

MOVING BEYOND THE SIMPLE: ADDRESSING THE “MISUSE” OF THE FASD-GANG LINK IN PUBLIC DISCOURSE

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ABSTRACT

The processes of colonization have created specific images and spaces for Indigenous peoples in contemporary Canadian society. Many of these labels are negative, casting Indigenous peoples and communities as deviant. This is particularly true when discussing the issues of Fetal Alcohol Spectrum Disorder (FASD) and gangs. Research into this issue has focused, particularly in the prairie provinces, on Indigenous peoples and communities, creating a link between FASD individuals and street gang members. The problem with this link is that it maintains a control of Indigenous bodies, and seeks to explain street gang involvement through a biomedical interpretation of reality. As a result, social factors and health determinants, such as housing, food, belonging, etc. are ignored. This paper examines how media and researchers have accepted the link of FASD with gangs, constructing a continued colonial fear of Indigenous peoples. Using the biomedical explanation linking street gang involvement and FASD, communities can absolve themselves from responsibility for social factors of street gang involvement, and maintain the blame on Indigenous communities for their own actions of alcohol addiction.

Keywords: mental health, FASD, gangs, Indigenous youth, youth “at-risk,” colonialism

If everything is constantly moving and changing then one has to look at the whole to begin to see patterns. Leroy Little Bear (2000)

INTRODUCTION

In the spring of 2010, I was forwarded an article from a major Canadian newspaper in which the journalist asked researchers and community social workers to comment on the effects and links between Fetal Alcohol Spectrum Disorder (FASD) and gangs (Kelley, 2010). The article focused on how Indigenous children were more likely to join street gangs, not because of their low economic or other positions of marginality, but because they are affected by FASD. The article asserts that Indigenous youth are lured into gangs because they do not have the ability to distinguish right from wrong, are easily influenced or manipulated by others, and the structure of gang organizations grounds FASD youth to a routine.¹

At first read, this article appears to alert its readers to the importance and need for support programming for FASD youth so that they do not become the pawns of street gangs. However, upon a closer examination it is obvious that the author is not creating a space for the discussion of FASD youth and gangs, but playing on the preconceived colonial fears of Indigenous peoples:

If we don't get engaged in a solution for this issue, we are creating a nightmare, because we do know 60 per cent of the Indigenous populations is under

¹ It must be noted here that street gangs are not considered to be structured organizations, but fluid in nature allowing people to come and go, albeit not without some repercussion. Few street gangs are considered such organized structures that individuals affected by FASD would be able to flourish there. See Chettleburgh 2007; Mellor et al., 2005 for more information on street gang structures in Canada.

25.... This is ... a demographic tsunami facing Canada. (Kelley, 2010)

Kelley (2010) pushes the notion that if we do not act fast, as responsible Canadian citizens, to address the FASD-gang link then Canadian society will be in disarray. Therefore, Canadian citizens are in danger from violent Indigenous individuals who, unable to differentiate right from wrong, are manipulated by criminal street organizations for control of illegal economies. In essence this article does nothing more than continue a culture of fear (Giroux, 2003; Glasser, 1999) directed towards youth (Schissel, 1997; Wotherspoon and Schissel, 2001) and particularly Indigenous peoples (Warry, 2007).

This paper is a discussion of how public media have begun to link FASD to Indigenous youth street gang involvement, and how this linkage perpetuates the negative labelling of Indigenous peoples in Canada through the stereotypical “drunken/savage Indian” lens (Browne et al., 2005; LaRocque, 2010; Tait, 2009; Thatcher, 2004). I will focus my attention on the “culture of fear” and the role of media; the role of biomedicine in the street gang construction; and why a critical anthropological lens is needed to create a “thick” (Geertz, 1973) descriptive analysis to disrupt the commonly held ideological underpinnings of FASD and gangs. In particular, I focus on Dr. Mark Totten’s analysis of the FASD-gang link in Indigenous communities, which does not address the underlying issues drawing particular Indigenous youth into a gang lifestyle. My intent is not to totally dismiss the issues of FASD in Indigenous communities, but to advocate for thorough research before making this connection a focal point in the issue of Indigenous street gangs. A brief history of FASD and Indigenous street gangs will be undertaken to position the concepts within a broader discourse.

AN INTRODUCTION TO THE CONSTRUCTION OF FASD AND GANGS

Fetal alcohol disorder (FAD), fetal alcohol effects (FAE), and alcohol-related birth defects (ARBD) have been used to create a spectrum of categories for individuals affected by the consumption of

alcohol while in utero. Today the term Fetal Alcohol Spectrum Disorder, more commonly addressed as FASD, is the umbrella term for the range of birth defects related to maternal alcohol consumption while pregnant (Totten, 2009a, p. 5).

There is an historical association between alcohol and its effects on the unborn child.

In ancient Carthage, there was a ritual forbidding the drinking of wine by the bridal couple so that defective children would not be conceived; Aristotle stated that ‘Foolish, drunken and hare-brained women most often bring forth children like unto themselves, morose and languid.’ (Page, 2001, p. 22)

Even though connections were made between alcohol consumption, pregnancy, and deviant children for hundreds of years, it was not until the 1970s that the issue of pregnancy and alcohol consumption became a popular topic within the health science community. Prior to the 1970s, most research on fetal effects focused on smoking and illicit drug use (Tait, 2001). In the 1970s, research began to focus on the harmful effects of maternal alcohol consumption while pregnant (Tait, 2001). It was during this shift that American medical professionals began to notice a plethora of Native American infants, children, and youth who were diagnosed with similar physical and cognitive impairments (Pauley, 1992; Tait, 2001, p. 96). These impairments were seen to be related to the increase in noted alcohol abuse, which was occurring in Native American communities in the United States.

In Canada, much of the data, statistics, and literature has been gathered from American research on FASD (Tait, 2001; Totten, 2009a). There have been a handful of studies on FASD conducted in Canada, primarily in Indigenous communities in western Canada (Bray and Anderson, 1989; Tait, 2009). Through this data, the Canadian government has estimated that there are approximately 300,000 Canadians living in Canada with some form of FASD, and that 9.1 out of 1000 live births show symptoms of FASD (Sampson et al., 1997). In comparison, these studies have estimated that anywhere from 7.2–190 per 1000 live births of Indigenous children show some forms of FASD (Totten, 2009a; Williams et al.,

1999). With such a disparity in research, it is difficult to accurately assess the impact among individuals born with FASD across communities. Instead, the high numbers in selected studies become associated to specific communities as blanket statements to help explain deviance and social issues.

Since FASD is a spectrum disorder, there are a multitude of characteristics that medical and non-medical professionals use to determine if a child has been affected by alcohol while in utero. The most common visual identifiers of FASD-affected individuals are the facial features, which include: thin upper lip, flat mid face, short separation between upper and lower eyelids, flat upper lip, and small wide-set eyes (Tait, 2003, p. 65). Since these features are also common in different cultural groups, diagnosis by physical features must be associated with other cognitive impairments.

Kathryn Page (2001) has noted that there are some core cognitive and emotional impairments that occur with great frequency in diagnosed FASD individuals. These attributes include: cognitive limitations (lower IQ, difficulty with concrete data, and inflexible thinking), interpersonal impairments (inability to understand social cues, lack of empathy or bonding, difficulty in distinguishing reality from fiction), limited executive functioning (difficulties with impulse, control, planning, judgement, focus), emotional instability (inability to recognize or show feelings, rage disorders, violent mood disorders, vulnerability to mental disorders), increased physical impairments (allergies, heart and kidney problems, increase in seizures), and speech or language delays (superficial fluency, talkativeness, parroting others) (Page, 2001, p. 23). Here again, there are many problems in an FASD diagnosis, because the attributes are also common in other mental health issues such as Oppositional Defiance Disorder (ODD), Attention Deficit Disorder (ADD), and Attention Deficit Hyperactivity Disorder (ADHD) (Page, 2001; Vaurio et al., 2008).

With such an array of physical, cognitive, and emotional impairments associated with FASD, its diagnosis or nondiagnosis can be questioned, particularly if one segment of a population is continuously diagnosed with having it, while other popula-

tion segments are not. Because of this, some doctors and researchers have now become hesitant to identify and accept the number of individuals affected by FASD by previous studies.

Although a single dose of alcohol has been shown to reduce cell adhesion during the period of exposure, there is no evidence that even high doses are universally destructive to the growing brain. Other factors in combination with alcohol have been demonstrated to make such damage more likely: tobacco, poor nutrition, stress, poverty, and other drugs. (Page, 2001, p. 23)

For an individual to be diagnosed as FASD, confirmation of alcohol consumption by the mother during pregnancy must be obtained along with the identification of one or more facial anomalies, evidence of growth retardation, and evidence of at least one of the neurodevelopment abnormalities (Tait, 2003, p. 71). Although all four identifiers are needed to fully diagnose an individual, the confirmation of maternal consumption of alcohol is seldom available (Tait, 2001, 2003; Totten, 2009a). Thus, the maternal confirmation is ignored and individuals are diagnosed based on these broadly constructed criteria. This results in individuals diagnosed with FASD based as much on their race and socioeconomic positions, as the symptoms displayed. These perceptions of who is affected by FASD then become the primary links that some researchers use to associate street gangs, FASD, and Indigenous communities (Chatterjee, 2006; Totten, 2009a, 2009b, 2012).

An example can be found in Micheal Chettleburgh (2007), who expresses the need for more program support for mental health services for youth due to the high rates of ADHD. He makes no connection to race, generalizing ADHD as something that affects all individuals. However, when he discusses briefly the impacts of FASD he links them explicitly to First Nations peoples, where

an estimated 1 percent of Canadians are living with the syndrome, or more than 300,000, many of who are from First Nations communities — which also happen to be challenged by street-gang issues. (Chettleburgh, 2007, p. 222)

Chettleburgh cites only one FASD study (Robinson et al., 1987), over twenty years old and focussing on one

isolated Aboriginal community in British Columbia. On the basis of this one study, Chettleburgh assigns FASD primarily to Indigenous peoples, without mentioning the rest of society. This narrows the ways in which programming is created to discourage Indigenous youth from joining street gangs. To further understand how FASD and street gangs can be linked to Indigenous youth and communities, a discussion of the history of the construction of street gangs in North America is needed.

A BRIEF HISTORY OF STREET GANGS AND THE CONNECTION TO INDIGENOUS PEOPLES OF SASKATCHEWAN

Street gangs have been a part of North American society since the early part of the 1800s (Delaney, 2006). The individuals involved with street gangs have been constructed as deviant, criminal, and “othered” by the dominant society. These individuals and groups primarily consist of those residing in low socio-economic and racialized neighbourhoods (Delaney, 2006; Klein and Maxson, 2006). Vigil and Yun (2002, p. 65) explain that street gangs are:

The result of complex processes that stem from the multiple levels and forces over a long period of time. Macrohistorical and macrostructural forces lead to economic insecurity and lack of opportunity, fragmented social control institutions, poverty, and psychological and emotional barriers in broad segments of ethnic communities....

Individuals then form specific groups under common names, colours, and identities to achieve the common group goal of survival against a social system set up to exclude them. To gather the means to survive, many of the earlier street gangs focused their attention on acquiring materials through illegal activities such as theft and racketeering (Delaney, 2006).

The first groups of marginalized individuals to occupy this space in North America were the orphaned Irish youth who immigrated to North America in the early part of the 19th century. These Irish youth had to band together to survive in a new hostile social environment that was set up to ex-

clude the Irish from “legal” economic opportunities. Irish immigrants were forced to live in specific communities and could only obtain low-paying manual labour positions because of their socially constructed positions (Roediger, 1991). From these early Irish street gangs grew some of the characteristics that we see with urban street gangs today, such as: specific identifying colours, names or symbols, a protection of turf, and engagement in specific “illegal” activities to gain material assets (Chettleburgh, 2007; Delaney, 2006; Henry, 2009; Klein and Maxson, 2006).

As migration and colonization spread across North America, different groups of individuals began to occupy the spaces previously delegated to Irish youth. After the abolishment of slavery, free blacks moved to northern cities such as Chicago and Milwaukee to escape persecution, Jim Crow laws, and to participate in economic opportunities (Delaney, 2006). A second migration occurred in California where Latino immigrant workers moved northward. In both cases, the migrant groups were limited to low-paying manual labour opportunities and segregated living arrangements controlled by those in dominant social positions (Delaney, 2006). Due to the racism and classism exhibited against African, Mexican, and Latin American peoples, many of the youth formed groups to protect themselves and their communities from the encroachment of the dominant society. Over time, much of the aggression and attitudes, directed towards the dominant white society by these groups, was internalized and directed towards other ethnic gangs, as well as gangs of the same race (Klein and Maxson, 2006).

Indigenous peoples throughout Canada have endured generations of colonial policies limiting the social spaces in which they have been able to participate with dominant Euro-Canadian society. Through specific policies of removal and control (the creation of reserves, the *Indian Act*, residential schools, etc.), Indigenous bodies have been controlled by non-Indigenous governments and told where to live, who is to be considered as Indigenous, and what one can do. The multicultural rhetoric of Canada (LaRocque, 2010; Lawrence and Dua, 2011; St. Denis, 2011) continues to support this erasure of Indigenous peoples and their issues. Indigenous

peoples are seen as the same as other ethnic minorities; therefore, the impacts of colonization are seen as something of the past and not active in today's social systems. The continuing socioeconomic and health impacts colonization can be ignored through the multicultural gaze because it allows non-Indigenous peoples to disregard the limited opportunities that Indigenous peoples have faced in economics (Carter, 1995), education (Van Ingen and Halas, 2006), and health care (Waldram et al., 2006). These spaces of inequality for Indigenous peoples are maintained through neocolonial ideologies which today see greater numbers of Indigenous youth removed from their families through the Child Welfare System (Tait and Cuthand, 2011), increased incarceration in both the provincial and federal correctional systems, and greater health disparities, primarily caused by the lack of access to equivalent education and economic opportunities (Calverley et al., 2010). These social inequities help to maintain specific spaces for Indigenous street gangs to form as a survival technique in a society which excludes them from many different social areas (Razack, 2002), similar to the early 19th century Irish youth gangs of New York.

Indigenous peoples are overrepresented at all levels of the justice system, from youth to adult, in child welfare systems (McKay et al., 2009; McKenzie and Kufeldt, 2011; Sinha et al., 2011; Tait et al., forthcoming), rates of suicide, drug and alcohol abuse, and other mental health issues, leaving many Indigenous youth at risk of gang recruitment (Chettleburgh, 2007; LaBoucane-Benson and Grekul, 2006; Totten, 2009a, 2009b, 2012). The historical trauma caused by colonization policies and their effects has left many Indigenous youth searching for a sense of identity, belonging, and acceptance. These social factors also make Indigenous youth more apt to be stopped, searched, labelled, and identified as gang members by justice officials, than other youth in the prairie provinces. Gangs and the street lifestyle are able to grab hold of Indigenous youth because they lack the economic and social supports to pull them out (Vigil, 2002). In 2006, Pattie LaBoucane-Benson and Jana Grekul investigated the ways in which Indigenous gangs recruited and formed their

presence in Western Canada, focusing particularly around Edmonton, Alberta. From their research, they explain that even the term gang is fluid, and that the structured groups that most Indigenous youth find themselves in are less organized, have less education, and are primarily economically disadvantaged compared to other organized crime syndicates (p. 16).

Although street gangs have a deep history in other parts of North America, in the prairie provinces, and in particular Saskatchewan, they are considered a recent phenomenon. Nevertheless, they have garnered much media attention (Criminal Intelligence Services Saskatchewan [CISS], 2005; Henry, 2009). Justice officials support the notion that street gangs did not create roots in Saskatchewan communities until later in the 1990s, when gang leaders were moved to Saskatchewan after riots at Stoney Mountain Penitentiary in Manitoba (CISS, 2005). At the time of the riots, the policies and procedures for convicted street gang members had been to house all Indigenous street gang members at the Stoney Mountain Penitentiary to control their movements and influence. After the riot, justice officials hastily relocated many of the individuals in an effort to suppress specific gangs and prevent their members from retaliating against rival gang members (CISS, 2005). This policy had a dramatic negative effect: gang leaders and members were able to use what they had learned at Stoney Mountain and recruit new impressionable inmates who were looking for a sense of belonging and acceptance.

As with FASD, street gangs, on the prairies specifically, have been subjectively defined as a social issue located only in lower socioeconomic Indigenous communities. This has helped maintain a culture of fear directed towards Indigenous peoples in public media discourse, particularly in the prairie provinces of Canada.² In Saskatchewan, the statistics of

2 Because the focus of the paper referenced Indigenous gangs, this paper has reflected that connection between FASD and street gangs. This is not to diminish the racialization of other ethnic minorities in communities across Canada seen as street gang members. Rather, other ethnic minorities, such as Asian or Jamaican youth are not connected or linked in literature or public media to FASD. As stated, the 2002 study asked participants to ignore biker gangs, prison gangs, and hate or ideology groups. These groups are primarily constructed of Caucasian youth, and therefore ethnic minority groups could be categorized as street gangs with greater ease. This admission goes to show the complexities of gang definitions, because gangs and their constructions differ not only from country to country but also from community to community in the same country.

individuals associated with or active members of a gang are staggering. There are an estimated 1315 gang members in Saskatchewan, with Saskatoon second in the country at 2.57 per 1000 youth active in gangs and gang activities (Astwood Strategy Corporation, 2004; Chettleburgh, 2007; Totten, 2009a). The data for this study were collected from the First National Survey on Youth Gangs (Astwood Strategy Corporation, 2004), which asked responsible adults in the community who work with youth to identify those who they believe to be or are considered youth gang members (Chettleburgh, 2007).

As with FASD, street gangs and their activities can be placed on a spectrum in relation to their behaviours (LaBoucane-Benson and Grekul, 2006; Mellor et al., 2005). This spectrum allows researchers, policy makers, and criminal justice officials to distinguish among groups of deviant youth, street gangs, and other organized criminal groups. In Canada, gangs are defined legally as those groups that are:

Composed of three or more persons in or outside Canada; and has as one of its main purposes or activities the facilitation or commission of one or more serious offences that, if committed, would likely result in the direct or indirect receipt of a material benefit, including a financial benefit, by the group or by any of the persons who constitute the group. (Jones et al., 2004)

Along with this definition from the Canadian Penal Code, gangs are also defined by communities as those groups of individuals who are identifiable by the general public (through clothing, tattoos, tags, name, or jewellery), have a hierarchy of command (generals, soldiers, associates), are profit driven (crimes include drug trafficking, prostitution, thefts, vandalism), and occupy a territory within a community (Mellor et al., 2005). These characteristics allow for much discretion by law enforcement, justice officials, policy makers, and researchers to determine who is considered a gang member. What also must be noted is that street gangs are unlikely to be associated with hate groups (Klu Klux Klan or Aryan Brotherhood), biker gangs (Hells Angels or Bandidos), or Mafia-type organizations in national gang surveys (Astwood Strategy Corporation, 2004; Klein and Maxson, 2006). These organizations con-

sist primarily of all-white membership, and therefore many white youth and their groups are disassociated from street gangs leaving the race and class construction of street gangs as nonwhite and living in poverty (Henry, 2009). The colonial discourse of protecting society from the “violent Other” is maintained in specific discourse surrounding who is and who is not a gang member, and this discourse of fear can be used to control access to particular social spaces in Canadian society.

THE BIOMEDICAL EMBRACE — HOW TO CREATE AND MAINTAIN CULTURES OF FEAR

Since contact, the image of Indigenous peoples has been used to strike fear into the collective minds of western Europeans to maintain specific practices of colonization (Thobani, 2007). One of the ways in which this fear has maintained its control over time has been through the colonial writing of the “other” through a strictly western European lens. Emma La Rocque (2010) suggests that descriptive written images of Indigenous peoples have been used to further the colonization of the Americas. Joyce Green (1997, pp. 25–26) argues that colonial writing has been

legitimised not only through racist construction but through creation of language celebrating colonial identities while constructing the colonised as the antithesis of human decency and development.

This construction of European superiority has led to a civilized/savage (civ/sav) dichotomy which locates the white, western European body as the pinnacle in the hierarchy of social power and all others as progressing to this evolutionary development (Deloria, 1969; LaRocque, 2010; for a global context see also Memmi, 1965; Said, 1978). Those in positions of social dominance have the power to define who is and who is not civilized (Memmi, 1965), and use their social positioning to create a culture of fear to marginalize those different from themselves (Johnson, 1997). How has this culture of fear been created towards Indigenous peoples, and how has biomed-

cine aided in the construction of whose body is to be feared?

Historically, many cultures have constructed different and distinct types of bodies that are favoured, in order to represent and produce the dominant characteristics of that cultural group. Lock and Scheper-Hughes (1996, p. 41) describe how medical anthropology aids in understanding how the body plays in health, illness, and social hierarchies through its social representation:

... medical anthropology's engagement with the body in context that represents this subdiscipline's unique vision as distinct from classical social anthropology (where the body was largely absent) and from physical anthropology and the biomedical sciences (where the body is made into a universal object).

The three ways in which physical bodies are represented in cultures around the globe include the individual body/self, the social body, and the body politic (Lock and Scheper-Hughes, 1996). Although all three bodies are important in understanding how cultures of fear are constructed and maintained, it is the body politic that has the greatest influence in the deconstruction and critical analysis of biomedicine's role in creating cultures of fear.

Lock and Scheper-Hughes explain that the relationship between bodies is more than just individual or based on metaphors, and that the value of bodies is constructed on power and control (1996, p. 61; Foucault, 1978; Rabinow and Rose, 2006). With the control of bodies based in dominant social consciousness, those who have been colonized are marginalized from positions of power and authority in their own communities. Foucault (1978) describes the power to move collective bodies to the margin as “biopower,” where dominant groups define which bodies have value over others. Foucault maintains that biomedicine has the power to remove bodies from political discourse and place them in “scientific neutral” discourses where the social becomes irrelevant (1978; Rabinow and Rose, 2006). This placement of specific bodies in scientific discourses has been used to describe traditional roles of men and women and the creation of white superiority during the age of “enlightenment” (Castagna and Dei,

2000). These discourses and ideologies maintain their positions of dominance even today where discussions of oppression and stereotypes are understood based on biological traits constructed over time as “common sense.”

A review of the social construction of “race” helps to explain how the biomedical embrace has shaped societal understandings of racial hegemony and categorization, from “enlightenment” to today's “common sense” understanding of racial differences (Omi and Winant, 1986). The categorization of cultures and races through biomedicine created a hierarchy of peoples where the “white, middle class, Anglo Saxon, Protestant, male” was seen as the most civilized and advanced, and all other peoples were less human or even “subhuman” (Castagna and Dei, 2000; Omi and Winant, 1986). Biomedicine was used as a way to explain and confirm this newfound hierarchy of racial superiority through the use of craniometry (Gould, 1981). Craniometry was a piece of biomedical technology that claimed to scientifically prove that those most different from the Western body (African peoples) were less than human because their cranial shapes meant less developed brains (Gould, 1981). One issue with these early classifications was that skulls that did not match the theory of evolution and social hierarchy, were disregarded (Gould, 1981). Many specific social characteristics such as savage, immoral, evil, and criminal were created and applied to those cultural and racial groups who shared similar cranial characteristics, to support their social positions of inferiority (Castagna and Dei, 2000). Through the creation of the “race” concept, biomedicine, and its authority in Western society as an objective science, has validated the policies and practices of colonization in some countries, constructing a “culture of fear” against those whose bodies were not considered “white” or part of the dominant culture.

Fear is a powerful human emotion. On an individual level, fear can help protect an individual from a dangerous situation. However, fear is also debilitating in the sense that phobias can limit individual experiences in daily life (Glassner, 1999; Zerubavel, 2006). Fear can also be used to control individual perceptions of reality and social issues (Johnson,

1997). This form of fear is how media, governments, and organizations determine who is or is not to be trusted. Zerubavel (2006, pp. 56–57) explains how social fear and control manifest from a micro to a macro level:

... one is thus surrounded by a group of people who are obviously all participating in one and the same conspiracy. Furthermore, moving from two- to three-person, let alone wider ... involves a significant shift from a strictly interpersonal kind of social pressure to the collective kind we call group pressure, whereby breaking the silence actually violates not only some individuals' personal sense of comfort, but collectively sacred social taboo, thereby evoking a heightened sense of fear.

Fear has the ability to construct ideologies and stereotypes of different peoples, framing one's construction of reality in ways that place specific bodies to the margins. Marginalization of these bodies allows dominant social groups to control the movements of those different from the norm. Through the creation of specific communities to be "feared," people in and outside the community learn that the feared community must not be entered because it is home to those individuals who have been constructed socially as evil, deviant, or less civilized than us (Razack, 1998, 2002).

Henry Giroux (2003) describes how cultures of fear have also created spaces for economic development for those with social power in the community. He explains how American culture has used the issue of terrorism to marginalize specific cultures and groups of people in American society. Through terrorism, politics controls public perceptions. It is a tool of propaganda to incite fear into the security and life of American people:

Moreover, such rhetoric is often used to redefine the delicate balance of freedom and security crucial to any democratic society, and it carries with it an enormous sense of urgency that often redefines community against its most democratic possibilities and realized forms. (Giroux, 2003, p. 5)

This fear then fuels the need for the North American public to continue to support the "war on terror," while at the same time ignoring the social politics and divisions it has created:

Rising from the ashes of impoverishment, human suffering, and religious fundamentalism, terrorism, at its worst, evokes a culture of fear, unquestioning loyalty, and a military definition of security from those who treat it as a pathology rather than as a politics. (Giroux, 2003, p. 5)

Paul Farmer (2003, p. 444) supports Giroux's position:

the call to a unifying nationalism across lines of race and gender often leads to a struggle for the advancement of one group at the expense of others.

Effective propaganda creates a reality in which individuals are influenced as to who is an ally and who is to be feared based on whose body holds greater social and political positions in a community.

Biomedicine's power in the construction of the oppressor/ally and civilized/savage dichotomies comes from its position as an objective science which is not influenced by the subjective (DelVecchio-Good, 2007; Farmer, 2003; Garcia, 2009; Kleinman, 1973). The notion of biomedicine as an objective science was constructed from the Cartesian theory that to understand illness or sickness of an individual, separation from head and body must occur.

This separation of mind and body, the so called Cartesian dualism, freed biology to pursue the kind of radically materialist thinking expressed by the medical student, an approach that has permitted the development of the natural and clinical sciences as we know them today. (Lock and Schepher-Hughes, 1996, p. 47)

From this perspective, individuals can lay claims and reinforce social ideologies from a "scientific objective" position in a manner that constructs them as truth.

The multiple truths constructed through biomedicine have created a system of understanding health that places biology at the centre of power and understanding. Biopolitics shifts the focus of health and illness onto entire populations as biological and political issues (James, 2004, p. 498). From this dominating position, explanations of health inequalities can focus on health outcomes, rather than health precursors.

Cultural representations authorized by a moral community and its institutions, especially one

as powerful as biomedicine, elaborates certain modes of suffering while downplaying or ignoring others. (Kleinman and Kleinman, 1997, p. 2)

Thus, biomedical explanations of social phenomena have the ability to remove individuals and their issues from a social context of inequality or dominant positions of privilege. This removal reinforces dominant hegemonic thinking and partly explains why particular groups of people are continually labelled as deviant, unhealthy, and occupy other marginal spaces in society.

DISCUSSION

THE FASD/GANG LINK

I have shown how biomedicine, biopolitics, and biopower are used to create cultures of fear that marginalize and label specific groups of people. I began with a historical description of FASD and gangs to create a foundation of the issues prior to undertaking the critical analysis of biomedicine and its role in creating cultures of fear in dominant Western thought. James (2004, p. 498) states, “power has become politics.” It is therefore important to understand how biopolitics and biomedicine have affected the social perceptions of FASD and gangs, a connection which has been specifically ignored, until now.

Public media have reported that FASD individuals pose a threat to the majority of society because they are easily manipulated by others, and thus are easy prey for gangs (Blatchford, 2011; Kelley, 2010). With a lifestyle of violence surrounding gangs and the unpredictability of FASD individuals, linking the two helps to explain the heightened violence in particular communities, and has the potential to carry over into other neighbourhoods where anyone can be a victim to gang violence (Ayed, 2001; Blatchford, 2011; Kelley, 2010; Totten, 2009; Zakreski, 1998), thus labelling specific youth as violent street gang members without due cause (Henry, 2009; LaBoucane-Benson and Grekul, 2006). There are many problems with creating this link between FASD and Indigenous street gangs. First, there is little to no research conducted on the link between FASD and street gangs. Even Totten (2009a, 2009b, 2012), who proposes a direct link between FASD individuals and gangs, has

no evidence to support his position. Rather, he uses information gathered from prison studies and hypothesizes that because individuals with FASD lack necessary social skills to make decisions, they are more susceptible to gang involvement. Although this seems like a reasonable connection it lacks extensive support. Nevertheless, Totten’s linkage has been incorporated into mainstream ideology through its media sources, perpetuating not only the unsupported claim that Indigenous youth are more likely to be gang members, but that Indigenous women who drink while pregnant are the primary reason for heightened street gang violence within Indigenous communities.

In his work, Totten falls victim to the social constructions that have aided in the misdiagnosis of Indigenous youth. He restricts his diagnosis to particular facial features common in those affected with FASD, without any other confirmation: “many of these youth [participants] have the facial features of FASD” (2009a, p. 12). Thus, the individuals in the programs where he collected his data were diagnosed as FASD only through facial features, which are highly subjective and open to error. The labelling of FASD for those individuals with certain facial characteristics maintains

... a type of informal labelling by community workers [where] the majority of individuals who are labelled FAS are of Indigenous heritage. This points to a situation whereby in practice a medical diagnosis becomes ‘known’ and ‘applied’ to individuals first in non-medical settings by non-medical community workers who are more likely to see ‘high risk’ individuals. (Tait, 2001, p. 103)

Instead of creating a solid link between FASD and gangs, Totten continues to construct Indigenous youth as those bodies to be labelled by society as FASD and/or gang members without evidence or careful diagnosis by those with proper training. This leads to the second issue in linking FASD and gangs, and that is the social construction and application of the labels to be used predominantly in Indigenous communities.

The social construction of FASD and gangs are two issues that are continually linked to Indigenous peoples and communities, particularly in western

Canada. Although current research has shown that non-Indigenous women often consume more alcohol prior to and during their pregnancy (Chasnoff et al., 2008), FASD is still constructed as an Indigenous issue in public discourse (Ayed, 2001; Kelley, 2010; Zakreski, 1998). The public media then maintain a culture of fear based on these discourses towards Indigenous peoples, constructed for the purpose of colonization and continued today (Freng, 2007).

The assumption is that because Canada is a society that upholds the ideals of a liberal democracy, it cannot possibly be racist. The denial of racism is so habitual in the media that to even make allegation of the bias and discrimination and raise the possibility of its influence on social outcomes becomes a serious social infraction. (Warry, 2007, p. 72)

Through the media's (mis)representation of FASD and gangs, Indigenous women are constructed as the producers of a volatile and deviant population because of their socially constructed relationships to alcohol usage. This maintains the colonial discourse that Indigenous women are unfit to care for their children, and therefore specific policies can be created to remove children from their care, i.e., residential schools and today's child welfare system.

Totten creates a third issue, by giving preference to a biomedical diagnosis and linkage to street gang involvement while ignoring specific social factors of gang formation. A biomedical diagnosis shifts the focus away from social determinants of inequality and opportunities, and removes non-Indigenous communities and neighbourhoods from a connection to gangs, erasing their role in creating spaces for gang involvement. The biomedical diagnosis then places the focus of gang involvement primarily on individuals, families, and communities because of their race, class, and connection to FASD. Gangs and FASD become Indigenous-only issues, and the broader community can ignore them. This perspective permits Canadian society to disregard the intergenerational traumas and mental health issues associated with the lasting effects of residential schools, the 60s scoop, and the child welfare system today, where children continue to be removed from their

families at alarming rates (McKay et al., 2009; Sinha et al., 2011). The impacts of these contemporary and historical traumas, as well as specific social health determinants such as housing, economic opportunities, and health disparities should be the focus. Linking these to street gang involvement is necessary if effective prevention and intervention programming is to be created.

CONCLUSION

The issues of FASD and Indigenous street gangs are complex. There are many factors to be considered when attempting to link these two social issues. Rather than constructing the linkage in and around deviance, communities and researchers need to take a step back and look at how such a linkage ignores social factors with a greater impact on the growing issue of Indigenous street gangs. The biomedical embrace also allows society to place Indigenous youth as violent and uncontrollable, ignoring the fact that these individuals are also brothers, cousins, sisters, mothers, fathers, and members of a larger community and social network.

To understand how FASD and street gangs are linked in the health literature, a critical medical anthropological approach should be utilized. This approach would give researchers the space necessary to address specific social issues and the linkages to health, without creating a system of fear and control. While Totten may correctly identify overlapping issues in the apparent linkage between FASD and Indigenous street gangs, without a critical perspective these are nothing more than a neocolonial attempt to maintain the control and fear of Indigenous peoples in Canada through the use of perceived biomedical objectivity. A critical approach would help to uncover linkages between FASD and Indigenous street gangs where the "social inequalities and power are [seen as the] primary determinants of health and health care" (Baer et al., 2003), specifically in marginalized communities. This perspective would then support the shift of Indigenous street gang formation and FASD from an individual health issue to that of a community health discourse.

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