Suicides and Homicides Among Indians

MICHAEL OGDEN, M.D., M.P.H., MOZART I. SPECTOR, B.A., and CHARLES A. HILL, Jr., M.A.S.

THE purpose of this paper is to compare suicide and homicide statistics for American Indians with those for the general U.S. population. The Indian Health Service (IHS) is responsible for providing comprehensive health services to about 400,000 Indians, Aleuts, and Eskimos residing in 24 Federal Reservation States, primarily west of the Mississippi. Another 150,000 Indians in those 24 States are not provided services by the Indian Health Service, mainly because they live off the reservations and long distances from IHS facilities.

With the exception of table 3 and the discussion related to it, all references in this paper to "Indians" mean the total estimate of 550,000 Indians, Aleuts, and Eskimos in those 24 States. Table 3, in which the vital events are presented by sex, is based on the total Indian population in all 50 States, including Aleuts and Eskimos beginning with 1964. This total population was estimated at 630,000 in 1967.

The sources of the statistics on Indians are tabulations derived from data furnished to the Indian Health Service by the Vital Statistics Division of the National Center for Health Statistics, Public Health Service. Figures for the United States were derived from data appearing in Vital Statistics of the United States, published annually by the National Center for Health Statistics.

Indian deaths from suicide and homicide in 1967 rose substantially over the numbers in past years, pushing these two causes into the leading 10. Suicide was the 10th leading cause of death in 1967, up from 13th in each of the previous 8 years. Homicide moved up to eighth from 11th or 12th during the previous 8 years. The 13 leading causes of Indian death in 1967, in order, were accidents; diseases of the heart; malignant neoplasms; influenza and pneumonia, except of the newborn; certain diseases of early infancy; vascular lesions affecting the central nervous system; cirrhosis of the liver; homicide; diabetes mellitus; suicide; tuberculosis, all forms; gastritis, duodenitis, enteritis, and colitis, except diarrhea of the newborn; and congenital malformations.

Suicides

Until 1967, Indian crude suicide rates were only slightly higher than those for all races, ranging from 1 to 1.2 times as high (table 1). In 1967 the ratio was 1.6. Age-adjusted rates place Indians higher relative to the general population, averaging about 1.5 times as high before 1967 and about twice as high in 1967. The 94 Indian suicides in 1967 were more than half again as many as the annual average of 60 from 1959 through 1966. It must be recognized that fluctuations from year to year are expected because of the relatively small numbers involved, but so sharp an increase in suicides had not occurred before.

Suicide rates by age (table 2 and fig. 1) indi-

Dr. Ogden is director, Indian Health Service Medical Center, Public Health Service, Gallup, N. Mex. Mr. Spector is chief, and Mr. Hill is a statistician, Program Analysis and Statistics Branch, Office of Program Planning and Evaluation, Indian Health Service, Health Services and Mental Health Administration, Public Health Service.

cate that Indian rates are greater than all races rates up to age 45 but less thereafter. Whereas the rates for all races are highest at the older adult ages, rates for Indians peak in the young-to-middle adult years, at levels two to four times as high as the corresponding age-specific rates for the general population. In recent years there has been a tendency for rates for all races to increase at ages under 45 and decrease over 45. There appears to be no similarly well-defined trend among Indians.

Far more males than females commit suicide (table 3). About 83 percent of all Indian suicides in the United States from 1959 through 1966 were males, compared with 74 percent for the overall population. There appears to be a slight decreasing tendency in the male suicide percentage in both population groups.

Homicides

Homicides reached new highs in 1967 for Indians and also for the general population (table 4). Crude homicide death rates for Indians have consistently been about three times as high as rates for all races, and age-adjusted rates have been 3.5 to 4.1 times as high. While Indian rates have fluctuated from year to year, U.S. rates have increased rather steadily, with a particularly large rise in 1967.

Both the general population and Indians show similar patterns in the age-specific rates of homicides, reaching high points in the young-to-middle adult years (table 5 and figure 2). Over the period 1960–66, homicide death rates increased in nearly every age group for both population groups. Approximately three-fourths of all homicide deaths from 1959 through 1966 were males, there being little difference between Indians and the general population in this respect (table 3).

Factors Related to Suicides

In analyzing the epidemiology of suicides in any population, Indian or general, it is worthwhile to remember that suicide (or for that matter attempted suicide) when considered as a disease, is greatly under-reported. Cultural, religious, and moral taboos against taking or attempting to take one's own life are such that grieving relatives and sympathetic physicians are reluctant to brand the patient with a diagnosis of suicide. A review of news reports of deaths of prominent people quickly indicates that under reporting of suicides is not confined to the Indian population.

Another fact in the under-reporting of suicides and suicide attempts is the increasing use of the automobile as the suicide weapon. What percentage of fatal automobile accidents results from attempts of suicide? What percentage from unconscious death wishes?

Table 1. Suicide deaths and rates per 100,000 population for Indians, Aleuts, and Eskimos in 24 Reservation States and for United States, all races, 1959–67

Year	Number		Rates [1] and their ratios					
			Crude			Age-adjusted [2]		
	Indian	United States, all races	Indian	United States, all races	Ratio of Indian to United States, all races	Indian	United States, all races	Ratio of Indian to United States, all races
1959	57	18,633	11.7	10.6	1.1	17.0	10.6	1.6
1960	57	19,041	11.7	10.6	1.1	16.8	10.6	1.6
1961	61	18,999	11.7	10.4	1.1	16.7	10.5	1.6
1962	59	20,207	12.1	10.9	1.1	16.9	11.1	1.5
1963	66	20,825	11.4	11.0	1.0	15.6	11.3	1.4
1964	52	20,588	11.6	10.8	1.1	15.8	11.0	1.4
1965	65	21,507	11.3	11.1	1.0	15.3	11.4	1.3
1966	64	21,281	13.6	10.9	1.2	18.6	11.2	1.7
1967	94	21,325	17.0	10.8	1.6	23.1	11.1	2.1

[1] Indian rates are 3-year averages through 1966. All other rates are based on single-year data.
[2] Adjusted to 1940 total U.S. resident population.

The interesting difference noted in the age-specific suicide death rates between Indians and others has not been adequately explained. One theory which has been advanced but not proved is that the younger Indian is caught in the cross-cultural conflict while the older Indian has made his peace with the two societies.

As tragic and as final as suicide and homicide are, they are but symptoms of deeper problems. Other symptoms of maladjustment among Indians are excessive use of alcohol, broken homes, neglect of children, juvenile delinquency, truancy, and school dropouts. The underlying problem appears to be difficulty in adjusting to a hostile environment. Poverty, unemployment, geographic isolation, cultural conflict, and resultant breakdown of old value systems lead to difficulties in adjusting to life and the resultant

Table 2. Age-specific suicide deaths and rates per 100,000 population for Indians, Aleuts, and Eskimos in 24 Reservation States and for United States, all races, specified years

Age (years)	Indian, 1965–67 average		United States, all races, 1966		Indian, 1959–61 average		United States, all races, 1960	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
All ages	74. 3	13. 6	[1] 21, 281	10. 9	58. 3	11. 7	[2] 19, 041	10. 6
Under 10	0. 0	0. 0	1	0. 0	0. 0	0. 0	3	0. 0
10–14	1. 3	1. 9	115	0. 6	0. 0	0. 0	90	. 5
15–19	10. 0	19. 2	765	4. 3	5. 7	11. 6	475	3. 6
20–24	15. 0	38. 8	1, 245	9. 2	11. 0	31. 9	764	7. 1
25–34	22. 0	35. 4	2, 757	12. 3	18. 3	32. 5	2, 284	10. 0
35–44	12. 3	25. 2	3, 812	15. 8	12. 0	27. 4	3, 416	14. 2
45–54	6. 3	16. 5	4, 463	20. 0	6. 3	19. 0	4, 250	20. 7
55–64	4. 3	15. 2	3, 955	22. 9	2. 7	11. 4	3, 690	23. 7
65 and over	3. 0	11. 5	4, 161	22. 5	2. 3	9. 8	4, 059	24. 5

[1] 7 suicides in which the age was not stated are included in the total but are not distributed by age.
[2] 10 suicides in which the age was not stated are included in the total but are not distributed by age.

Figure 1. Age-specific suicide rates for Indians, 1965–67, and the United States, all races, 1966

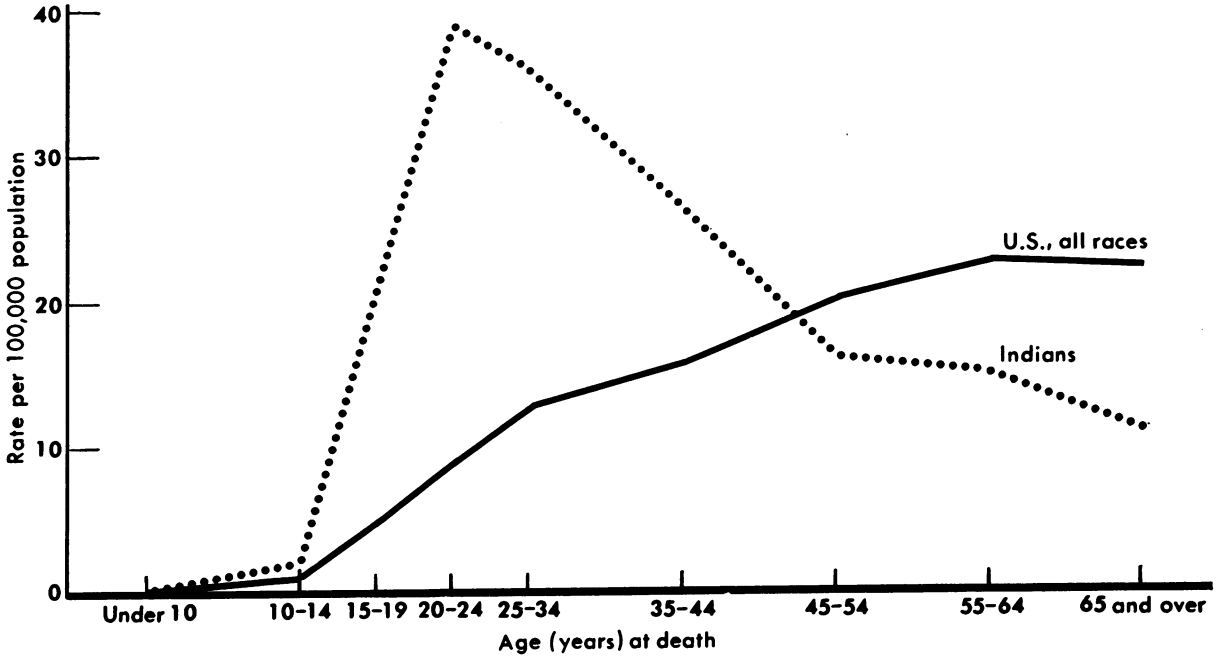


Table 3. Suicide and homicide deaths by sex for Indians [1] in all 50 States, and for the United States, all races, 1959–66

Year	Indians				United States, all races			
	Total	Male	Female	Percent male	Total	Male	Female	Percent male
	Suicide							
1959	60	55	5	92	18, 633	14, 441	4, 192	78
1960	59	49	10	83	19, 041	14, 539	4, 502	76
1961	60	50	10	83	18, 999	14, 460	4, 539	76
1962	59	52	7	88	20, 207	15, 062	5, 145	75
1963	67	55	12	82	20, 825	15, 276	5, 549	73
1964	61	52	9	85	20, 588	15, 092	5, 496	73
1965	72	52	20	72	21, 507	15, 490	6, 017	72
1966	70	55	15	79	21, 281	15, 416	5, 865	72
Average	63. 5	52. 5	11. 0	83	20, 135	14, 972	5, 163	74
	Homicide							
1959	67	51	16	76	8, 159	6, 068	2, 091	74
1960	80	62	18	78	8, 464	6, 269	2, 195	74
1961	65	47	18	72	8, 578	6, 346	2, 232	74
1962	80	54	26	68	9, 013	6, 707	2, 306	74
1963	90	61	29	68	9, 225	6, 921	2, 304	75
1964	85	67	18	79	9, 814	7, 367	2, 447	75
1965	108	77	31	71	10, 712	8, 148	2, 564	76
1966	86	62	24	72	11, 606	8, 729	2, 877	75
Average	82. 6	60. 1	22. 5	73	9, 446. 4	7, 069. 4	2, 377. 0	75

[1] Beginning in 1964, Aleuts and Eskimos were included with Indians.

SOURCE: Vital Statistics of the United States, Public Health Service, National Center for Health Statistics, published annually.

Table 4. Homicide deaths and rates per 100,000 population for Indians, Aleuts, and Eskimos in 24 Reservation States and United States, all races, 1959–67

Year	Number of deaths		Rates [1] and their ratios					
			Crude			Age-adjusted [2]		
	Indian	United States, all races	Indian	United States, all races	Ratio of Indian to United States, all races	Indian	United States, all races	Ratio of Indian to United States, all races
1959	62	8, 159	14. 5	4. 6	3. 2	20. 5	5. 1	4. 0
1960	80	8, 464	13. 7	4. 7	2. 9	19. 5	5. 3	3. 7
1961	63	8, 578	14. 7	4. 7	3. 1	20. 9	5. 3	3. 9
1962	80	9, 013	14. 8	4. 8	3. 1	21. 0	5. 5	3. 8
1963	85	9, 225	16. 0	4. 9	3. 3	22. 3	5. 5	4. 1
1964	84	9, 814	17. 1	5. 1	3. 4	23. 6	5. 8	4. 1
1965	102	10, 712	16. 5	5. 5	3. 0	23. 1	6. 3	3. 7
1966	79	11, 606	17. 8	5. 9	3. 0	24. 6	6. 7	3. 7
1967	110	13, 425	19. 9	6. 8	2. 9	26. 6	7. 7	3. 5

[1] Indian rates are 3-year averages through 1966. All other rates are based on single-year data.
[2] Adjusted to 1940 total U.S. resident population.

symptoms just mentioned, of which violence is but one.

A multidisciplinary, multiagency public and private effort is being undertaken on many reservations to solve the underlying problems. The Indian Health Service joins with the Bureau of Indian Affairs, the Office of Economic Opportunity, the Department of Agriculture, State and local health and welfare agencies, tribal groups, and private industry to attack the root causes of poverty, unemployment, geographic isolation, and cultural shock.

Prevention of Suicide

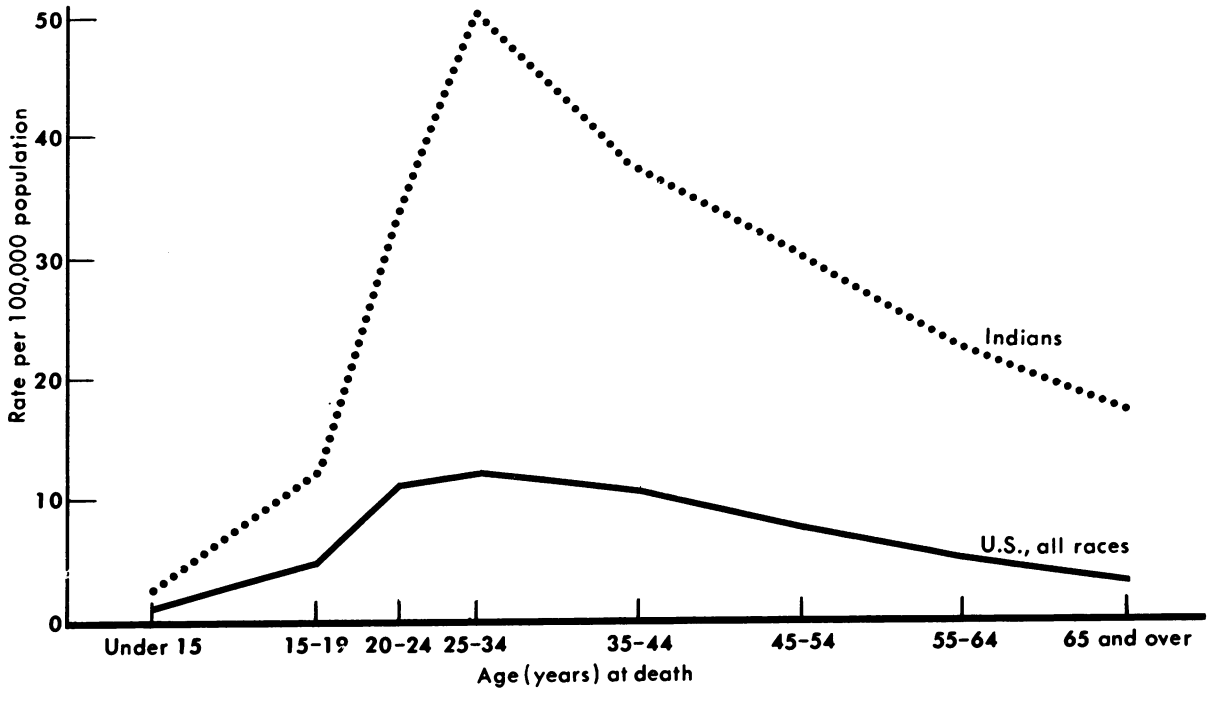
An example of one program is the project to help potential suicides on Idaho's Fort Hall Indian Reservation. Investigation showed that

Table 5. Age-specific homicide deaths and rates per 100,000 population for Indians, Aleuts, and Eskimos in 24 Reservation States and for United States, all races, specified years

Age (years)	Indian, 1965–67 average		United States, all races, 1966		Indian, 1959–61 average		United States, all races, 1960	
	Number	Rate	Number [1]	Rate	Number	Rate	Number [2]	Rate
All ages	97. 0	17. 8	11, 606	5. 9	68. 3	13. 7	8, 464	4. 7
Under 15	5. 7	2. 3	650	1. 1	3. 3	1. 4	488	. 9
15–19	6. 3	12. 2	912	5. 1	3. 7	7. 5	535	4. 0
20–24	13. 0	33. 7	1, 485	10. 9	10. 0	29. 0	887	8. 2
25–34	31. 0	49. 9	2, 744	12. 3	20. 0	35. 5	2, 208	9. 7
35–44	18. 7	38. 2	2, 546	10. 6	17. 7	40. 3	1, 948	8. 1
45–54	11. 7	30. 3	1, 711	7. 7	7. 7	23. 0	1, 269	6. 2
55–64	6. 3	22. 2	931	5. 4	3. 3	14. 3	656	4. 2
65 and over	4. 3	16. 6	598	3. 2	2. 3	9. 8	443	2. 7

[1] 29 homicides in which the age was not stated are included in the total but are not distributed by age.
[2] 30 homicides in which the age was not stated are included in the total but are not distributed by age.

Figure 2. Age-specific homicide rates for Indians, 1965–67, and the United States, all races, 1966



most suicides were among teenagers with a history of recent spree drinking. Concerned local Indians acted to bring together available resources to meet the needs. The Bureau of Indian Affairs, tribal and community leaders, VISTA and local law enforcement personnel, and the Indian Health Service cooperated to develop a program to deal with spree drinking. In response to requests of the tribal leaders, the Indian Health Service has converted a building into a medical holding facility designed so immediate care can be given to acutely intoxicated teenagers. Previously, intoxicated youths were jailed, where their risk of suicide was increased. By bringing these youths under medical treatment and observation, however, this risk is minimized.

Further, during this critical phase a one-to-one relationship can be established with the patient. Interested members of the Indian community have organized themselves into a volunteer group who are on call 24 hours a day, 7 days a week. When youngsters are brought into the holding facility, these volunteers go to be with the teenagers and establish one-to-one contact with them. After the acute intoxication is over, these volunteers help the patients cope with their problems on return to the community.

Concurrently, the patient may be guided to appropriate psychotherapy. A local psychiatrist is on contract and often called to provide immediate psychotherapy. The Indian Health Service has stationed a mental health social worker at Fort Hall to provide appropriate therapy. In addition, a consultant psychiatrist and other mental health workers from the Indian Health Service Area Office are available on a regular basis every 6 weeks.

The Fort Hall program and others like it have not been in operation long enough to show a statistically demonstrated effect on the suicide rate. It is of interest, however, to note that in the past 14 months during which the community effort has been organized and started, there have been no suicides in the community. This is the longest period with no suicides on record in this community.

Tearsheet Requests

Mrs. Jean M. Nowak, Office of Information Services, Indian Health Services, Room 5–A–43 Parklawn Building, Rockville, Md. 20852

Licensing Examinations for Nursing Home Administrators

The Professional Examination Service (PES) of the American Public Health Association is now negotiating contracts with a number of newly established State licensing boards for nursing home administrators to cover the use of the licensing examinations developed by PES under a contract with the Community Health Service, Public Health Service.

Each State participating in title XIX of the Social Security Act will have to adopt administrator licensing legislation in 1969 or 1970, and licensing procedures and regulations must be in operation by July 1, 1970.

PES has developed a written, objective-type examination to be used by State examining boards. This examination may be administered by the boards in conjunction with other assessments which States will employ to determine the qualifications of candidates for licensure.

PES has published two pamphlets about the examination program. One pamphlet, "The Professional Examination Services Announces an Examination Program for the Licensing of Nursing Home Administrators," was prepared for licensing and related agencies. It describes the development of the licensing examination and the procedures for its use, and the testing services available to the licensing authorities charged with administering examinations to nursing home administrators. The second pamphlet, "Information for Candidates on an Examination for the Licensing of Nursing Home Administrators," is addressed to candidates who may be required to take the examination prepared by PES. It contains sample test questions and is available upon request from the Professional Examination Service, American Public Health Association, 1740 Broadway, New York, N.Y. 10019.