci, 1971) are ignored, or turned into personal, internal and individual explanations. Consequently, the assimilationist attack against First Nations can continue unabated. Debate, such as it is, revolves around the relative importance of internal variables assumed to be involved, or in proposing new internal variables to provide a new key to understanding.

In the following section I review the literature on alcohol studies and its application to Aboriginal peoples. Characteristically, these studies aim to understand alcohol problems among First Nations by empirically analyzing the personal characteristics of individuals, and as such are consistent with Methodological Individualism and its limitations.

### **Literature Review of Alcohol Studies and Aboriginal Peoples**

In this section the topics covered include: 1) definitions of alcohol terminology and their application to Aboriginal populations; 2) an overview of how data is gathered on the prevalence of alcohol abuse; 3) a review of the literature on the etiological and risk factors and; 4) evaluation of alcohol treatment

intervention aimed at indigenous populations. This cannot be a comprehensive report, because, despite their ideological commitment to empiricism, programs serving Aboriginal populations are not evaluated (Thatcher, 2004). Researchers and theorists merely repeat what they have been led to believe resulting in a strong, almost aggressive loyalty to unexamined dogmas (Waldram, 2004).

*Definitions.* In reviewing the literature on alcohol studies, there is disagreement among researchers on the classification and aetiology of alcohol problems. Some researchers contend alcohol problems should be defined in biological terms, others argue for psychological and/or social definitions, and others suggest alcohol problems should be mainly understood as multifaceted (a combination of biological, psychological and environmental factors). Furthermore, in many studies there is considerable terminological confusion in distinguishing such terms as “abuse,” “dependency,” “addiction,” “alcoholism,” and “problem drinking” (Young, 1994). Also, the application of these terms in cross-cultural settings makes it even more problematic to define alcohol problems.

Because of the various meanings of these terms, the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 1994) (including the DSM III-R, DSM-IV) and the International Classification of Diseases (ICD-10) (World Health Organization, 1990b), in an attempt to better present the multi-dimensional nature of alcohol problems, distinguish between “alcohol abuse” and “alcohol dependence.” Alcohol dependence is defined virtually identically in the DSM-IV and the ICD-10; the

categories of “alcohol abuse” and “harmful use” diverge in that the latter does not include harm arising from social reactions to alcohol abuse (Room, 1998a).

Alcohol abuse is roughly defined in the DSM-IV as at least a one month pattern of alcohol usage which causes psychological or physical harm to the user. The diagnosis of alcohol dependence includes tolerance and withdrawal, which together comprise physiological dependence; impaired control and compulsive use; disproportionate amount of time spent in alcohol-related activities; and continued use despite problems (Durrant & Thakker, 2003). One important change over earlier classification systems is the broadening of the concept of dependence to include psychological and behavioural aspects in addition to physical dependence. As such, the DSM-IV and the ICD-10 embrace a range of physiological, psychological, and behavioural criteria.

The disease theory of alcohol use remains the most popular model within both the treatment and the medical community. Critics such as Alexander (1988), Fingarette (1988), Peele (1985), Schaler (2000), and Szasz (1987) argue the disease model best serves the economic and political interests of those involved despite little scientific support. Schaler (2000) argues that mental illness is diagnosed on the basis of symptoms, not signs. Forms of antisocial behaviour categorized as psychiatric illness include crime, suicide, personality disorders, and maladaptive and maladjusted behaviour. Some people consider these “disorders” because they vary from the norm and involve danger to self or others. According to Szasz, however, they are “neither ‘mental’ nor ‘diseases’” (Szasz, 1988, pp. 249-251). If addiction qualifies as an antisocial behaviour, this does not

necessarily imply that it is mental disorder or a disease. As Schaler (2000) notes, “The term ‘alcoholism’ has become so loaded with prescriptive intent that it no longer describes any drinking behaviour accurately and should be abandoned” (p. 19).

Diagnosis of alcohol abuse becomes further misconstrued when applied in cross-cultural settings. With respect to the diagnostic criteria of the DSM and ICD, diseases should have cross-culturally valid diagnoses (Vaillant, 1983). Within a culturally diverse population, the disease model is difficult to apply consistently (Fisher, 1987). More importantly, Cho and Faulkner (1993) point out that the concept of alcoholism and the scales used to diagnose it have limited cross-cultural validity since the diagnostic criteria put forth in the DSM and ICD have not been normed for populations other than Anglo-American societies.

*Prevalence.* There are many studies indicating that alcohol problems are a major social and health issue among indigenous populations in North America. Yet, there is no extensive epidemiological study on the prevalence of alcohol use in this population. Estimates of prevalence are primarily based on mortality figures. In Canada, injury and poisoning are the leading causes of death among Status Indians and Inuit peoples. Injuries primarily involve alcohol-related motor vehicle accidents (Aboriginal Health in Canada, 1992). While alcohol is “involved” in a high percentage of Aboriginal deaths (Statistics Canada, 1993), such a determination does nothing to establish “alcoholism” as the primary factor contributing to death.

Researchers have used a wide variety of techniques to assess the extent of

alcohol abuse in Aboriginal communities; however, survey data seems to be the most popular approach. Rogers & Abas (1988) conducted a survey in 57 Aboriginal reserves in Manitoba from 1984-1985. Eighty-six per cent of the reserves rated alcohol abuse as a serious problem. Solvent abuse was reported as a problem in seven percent of these reserves. The results of the Manitoba survey were replicated by the 1991 Aboriginal Peoples Survey (APS) which found that 73 % of Aboriginal persons on reserves thought that alcohol abuse was a problem in their community; family violence was a problem in 44%, drug abuse in 59% and suicide in 35% of these responses (Statistics Canada, 1993 cited in NNADAP, n.d).

In 1984, the Federation of Saskatchewan Indians conducted a survey of alcohol and drug use among 898 adults and 385 high school adolescents who lived either on or off reserve (Federation of Saskatchewan Indian Nations, 1984 cited in Kirmayer, 1994). In total, 39 of 68 bands across the province were surveyed. Among the adult population, 83.9% had used alcohol in the past year, and 34.6% reported regular drinking. Binge, chronic or problem drinking was reported by 37.7%. In the adolescent population, although the usage of alcohol in the past year was high (74.2%), only half as many reported regular drinking as with the adult population (14.8%) and alcohol abuse, as measured by binge, chronic or problem drinking was seen in 11.4% of these self-reports.

The Northwest Territories Health Promotion Survey in 1989 which provided a grouping of Inuit and Dene respondents reported a prevalence of non-drinkers and heavy drinkers in the Aboriginal population (Health and Welfare

Canada, 1989 cited in NNADAP, n.d). This was confirmed by Health and Welfare Canada in 1996, as only 60.1% of NWT Aboriginal persons stated that they had drunk alcohol in the past year (compared to 85.2% among non-Aboriginal persons) and heavy drinking was reported by 33.0% of Aboriginal persons compared to 16.7% in the non-Aboriginal populations (Northwest Territories Bureau of Statistics, 1996). Similarly, the APS found that within the Aboriginal sub-groups, Inuit groups were more likely to report abstinence than Indian or Métis groups. The Inuit groups also differed from the Indian and Métis in that they most often reported that alcohol abuse was not a problem in their communities (Statistics Canada, 1993).

Despite the popularity of using survey research studies to measure the prevalence of alcohol use among Aboriginal populations, serious issues remain regarding their adequacy and interpretation. There is enormous diversity among North American indigenous populations, and consequently, data from disparate communities cannot simply be aggregated in large-scale survey studies. As well, researchers using survey data assume variation in populations can be captured with a few questions or categories. And most importantly, methodological issues abound in regard to the interpretation of the data and validity of research designs (Chrisjohn & Young, 1997).

*Aetiology and risk factors.* Although there are studies indicating a genetic-metabolic trait which predisposes indigenous peoples of North America to abuse alcohol, other comparative studies report contradictory findings. Fenna et al. (1971) compared rates of alcohol metabolism and found non-Aboriginal

participants metabolized alcohol at a significantly faster rate than Aboriginal “subjects” and concluded that differences in metabolism were likely due to genetic differences. However, Leiber (1972) and others (Farris & Jones, 1977; Schaefer, 1981; Zeiner et al., 1976) criticized this study as flawed since blood levels were measured indirectly by the use of a breathalyser and because hospitalized Aboriginal individuals were compared to healthy non-Aboriginals. In another study, Bennion and Li (1976) used more comparable participants and a more direct analytical method and found the average rates of alcohol metabolism between Aboriginal and non-Aboriginal participants were virtually identical. All remaining studies have found Aboriginals metabolize alcohol as rapidly as non-Aboriginals (Farris & Jones, 1977; Leiber, 1972; Schaefer, 1981).

Some studies consider biochemical factors such as variations in dopamine D2 receptors in the brain, which may influence individual responses to alcohol. Noble (1992) examined brain samples from deceased persons and found the allele which genetically codes for few receptors was more common in deceased alcoholics than in deceased non-alcoholics. He hypothesized individuals who had a lower number of receptors may require strong stimulation of their few receptors. However, Noble found no differences based on racial categories between Caucasian and Black “subjects”.

In criticizing these studies (metabolic and biochemical factors), Saggars and Gray (1998) point out while there are biochemical and physiological factors influencing individual responses to alcohol and its metabolites, there is no firm evidence these differences cause the misuse of alcohol or explain differences

between populations in either patterns of alcohol consumption or its consequences. Furthermore, the relationship between alcoholism and the presence of the D2 receptor remains simply an association; that is, no causal relationship has been demonstrated.

Another consideration is whether “biological race” is a scientifically useful concept. Lewontin (1972, cited in Fisher, 1987), who studied intra-group versus inter-group variation, set out to find how much variation there was in populations and whether the degree of variation *within* and *between* human populations could be estimated. Beginning with mostly classical racial groups, Lewontin estimated diversity within populations, among populations, within “races” among “races.” In the end, he concluded, based on blood type data, only 6.3 % of human variability accounted for differences among racial groupings. Somewhere between 90.7 % and 67.4 % of human variability is to be found within these populations. As such, Lewontin concluded human racial classification is of no social value, and that such racial classification is now seen to be of virtually no genetic or taxonomic significance (1972 cited in Fisher, 1987). The racial category “Indian” is as thoroughly useless as “Negro.”

Some researchers suggest differences in metabolism as a risk factor for Fetal Alcohol Syndrome (FAS). Aase (1981) speculated about the relationship between maternal physiology and FAS in Aboriginal children. She suggested differences in metabolism of alcohol by different racial groups could impact negatively on fetal development, producing different outcomes with regard to alcohol-related birth effects, with Aboriginals and “Orientals” being at greater



risk. Setting aside previously mentioned issues by Sagers and Gray (1998) and Lewontin (1972), the term FAS can be misleading. Granted alcohol is a known teratogen and therefore FAS is considered a real medical disorder caused by the exposure of a fetus to alcohol. However, Chrisjohn (1999) points out to focus on the history of alcohol use on the part of the mother negates responsibility the male might have of indulging in alcohol or drug use before and at the moment of conception. Little is known on the effects of alcohol use during pregnancy nor at what point it is crucial to abstain, and very little is known as to what effect alcohol use on the part of the father might play in the future health of the child. Furthermore, there are many other plausible alternative explanations (e.g., environmental toxins, unhealthy food or water) which are known to cause central nervous system damage to a fetus and birth defects in children. Until any and all of these other factors are ruled out as potential causes, a diagnosis of FAS cannot be made (Chrisjohn, 1999). Alternatively, Fetal Alcohol Effects (FAE) has been used to diagnose children who display behavioural problems (inattentiveness, hyperactivity, lack of motivation) in their school or home life. These symptoms are said to demonstrate themselves later in a child's life. Often referred to as a lesser version of FAS, a diagnosis of FAE is made without any demonstration of central nervous system damage or neurological abnormality and the child does not display any of the birth defects resulting from exposure to a teratogen. Chrisjohn (1999) points out there exists no evidence FAE is a medical condition. Rather this diagnosis serves to blame individual children for not doing well in school or getting along with their parents, teachers and communities. It also justifies the

limiting of opportunities and what we should or can expect from a child. For these reasons, Aase's (1981) speculation about the relationship between maternal physiology and FAS in Aboriginal children is entirely premature.

Rates of major psychiatric disorders are believed to be much higher among alcohol abusers. Westermeyer et al. (1993) described comorbidity in a sample of 100 Aboriginal patients diagnosed with a substance abuse disorder and found the majority also received an additional diagnosis, primarily organic mental disorder, major depression, panic disorder or social phobia, and concluded that rates of psychiatric disorders are likely to be much higher among alcohol abusers. However, explanations for the causal relationships between alcohol abuse and psychiatric disorders are difficult to establish. As well, Good (1993) warns diagnostic difficulties or misdiagnoses are particularly likely to occur among members of ethnic minorities since cultural factors affect reliable measurement and diagnosis. For example, cultural differences in patterns of communication, care-seeking and reporting of symptomology contribute to possible misdiagnoses. Any research into the prevalence of these disorders needs to be particularly sensitive to these issues. Furthermore, since there is no mention whether the diagnostic assessment was standardized for particular Aboriginal populations, the validity of the study is questionable at best.

Several other research efforts attempt to identify personality characteristics of Aboriginal individuals in treatment programs. The Minnesota Multiphasic Personality Inventory (MMPI) and Eysenck Personality Questionnaire (EPQ) are popular tests to measure personality traits among this

population. Hurlburt and Gade (1984) applied the EPQ on 95 Aboriginal women and 39 non-Aboriginal women alcoholics. Aboriginal alcoholics were more “tough-minded” than non-Aboriginal alcoholics and Aboriginal individuals in the extended treatment program were significantly more “extroverted” than non-Aboriginals. However, inferences about Aboriginal populations from data collected from these standardized psychological tests (which have not been “standardized” for use with indigenous peoples) cannot be made if the tests and the person administering them are not following the guidelines set out for the administration of psychological tests (Chrisjohn, 1997). In the case of Hurlburt and Gade’s study (1984), there is no mention of this test being normed for Aboriginal populations (even this is problematic since Aboriginal groups are quite diverse) and therefore the results cannot be treated seriously.

Psychological responses to “acculturation stress” brought on by rapid cultural change have been the focus of other studies. Mail (1989) suggests Aboriginal peoples, along with many other suppressed peoples, suffer disproportionately from both “acculturation” and “deculturation” stresses (e.g., the combined demands to integrate with the dominant culture and the loss and devaluation of their historical traditions and economic standing). In such cases, some individuals use alcohol to help cope with feelings of inadequacy during periods of rapid personal, cultural or social trauma. In criticizing acculturation models, Kirmayer (1993) points out existing measures of acculturation are often based on only a few items which render these scales psychometrically inadequate. Acculturation literature also tends to minimize the profound social impact the

predominant culture may have on Aboriginal peoples' ways of life.

A number of reports focus on establishing the relationship between suicide and alcohol abuse. Despite the considerable attention paid to the association between alcohol abuse and suicide, no evidence exists to establish alcohol abuse as causally implicated in the occurrence of suicide (Kirmayer, 1993). In their review of the literature on alcohol abuse and suicide, Whitehead and Hayes (1998) suggest part of the problem in establishing a causal relationship between alcohol abuse and suicide stems from the inherent difficulties in applying adequate research designs. Consequently, most studies are unable to determine the temporal ordering of potential explanatory and intervening variables and are unable to eliminate competing explanations of observed associations. Frances et al. (1987) suggest the true picture may be so complex, involving an array of prior and intervening variables, a full appreciation of causality may continue to elude us for some time.

The possible relationship between alcohol dependence and childhood abuse and neglect are presently being explored among Aboriginal populations. In a major study which included 1660 participants across seven Native American reservations in the United States, Koss et al. (2003) concluded childhood experiences of sexual and physical abuse had an impact on alcohol dependence within these populations. The percentage of alcohol dependent tribe members varied significantly among tribes, from only 1 to 2 % of men in one tribe to 56 % of men in another. Across all the tribes, 30 % of men and 18 % of women were diagnosed with some form of alcohol dependence. More than half indicated they

had at least one parent with alcohol problems. More than two-thirds of respondents reported at least one kind of adverse childhood experience. Physical neglect and abuse were among the most widely reported childhood experiences, while emotional neglect was the least prevalent.

Koss and colleagues used the Alcohol Use Disorder and Associated Disabilities Interview Schedule (AUDADIS) to assess alcohol dependence. The AUDADIS was developed for the general population and therefore the study has no validity in its application to Aboriginal populations. Furthermore, biased sampling may have occurred since interviewers were selected by tribal leaders.

A number of authors rely on culture as an explanatory factor in alcohol abuse. Hamer (1980) and Weibel-Orlando (1985) point out communication with the spirit world through visions was highly valued in many Aboriginal cultures. Alcohol may be seen as an easy and quick method to attain a state of altered consciousness. Oetting and Beauvais (1991) point out, although ceremonial use of substances played a role in some Aboriginal cultures, such substances were not used recreationally. Therefore, explanations pointing to substance abuse as an outgrowth of cultural practices do not stand up under scrutiny. Additionally, the diverse cultural practices of the hundreds of indigenous groups of North America make such explanations inappropriate. Brady (1995) speculates the value placed on personal autonomy in Aboriginal societies facilitates excessive consumption of alcohol. As such, communities are reluctant to impose sanctions on individuals who drink in excess. Levy and Kunitz (1974), state consumption behaviours among Aboriginal peoples are a reflection of traditional forms of social

organization and cultural values, rather than societal disorganization. This is less a consequence of the pathological aspects of Aboriginal cultures and more a reflection of positively valued forms of expression. When dealing with culturally distinctive groups, it is tempting to attribute any special features to cultural differences. As Thompson, Walker & Silk-Walker (1993) note, such 'cultural' explanations have been used against Aboriginal peoples to treat alcohol problems as a consequence of the environment or social situations and to stop the search for other conditions. Furthermore, Mendelson and Mello (1985) point out cultural explanations cannot be operationalized and tested.

Some authors argue current patterns of alcohol abuse among Aboriginal groups reflect learned behaviours stemming from historical roots. Frank, Moore & Ames (2000) suggest drinking behaviours were learned from Europeans during the fur trade. They suggest European men binged (drank large quantities of alcohol in short spans of time) on alcohol and had little concern for their disruptive and uncontrollable behaviour. This was consequently adopted by Aboriginal people in their attempt to identify with these men. However, Kleinman (1987) claims the tendency to attribute differences of alcohol patterns among Aboriginal populations to the consequence of historical features ignores economic problems and issues of scale.

While many studies suggest socioeconomic factors should be considered, there are very few studies which do so. The most common explanations of alcohol abuse point to the dispossession and consequent political and economic marginalization of indigenous peoples. However, these studies tend to focus on

the psychological effects of these societal-level acts and thereby minimize them as political and economic causes.

*Evaluation of alcohol treatment programs.* Reviewing the types of alcohol intervention treatment programs aimed at Aboriginal peoples in Canada reveals the passive acceptance of current explanations and treatment recommendations prevalent in mainstream literature. Treatment programs stemming from this acceptance are managed through the NNADAP within Health and Welfare Canada. Scrutiny of the literature on treatment efficacy reveals a paucity of published reports evaluating indigenous alcohol abuse intervention programs in Canada. This is a particularly critical omission if the point, of and justification for, treatment interventions is to be empirical and scientific.

### **Summary**

Much of the literature reviewed on alcohol and Aboriginal peoples of North America focuses on social, psychological and biological causal models to explain how Aboriginal people drink, where they drink, why they drink, with whom they drink, how much they drink and what happens to them when they drink. Biological models emphasize genetic and physiological processes as the causes of alcohol abuse; other models have postulated alcohol dependence and misuse occurs as a result of individual psychological or personality deficits, social, environmental or cultural influences. Social and learning models, in particular, have considerable currency as explanations for Aboriginal drinking.

What should not be overlooked is the consistency of these different models. Because of their ideological commitment to Methodological

Individualism, biology, psychology, and sociology presume the personal, internal, and individual contents of people account for their behaviour. For example, psychologists accept a genetic basis for personality traits, and sociologists are comfortable with the notion of social forces internalizing within individuals.

What is superficially a divergence between disciplines is in actuality conformity with Methodological Individualism; and these disciplines fail to draw a picture of the phenomenon for which they hope to account. As a result of this failure, these types of analyses accept and enforce a particular view of society, and reinforce widely-held racist beliefs on the nature of alcohol and First Nations peoples in Canada.



## **CHAPTER FIVE**

### **The Biologically Diseased Indian**

In this section I briefly examine the biological model and the disease model since these are commonly used to explain why First Nations abuse alcohol. These models presume all individuals contain within themselves the genetic cause of an ability or inability to control their alcohol use. Whatever that genetic cause is in the general population, this reasoning is extended (without evidence) to First Nations populations to account for differences in drinking patterns between these two groups.

### **The Biologically Susceptible Indian**

A great deal has been written about the biological susceptibility to alcohol of North American Aboriginal peoples (see literature review). It is often claimed the rise of alcohol abuse among Aboriginal peoples is the combined result of a genetic predisposition and rapid socio-cultural change. Historically, the rapid socio-cultural change brought about through increased contact with Europeans has led to out of control or irresponsible drinking behaviour, eruptions of violence and chronic disarray within Aboriginal communities. Aboriginal peoples have been severely handicapped in their adjustment to alcohol use as they have not been allowed to develop acceptable drinking norms within their cultures (French & Hornbuckle, 1980). The combination of a certain "Indianness" and the socio-cultural changes brought about historically have been put forth as an explanation for Aboriginal Peoples' inability to control themselves and hold their alcohol

(Brody, 1977; Quintero, 2001; Sagers & Gray, 1998; Thatcher, 2004; Waldrum, 2004).

Despite being commonplace, these explanations do not sufficiently account for problem drinking within Aboriginal communities. First, it must be repeated there exists no evidence Aboriginal peoples are genetically predisposed to alcohol abuse; rather, it is sheer speculation, and racist speculation at that. As Lewontin (1991) points out, since race is not a useful or valid biological concept, research explaining Aboriginal peoples' out of control drinking as a result of their "Indianness" constitutes ideology and not science (see literature review for why this is the case). Moreover, even if Aboriginal peoples possess a gene for alcohol, this does not mean the drinking behaviour in question must manifest itself or is unchangeable. Indians were not incipient alcoholics, waiting for the first Europeans to show up before 1492. Furthermore, human biology changes in our dialectical relationship with our environment (Lewontin, 1990). Understanding alcohol abuse as a biologically determined response implies a certain inevitability to behaviour, thereby creating the expectation that Aboriginal peoples are destined to be alcoholics.

Furthermore, while no one disputes violence is occasionally exhibited under the influence of alcohol, to specifically point out Indians are more prone to violence due to their "Indianness" (genetically or culturally defined) is yet another assertion, one which ignores the social, political and economic relations existing between Aboriginal and Western societies.

Reducing a history of colonialism to a focus on genes or certain cultural

aspects of Aboriginal peoples serves to blame the victims and to deflect attention from the historical and material context of alcohol abuse among First Nations. In fact, increasing prevalence of alcohol abuse among Aboriginal peoples of North America is directly related to the pattern of colonization (Saggers & Gray, 1998); through the theft of land and resources, the various assimilationist policies, legislation deliberately imposed to destroy economies, political systems, spiritual and cultural aspects -- the very means essential for the survival of any people. As I will demonstrate, the alcohol problems faced by Aboriginal peoples have arisen out of these alienated social relations imposed as features of a capitalist mode of production (Waterston, 1984).

It must be noted attributing disruptive behaviour to peoples' genetic material has a long and disreputable history (most of it arising, spreading, and cementing itself in Western ideology long before there was any understanding of what genetics were). The oppression of women is often justified as being natural and inevitable as they are biologically inferior to men and therefore less intelligent and less capable. It has been claimed Blacks are innately violent, criminals, oversexed and less intelligent, and Asians are sly, disingenuous, duplicitous and intelligent. And, it is also commonly asserted indigenous peoples are born suicidal, alcoholics, stupid, lazy and passive. Of course, there is no actual science behind these insults and they are readily dismissed by some thoughtful people (Hubbard, 1990; Lewontin, Rose & Kamin, 1984; Marks, 2002; Montagu, 1997). It is often not recognized that present day genetic explanations are merely a continuance of this racist ideology under a veneer of science. And,

although few disciplines would be so bold as to assert First Nations are racially inferior, there is no shortage of individuals claiming Indians have a genetic predisposition to alcohol abuse (and cognitive deficits and behavioural problems, etc.). Unfortunately, this notion is widely accepted even among many Aboriginal groups who fail to recognize the ideological nature of such assertions and how they are used to justify marginalization, exploitation, dispossession and oppression.

### **The Disease Model**

Another explanation for the prevalence of alcohol abuse in First Nations communities is based on the view that Aboriginal peoples suffer from the disease of alcoholism. The disease model has justified the implementation of various alcohol policies and treatment programs aimed at First Nations in Canada. As its basic tenet, the disease model posits alcoholism is a disease like any other. Despite the predominance of this model as an explanatory framework, there is extensive literature refuting this notion (Alexander, 1988; Fingarette, 1988; Peele, 1985; Schaler, 2000; Szasz, 1987).

The disease model maintains alcoholism is rooted in biology – specifically in the distinctive, genetically determined chemistry of the alcoholic's brain (Thatcher, 2004). By taking the disease metaphor/analogy too seriously, social scientists reify the social meaning of drinking behaviour, considering it to be an underlying sign or symptom of a disease inhering within the individual's biology and/or mental state (Schaler, 2000; Szasz, 1987). While it makes perfect sense to apply the medical model to conditions like diabetes, heart disease and so

forth, there is no logical or verifiable objective evidence to support the claim that “drinking behaviour” is a disease.

The reason for accepting alcoholism as a disease is it “borrows from, and leans on, the concept of bodily illness” (Szasz, 1987, p. 9). This, however, is problematic since it is impossible to clarify whether alcoholism is a disease without coming to grips with the meaning of bodily illness. Szasz (1987), a critic of psychiatry, states:

psychiatrists and all those steeped in the psychiatric ideology take the initial step of omitting to define illness [including disease and disorder], or bodily illness in particular, and instead *define mental illness* (whatever they mean by it) *as a member of the class called illness.* (p. 12)

In other words, alcoholism as a disease is based on nothing more than psychiatric faith.

Schaler (2000) also points out the logical absurdity for the claim that alcoholism is a disease. Socially unacceptable activity is not in of itself evidence for the presence of a disease. The fact that some human activity has horrible consequences does not indicate the presence of an underlying disease. For example, there is a pattern of lung and other diseases associated with working in a coal mine, yet this does not show that mining coal is itself a disease. There is a pattern of disease resulting from swimming, another from football, and yet another from long-distance running. This does not demonstrate that these sports, or the inclination to pursue these sports, are/is a disease. For instance, the fact that a doctor may be exceptionally knowledgeable about the effects of alcohol on

the human body does not make the activity of drinking a legitimate medical concept.

In standard medical practice, the diagnosis of a disease can be based on signs alone (identifying an alteration in the patient's bodily tissue, a change in the cells of the body and so forth) or on a combination of signs and symptoms, but rarely on symptoms alone (Schaler, 2000). For instance, a patient may report certain symptoms such as nausea, loss of appetite, dehydration, weakness and a feeling of sluggishness. However, since these symptoms are common to many conditions and can often lead to inaccurate diagnoses, doctors use a variety of medical tests to verify whether or not a person has a particular disease or another.

In the case of alcoholism (the human activity of drinking), no such identifiable bodily pathology exists: no blood test (except those demonstrating the presence of alcohol in the body), no medical imaging device, and so forth, is able to uncover the presence of a disease. Rather, a diagnosis of alcoholism is based on the display of disruptive human activity by an individual (for a list of symptoms indicating alcohol dependence, see DSM IV, 1994). This activity is said to be a disease without any of the signs necessary to make such a diagnosis. The symptoms of the disease of alcoholism alone (i.e., excessive consumption, impaired control, withdrawal, diminished quality of life and health effects) are considered enough to make a diagnosis.

To establish a pattern of disruptive behaviour on the part of an individual does not translate into a medical condition. Rather, the common consideration of alcoholism as a disease is based on an analogy, one that has been extended too far

(Szasz, 1987).

To solely consider the physiological and/or mental processes as encapsulated in the disease metaphor is to think wrongly about the problem of alcohol use. There is no doubt alcohol has an affect on our physiology. Indeed, alcohol is a toxic organic compound of carbon, oxygen, and hydrogen. When indigested, alcohol passes from the stomach into the small intestine, where it is rapidly absorbed into the blood, is distributed throughout the body, and can affect the central nervous system even in small concentrations. Accordingly, physiology must be involved somewhere. However we do not live in our bodies, but in a social and cultural context and it is therefore quite irrelevant to our task what alcohol does after it is ingested.

That all social action consists of social and biological dimensions does not necessarily mean one entails the other. It might be interesting to study how alcohol affects the body (including the brain), but when trying to understand drinking behaviour we are more interested with the circumstances under which this human activity occurs. The imputation of biological/physiological processes does not add to our understanding of the problem, nor does it suggest what to do. In the end, physiological talk yields nonsensical assertions. Explanations of why individuals drink do not work by explaining the behaviour of wholes in terms of the properties and behaviours of their parts. Rather, they work by “explaining the behaviour of human beings by reference to the context in which they find themselves and to the reasoning they go through or would go through if asked why they did what they do” (Bennett & Hacker, 2003, p. 364).

To posit alcoholism is a disease corresponding to the physiology or mental processes of a human being is to take the metaphor/analogy too far, and thereby goes beyond the bounds of sense into nonsense.

The rationale for ignoring external factors (i.e., objective material circumstances) and instead designating normal human activity as a disease (in the absence of physical evidence) is in keeping with Methodological Individualism. Any exhibited problem behaviour must be found to be personal and internal to the individual. This allows the blaming of the individual for his/her own problems and has had a long past, justifying the removal of individuals from their communities; their incarceration in psychiatric and/or penal institutions; and forced interventions in the name of treatment, i.e., psychosurgery, electroshock therapy, and so forth. Often these forced interventions are applied to ethnic minorities and those in lower socio-economic categories.

### **More Racist Fictions**

Criticisms notwithstanding, the disease model survives as the popular explanation for drinking among First Nations. Here I summarize Thatcher (2004) (who does not endorse but merely outlines), as he presents us with the basic tenets of this model in relation to First Nations:

1. First Nations people have an extraordinary attraction to beverage alcohol, a characteristic that has made them far more likely than other Canadians to be current drinkers.
2. The vast majority of First Nations problem drinkers suffer from the 'disease' of alcoholism. They have a genetic predisposition to



alcohol addiction, which is to say they have a special biological predisposition to alcohol dependency which is exhibited through alcohol cravings.

3. If the First Nations attraction to excessive drinking is not explicable in biological terms, it can be attributed to a unique, unwavering pan-drinking.
4. First Nations drinkers have a genetic predisposition towards 'out of control,' irresponsible, and often violent behaviour when they are inebriated. Drinking excessive amounts of alcohol and the resulting neurological impairment and lack of inhibition cause much of the brawling that so often that [sic] takes place during drinking episodes. It also explains the exceptional rates of spousal battery and various other antisocial, criminal, and negligent behaviours that occur, with such tragic frequency, during or upon the heels of the drinking episodes of First Nations people.
5. The typical, reckless drinking style of First Nations drinkers was, from the outset, fundamentally different from the drinking norms of non-aboriginal, Caucasian Canadians.
6. First Nations problem drinkers in Canada with an addictive pattern of alcohol use will necessarily be permanently afflicted with this problem. They can successfully overcome their abuse patterns only by completely refraining from the recreational use of alcohol. They cannot learn to moderate their use of alcohol.

7. Most problem drinkers from First Nations are best treated by intensive, four- to six- week treatment in in-patient centres intended to promote abstinence.
8. If a problem drinker who has refrained from drinking for an extended period of time has a drinking episode (i.e., ‘falls off the wagon’), s/he will begin a relapse which can be effectively addressed only by starting back at the beginning of therapy or at the first step of a twelve-step program (p. 10-11).

I shall briefly comment on each of these points and demonstrate how racist arguments are hidden behind the veneer of science.

1. To claim First Nations have an extraordinary attraction to alcohol compared to Canadians is a blind assertion without evidence. Moreover, to state First Nations have an extraordinary attraction to alcohol is as circular as saying an individual has an extraordinary attraction to chocolate. “Why? Because he/she eats a lot of chocolate.” No one has ever seen the “extraordinary” or the “attraction;” it is simply an abstraction of the behaviour one is trying to explain. Evidence needed for such assertions must be judged in terms of, first, the grounds for the presumed existence of these internal causes, i.e., extraordinary attraction, and second, the evidence linking the internal causes to the actions being explained. Otherwise, explanations invoking internal causes for external actions are merely disguised ways of making circular racist arguments appear scientific.

2. Once again, there is no evidence that alcoholism is a disease. In regard to First Nations being genetically predisposed to alcohol, aside from the arguments

made previously, there is no evidence linking genes to behaviour. Linking genes with behaviour is an ideological bias not a scientific understanding of what genes do. Even geneticists would not make such assertions. In addition, Dagg (2004) illustrates how genes are used to explain almost every aspect of human life, from social inequalities to health, sexuality and criminality. She points out, despite such explanations, few people have studied genetics. References to a “shopping gene,” “reading gene,” “humility gene” and “coaching gene” are fostered by Darwinian psychology, based on flawed data, faulty analysis and political motives.

3. It is true First Nations share a certain commonality of experiences, primarily in our treatment by Canadian society, but otherwise, there is enormous diversity among First Nations groups, e.g., Cree, Mohawk, Maliseet, Mi’gmaq. Grouping us together originated in racism and bureaucratic convenience, not in any real or apparent uniformity of language, culture, beliefs, and so forth. Hence, to assert alcohol problems are a common experience of First Nations does not mean it is within our cultures, but has more to do with the similarity of the material circumstances imposed upon us by an oppressive society.

4. As previously stated, no one disputes violence may be exhibited while under the influence of alcohol, but to specifically state First Nations are more prone to violence is yet another racist argument.

5. Interestingly, Fingarette (1988) gives examples of alcohol consumption patterns during early colonial days:

In early America, indeed, some form of spirits – and in large quantity –

was indispensable for collegial conviviality. When the Virginia Council of State convened, a brandy punch was always at hand, and councillors commonly were quite merry, if not drunk. During a dinner reception hosted by New York Governor De Witt Clinton for the ambassador from France, the 120 guests consumed 135 bottles of Madeira, 36 bottles of port, 60 bottles of beer, and 30 bowls of rum punch. (p. 14)

Was the gene for “uncontrollable consumption” somehow bred out of these blue-blooded ancestors during the last 200 years or so? Was anyone left standing at these soirees?

6. No evidence for this exists.

7. There is no evidence to substantiate whether alcohol programs are effective in promoting abstinence from alcohol since there has never been a systematic evaluation on the outcome of such programs (Saggers & Gray, 1998; Thatcher, 2004). Furthermore, if such an evaluation was conducted, it would be difficult to prove it was these programs which impacted individuals. Among the many difficulties, what cannot be accounted for are the external factors or hidden variables impacting individuals.

8. This is but another blind assertion.

### **Nechi Institute and Poundmaker’s Lodge**

So far I have discussed the major shortcomings of the disease model as a framework for understanding alcohol abuse. I will now examine how this model has been instituted, in practical terms, in First Nations communities. Although

the disease model is pervasive, rather than detailing its implementation in one treatment program after another, I will focus on a single characteristic case.

One of the best known training and treatments centres in Canada is Nechi Institute and Poundmaker's Lodge Alcohol and Drug Treatment Centre. It is promoted as a major catalyst for positive change in Native communities (Poundmaker's Lodge, n.d.). As compared to other alcohol treatment programs, this initiative enjoys a secure funding base, including lavish resources provided through the Medical Services Branch of the NNADAP. Established by First Nations individuals, often recovering alcoholics, and developed primarily in the province of Alberta, this program has since expanded to provide a range of services to First Nations communities across Canada and internationally (Saggers & Gray, 1998).

Nechi and Poundmaker's Lodge recognizes what it calls cultural oppression and urges its clients to understand alcohol problems in terms of colonial domination. As will be shown, however, it is quick to discard this insight and redirects its focus to the psychological effects alcohol and substance abuse have on individuals. A Nechi pamphlet on Adult Children of Alcoholics makes clear its ideological approach to the issue of alcohol:

Today in our healing from the effects of alcoholism and other painful ways of living, we are re-discovering that what we are doing is a spiritual healing journey to be shared for the recovery of all our relations. In this century we have gradually come to know much about alcoholism and its effects. Medical research has shown that alcoholism is a disease with

recognized symptoms and named progression. Consequently, we now know a great deal about how this disease can physically destroy people. Psychology has brought insights to the emotional pain resulting from alcohol... This movement is guided by two spiritual principles; self-empowerment and mutual aid. (White, nod, cited in Samson, 2003, p. 275)

As is obvious from the above statement (or by browsing the Poundmaker's Lodge website), the disease model is the underlying philosophy of this program, and the road to recovery is based upon healing the personal and spiritual well being of Aboriginal peoples. On the whole, Nechi and Poundmaker's Lodge aims to provide tools of empowerment to re-establish personal harmony within Aboriginal individuals despite the oppressive material circumstances acting upon them.

The first difficulty with the espoused philosophy of this program is its adherence to the disease model of alcoholism. As I have already established in the previous section, there is no empirical evidence supporting this view. Designating this as the foundational principle of its approach is in keeping with Methodological Individualism; and thus, Nechi and Poundmaker's Lodge joins in the process of blaming victims.

More troubling is some First Nations are willing to label their members as diseased in order to maintain program funding from the Canadian government. At an international workshop to develop alcohol policy and programs for Aboriginal peoples, it was argued a medical understanding is inadequate for developing effective health policy. Rather, alcohol problems should be

understood in a socio-historical context which takes into account the cultural conditions and colonial history of Aboriginal peoples. The co-founder of Nechi and Poundmaker's Lodge took issue with this approach, arguing models situating alcohol problems as symptoms of social and cultural conditions serve only to justify government refusals to fund Aboriginal run alcohol treatment programs (O'Neil, 1993).

In this vein, recall my review of the aftermath of Indian residential schooling: many Aboriginal peoples forced to attend these institutions were said to be suffering from "Residential School Syndrome," and thereby in need of treatment. By attributing "Residential School Syndrome" (a fabricated disease) to those who attended these schools (assimilationist and alienating institutions) the issue was gravely distorted. The terms of discussion were set, and revolved around the nature and extent of First Nations presumed pathology rather than the immoral and genocidal nature of residential schooling itself. In fact, legalities and moralities were avoided completely.

The implications of the disease model as applied to First Nations is no different than attributing "Residential School Syndrome" to those forced to attend residential schools. By representing alcohol problems among First Nations as a disease to be treated by mainstream specialists, the economic, social, legal and moral issues surrounding the Canadian assimilationist agenda (ultimately responsible for these problems in the first place) are successfully avoided. Aboriginal individuals are encouraged to see themselves as dysfunctional and defective, suffering from the disease and in need of treatment; they are not

encouraged to insist on alterations in their social and economic relations with Canadian society.

Yet another difficulty with Nechi and Poundmaker's Lodge is its focus on empowerment. Empowerment is a fulcrum word, one with a political and social meaning. Young (1993) demonstrates how the concept of empowerment has been stripped of its real significance and reinstated as a psychological experience. According to Young, to empower has two senses: (1) Power as authority, to bestow a right, responsibility, or privilege within a network of shared social relations (e.g., as a judge, police officer, or hockey referee are empowered to do their jobs), and (2) Power as ability, to perform skilled actions or to teach someone how to do something they did not know previously (e.g., one learns to ride a bike or to play racquetball).

Nechi and Poundmaker's Lodge ignores the legitimate usage of empowerment as political and social action (or as a teaching/learning experience) and instead, replaces it with a warm and fuzzy feeling notion. As Kitzenger and Perkins (1993) note, such a move depoliticizes political and social issues, replacing actual holding and use of power with feelings of power. The difference is obvious: with real political/social power, people may change things (including their living circumstances); with the feeling of power (such as may be found in any bottle of alcohol), one can accomplish nothing. That is, the drug of alcohol is replaced with the drug of empowerment while the oppressive circumstances remain steadily in place.

By conflating the social/political usage of empowerment in terms of



personal and emotional spiritual experiences, Nechi and Poundmaker's Lodge encourages a selfish and egotistical concern with personal well-being rather than actual reform for First Nations as a whole. Rather than promoting an understanding of the society in which we live and an involvement in social and political action to address circumstances impinging on First Nations, Nechi and Poundmaker's Lodge invites us "to plunge into self-absorption, to find a universe of empowerment [and spirituality] entirely within ourselves. It is solipsism writ large" (Parenti, 2006, p. 114). However, we neither are autonomous individuals set apart from other human beings nor are we set apart from the world in which we live. To think otherwise says more about the alienated conditions of Western capitalism. I do not believe our ancestors thought this way; otherwise we would not be here today.

Another troubling aspect of Nechi and Poundmaker's Lodge is its emphasis on healing. The term healing is predominant throughout the literature addressing the social relations between First Nations and Canadian society (RCAP, 1996). In the context of Canada's ongoing deliberate destruction of Aboriginal peoples' forms of life it is highly inappropriate to imply First Nations individuals are the people in need of healing. This serves to pathologize First Nations peoples rather than address the inequities and oppression in question. Not only is this therapeutic approach conveniently used in most issues faced by Aboriginal peoples in Canada, but is used as a response for the genocide of Indian residential schooling.

Although Nechi and Poundmaker's Lodge has been endorsed as a

“miracle machine” (Brady, 2000, p. 6), helping First Nations communities to overcome alcohol, I contend, it is an assimilationist program which maintains and perpetuates the status quo. By presuming alcohol is a disease located within the First Nations individual, Nechi and Poundmaker’s Lodge accepts Western capitalist ideologies of Methodological Individualism, meritocracy and blaming the victim; by adhering to the ideology of Methodological Individualism it presumes the problem of alcohol and its solution are located within the First Nation individual. This ideology leads to the blaming of First Nations individuals rather than recognition of the systemic sources of the problem, i.e., racism, oppression, colonialism, and exploitation. Methodological Individualism also forms the basis for the predominant yet false view of society as a meritocracy – where everyone gets what they deserve because of their own personal, individual and internal characteristics (Ryan, 1981; Young, 1958). Thus, meritocracy is implicit within Nechi and Poundmaker’s Lodge’s definition of success:

Success is defined in terms of specified percentages of its graduates who fall into such categories as returning to school, increasing their income, holding program management positions, or, in a more personal sense, improving their family life and strengthening their identity as Native people. (Samsom, 2003, p. 279)

Accordingly, First Nations individuals who lead drug and alcohol free life-styles and demonstrate a tendency for upward mobility within Western capitalist society are simply demonstrating their superior personal, internal and individual characteristics; individuals who fail are demonstrating their inferiority. In short,

success is measured by the degree of First Nations adherence to and participation within the political economy of Canada.

By failing to understand and challenge the ideological, political and economic biases of Western capitalism, Nechi and Poundmaker's Lodge participates in the assimilationist program. All such programs have as their ultimate consequence the elimination of First Nations peoples. By shifting responsibility for the problems of alcohol onto First Nations, the issue is recast as a pathology inhering in First Nation individuals. The solution becomes the modification of drinking behaviour in order to adapt to Canadian society rather than to confront the social, economic, legal, and political injustices impinging on First Nations peoples.

In the end, I believe the impact of Nechi and Poundmaker's Lodge on long-term alcohol consumption in First Nations lives will be non-existent. Because no steps are taken to eradicate the systemic aspects giving rise to the problem in the first place, "alcoholics" will continue to be produced at a faster rate than they are unmade. In fact, the long term impact of Nechi and Poundmaker's Lodge will serve to perpetuate the genocide machine currently operating in our communities.

### **Summary**

Both the biological model and disease model of alcoholism locate the problem of alcohol within First Nations individuals. It makes no difference which emphasis is used for understanding drinking behaviour among First Nations: both result in the ideological position of Methodological Individualism and give rise to interventions (i.e., Nechi and Poundmaker's Lodge) which maintain the status

quo. Furthermore, interpreting alcohol problems among First Nations in Canada as a failure on the part of First Nations individuals not only misunderstands the source of the problem, it constitutes a continuation of the difficulties.

Thus far I have argued that a commitment to Methodological Individualism on the part of Western social-science has given rise to a particular form of analysis, one which locates the causes of alcohol problems within the personal and internal properties of First Nations individuals. As noted, this Western ideological approach to alcohol research provides a limited picture of what is going on among First Nations in Canada. The whys of alcohol abuse are left unexamined and unanswered in such an analysis. More importantly, Methodological Individualism (and by default empiricism) necessarily exclude the historical and material context crucial to the understanding of First Nations circumstances in Canada.

In a sense, programs such as Nechi and Poundmaker's Lodge are designed to contribute to the ongoing assault on First Nations: after all, they are working from blueprints supplied by the (usually ignorant) operatives of mainstream methodologically individualistic domination. I believe the agenda for authentic alcohol research must be to fill the conceptual gap presented in the literature. In the next chapter I present my thoughts on an alternative approach for understanding the impact of alcohol on Aboriginal peoples of North America.

## CHAPTER SIX

### Toward an Alternative Understanding

I have not been alone in stating alcohol abuse in our communities is rooted in the social, political, economic, historical and ideological relations between Aboriginal peoples and Canadian society. Among the few scholars recognizing this are Brody (1977) and Fisher (1987). Fisher (1987) concluded:

The common alcohol abuse problems shared by these groups [indigenous] are most probably rooted in the groups' [indigenous] relations to the means of production in North America, and not in their 'Indianness,' whether biologically or culturally understood. (p. 81)

The spirit of an historical and material approach to the whys of alcohol problems demands an examination of indigenous peoples' relationship to the means of production in Canada. More precisely, Aboriginal peoples of North America historically lived under economic and material conditions different from capitalism, "and the relationship between these conditions and North American society as a whole is the guide to [understanding] the alcohol problem" (Brody, 1977, p. 40).

For Marx, society is situated in the relations and forces of production – the ways in which people necessarily relate to each other in the course of producing and reproducing their lives (Leacock & Lee, 1977). An Historical Materialistic approach requires:

both placing society fully in the historically specific context of its

relationships and dealing with the complex interrelations and interactions within and between the relations and forces of production on the one hand and the social and ideological superstructures on the other. (Leacock & Lee, 1977, p. 7)

As stated in chapter three, Historical Materialism challenges the Idealist perspective that society is the way it is because people are the way they are. Instead, people are the way they are because society is the way it is. Rather than reducing society to components, this analysis understands the whole as something other than the sum of its parts; it follows that, for human individuals to be understood, society and history must be understood.

However, society must not be universalized, for there have been different modes of production in human history. This point becomes central when understanding the relations between Aboriginal peoples and Canadian society. Wolf (1982) illustrates the importance of understanding different modes of production within the context of Marx's Historical Materialism:

Each mode [of production] represented a different combination of elements. What was true of one mode of production was not true of another: there was therefore no universal history. But Marx was profoundly historical. Both the elements constituting a mode of production and their characteristic combination had for him a definable history of origin, unfolding, and disintegration. He was neither a universal historian nor a historian of events, but a historian of configurations or syndromes of material relationships. (p. 21)

Marx's major contribution, of course, was describing the history and workings of one particular mode of production, capitalism. Marx was not defending the mode of production of capitalism, but aiming "to effect its revolutionary transformation" (Wolf, 1982, p. 21).

Marx demonstrated that Western capitalism gives rise to a form of life he characterized as alienated (1988). This had nothing to do with hypothetical mental states or objects, but with the kind of person capitalism needed to continue its operation. If there was something in the head of people causing them to behave (both personally and collectively) in particular ways, this was principally because the capitalist mode of production put it there. By extension, alcohol problems are not a natural condition of Aboriginal peoples, but are brought about by the social, political and economic forces of living on the fringes of Canadian society. Why First Nations drink, how they drink, where they drink, what happens to them when they drink, with whom they drink, and the answers proposed to these questions within the methodologically individualistic framework are misleading and serve only to obscure the objective material conditions giving rise to alcohol in the first place.

#### **Western Capitalism and the Objective Circumstances of Alienation**

How does alcoholism arise in an alienated society? To start, consider what kind of human beings are being produced under alienated societies of capitalism: people who do not like their jobs and the people around them; who have learned they can purchase something to fill in any need they feel they have; who quickly run out and purchase goods and services they see advertised on television; who

are taught and believe they must look out for themselves; who do not know their neighbours nor want to know their neighbours; who pay taxes to look after the sick and the elderly and complain about it; who are often specialized to the point where they literally cannot do anything outside the narrow range of their occupation; who spend thousands of dollars to get away from it all in a commodified preserve of the natural world that will sooner or later be commercially developed; and on and on and on. Is it any wonder such people occasionally feel disconnected, irrelevant, burnt out, selfish, unappreciated, lonely, angry, or unfilled? Is it any wonder such people may feel like killing themselves or are successful at it, drink themselves to oblivion, feel stressed or depressed?

Now consider small, self-sufficient, non-capitalist communities, such as numbered in the thousands in North America before the rise of capitalism. In non-capitalist societies individuals are not alienated from their means of production and from their social relations since the mode of production was not capitalism. Nobody was apart from nature, i.e., land and resources, because everybody depended on it for their survival; it provided food, clothing, shelter, and the opportunities for life itself. As such, land and resources were used for social/human need. Nobody was apart from community, for to be outside the community amounted to a death sentence. Individuals within these communities worked together cooperatively in conjunction with great respect for individuality, and common ways for handling problems or conflict quite often entailed teasing, joking and gossiping (Leacock & Lee, 1977). Moreover, everyone knew



everyone, knew each other's strengths and forgave each other's weaknesses, and celebrated the communal diversity, because diversity made them stronger. A degree of specialization existed (i.e., women giving birth) but everybody could, with fair proficiency, do a whole host of tasks indispensable for day-to-day living. Everyone was engaged in the same tasks, but perhaps not in the same way (the old man tells the young men where there are likely to be deer, but it is the young men who chase after it). If you made something, it was yours to keep or to give away as you saw fit. And there was no accumulative capital, because there was no capital to accumulate; if you had 10,000 fish, after three days 9,997 of them would go to waste.

Colonization and the imposition of capitalism became, once physical genocide was abandoned, the norm for Aboriginal forms of life. Indigenous peoples became beset by famine, violence, and the deliberate introduction of diseases (Churchill, 1997; Lux, 2001; Neu & Therrien, 2003). The separation of Aboriginal peoples from their land and resources including the incursion of settler populations within Aboriginal peoples' territories and missionary conversion and the imposition of patriarchal relations between men and women (Anderson, 1993) are a result of colonial domination. With the capacity to defend themselves undermined, with the rights of access to the means of production and the products of labour stolen, with the basis for their participation in political decision-making processes destroyed and, finally, with spiritual practices, values and philosophies discredited, Aboriginal peoples were forced into a subservient position by the European colonizers.

Beginning as sovereign peoples following their own forms of life, First Nations were driven to the margins of Canadian society (with the understanding either they would accept capitalist-style alienation or nothing at all). If citizens of Western nations can be reduced to caricatures of human beings by alienation, what more could be expected to happen with people not even getting the incentive of a “living wage” from the mode of production? Suicide, educational failure, spousal abuse, hopelessness... and, because it is cheap and readily available, alcohol.

It must be remembered: drinking oneself into oblivion works! It temporarily alleviates submersion in immediate oppressive circumstances. Drinking removes one from the horrible realities of daily marginal living: poverty, unemployment, meaningless work, financial difficulties, sickness, and interpersonal conflicts. Drinking numbs loneliness, emptiness, depression, stress, frustration, boredom, and isolation. Drinking can be pleasurable and social, even therapeutic, creating a warm fuzzy feeling inside users. Drinking can make you feel powerful. Drinking can be seen as a protest against this life, or a way of not participating in an imposed form of life. It is just an impermanent and unhealthy solution.

Of course, there are plenty of other ways First Nations deal with their oppressive living circumstances. Some people commit suicide. Others see the solution as entering into the workings of the colonial-capitalist system, becoming elites, compradors, administrators and professionals (Bear Nicholas, 2003); in other words, “if you can’t beat them you might as well join them.”

In the face of oppression, domination, exploitation and marginalization

Aboriginal peoples have responded in many different ways. However, it is important to note this is not unique to Aboriginal peoples in North America, but common to all people who have been brutalized, oppressed and exploited. Thus, it is absurd to conceive of problems facing Aboriginal peoples – alcohol, suicide, family violence, educational failure, etc. – as anything other than a clash of economic, political, legal, social and moral issues between Canadian society and indigenous ones. Problems cast as “personal, individual, and internal” are nothing less than intelligible human reactions to an oppressive dominating mainstream that continually confronts our humanity.

This strikes to the heart of the limitations and inaccuracy of Methodological Individualism. Since all social phenomena (including alcoholism) must, in principle, be accounted for in terms of what people think, choose and do, Methodological Individualism cannot take into consideration the objective material conditions; for these external factors are not represented within First Nations individuals; nor are they represented within the minds of thoughtful or thoughtless oppressors. It is not necessarily animosity or a drive for domination that drives the operators of Canada’s “genocide machine” (Davis and Zannis, 1973), though bigots and bullies certainly could be employed by it; it is because of the blindness of all involved that the problems seen must somehow reside in the minds and hearts of the machine’s victims.

### **“Ordinary” Genocide by Assimilation**

In his examination of the moral implications of the Holocaust, Bauman (2000) writes:

“Ordinary” genocide is rarely, if at all, aimed at the total annihilation of the group; the purpose of the violence (if the violence is purposeful and planned) is to destroy the marked category (a nation, a tribe, a religious sect) as a viable community capable of self-perpetuation and defense of its own self-identity. If this is the case, the objective of the genocide is met once (1) the volume of violence has been large enough to undermine the will and resilience of the sufferers, and to terrorize them into surrender to the superior power and into acceptance of the order it imposed; and (2) the marked group has been deprived of resources necessary for the continuation of the struggle. With these two conditions fulfilled, the victims are at the mercy of their tormentors. They may be forced into protracted slavery, or offered a place in the new order on terms set by the victors – but which sequel is chosen depends fully on the conquerors’ whim. Whichever option has been selected, the perpetrators of the genocide benefit. They extend and solidify their power, and eradicate the roots of opposition. (p. 119)

This “ordinary genocide” applies to the actions carried out by Canada against Aboriginal peoples from the time of Confederation in 1867 to present. The full range of policies and laws (including the various Indian Acts, the reserve system, residential schools, the abolishment of Aboriginal peoples’ political and economic systems, the banning of spiritual practices, defining who is legally an Indian and so forth) were the means by which Canada carried out “ordinary” genocide for the material purpose of expropriating the wealth from Aboriginal peoples. The point was to alienate Aboriginal peoples from their forms of life, which otherwise kept

them self-sufficient and capable of defending themselves. Once Aboriginal peoples became indistinguishable from other Canadian citizens there would no longer be the question of who legally holds title to the land and resources of North America.

### **Alcohol and Related Social and Health Problems among First Nations in Canada.**

I do not suggest Canada implemented such policies for the purpose of getting Aboriginal peoples to drink themselves into oblivion. In fact, it is likely Canada would prefer both historically and presently such outcomes did not exist within their geopolitical borders, since these constitute an embarrassment within and beyond their claimed borders. The health, educational, and social disparities which ravage indigenous communities are incidental to the various policies undertaken by the Canadian government. It is unthinkable that governments and churches either had the intention of driving Indians to drink, or had sufficient knowledge of social engineering to understand what they were doing; rather, it is far more likely alcohol abuse (and educational failure, family violence, suicide, etc.) in First Nations communities is, in part, “a normal human reaction to conditions of prolonged, ruthless domination” (Chrisjohn & Young, 1997, p. 271) and on a whole, a human response to living under the conditions of alienation. However, what is blatantly obvious is turned into something hidden and mysterious within the framework of Methodological Individualism. Andrea Smith (2002) points out the non-sensibility of a methodological individualist interpretation of the Jewish suicide rate during the Holocaust:

Consider, for a moment, what a MI interpretation makes... Is the Jewish suicide rate during the Holocaust difficult to understand unless we translate it somehow into the mental contents of perpetrator, victim, and bystander? Should we entertain, even for a second, the notion that, say, a generalized serotonin deficiency was the “real” reason the Jews were killing themselves? That “a gene” just decided to “kick in” in 1933 and phase itself out in 1945 (when the suicide rate began to drop toward pre-war levels)? Or that depression and anomie in concentration camps were the causal agents for the Jewish deaths by action or omission of action? To entertain seriously any of these suggestions entails the notion that the “real problem” with the Holocaust was the primitive state of psychoactive medications, the absence of access to therapists, or the lack of funding for such intervention, and that the material circumstances of existence of Jews in occupied Europe be completely ignored.

She concludes:

This reveals, I believe, the blindness to material conditions imposed by a methodological individualist ideology. Those dedicated to the MI position (psychiatrists, psychologists, social workers, etc) have nothing to do, as members of their disciplines, in regard to the material conditions of oppressed peoples; that is, Jews in Nazi Germany did not need better medications or someone to talk to. The people who acted most directly to eliminate the “Jewish suicide problem,” Marshall Zhukov and General Patton, acted not as therapists but as liberators (and even that action depended in no way on

Zhukov's and Patton's *personal* knowledge of and attitude toward the Holocaust). In fact, action as a medical officer or therapist would only mask and perpetuate the oppression the medical officer or therapist was ostensibly designated to address. To put it bluntly, there is no long-term growth potential for methodological individualist interventions that recognize the central role of oppression in the production and maintenance of human misery. (p. 39)

Yet, the dominant depiction of alcohol among First Nations in Canada rhetorically neglects this parallel, relying on putative internal, personal, individual characteristics instead of looking at the oppressive social, economic and political forces impinging on First Nations peoples. Existing explanations and causal models of alcohol blame the victim, finding First Nations suffer from a disease, acculturation, anomie; they have a genetic predisposition, an alcoholic personality, or an emotional deficiency such as low-self-esteem, stress or depression; they come from bad family lives, drinking cultures, and so on. Existing intervention programs and policies aimed at First Nations do nothing to address the situation by acting or suggesting action against the forces of oppression; they do not even recognize them due to their immersion into the Western ideology of Methodological Individualism. The cost-effectiveness of the government's provision of humanitarian end-of-pipe intervention programs rather than upholding their contractual treaty obligations does not surface as an issue. And the individuals designated to "cure" First Nations of their supposed deficiencies accept this frame of reference and repeat the irrelevancies of the

mainstream. In short, existing explanations and intervention programs aim to convince First Nations to accept their oppressive circumstances and thus accomplish the Canadian government's task of eliminating the "Indian Problem". However, the proper treatment for the "Jewish suicide problem" in Nazi Germany was not to send in psychiatrists, psychologists, and social workers to make them feel better about their situation, but rather to liberate the Jews from their oppressive circumstances. The "Indian alcohol problem," beset by well-meaning ideologues, still awaits its liberators.

No sensible person would blame the Jews for their suicide rate during the Holocaust. Why, then, is it so easy to blame First Nations for their drinking problems? By not blaming First Nations the genocidal nature of the unequal social relations between First Nations and Canadian society might well be called into question. Perhaps Canada would decide to uphold its treaty obligations to Aboriginal peoples and recognize them as human beings and sovereign peoples; to provide compensation for the land and resources stolen from Aboriginal peoples; to undertake actions (in whatever form deemed necessary by Aboriginal peoples) to reconstitute their nations; to provide open-ended funds for health, education, language, economic development and allow Aboriginal peoples the freedom to implement these systems/programs on their terms; and to dismantle institutions belonging to Canadian society and allow for their replacement by institutions reflecting Aboriginal philosophies and under Aboriginal control. In short, once the inadequacies of victim-blaming are revealed, the entire economic system of Canada (including the standard of living of many who benefit from the



destruction of Aboriginal peoples' forms of life) would eventually be called into question. Thus, there are material incentives for the internalization of problems and the enforcement of "cures" adhering to methodologically individualistic and meritocratic depictions of social problems. Malcolm X recognized the importance of this point as applied to African communities in the United States: "if Black people really understood why, for whose benefit, alcohol and drugs were in the ghettos, there would be no need for social workers or treatment programs – we Black people would eliminate these scourges all on our own" (Reference unknown).

## CHAPTER SEVEN

### Some Possible New Directions

As long as alcohol research continues to be committed to putative, internal and personal causal models of alcohol abuse, I am convinced this will have no discernible impact on alcohol problems in First Nations communities.

Researchers rarely question the conceptual assumptions guiding their endeavours and the implications these may have, preferring instead to establish causal models explaining drinking behaviour. Rather than helping First Nations overcome alcohol problems they, by default, perpetuate the genocide machine currently operating in our communities.

The ideology of Methodological Individualism forms the background assumptions of investigation and explanation in alcohol studies of Aboriginal peoples. Throughout this work I provided a materialist critique of methodologically individualistic approaches to alcohol abuse and have worked toward an alternative understanding of the issue. Although the next logical step may seem to be to develop alternative research strategies, this is not the concern of this thesis; that task is a thesis unto itself. Thus, no advances for how to change the way we investigate the issues of alcohol and its impact on First Nations will be provided here. To conclude I prefer to discuss some possible alternatives to the individualist form of thinking criticized throughout this work.

## **Conceptual Clarification**

To begin, there are numerous dangers arising from inadequate conceptual clarification in connection with empirical research. All too often investigators are content to pursue mechanistic causal models of drinking behaviour without thoroughly analysing the contexts of the behaviour of interest or considering the logic of the descriptive language employed. I believe Wittgenstein (1953) is useful here. Wittgenstein outlined an alternative approach, based on concept clarification, which deserves attention. He was not putting forth a general method: his warning about contempt for the individual case reflects this. Thus, how we clarify one concept may not be useful for how we go about clarifying other concepts. And, as Young (1991) notes, "Reliance on a 'method' of concept analyses is, for Wittgenstein, a moral failing, in that it disposes us to be lazy. Perhaps not surprisingly, this laziness is of the sort induced by reliance on empirical methods to get us out of conceptual jams" (p. 13). Since Wittgenstein's arguments are extensive, in this following section I will provide only a brief survey of what he meant by conceptual clarification.

For Western social science, the meaning of a word or a concept is the concrete thing to which it refers. Because of this mistake, scientists believe the meaning of a word or concept can be clarified by gathering empirical data about the word or concept. Wittgenstein (1960) says "One of the great sources of philosophical bewilderment: a substantive makes us look for a thing that corresponds to it" (p. 1). Wittgenstein refutes this notion at length, and distinguishes sharply between conceptual and empirical matters. Conceptual clarification is logically prior to

empirical investigations, and no factual discoveries concerning what is signified by a given concept can have any bearing on the clarification of a concept (Baker & Hacker, 1982). Accordingly, when empirical issues are addressed without adequate conceptual clarity, misconceived questions are bound to arise, and misdirected research is likely to result (Bennett & Hacker, 2003). For example:

One cannot look for the poles of the Earth until one *knows* what a pole is – that is, what the *expression* ‘pole’ means, and also what *counts* as finding a pole of the Earth. Otherwise, like Winnie-the-Pooh, one might embark on an expedition to the East pole. (Bennett & Hacker, 2003, p. 71)

Wittgenstein shows how meaning, for the most part, is use in everyday language within a social context. While not rejecting the idea that something may be going on inside us, Wittgenstein argued against the view that the meaning of words (i.e., psychological, biological and social concepts) is their association with something internal to the individual. Wittgenstein (1953) uses the analogy of the “Beetle in the Box” to show how words or concepts do not acquire their meaning through reference to an inner object:

Suppose everyone had a box with something in it: we call it a “beetle.”

No one can look into anyone else’s box, and everyone says he knows what a beetle is only by looking at his beetle. – Hence it would be quite possible for everyone to have something different in his box. One might even imagine such a thing constantly changing. – But suppose the word “beetle” had a use in these people’s language? If so it would not be used as the name of a thing. The thing in the box has no place in the language-

game at all; not even as something: for the box might be empty. – No, one can “divide through” by the thing in box; it cancels out, whatever it is.

That is to say: if we construe the grammar of the expression a sensation on the model of “object and designation” the object drops out of consideration as irrelevant. (p. 293)

As suggested by Wittgenstein, “the beetle in the box” is a reification of ordinary everyday acts and experiences into special kinds of objects and processes bearing some kinds of properties. This reification of everyday acts is prevalent throughout the literature on alcohol studies. In the absence of conceptual clarification, alcohol researchers treat drinking behaviour as an object, reified into putative, internal and personal properties located inside individuals and the reified properties are then measured on a sort of scale so that individuals can be ranked according to the amounts they possess.

However, rather than reifying the concept and trying to search for the necessary and sufficient discernable properties of the “object,” Wittgenstein shows how meaning arises out the actual use or uses of words and concepts, and what characterizes employment is often in the situation, the circumstances of its use, not the material or immaterial presence of something being referred to (i.e., name-object).

Some words obviously are used as names for objects, but the practice of naming does not itself explain anything. The meaning of our concepts is based in the fact that they arise within a shared network of social relations. Concepts can have different uses in different circumstances; that is, there are a lot of different

kinds of games that may be played with a single word. But the family resemblance between horizontally and/or vertically related concepts derives from variations in how they are used (ter Hark, 1990).

Hence, designating the human activity of drinking as a disease located within individuals falls into the trap Wittgenstein warns us against. Rather than look for a beetle inside an alcohol abuser's box, we should first "develop a perspicuous overview of the term" (Young, 1993, p. 13), clarifying the many ways in which the word or concept is used in a particular language.

The conceptual approach has been used successfully for quite some time. Young (1993), as already mentioned, examined the concept of empowerment and showed there are two primary metaphors underlying ordinary usage: *power as ability* and *power as authority*. The other part of empowerment, the "em-", refers to making, causing to resemble, or bestowing. Empowerment, then, broadly means making a person or persons capable in ways they were previously deficient, or according a person (or persons) authority they previously did not have. In another study, Maraun and Chrisjohn (1997) examined metaphors commonly associated with intelligence in order to critique existing psychological definitions. For example, the metaphor *intelligence is a light* source conveys the term is appropriately applied to people who *shed light* on subjects, *illuminate* difficult ideas allowing us to *see clearly* in a metaphorical sense. They suggested reified definitions of intelligence missed what the term actually conveyed about intelligent people and how we identified them.

Baker and Hacker (1982) give general guidelines for pursuing a conceptual

approach. Their work should be the starting point of anyone wishing to embark upon useful empirical research on Indians and alcohol use/abuse.

But what general directions would emerge from taking a Wittgensteinian approach to this area. The move away from internal explanations to ordinary language would clear up certain presumptions. For example, perhaps we would realize that, first and foremost, “alcoholism” is behaviour; a person who drinks and becomes an annoyance to people around him or her and society at large is “what an alcoholic” is. When we call someone an alcoholic, or call ourselves an alcoholic, we are speaking of observable behaviour, not hypothetical mechanisms. As well, our search for inner causes might be refocused on the external conditions that give rise to and maintain our behaviour, rather than encouraging us to assert a hidden mechanism and then give up. These improvements alone might serve to put research on a proper track.

Throughout this thesis I have kept Wittgenstein’s consideration in mind when examining the issue of alcohol among First Nations in Canada and providing a context that makes drinking behaviour intelligible. Reminding ourselves that, from the start, we are examining how we talk about things rather than how they actually are should give us pause concerning what we really know. There are, as Wittgenstein said, real empirical questions out there: however, they must be separated from our prejudices and conceptual confusions.

## **Historical Materialism**

I also believe that Karl Marx's Historical Materialism provides an alternative approach to the individualist form of research that does not (and cannot) incorporate the objective material conditions into the explanation and prevention of alcohol problems. In addition, Historical Materialism has as an explicit part of its approach the corollary of possibility for preventing current social and health problems by changing the social, political and economic conditions contributing to their development (Saggers & Gray, 1998; Schnall & Kern, 1981; Tesh, 1988; Turshen, 1989). As well as being helpful in the understanding of individual cases (e.g., where does personal responsibility begin and end?), Historical Materialism gives insight into personal-level and societal-level intervention strategies.

Unlike the individualistic approach, Historical Materialism does not take existing political and economic systems as natural and inevitable; they become possible sites of intervention. Thus researchers and policy makers adopting a Materialist perspective need not limit themselves to intervention proposals that maintain the status quo. Moreover, and most importantly, policies proposed within such a framework have the possibility of benefiting whole populations, not just certain individuals (Saggers & Gray, 1998; Tesh, 1988; Turshen, 1989).

A Materialist perspective also provides an alternative conception for viewing the causes of alcohol problems in our society. It takes into consideration the complexity of the political, social and economic relations of our society. Unlike the biological, social, psychological and disease models, it "guards against reductionist thinking, and it includes nonempirical aspects of causality" (Tesh,



1988, p. 80).

However, a Materialist approach for alcohol prevention policy might seem to imply that a reduction of alcohol problems must wait on a major social change. That is, it might be useful to understand the root of alcohol problems in First Nations communities, but it does not help to address their immediate circumstances. In answer, nothing in an Historical Materialist approach stipulates ignoring an individual's problems; rather, it makes clear to the client relevant external influences on his/her behaviour (which are ignored in methodologically individualistic approaches) while suggesting alteration and interventions which simultaneously benefit not only him/herself, but his/her friends, neighbours, and community members, too. Unlike Historical Materialist programs, methodologically individualistic programs cannot target internal and external sources of alcohol abuse problems in their programs, since they fail to recognize what Historical Materialism can bring into sharp focus.

In the long run, the most logical and safe approach for reducing alcohol problems in First Nations communities is to prevent it. This means, of course, identifying and eliminating those sources causing individuals to drink. I believe an analysis such as Historical Materialism can help alcohol researchers and policy makers develop an integrated understanding of the relationship between society and individuals within an historical context, and thereby begin to develop insights and recommendations for reducing alcohol through its prevention.

## **Summary**

If we truly want to implement effective policies for preventing alcohol problems in First Nations communities we must begin to overthrow the ideology of individualism and come up with completely different strategies that do not maintain the oppressive circumstances of First Nations in Canada. I provided some preliminary suggestions of how we might go about accomplishing this task.

## CHAPTER EIGHT

### Ideology in a Bottle

A recent federally commissioned review described NNADAP as “the Federal Government’s primary line of attack to combat alcohol and substance abuse in First Nations communities” (Thatcher, 2004, p. 35). However, in my thesis, I have argued current alcohol policy aimed at First Nations is neither effective nor neutral, but simply continues and extends the genocidal attack on the people they are supposed to be helping. As discussed, alcohol problems among First Nations in Canada are a reflection of the success of the various assimilation-as-genocide policies carried out by the Canadian government. The Canadian political economy has a *material interest* in assimilating indigenous peoples and internalizing the problems arising from this process. I also argued that since the material circumstances necessitating the assimilation of First Nations have not altered since the time of Confederation, current alcohol policies and programs constitute a continuation of Canada’s assimilationist/genocidal program.

In reviewing the literature on alcohol studies and Aboriginal peoples of North America, I repeatedly found explanations of alcohol problems as being the outcome of putative personal, internal characteristics of First Nations individuals. From a scientific perspective, surprisingly, in the absence of any supporting empirical data, the biological model and the disease model were most commonly used to explain why First Nation individuals abuse alcohol. This is, however, not surprising from a rhetorical, political-economic perspective. Even studies that

suggest dispossession and the consequent political and economic marginalization of Aboriginal peoples play a role (major or not) in alcohol abuse, concluded by transforming these influences into psychological effects and thereby minimized them as political and economic causes. I have argued that passing off ideology as science has a pedigree originating in capitalism and its concomitant philosophy of Methodological Individualism. Accordingly, Western theories of alcohol among Aboriginal peoples are nothing more than ideology in a bottle.

I have argued that understanding alcohol problems with Methodological Individualism as a background assumption produces a limited and inaccurate analysis of Aboriginal peoples' circumstances in general and alcohol use/abuse in particular. By understanding the issue of alcohol as a cause and effect within First Nations individuals, Methodological Individualism obscures the social, political, economic, legal, historical and moral issues of their oppressive circumstances within Canadian society. I examined a number of ways how the ideology of Methodological Individualism maintains the oppression of First Nations in Canada. For example, I demonstrated how the biological model and present day genetic explanations are merely a continuance of this racist ideology under a veneer of science. Unfortunately, this form of positive racism is widely accepted even among many Aboriginal groups who fail to recognize the ideological nature of such assertions and how they are used to justify marginalization, exploitation, dispossession and oppression.

Similarly, the disease model, which views alcoholism as a disease like any other may make perfect sense as applied to conditions like diabetes, heart disease

and so forth. However, there is no logical or verifiable objective evidence supporting the claim that drinking behaviour is a disease. Rather, the common consideration of alcoholism as a disease is based on an analogy that has been extended too far. Like biology, the disease model reinforces the pathological, defective Indian stereotype and blames Indians for the problem of alcohol rather than the oppressive material circumstances in which Aboriginal peoples are forced to live.

Native alcohol programs, especially those operated by First Nations, end up emulating mainstream programs. This is partially due to funding being provided by the Canadian government, who ultimately control the direction and extent of intervention programs; but also from a failure to understand the ideologies of Methodological Individualism, meritocracy and victim blaming, imbued within mainstream programs.

Perhaps it would be simplest to say, with respect to programs for Aboriginal peoples and alcohol abuse: the programs are misconceived, are irrelevant at best, and even if they worked, perpetuate a long-standing attack upon us. It is difficult to imagine anyone, working in the area or not, of Aboriginal origin or not, being pleased with my conclusions. It is even more difficult to imagine any interest in attending to the recommendations arising from my conclusions. Nevertheless, I will conclude by making them, rudimentary though they may be. As I see it, the logical extensions of my analyses collide in different ways with the ideologies I have examined, so I provide recommendations that depend on different positions within Canada's political economy.

## **Recommendations**

With respect to the Canadian governments, an authentic approach to modifying First Nations alcohol usage would require a fundamental restructuring of Canada. Treaties would have to be honoured; perpetrators of injustices would have to be tried and sentenced; land, resources and lives stolen would have to be compensated for and/or returned; in short, the capitalist political economy of Canada would largely have to be abolished, and everyone would bend his/her will to the reconstitution of Aboriginal forms of life.

This, of course, is not going to happen. Even piecemeal recommendations like broadening the range of intervention programs you are willing to support would not be entertained, since, at the most fundamental level, questioning Methodological Individualism amounts to questioning everything. If government is, as John Dewey said, “the shadow of big business cast over the population,” I cannot imagine the circumstances where government would voluntarily and willingly relinquish its ideological power.

With respect to academic and professional service providers I expect similar reactions. After all, being told that everything they think and everything they have done is more or less irrelevant and having to change themselves and their roles in their professions from the ground up, would be something they are well-motivated to avoid. However, unlike bureaucrats: academics and professionals have an ethical and disciplinary obligation to ensure they do research properly. Inconvenient data and analysis cannot be ignored or wished away; that is supposed to be the difference between science and superstition. So,

as long as the pretence of science is to be maintained, academics and professionals have an obligation to adhere to Oliver Cromwell's advice:

"Gentlemen, I beseech you, in the Bowels of Christ, think it possible you might be wrong."

With respect to indigenous peoples in general, I can only point out that forewarned is forearmed. The forces of mainstream society will continue to insist the problems are within us and it is us which needs fixing. However, it is important to understand this is not a fact but an ideology which exists to marginalize and defeat our nations and to marginalize and defeat its own mainstream citizenry. If First Nations peoples are going to learn the truth of their personal and collective circumstances, the ideologues of the oppressor are not acceptable sources of understanding.

Finally, I want to make a general point: the genocide of turning Aboriginal peoples into ordinary Canadians may be a material necessity under capitalism, but it is not an inevitability to be this way. The treaties establish our *legal* right to engage as we see fit in our own forms of life; our treatment by various designates of mainstream institutions establishes our *moral* right to do so. This is not a call to "live in tipis" as is often a rhetorical characterization by some critics. Rather, it is the assertion that things cannot be right again with us until we re-establish our forms of life and decide for ourselves whatever modifications we might wish to make in our modes of production and relations of production.

When we understand why alcohol is in our communities, and whose purpose it serves in doing what it does to us and to our individual and collective

**lives, we will not need anyone's help... we will get rid of it ourselves.**



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## **RESEARCH AND TEACHING EXPERIENCE**

2004 to Present *Teaching Instructor Apprentice*, St. Mary's UCEP, St. Thomas University, Fredericton, NB

Responsibilities: Conducting lectures; facilitating in-class assignments and preparing and conducting examinations for the material covered in class.

Summer 2004 *Research Associate*, Faculty of Native Studies, St. Thomas University, Fredericton, NB

Responsibilities: Evaluating the political, economic and ideological implications of Canadian policy as it pertains to First Nation, specifically in the areas of health delivery and Residential schooling. Organize and facilitate access to the department's audio/visual and text resources. Research and complete grant applications, co-authoring publications and publicly present research findings. Assist with daily operations and other administrative tasks.

2002 to 2003 *Research Associate/Teacher's Assistant*, Faculty of Native Studies, St. Thomas University, Fredericton, NB

Responsibilities: Analyzed federal and provincial policy pertaining to First Nation's health concerns, communicated research findings through publications and oral presentations, designed and delivered a First Nation's based race awareness workshop, and supported daily operations through program development and administration. As well, teaching several class sessions in Cultural psychology (NATI 3813) and Native Education and Colonization (NATI 3623). Compiled course materials, and graded term papers

Summer 2001 *Research Assistant*, Faculty of Native Studies, St. Thomas University, Fredericton, NB

Responsibilities: Library work, Archival Research, Data Base Management, and Editing published articles, and writing/contributing to published research articles on Indian Residential Schooling, precise research articles.

Summer 2000 *Research Assistant*, Faculty of Native Studies, St. Thomas University, Fredericton, NB

Responsibilities: Library Archival Research, Typing and Editing Published Works.

## WORKSHOPS CONDUCTED/ATTENDED

- 2005 Participated in the Ethics and Aboriginal Health Research Workshop organized by the Atlantic Aboriginal Health Research Program (May, 2005).
- 2005 Participated in the National Aboriginal Health Blueprint organized by the Union of New Brunswick Indians (July, 2005).
- 2003 Attended a weekend workshop organized by Native Women's Association of Canada titled *Indigenous Women's Gathering on Self-Determination*. January 17-19, 2003. The workshop consisted in developing strategies to educate indigenous women on governance issues.
- 2002 Wasacase, T. *A Materialist Perspective on Indigenous Culture, Education and Spirituality*. Paper presented to the 1<sup>st</sup> Indigenous Women Summit of the Americas held by the Indigenous Initiative for Peace (IIP) in coordination with the International Forum of Indigenous Women (IFIW), the Continental Network of Indigenous Women (CNIW) and with the support provided by the Women in Development unit of the Inter - American Development Bank (IADB). Oaxaca, Mexico, December 1 - 4, 2002.
- 2002 Attended a weekend workshop given by Bruce Levine, Ph.D and Roland Chrisjohn, Ph.D. and organized by the Chair in Native Studies and the Program in Native Studies. *Commonsense Rebellion: Debunking Psychiatry, Confronting Society, and Rehumanizing Our Lives*. The workshop covered issues of what psychiatry is not, and telling parents about ADD/ADHD and ritalin, FAE is not FAS and the difference, and why it is important. November 22-23, 2002
- 2002 *Malevolent Benevolence: Canada's health care policy and Indigenous Peoples*. Paper presented at conference by Andrea Smith held by the American Society of Law, Medicine and Ethics, UNAIDS, the World Health Organization, Francois-Xavier Bagnoud Centre for Health and Human Rights at Harvard School of Public Health, and Temple University Beasley School of Law, Philadelphia, PA. Smith, A., Chrisjohn, R., Nussey, L., Wasacase, T., Loiselle, P., Legault, M..
- 2001 *Racism, Indigenous People and Educational Testing*. Paper presented to Educational Psychology Seminar, Department of Education, St. Thomas University, Fredericton, NB. (With Smith, A., Nussey, L., Jury, S., and Legault, M.)

2000 Informational Seminar on Burnt Church Fishery (With Loiselle, P., Smith, A., Bourgeois, M., and Legault, M.)

2000 *Residential Schools: The past is present*. Conference co-ordinator, Department of Native Studies, St. Thomas University, Fredericton, NB

#### **PAPERS & PUBLICATIONS**

Wasacase, T., *The Empty Mirror: Western Theories of Identity and the Attack on Indigenous Peoples*. Dark Night Field Notes, an independent news/analysis electronic magazine.

Chrisjohn, R., Wasacase, T., Nussey, L., and Smith, A. *Genocide and Indian Residential Schooling: The past is present*. In Richard Wiggers (Ed.), *Canada and International and Humanitarian Law: Peacekeeping and war crimes in the modern era*. Halifax: Centre for Foreign Policy Studies, Dalhousie University Press.

Smith, A., Chrisjohn, R., Wasacase, T., Nussey, L., Loiselle, P., & Sullivan, T. (2001, Fall). *Malevolent Benevolence: Canada's health care policy of indigenous peoples*. Newsletter of the Native Psychologists of Canada.

Wasacase, T., & Stote, K. (October 2002). Produced The Mackinnon Lectures, a 4 part series lecture given by Dr. Roland Chrisjohn. Lecture One, *Do Unto Others: The Revelations of Indian Residential Schooling and the Ecclesiastical Counter* (October 2002). Lecture Two, *Salt without Savor: The Historic Mission Churches and Damage Control* (October 2002). Lecture Three, *Nations Shall Rise against Nations: The Ideological Basis of Residential Schooling and the Aftermath* (October 2002). Lecture Four, *Heal Thyself: What the Churches Could Have Done, and Still Might Do* (October 2002). National Broadcast, Fredericton, NB: CHSR 97.9FM.

Wasacase, T., Chrisjohn, R., Jury, S. (March 2001). *Racism and The World Conference Against Racism*. (National Broadcast), Fredericton, NB: CHSR 97.9FM.

Wasacase, T., Barnaby, T., Smith, A., (March 2001). *The Monopoly on Truth*. (Live Broadcast), Fredericton, NB: CHSR 97.9FM.

Wasacase, T., (May 2002). Interview with Andrea Smith on *Bearing the Burden of Proof: Theory and Practice in First Nations Suicidology*. (Live Broadcast), Fredericton, NB: CHSR 97.9FM.

Chrisjohn, R., Bourgoise, M., Legault, M., Loiselle, P., Nussey, L., Smith, A., Stote, K., & Wasacase, T. (in press). *Torment without End: Indigenous peoples and the Canadian form of racism*. (Working title). Penticton: Theytus Books