SUICIDE AND ETHNICITY IN THE UNITED STATES

Formulated by the Committee on Cultural Psychiatry

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY

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STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP’s working principles. Since the formation of GAP in 1946, its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the fields of psychiatry, mental health, and human relations;
2. To reevaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

Suicide and Ethnicity in the United States was formulated by the Committee on Cultural Psychiatry. The members of this committee are listed on page vii. The members of the other GAP committees, as well as additional membership categories and current and past officers of GAP are listed at the end of the report.
This report is dedicated to the memory of Dr. Andrea Kathryn Delgado. She was the force behind the development and inception of a Committee on Cultural Psychiatry within GAP and was the Committee's first chairperson. Her death in June 1984 after a long illness was a tragic loss for us. This book celebrates her prodigious effort, inspiring leadership and wholehearted commitment to cultural psychiatry. It also symbolizes our affection for a friend and distinguished colleague.

Committee on Cultural Psychiatry
GROUP FOR THE ADVANCEMENT OF PSYCHIATRY

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*This work was supported in part by National Institute of Mental Health grant 1 R01 MH44581-0, National Research Center on Asian American Mental Health.
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INTRODUCTION

STATEMENT OF PURPOSE

More than five years ago, the Committee on Cultural Psychiatry began studying the broad issues of differences in the presentation of affective disorders among racial and ethnic minority populations in the United States. Beginning with an exploration of cross-cultural studies of depression and manifestations of depression within the United States population, the Committee determined that in order to obtain reasonably comparable empirical data, the focus of study would need to be more sharply defined. By phases, the focus moved from the broad category of clinical depression to the problem of suicide. Furthermore, in order to avoid confusing concepts, as well as empirical data, on suicidal ideation, intent, gesture and suicide attempt—all subject to much interpretation within a single cultural group and compounded by cross-cultural comparison—the Committee ultimately decided to limit its focus to the subject of suicide and to exclude consideration of attempted suicide.

The first purpose of this report is to draw together existing empirical data on suicide among the major racial and ethnic groups in the United States, to compare suicide rates among each of these groups by age and sex, and to compare these data with those of the majority population. The second purpose is to increase understanding of the psychocultural factors that may account for some unique features of suicide data among the racial and ethnic groups, particularly for youth and young adult males, the older age groups, and women.
Consideration of these issues will be guided by the application of two questions crucial to the outcome of acculturative stress for each group and each individual: 1) To what extent are cultural heritage and ethnic identity of continuing value? 2) To what extent should positive relations with the dominant society be sought and strengthened? The implications of these questions for understanding the patterns of suicide in the minority groups will be elaborated in the discussion of findings concerning suicide among Black Americans, Native Americans, Asian-Americans, and Hispanic-Americans. Themes common to several minority populations will be summarized in the last chapter and discussed in relation to the psychological outcome of acculturative stress. The Appendix to our report contains a descriptive, theoretical outline of acculturation and the outcome of acculturative stress for groups and for individuals.

The committee hopes that this report will provide a psychocultural perspective on suicide to supplement the biogenetic, psychosocial, and intrapsychic perspectives more familiar to mental health professionals.

SCOPE OF THE PROBLEM

Suicide is the tenth most frequent cause of death in the United States and continues to be an important public health problem: almost 30,000 people die by their own hand each year (Table 1). Between 1960 and 1975 the suicide rate rose steadily from 10 per 100,000 population to 12.7 (Frederick, 1978). By 1980, the suicide rate in the United States had declined somewhat to a rate of 11.9 in 1980 (US Bureau of the Census, 1987). However, since 1980, the suicide rate has increased slightly, reaching a rate of 12.3 in 1985 (US Bureau of the Census, 1987).

Placing these data in a context of cross-national comparison, it can be seen (Table 2) that United States suicide rates in the decade 1971-1980 are in the mid-range—markedly lower than suicide rates for West Germany and Sweden, where rates of suicide remained stable at about 20 per 100,000 population; and substantially lower than Japan, where suicide rates have also been both comparatively stable and lower than might have been expected from popular belief about suicide being positively sanctioned in Japanese culture. Suicide rates in the United States and Canada are similar. Suicide rates in the US are significantly higher than in the United Kingdom and much higher than in Spain and Mexico, with Puerto Rico more closely resembling the picture in the United States than that in Mexico.

Taking account of the variation in suicide rates according to gender and age, we find that the incidence of suicide is three times greater among males than females, and that suicide incidence peaks in the over-65 age group for men and in the early 50s for women (Table 3). Looking more closely at these data for 1970-1985, we find that these trends for both gender and age differences in suicide rates have not changed significantly between 1970 and 1985.

Central to the focus of this report is the variation in suicide rates according to racial and ethnic composition of the population. We find that Native Americans (Indians and Eskimos) have a considerably higher suicide rate than the national mean; and these comparative rates have not changed appreciably from 1970 to 1980 (Table 4). By contrast, the suicide rate for Blacks is much lower than for whites. Table 5 shows that the preponderance of male over female suicide is even greater among Blacks, Mexican-Americans, and Native Americans than among Whites, but less so for Chinese and Japanese-Americans. Data on suicide among Puerto Ricans also reveals higher rates among males than females (Monk & Warshauer, 1974).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>US Suicide Rates per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985 (All Races)</td>
<td>Both Sexes</td>
</tr>
<tr>
<td>Number of Suicides</td>
<td>29,453</td>
</tr>
<tr>
<td>Suicide Rate</td>
<td>12.3</td>
</tr>
</tbody>
</table>

### TABLE 2
Cross-National Comparison
Suicide Rates per 100,000 Population

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<th></th>
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</thead>
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<tr>
<td>United States</td>
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<td>12.0</td>
<td>12.0</td>
<td>12.1</td>
<td>12.7</td>
<td>12.5</td>
<td>13.2</td>
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<td>11.9*</td>
<td>11.6</td>
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<td>Canada</td>
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<td>12.2</td>
<td>12.6</td>
<td>13.0</td>
<td>12.4</td>
<td>12.7</td>
<td>14.3</td>
<td>14.8</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>United Kingdom (England &amp; Wales)</td>
<td>8.1</td>
<td>7.7</td>
<td>7.8</td>
<td>7.9</td>
<td>7.5</td>
<td>7.8</td>
<td>8.0</td>
<td>8.2</td>
<td>8.5</td>
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<tr>
<td>Germany (Fed. Republic)</td>
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<td>21.0</td>
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<td>22.7</td>
<td>22.2</td>
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<td>Austria</td>
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<td>23.3</td>
<td>21.9</td>
<td>23.7</td>
<td>24.1</td>
<td>22.7</td>
<td>24.3</td>
<td>24.8</td>
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<tr>
<td>Sweden</td>
<td>20.3</td>
<td>20.3</td>
<td>20.8</td>
<td>20.1</td>
<td>19.4</td>
<td>18.9</td>
<td>19.7</td>
<td>19.0</td>
<td>20.5</td>
<td>19.4</td>
</tr>
<tr>
<td>Spain</td>
<td>4.2</td>
<td>4.2</td>
<td>4.2</td>
<td>4.2</td>
<td>3.6</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
<td>N/A</td>
</tr>
<tr>
<td>Mexico</td>
<td>0.7</td>
<td>0.7</td>
<td>0.7</td>
<td>N/A</td>
<td>1.7</td>
<td>1.7</td>
<td>N/A</td>
<td>1.7</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>9.8</td>
<td>10.0</td>
<td>9.1</td>
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<td>9.5</td>
<td>10.1</td>
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<td>9.1</td>
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<tr>
<td>Japan</td>
<td>15.4</td>
<td>16.8</td>
<td>17.3</td>
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<td>17.9</td>
<td>17.5</td>
<td>17.8</td>
<td>17.7</td>
<td>18.0</td>
<td>17.6</td>
</tr>
</tbody>
</table>

*N: National Center for Health Statistics (1982)
N/A: data not available

### TABLE 3
US Suicide Rates per 100,000 Population
According to Age and Sex, 1970 to 1985

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1970</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>15-19</td>
<td>5.9</td>
<td>9.4</td>
<td>2.9</td>
<td>7.6</td>
<td>12.2</td>
</tr>
<tr>
<td>20-24</td>
<td>12.2</td>
<td>19.3</td>
<td>5.7</td>
<td>16.5</td>
<td>26.4</td>
</tr>
<tr>
<td>25-34</td>
<td>14.1</td>
<td>19.8</td>
<td>9.0</td>
<td>16.4</td>
<td>24.3</td>
</tr>
<tr>
<td>35-44</td>
<td>16.9</td>
<td>25.3</td>
<td>13.0</td>
<td>17.4</td>
<td>23.5</td>
</tr>
<tr>
<td>45-54</td>
<td>20.0</td>
<td>29.5</td>
<td>13.5</td>
<td>20.0</td>
<td>27.9</td>
</tr>
<tr>
<td>55-64</td>
<td>21.4</td>
<td>35.0</td>
<td>12.3</td>
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<td>30.1</td>
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<tr>
<td>65-74</td>
<td>20.8</td>
<td>38.7</td>
<td>9.6</td>
<td>19.8</td>
<td>33.9</td>
</tr>
<tr>
<td>75-84</td>
<td>21.2</td>
<td>45.5</td>
<td>7.2</td>
<td>21.2</td>
<td>42.5</td>
</tr>
<tr>
<td>All Ages</td>
<td>11.6</td>
<td>18.0</td>
<td>7.1</td>
<td>13.6</td>
<td>20.1</td>
</tr>
</tbody>
</table>

TABLE 4
US Suicide Rates for Selected Racial/Ethnic Groups per 100,000 Population Annually

<table>
<thead>
<tr>
<th>Year</th>
<th>All Races</th>
<th>White</th>
<th>Black</th>
<th>Indian</th>
<th>Chinese</th>
<th>Japanese</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>11.6</td>
<td>12.4</td>
<td>5.2</td>
<td>15.9</td>
<td>10.3</td>
<td>9.3</td>
<td></td>
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<tr>
<td>1975</td>
<td>12.7</td>
<td>13.6</td>
<td>6.2</td>
<td>21.6</td>
<td>7.1</td>
<td>9.8</td>
<td>9.5</td>
</tr>
<tr>
<td>1980</td>
<td>11.6</td>
<td>12.5</td>
<td>6.8</td>
<td>14.2</td>
<td>8.0</td>
<td>7.8</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Adapted from: Frederick (1978), Liu & Yu (1985), and Smith et al. (1985)

TABLE 5
US Suicide Rates per 100,000 Population by Race and Sex (1980) (Age-Adjusted)

<table>
<thead>
<tr>
<th>Race</th>
<th>Both Sexes</th>
<th>Male</th>
<th>Female</th>
<th>Male/Female Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>11.0</td>
<td>18.0</td>
<td>5.4</td>
<td>3.3</td>
</tr>
<tr>
<td>White</td>
<td>12.5</td>
<td>18.9</td>
<td>5.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Black</td>
<td>6.8</td>
<td>11.1</td>
<td>2.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Mexican Americans*</td>
<td>10.5</td>
<td>17.8</td>
<td>4.0</td>
<td>4.5</td>
</tr>
<tr>
<td>Native Americans</td>
<td>14.2</td>
<td>24.2</td>
<td>4.6</td>
<td>5.3</td>
</tr>
<tr>
<td>Chinese Americans</td>
<td>8.0</td>
<td>7.9</td>
<td>8.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Japanese Americans</td>
<td>7.8</td>
<td>11.0</td>
<td>5.0</td>
<td>2.2</td>
</tr>
</tbody>
</table>

* Cumulative Data: 1975-1980
Sources: Liu & Yu (1985), National Center for Health Statistics (1983), and Smith et al. (1985)

During the past 30 years there has been a marked increase in suicide among youth and young adults. Between 1955 and 1985, the suicide rate for males age 20–24 increased from 8.8 to 27.4 per 100,000; this represents a rise of over 200% (Frederick, 1978; US Bureau of the Census, 1987). Rates for females followed the same trend to a lesser degree. Table 3 demonstrates that suicide rates among males age 15–19 increased from 8.8 to 17.3 between 1970 and 1985, and for males age 25–34 suicide rates have risen from 19.8 to 25.4 per 100,000. The suicide rate for females in the US has been declining since 1975, when the rate peaked at 7.4. By 1985, the suicide rate for females was 5.6 per 100,000 for all age groups combined. However, there has been a steady increase in suicide rates among females age 15–19: from 2.9 in 1970 to 4.1 in 1985. This is the only age group among females to show steadily rising suicide rates during the past 30 years.

High suicide rates among youth and young adults have most dramatically affected some tribes of Indians and Alaskan Natives, as well as Blacks, as will be shown in subsequent chapters devoted to these groups. The incidence of suicide among Puerto Ricans living in the continental United States also peaks in young adulthood, particularly among males. The same is the case for Mexican-Americans. On the other hand, it should be noted that suicide rates are remarkably low among Native Americans over 50 years of age, and that this is so for both men and women. Suicide rates for Black American women and for Mexican-American women are much lower than those of women of the same age cohorts in the majority population.

Among Asian-Americans, available data suggest that sex differences in incidence of suicide are less striking, especially among Chinese-Americans, and that by contrast with other population groups in the United States, suicide rates among Chinese-American women rise steadily with increasing age and tend to exceed rates for men in categories over age 45. With respect to Japanese-Americans, there is a minor peak in suicide rates among youth and young adults, particularly notable for males, and a major peak among the elderly, those over age 75 of both sexes.

These themes will be addressed at greater length in the separate chapters of this report devoted to Blacks, Native Americans, Asians, and Hispanics to the extent that the available data allow. For each group, we will consider: the history of their immigration experiences; the extent to which their contact with the dominant or mainstream American society has been stressful; and their group and individual efforts to adapt to the stressors experienced.
LIMITATIONS OF THE REPORT

Our two major parameters are racial/ethnic groups on the one hand and suicide on the other. In choosing to focus on racial and ethnic group variations, we wished to include the major definable groups in the country. Here we encountered our first obstacle: census data, including health and mortality statistics, have not been systematically collected with reference to race and ethnicity. In particular, data are all but totally lacking on White ethnic groups. Only isolated reports could be found dealing with morbidity and mortality of even such large groups of White ethnics as Italian or Jewish or Anglo-Americans. For comparative purposes, only White and Black aggregate data could be obtained. That is, for at least 40 years now, statistical data have been collected for the total national population of Whites and of Blacks, and this includes suicide statistics. For both groups, survey data on state and regional populations are available. A similar situation applies in the case of Native Americans, for whom national and state statistics have been collected for many years. However, just as the category white blurs many important ethnic differences in the population, so black prevents systematic comparisons between those whose families have lived in the United States for generations and more recent immigrant groups from the Caribbean and elsewhere.

Defining Hispanics and obtaining discrete statistical data on ethnically different groups of Hispanics, such as Puerto Ricans and Mexican-Americans, have been equally difficult. It was not until 1980 that the census and subsequent national statistical data have addressed the subject. Consequently, our data for Hispanics have, by necessity, been limited to regional and local studies. The same problem exists for Asian-Americans, with the exception of statistics for Hawaii, where distinctions are made between Native Hawaiians, Chinese, Japanese, Filipino, and Korean components of the state’s population. A report by Liu and Yu (1985) has contributed valuable national aggregate data on suicide among Asian-Americans, as well as other minority populations relevant to this report.

Statistical data are crucial for demonstrating similarities and differences between population groups, but only the richness of detailed clinical case studies can elucidate the interplay of societal, familial, interpersonal, and intrapsychic factors that make for intragroup variation in coping styles and coping ability. This report deals mainly with aggregate statistical data applicable to the racial and ethnic groups. In some cases the data are drawn from small representative samples, allowing for some finer grained analysis of groups and individuals. However, individual case histories have not been included.

In limiting our focus to suicide, the Committee on Cultural Psychiatry recognizes that suicide is one among a number of harmful behavioral outcomes associated with acculturative stress. Others are family violence, child neglect and abuse, alcohol and drug abuse, accidents, assault, violent crime, and homicide. Indeed, analysis of the data on suicide for certain of the groups studied (for Indians and Eskimos, for Blacks, and for Hispanics) shows that there are striking positive correlations between rates of suicide and those for other forms of violence.

In any complex society such as the United States, variations occur in the extent and quality of contact between different ethnic and racial groups and the majority population. There is also variation by region, by community, and over time. In considering any group, we must also recognize variation within the group. Individuals who share racial or ethnic group membership differ in their community participation, family experience, socialization and educational trajectories, interpersonal relations, and psychological characteristics. These intragroup variations must be accounted for in the discussion of some of the findings on suicide for each of the racial and ethnic groups considered in this report.

REFERENCES


Studies during the last 20 years have shown statistical differences between Black and White suicide in the United States, and several authors have addressed the reasons for this distinction (Bush, 1976; Christian, 1977; Davis & Short, 1977; Hendin, 1978; King, 1982), although not comprehensively.

These data argue persuasively for reconsideration of the subject of Black suicide. Our principal interest here is to review the data on suicide among Blacks in the light of a framework of adaptation to acculturative stress. This should provide a useful context for reexamination of the data.

DEFINITION OF THE POPULATION

For purposes of this presentation, the term “Blacks” refer to individuals in the US who, by virtue of their skin color and African heritage, have been classified or have identified themselves as being Black. The term includes individuals who were born in the US and immigrants from a number of African and Caribbean countries. Accordingly, it should be understood that Blacks in the US may speak languages other than English as their mother tongue. It is unclear at this time how the African and West Indian sub-populations influence the general data on Black suicide in the US. Furthermore, while it is of significant interest, it still remains unclear how any cultural connection between American Blacks and their African heritage may influence suicide rates.

In 1980, the Black population of the US was reported to be 26,495,000 (US Bureau of the Census, 1982) and estimated to have
been 28,538,000 in 1986 (US Bureau of the Census, 1987). They were distributed in 1980 throughout the country in the following manner: Northeast (4,848,000, or 18%); Northcentral (5,337,000, or 20%); South (14,048,000, or 53%); and West (2,262,000, or 9%). Black males numbered 12,519,000, or 47%; and Black females numbered 13,976,000, or 53%. In 1970, 81.3% of the Black population was considered to be living in urban areas. By 1980, that urban group had increased to 85.3%. In 1986, 19% of Blacks, compared to 13% of Whites, was reported to have an educational level of 8 years or less; 54% of Blacks, and 50% of Whites, had some high school education. The larger percentage of Blacks having only high school education is accounted for by the fact that more Whites went to college (37% for Whites compared to 27% for Blacks). In 1986, about 12.7 million of the estimated 20 million Blacks over age 16 were in the civilian labor force. Of these, about 10.8 million were employed (US Bureau of the Census, 1987). Figures available for 1986 show that 70% of Black families, compared to 42% of White families, earned under $25,000 annually. Fourteen percent of Black families, compared to 19% of White families, earned between $25,000 and $35,000 annually. About 19% of Black families, compared to 39% of White families, earned over $35,000 annually.

Glick (1981) reminds us that the Black family takes different forms at different class and income levels; this notion is not new and was asserted earlier by Willie (1970). In general terms, 1986 figures (US Bureau of the Census, 1987) show that 53% of Black families included both parents, in comparison to 84% of White families. Forty-two percent of Black families were headed by females; only 5% were headed by males. In comparison, 13% of White families were headed by females and 4% were headed by males. In 1950, 9% of Black families were of the one-parent type (Glick, 1981). Black women remain more likely than women of the majority population to have less education than their spouses.

PROBLEMS OF POPULATION VARIATION

It should be evident that there is substantial variation of skin color throughout the US. This reflects the history of the country. Early slave narratives have pointed out how Blacks varied significantly in coloration from the fairest to the very dark, and this situation has continued. The migration of West Indians, with their different hues, to the US has also contributed to wide variability in skin color, as has the increasing phenomenon of interracial marriages in this country. In practical terms, this means that Blacks may perceive their interactions with Whites in different ways simply as a function of their own skin color. However, skin color is but one of a number of different elements that lead to significant differences among US Blacks. Levels of education, Southern versus non-Southern upbringing, the nature and extent of intercultural contact, exposure to rural versus urban culture, industrial as opposed to agricultural occupations, racial discrimination in housing and the workplace, and differences in individual and family income levels all contribute to these contrasts.

This variability among Blacks affects the central issue of how individual Blacks relate to the group and to the group’s history as a class of Americans who have endured a special form of discrimination. Jackson et al. (1981) point out how researchers have been preoccupied with the idea that Blacks’ minority status is a critical determinant of general psychic health and functioning. They criticize the excessive simplicity of the assertion and emphasize that researchers have not been clear even about the connections between personal identity and minority or group identity. They make the point that the Black individual’s relationship to the Black group is complex. Thus, the assertion that positive identity leads to positive psychological benefits may be too simplistic. It may indeed be more critical to understand how the individual keeps in equilibrium both negative and positive images of the group. Thus, it may be difficult to postulate basic theories that explain in some general way the relationship of being Black to rates of suicide among the Black population in the US.

REVIEW OF SUICIDE RATES

Prudhomme (1988) argued that the number of suicides in Blacks was unmistakably smaller than in Whites. However, in 1920 it was
demonstrated that Black suicide rates in Los Angeles County exceeded the overall national rate by 2.5 per 100,000 (King, 1982). Thus, King contradicted the notion that the Black suicide rate was insignificant in all geographic settings and contended that at least in urban areas the Black suicide rate clearly merited attention. This was confirmed by Hendin (1969a), who showed that between 1920 and 1960, the ratio of White suicide rates to Black suicide rates in New York City was 1.75 to 1. In the same years, the national White rate compared to the national Black rate was 3 to 1. Such data show that Black suicide rates in urban areas had been high over a period of 40 years. Thus, although rates of suicide among Black Americans have been substantially lower than rates for White Americans, the problem of Black suicide was certainly significant in some geographic settings.

Mortality statistics for the year 1985 (US Bureau of the Census, 1987) show that the overall rate of suicide for all races and both sexes was 12.3 per 100,000 population. The White male rate was 21.5 compared to the Black male rate of 10.8. The White female rate was 5.6 compared to the Black female rate of 2.1.

Table 6 shows the suicide rates for 1970, 1980, and 1985 delineated by race and sex. From this table, one can see that the rates for Black males increased, while the rates for Black females decreased slightly over the 15-year period. These figures are better appreciated when examined according to age. From Figure 1 it is clear that Black male suicide rates did not increase in all age segments in 1985; however, the peak continued to be in the 25-34 age group for males. The Black 65+ age group of males had a rate significantly lower than that of Whites in the same age bracket (Figure 2); nevertheless, the 65+ Black male group showed a 75% rise in suicide between 1970 and 1985. This striking contrast in the age distribution of Black and White male suicide, with the peak for Blacks in the 25-34 age group and the peak for Whites in the 65+ category, was previously emphasized by Davis (1979). If one examines in Figure 1 the trends between 1970 and 1985 for all the age categories of Black males, it is clear that most of the groups showed some increase in their suicide rates. However, the major increase was borne by the over 65 age group. It is important to note that in 1985 (Figure 2), the suicide rate of Black males between age 25 and
Figure 1. US Suicide Rates in Black Population by Sex and Age, 1970, 1980, 1985

Figure 2. US Suicide Rates in Population by Sex, Race, and Age, 1985

34 was relatively close to that of White males in the same age group. Within this same age range, Black males committed suicide three times more often than the total Black population.

Slater (1973) and Christian (1977) were concerned that suicide among Black women might be increasing. However, between 1970 and 1975, the ratio of Black male to Black female suicide was 3.4 to 1 for the total Black population of all ages and 4 to 1 for the peak age range of 20 to 34 (Davis, 1979). In 1985, the overall Black male rate of 10.8 was dramatically higher than the overall Black female rate of 2.1. In addition, the 1985 figures show that the highest Black female rate belonged to the 35–44 age group and was still only 3.6 compared to the comparable Black male rate of 14.9 (Figure 2). So Black female suicide remains significantly less frequent an occurrence than Black male suicide.

A 1975 estimate of the Black population was 24.4 million people (Davis, 1979). Of those, 53% lived in the South, 38% in the North, and 9% in the West. In contrast, 29% of the White population lived in the South, 53% in the North, and 18% in the West. Davis (1979) compared regional suicide rates by race for 1970 and 1975: In both years, White (17.7 in 1970 and 17.8 in 1975) and non-White rates (8.7 and 9.8) were highest in the West. However, non-White rates (4.4 and 5.7) were lowest for both years in the South. White rates
(10.2 and 11.1) were lowest for both years in the North. Non-White rates for both years in the North were 5.4 and 6.8. White rates for both years in the South were 13.1 and 15.8. Davis concluded that these data reflected an inverse relationship between the proportion of the population residing in a region and its suicide rate. In the 5-year period, suicide rates in all regions increased for both Whites and non-Whites, and in all regions, the White rate was greater than the non-White rate.

Boyd (1983) pointed out that during the past 25 years, the rate of suicide by means of firearms has risen continuously. Boyd did not refer in his work specifically to Blacks, so the question remains as to whether Blacks have followed this national trend. Markush and Bartolucci (1984) noted a strong association between possession of a pistol and White male suicide rates for the years 1973-1974 and 1976-1977. Once again, their evidence did not point specifically to Blacks as significant users of handguns to commit suicide. Hendin's classic Harlem study (1969b) showed that among Blacks, jumping from a building was the most frequent method of suicide. However, Christian (1977) found that in a 1972 study of Los Angeles County, most Blacks had killed themselves with firearms. Her reference to victim-precipitated homicide among Blacks, particularly among the 20–34 age group, suggests that firearms were indeed a common method of committing suicide among Blacks, once it is understood that the homicide victim had indeed caused his own death through some violent interaction with the person who perpetrated the homicide. In a 1972 study carried out in Philadelphia, it was shown that the most frequent methods of suicide among Blacks were firearms and jumping (Lester et al., 1976).

Several authors (Holinger, 1979; Warshauer & Monk, 1978) have referred to the methodological problems inherent in using national and regional data to discuss the trends in suicide, namely, underreporting and changes over time in data classification. In addition, there is the recurrent question of whether some of the other violent deaths (accidents and homicides) are in fact suicides. This is of significant concern particularly in regard to homicide. The Black homicide rate in 1985 was 29.7 per 100,000 compared to the White rate of 5.6 (US Bureau of the Census, 1987). Such an alarmingly high rate for Blacks has provoked questions about Black homicide being linked to Black suicide (Poussaint, 1972). Interestingly enough, the Black male homicide rate for 1985 of 48.4 contrasts with the White male rate of 8.2. Comparative homicide rates for females are 11.0 for Blacks and 2.9 for Whites. Once again the peak rate is in the 25–34 age bracket among Black males (US Bureau of the Census, 1987).

**DISCUSSION**

In general, the theories that have been offered to explain the Black suicide statistics reviewed in this chapter have addressed several cardinal points:

- The brunt of Black suicide is borne by the 25–34 age group, particularly by the males in that age bracket.
- Black males commit suicide far more often than Black females.
- Black suicide is higher in urban areas than in rural regions.
- The lowest rates of suicide among Blacks occur in the South where their population density is highest.
- In the 65+ category, Black suicide is increasing, although it remains significantly lower than White suicide in the same age group.
- Overall, Black suicide rates have been quite low compared to White rates. However, both Black and White rates have increased slightly in recent years.

Prudhomme (1938) argued quite early that the low suicide rates of Blacks was influenced by the “peculiar and psychologically vicious environment that the White majority group had imposed on the minority group.” He expected that as the social environment of the Black person approximated that of the White majority, the Black suicide rate would increase. Prudhomme felt that the constant tension under which Blacks lived, coupled with their primitive culture and poor education, led them to have fewer inhibitions than Whites. Consequently, Blacks’ emotional energy was largely uncontrolled and was therefore not likely to be turned inward on the self. In addition, Blacks had emotional outlets such as religion
and music. Their habitual external emotional expression was more likely to result in assault and murder than in suicide. Wolfgang (1968) went further and formulated the concept of “victim precipitated homicide,” hypothesizing that unconscious guilt was a developmental characteristic of Blacks that led to physical aggression and punishment from others. Both Prudhomme and Wolfgang attempted to explain the low suicide rate of Blacks, while addressing the issue of the high Black-on-Black homicide rate. Obviously, recent data have cast doubt on the justification of this classic dichotomy between suicide and homicide, as Black males between 25 and 34 are at greatest risk for both suicide and homicide. In addition, the demographic characteristics of both victims and perpetrators involved in Black homicide are remarkably similar (Jason et al., 1983; Seiden & Freitas, 1980).

Breed (1966) argued that a serious problem for Black males who committed suicide was conflict with authority figures such as police and difficulty with the burden of social regulation. This argument seemed particularly appropriate for Black males age 20–35 living in urban areas. However, Hayes and Johnson (1979) pointed out that conflict with authority simply could not represent the entire picture, since young Blacks in the military had a significantly lower suicide rate than their counterparts in civilian life. These authors concluded that the tightly controlled military environment, with strict laws and regulations, was supportive because of the economic security and the opportunities for personal improvement and advancement the armed services provided.

Hendin (1978) was particularly concerned with the high suicide rate among young adult Blacks in urban environments. He postulated that suicide among this group was often the “outgrowth of a devastating struggle to deal with conscious rage and conscious murderous impulses.” He went on to argue that suicidal Blacks often had a striking history of violence in their childhood, such as fathers and mothers who were physically abusive. In studying this particular group, Hendin insisted that Freud’s conception of suicide as an inverted homicide was wrong since among young adult Blacks there was a direct relationship, not an inverse one, between suicide and homicide. Hendin saw the overt rejection by Whites of Black people in the ghetto as reinforcing feelings of rage and worthlessness. On the other hand, he explained the low suicide rates among Blacks over 40 as a result of their having reached some compromise in their life that usually meant a reduction in their aspirations. Hendin’s indictment of the Black family and community was challenged by Poussaint (1972), who instead saw the family and the Black community as the only buffers against self-destruction.

Six explanatory hypotheses were proposed by Seiden (1981) to account for the divergence of Black and White suicide rates in the 65+ age group. First, the Blacks have a less favorable life expectancy than Whites. Thus, fewer Blacks survive to the advanced years where the suicide risk would be highest. Second, deviant behavior requires extra energy and therefore tends to be an activity of the young. Thus, older Blacks would be expected to have adapted to the White-dominated society and would have lower suicide rates. Third, the most violent Black individuals in the community have either killed themselves or been killed by the time they reach age 40. Fourth, the Black elderly have more purposeful roles and higher status than White elderly and are therefore better integrated into a social network. In addition, institutions such as the Black church and Black extended family emphasize this traditional value of respect for age. Finally, a major reason for suicide among the elderly is the loss of employment status and financial security following retirement. Blacks are protected against this on the basis of relative deprivation. In other words, Blacks are accustomed to a lower status and suffer less from these losses in old age. The clear increase in the suicide rate of Black males in the over-65 age group that took place between 1970 and 1985 evokes considerable skepticism about Seiden’s hypotheses, however.

Bush (1976) developed a special framework that conceptualized Black suicide as taking place in a bifaceted context characterized by extragroup and intragroup pressures. Extragroup pressure was encapsulated in the term “racism.” It referred mainly to the policies and programs of Whites and their institutions. Bush felt that Whites’ attitudes were prejudicial to the interests of Blacks and could therefore be considered racist. The intragroup pressure was defined as the “Black perspective,” or the collective experience
common to Black Americans. Out of the collision of extragroup and intragroup pressures came the value orientation of the individual, which was a critical source of personal validation. For Bush, the extragroup pressure was generally perceived by Blacks as negative; therefore, it was the intragroup pressure that was ultimately important. If a Black person had difficulty in accepting the Black perspective, the intragroup pressure was a negative force, the value orientation was negative, and the individual became a “depreciated character.” Suicide could be seen as a solution to this dilemma. In other words, Bush posited that intragroup solidarity decreased the Black individual’s risk of experiencing identity confusion.

King (1982) argued persuasively that explanatory models of Black suicide ought to be reformulated from a “Black reality” perspective, and he emphasized the sociopolitical context in which to set this new formulation. From King’s point of view, Blacks in America constantly confront racist, oppressive, violent treatment from Whites. Given this repeatedly caustic experience, power plays a crucial role in the eventual reaction of the Black individual. Power was defined by King as “feelings, real or imagined, that one can create change,” and much of this power may be economic. As a function of other experiences (personal, familial, spiritual), the individual could respond with a will to live or with a malignant sense of hopelessness that may lead to suicide, depending on the degree to which the individual felt empowered or powerless to effect change in his or her life. King’s arguments seem plausible when used to explain the high suicide rates among young adult Black males. However, they do not explain the consistently low rates among Black females.

The low suicide rate among Black females has been attributed to their connections to community institutions such as the Black church (Comer, 1973). Such resources have provided significant reinforcement of self-esteem to these women and have made it unnecessary for them to depend on the White community for approval. Working at home within the context of the family may also provide Black women a buffer against the offensiveness of dealing with White prejudice in the workplace (Christian, 1977). This has presumably helped to protect Black women from some of the major sources of stress and despair that Black males have experienced. At the same time, the relative isolation from the White society that has protected Black females has also made them more vulnerable to suicide following the loss of important social relationships (Slater, 1973). However, the view that Black women have been isolated from the White-dominated world of work seem inconsistent with the age-old pattern of Black women, even as far back as slave times, frequenting White institutions in the work context. There is also the possibility that Black women, because of strong group psychosocial support through personal connections to each other, would be less likely to commit suicide.

By extension, several of the arguments summarized in this section may be used to explain the finding that living in the South, particularly in the rural South, seems to reduce the risk of Black suicide. First, it may be postulated that community institutions such as the Black church and the Black family are strongest in rural Southern areas. Second, Blacks in these regions have lower socio-economic expectations and therefore may be less at risk of becoming enraged with their life circumstances. Rural and Southern Blacks could be expected to identify more readily with the value orientation of the Black perspective and would, consequently, be less alienated (Bush, 1976). In addition, more recent work (Stack, 1983; Stark et al., 1983) has confirmed the positive effect of high church membership on reducing the suicide rates. Conversely, the decline in church attendance among young adults is closely associated with the persistent rise in suicide rates among that group. This evidence would seem to buttress the view that the Black church exerts a protective and buffering influence that would be felt most in Southern regions where Black community and religious institutions are strongest.

None of the theories presented so far has utilized the concept of acculturation, whereby phenomena of change occur as the result of continuous first-hand contact between groups of individuals having different cultures, in this case, Blacks and Whites in the United States. Berry and Kim (1988) have theorized that there is a systematic course to acculturation that is characterized by contact of the two groups, conflict between them, and adaptation to the
TABLE 7
Possibilities of Black Adaptation to Black/White Interactions

<table>
<thead>
<tr>
<th>Different Stances</th>
<th>Question 1: Is My Black Identity of Value?</th>
<th>Question 2: Should I Seek Positive Relations with Whites?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Separation</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Assimilation</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Marginalization</td>
<td>no</td>
<td>no</td>
</tr>
</tbody>
</table>

Adapted from the Model of Acculturation by Berry & Kim (1988).

interaction. Conflict occurs particularly when there is resistance by the nondominant group to the process. Such stress influences the type of acculturative outcome. In the case at hand, Blacks in the US must ask of themselves two questions (Table 7):

1) Is my cultural identity of value and should it be retained?
2) Are positive relations with the White group to be sought?

The varieties of answers to these two questions obviously influence the degree of crisis present in the acculturative process at the level both of the group and of the individual. Furthermore, what is of interest to us here is how this framework facilitates our understanding of the suicide data that have been presented.

In the application of the model showing the outcome of acculturative stress to the study of how any dominant and nondominant group interact, Berry and Kim (1988) have been careful to assert that the outcome of acculturative stress is determined in large part by the psychology of the individuals involved and the full range of economic and political forces impinging on them. For example, Blacks may seek to pursue a strategy of integration by answering Yes to both questions above. In doing this, they may be purposefully looking for a style of acculturative adjustment that has minimal stress. However, the White group may simultaneously be following a political course of blocking such integration by denying the importance of a distinct Black cultural identity. In such a case, the integration mode of adaptation to acculturative stress could engender significant psychological conflict for Blacks.

In looking at Table 7, it seems clear that marginalization (where both questions are answered No) represents such a hopeless and negative view of life that individuals who have adopted this position are likely to be functioning at the periphery of their own community as well as that of the dominant society. By answering No to both questions, they reject any compromise with the dominant group. Neither do they see value in the individual or group Black perspective. The consequence of this position would obviously be intense conflict and confusion about personal and political allegiance to the Black group. We think it a difficult position to maintain but hypothesize that it might be found among young adult urban Black males who politically reject positive relations with the White majority group. These Blacks are also impatient with what they see as the Uncle Tomism of many oth er Blacks. However, they are most severely oppressed by the poverty and joblessness around them, are disenchanted by the Black church and other community institutions, are at greatest risk of being involved in the maelstrom of alcohol and drug abuse, and have easy access to handguns. It is also the group most likely to be unprotected by the buffer effect of families and community institutions such as the church. In addition, the difficult developmental tasks of adolescence and young adulthood would be expected to exacerbate the conflict-ridden strivings of this group.

On the other hand, integration, characterized by affirmation of the value of Black identity and the wish to seek positive relations with Whites, would be at the other end of the spectrum of possibilities and would be characterized by less psychological and social distress due to acculturation. We hypothesize that this mode of adaptation to acculturative pressures represents the least stressful alternative because it is characterized by healthful ego adaptation and puts a positive premium on Black institutions. At the same time, seeking positive relations with Whites is a political approach that is not frightening to the majority group and sets up a terrain for constructive interaction. This is the position pursued historically by the major civil rights organizations in this country and by
Black colleges, churches, and other major Black social institutions. Ultimately, it is also the adaptation that requires the least expenditure of psychic energy and that leaves Blacks least vulnerable in their necessary occupational, social, and political interactions with Whites. This is not to suggest that the integrationist stance may not be fraught with problems when the majority group is intent on frustrating the communal and individual aspirations of the minority group. This may be particularly true in the political arena.

This leaves two other possibilities of Black adaptation to Black-White interactions: separation or resistive acculturation, on the one hand, and assimilation, on the other. We consider both to be predictive of some psychological and social distress. Resistance implies a state of perpetual conflict with the majority White group. While it is true that resistive acculturation may provide group support and enhancement of self-esteem, remaining opposed to seeking positive relations with Whites leaves the individual and the resistive group in a constant state of vigilance to protect the self and community from White retaliation. It is here that the techniques of “paranoid adaptation” are probably most frequently encountered.

We consider the Black Panther philosophy to be an example of the resistive style in its most activist form. Again, that stance requires such energy that it would be found most often among the young, and it is such a rebellious philosophy that it would be most frequently encountered in urban areas.

While separation potentially leads to a harsh and costly interaction with Whites, the assimilationist stance destroys the Black self and leads to the “depreciated character” so eloquently formulated by Bush (1976). Both he and King (1982) would certainly argue that any refutation of the Black self, and consequently of the Black perspective, must inevitably lead to a pervasive sense of hopelessness. Indeed, we suspect they would insist that the assimilationist position is by definition self-destructive, both politically and personally.

It is our hypothesis that assimilation is not consonant with the maintenance of strong social institutions, such as the family and church, in any community. Or, if these institutions do exist in the community, the individuals adopting assimilation as their mode of adaptation to acculturative stress would not be active participants in them. In these days of increased visibility of Black institutions, Black politicians, and Black success in many different spheres, assimilation would seem to be an unlikely mode for many Blacks to use. But that may be wishful thinking. Indeed, it may simply be that the external marker of Black skin is what makes the assimilation mode unavailable to many Blacks.

It is still an intriguing question whether resistive acculturation and marginalization do lead differentially to homicide and suicide. We hypothesize that the same vulnerable group of adolescent and young adult males may be employing these two mechanisms, and depending on whether rage or hopelessness predominates, homicide or suicide is the ultimate result.

Black females and the aged may be the two groups formerly least involved with the political task of opposing positive relations with Whites. This has brought them some protection against the stress of acculturative interaction and, by extension, against suicide. However, as females compete successfully in increasing numbers and fulfill roles that have been previously reserved for males, one would expect their suicide rates to reflect this more direct participation in the acculturative process. Alternatively, older Blacks would be expected to have followed the path of integrative adaptation or possibly some attenuated form of resistive acculturation characterized by a more-or-less voluntary withdrawal into the segregated Black community, rather than joining the more activist and caustic opposition to domination by Whites. This would account for their having survived the destructive stresses and difficulties of the adolescent and young adult years. It is expected that as older Blacks achieve more and more financial success, they will experience the retirement years as being more unpleasant and more of a sociopsychological letdown.

These hypotheses clearly require further research and exploration. Furthermore, none of the theories advanced to explain Black suicide trends really explains the marked difference between Black and White suicide rates. The fact remains that even the rate for young Black adult males is lower than that of young White adult males. Consequently, no theory adequately explains why Blacks as a group, in comparison to Whites, are protected against suicide.
However, it is interesting to note that when overall violent rates (suicide and homicide) for young Black males are considered, the rates are clearly higher than those for young White males.

Whatever its causes may be, the overwhelming weight of empirical data demonstrates that Black suicide is primarily a problem of youth and young adult males (Gibbs, 1984; Holinger & Offer, 1982). Consequently, preventive intervention and national policy should focus on this high-risk group. If it is right that hopelessness is the key concept in understanding suicidal behavior (Beck et al., 1975), it is unfortunate that the hopelessness of the Black population is being borne by the young, those who would seem to merit most the chance to achieve their dreams.

REFERENCES


3

SUICIDE AMONG AMERICAN INDIANS AND ALASKAN NATIVES

Awareness of the higher rates of suicide among American Indians and Alaskan natives has been evident in popular and scientific literature for several decades (Havighurst, 1971; Ogden et al., 1970; OIA, 1986). Dramatically high rates have been reported among particular tribes and communities as well as among Indian and Eskimo youths in general (Kraus & Buffle, 1975). Social, cultural, and psychological breakdown following contact with the new dominant culture have been discussed as major factors in accounting for these suicide patterns.

However, our review of the literature about Native American suicide indicates that culture contact is not inevitably associated with high rates of suicidal behavior. Berry et al. (1982) point out that stress and its associated pathologies are functions of both the cultural and psychological characteristics of groups and individuals in contact and may decline after the initial crisis encounter. Chance (1965), working with Alaskan Inuit (Eskimo), found that high stress was associated with low personal contact but high psychological identification with Western life, while those with low contact and low identification and those with high contact and high identification, exhibited less stress.

DEFINITION AND VARIABILITY OF THE POPULATION

In 1980, there were 1,423,043 American Indians, including approximately 64,000 Alaskan natives. Native Americans constitute numerically the smallest of the four minority ethnic groups discussed in this report. Presently they are only 0.6% of the total US population. Native Americans are also the most rural of the four groups—about 70% live in rural areas, compared with 21% of Hispanic and 27% of Black populations. More than half the rural Native Americans (55%) are nonfarm residents, relying for a substantial part of their subsistence on traditional occupations of hunting, trapping and fishing. Native American populations have also have characterized by very high levels of unemployment, especially among youth and young adults. Unemployment itself can be considered an indicator of nonparticipation in the dominant culture and contributes to resistive or marginalization modes of acculturation. Partly as a consequence of these economic factors, and partly due to US government employment training incentives, there has been a steady increase in urban migration among Native Americans during the past three decades, perhaps indicating a trend toward cultural integration and assimilation (US Government, 1969).

The 1980 census found that most Native Americans were located in 27 states; more than 50% of the total Native American population live in Arizona, New Mexico, California, and Alaska (see US Bureau of the Census, 1982). Only 37% now live on reservations or native villages and 30-96% remain rural in spite of the trend toward urban migration in the past 10 years. The Native Americans migrating to cities are predominantly young adults. The trend has been most notable in Western and Southwestern states: Denver, Tucson, Albuquerque, and Los Angeles, for example, have rapidly growing Native American populations.

The Native American population as a whole is comparatively young, with a median age of 22.9 years, compared to 31.1 for US Whites, which is a confounding factor in comparing their overall higher suicide rates with other population groups unless age-adjusted. Rural Native Americans have one of the highest birth rates of the minority groups discussed in this report. More than 25% of Native American families have seven or more members, and 70% of rural families have more than four. Poverty and remoteness from urban centers contribute to the difficulties a large family encounters in attempting to participate in the dominant culture.

Since 1955, on about 250 reservations in 23 Federal Indian Reservation States and in several hundred villages in Alaska, health
services have been provided for the Native American population by the US Public Health Service. Nevertheless, maintaining adequate health care has been complicated by geographic, cultural, and social barriers. Housing for Native Americans, whether in rural or urban areas, has often been overcrowded and lacking a safe water supply and adequate sanitation facilities. Dietary deficiencies in many populations contribute to increased risk of infectious disease and physical debilitation. Epidemics have resulted in high rates of sickness and death throughout the period of culture contact and continue even today. Many Native Americans have had parents, other relatives, or friends who died or were debilitated by tuberculosis and infants and children lost to measles and enteric diseases. During the past 20 years, however, considerable progress has been made by the Public Health Service to reduce mortality from communicable diseases and to lower infant mortality rates.

Through the Bureau of Indian Affairs (BIA), the US government provides education for Native Americans not served by local public or private schools. Prior to 1970, most rural Native Americans who attended high school were required to go to BIA-administered boarding schools, often in locations distant from their homes. This introduced the stresses of separation from family and clan and the psychological stresses of imposed cultural change. Native American children, like other minority groups, face special problems that complicate their education. More than half must learn English as a second language and must contend with culturally divergent concepts, values, and attitudes of the majority culture represented by peers, townspeople, and their teachers. Educational materials and curricula sometimes portray Native Americans in a negative light and contribute to their rejection of traditional cultural values and behavioral norms.

In addition to these difficulties, lack of economic opportunity and increasing social disorganization have adverse effects on Native youth. Throughout North America, pressures of unemployment, as well as tensions between the Indian and non-Indian communities, have disrupted traditionally close family ties. The escalating prevalence of separation, divorce, and family violence has resulted in a disproportionately high number of broken homes and placing of Native American children in foster care with non-Native American families. In North Dakota, for example, the rate of Indians placed in foster care in the mid-1960s was 17 times that of Whites (Blyer & O’Connell, 1968). Among Native Alaskans, foster care and adoption are also common factors that engender stress in a large proportion of youth. However, despite separation and loss, recent studies in Alaska have found no greater vulnerability to suicide among adoptees than those not removed from their family of origin (Krais & Buffler, 1975).

While sharing many problems of acculturation, Native Americans are not a culturally homogeneous population. Major differences exist in the way of life, customs, language, social organization, history, personality, and values of tribes in different regions of the country and even within the same geographic region. The cultures and languages of the Plains Indians, Pueblo Indians, and Arctic Inuit differ as much from each other as the cultures and languages of the Celtic Irish, the Hungarians, and the Lapps. Just as these European populations show differences within their countries and territories, so do Native American groups exhibit great intragroup variations of language, economic activity, social organization, attitudes, values, and customs. These intragroup and intragroup cultural variations influence the acculturative process when Native American communities come into contact with Western society and help to account for the variation in suicide rates of different Native American populations.

**REVIEW OF SUICIDE RATES**

Shore et al. (1974) demonstrated that the stereotype of the “suicidal Indian” is not accurate and that suicide rates vary greatly among the different Native American groups. Rates ranged from 6 per 100,000 among the Chippewa to 100 per 100,000 among the Shoshone-Bannock during the early 1970’s, for example. Native American groups differ in their traditional cultural characteristics as well as in their acculturative experiences and their degree of overall health, social organization, and economic well-being—all conditions that affect stress levels and suicide. Rates have also varied over time.
with groups, perhaps reflecting changes in acculturation responses, economic conditions, and the oftentimes socially infectious nature of suicidal behavior among young people.

Odgen, et al. (1970) compared suicide rates among Native Americans with those of the overall United States population (see Figure 3). Their sample covered an estimated 630,000 American Indians and Native Alaskans (see US Government, 1967). They found that the overall Indian death rate from suicide had risen substantially. Suicide was the tenth leading cause of death in 1967, up from thirteenth in each of the previous eight years. Until 1967, Indian crude suicide rates were only slightly higher than those for the total population, ranging from 1 to 1.2 times as high but in 1967, the ratio was 1.6. Age-adjusted suicide rates placed Indians higher relative to the general population, averaging about 1.5 times as high before 1967 and about 2 times as high in 1967.

The escalation of the Native American suicide rate compared to the total United States population continued through the 1970s. Between 1970 and 1975, Frederick (1978) discovered increases of over 36% in this population, compared to 6% for Whites and 17% for Blacks. The Native American suicide rate of 21.6 per 100,000 in

<table>
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<tr>
<th>Age Group</th>
<th>Indian</th>
<th>All Races</th>
<th>Ratio Indian to All Races</th>
<th>Indian</th>
<th>All Races</th>
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</thead>
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<tr>
<td>15-24</td>
<td>45.7</td>
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<td>3.7</td>
<td>4.5</td>
<td>0.4</td>
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<td>55-64</td>
<td>13.0</td>
<td>20.8</td>
<td>0.6</td>
<td>139.3</td>
<td>50.9</td>
<td>2.6</td>
</tr>
<tr>
<td>65-74</td>
<td>3.5</td>
<td>17.5</td>
<td>0.2</td>
<td>62.2</td>
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<td>19.7</td>
<td>1.3</td>
<td>51.6</td>
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<td>2.8</td>
</tr>
</tbody>
</table>

*The Indian population includes Alaskan Natives.

1975 was 70% higher than for the overall population, 64% higher than for Whites, and 254% higher than for Blacks (Frederick, 1978).

In 1970, the suicide rate for Native Americans between 15 and 24 years of age was 45.7 per 100,000, or 3.7 times higher than the 12.2 national rate. By 1975, suicide rates by age indicated that Native American rates were greater than those for all races up to age 45, but for people over 55 rates were very low by comparison with the national sample (see Table 8). Whereas rates for Whites were highest for those over age 50, rates for Native Americans peak in the youth and young adult years. Far more Native American males than females committed suicide. About 83% of all Indian suicides in the United States from 1959 through 1966 were males, compared with 74% for the overall population. Kraus and Buffler (1975) demonstrated similar escalating suicide rates for Alaskan Indians, Eskimos, and Aleuts, of as much as five times the national
rates, and rates for Inuit consistently higher than for Northwest Coast Indian groups.

US Division of Vital Statistics data for 1980 indicate suicide rates for Native American young adult males continue to be high (Liu & Yu, 1980). The average annual, age-specific and age-adjusted death rates for suicide were, for example, 49 per 100,000 for males age 15-24 but only 7 per 100,000 for females, giving a combined rate of 28.18. The rate is still more than twice the national average for this age group. Except for those age 45 or more, the suicide rate for Native Americans appears to have peaked in the early 1970s, however, and has declined since (Table 9). Peters (1981) has reviewed suicide patterns among Native American groups according to their geographical region. While overall rates remain high, there is great variation based on the gender, age, socioeconomic status, geography, and cultural history of each tribal group (see Fenton, 1941). Table 10 illustrates the suicide rates for a variety of Native American groups according to region and/or tribe. For comparative purposes, some data from Canadian sources is included. Incomplete as some of these studies might be, a consistent pattern emerges within regional groups.

**SOUTHWESTERN INDIANS**

The largest group of Southwestern Indians is the Navajo, a branch of Athabaskan-speaking peoples who migrated to the area about 300 years before the Spanish conquest. The arrival of the Spanish provided the Navajo with sheep to herd and silver to work into jewelry. With over 100,000 members, the Navajo are the largest Indian tribe in the United States. Levy and Kunitz (1965, 1969) studied suicide patterns among the Navajo and found rates of only 8 per 100,000 during 1954-1963.

Navajo have traditionally believed that any death that is not the result of old age is unnatural, and that contact with unnatural death leads to sickness and misfortune (see Wymann & Thorne, 1945). “The act of suicide is universally condemned by the Navajo, not because it is inherently bad but because it has an adverse effect on the living”—because it may cause ghost sickness (Levy & Kunitz, 1969). The powerful influence of traditional values on the patterns of suicide among the Navajo is reflected in the following facts: 1) suicide rates have remained fairly constant since 1900; 2) when suicide does occur, it is usually precipitated by tensions with kin; and 3) suicide usually occurs near the home of the victim. The Navajo believe that the act of suicide does not allow the individual to resolve an untenable situation but rather causes the victim to remain in the situation in a new status, as a ghost.

Van Winkle and May (1986) examined suicide patterns among the Apache, Navajo, and Pueblo Indians of New Mexico from 1957 through 1979. They found a high male-to-female ratio (7-10:1), an age range of 10-99 years, and a high percentage of both males and females using extremely violent methods such as firearms and hanging. High contact with the dominant society predicted high rates of suicide when groups were compared. The crude suicide rate for New Mexico Apache for 1957-1979 was 43.3. The lowest rates (12 per 100,000) were found among the Navajo from 1958 to
<table>
<thead>
<tr>
<th>Region</th>
<th>Tribe/Area</th>
<th>Rate/100,000</th>
<th>Years of Study</th>
<th>Alcohol Involved</th>
<th>Source</th>
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<tr>
<td>Northwest</td>
<td>Wash.—Oregon</td>
<td>28</td>
<td>1960s</td>
<td>Yes</td>
<td>Shore (1972)</td>
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<tr>
<td></td>
<td>British Columbia</td>
<td>39</td>
<td>1960s</td>
<td>Yes</td>
<td>Cutler &amp; Morrison (1971)</td>
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<tr>
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<td>Black Feet</td>
<td>130</td>
<td>1950s</td>
<td>Yes</td>
<td>Pamburn (1970)</td>
</tr>
<tr>
<td></td>
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<td>100</td>
<td>1960s</td>
<td>Yes</td>
<td>Watson (1969)</td>
</tr>
<tr>
<td></td>
<td>Shoshone-Bannock</td>
<td>98</td>
<td>1960-1967</td>
<td>Yes</td>
<td>Dizmang (1968)</td>
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<tr>
<td></td>
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<td>100</td>
<td>1938-1970</td>
<td>Yes</td>
<td>Duck Valley (1970)</td>
</tr>
<tr>
<td>Southwest</td>
<td>Arizona Pima</td>
<td>40</td>
<td>1960-1970s</td>
<td>No</td>
<td>Sievers et al. (1975)</td>
</tr>
<tr>
<td></td>
<td>Papago</td>
<td>100</td>
<td>1960-1970</td>
<td>Yes</td>
<td>Conrad (1972)</td>
</tr>
<tr>
<td></td>
<td>Navajo</td>
<td>10</td>
<td>1954-1963</td>
<td>Yes</td>
<td>Levy (1965)</td>
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</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Tribe/Area</th>
<th>Rate/100,000</th>
<th>Years of Study</th>
<th>Alcohol Involved</th>
<th>Source</th>
</tr>
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<tr>
<td>Boreal</td>
<td>Yukon</td>
<td>19</td>
<td>1959-1964</td>
<td>Yes</td>
<td>Butler (1965)</td>
</tr>
<tr>
<td></td>
<td>Chippewa</td>
<td>6</td>
<td>1940-1969</td>
<td>?</td>
<td>Westermeyer (1972)</td>
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<tr>
<td>Athabascan</td>
<td>Yukon-NW</td>
<td>20</td>
<td>1959-1964</td>
<td>Yes</td>
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</tr>
<tr>
<td>Arctic Coast</td>
<td>Inuit-Alaska</td>
<td>15-50</td>
<td>1950-1974</td>
<td>Yes</td>
<td>Kraus &amp; Bufller (1975)</td>
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<tr>
<td></td>
<td>Northwest Territory</td>
<td>41</td>
<td>1977</td>
<td>Yes</td>
<td>Seyer (1979)</td>
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<tr>
<td>Overall</td>
<td>Population:</td>
<td>11.7-17</td>
<td>1968-1969</td>
<td>Yes</td>
<td>Miller (1971)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.6</td>
<td>1970-1975</td>
<td>Yes</td>
<td>Frederick (1978)</td>
</tr>
</tbody>
</table>
1962, when suicide declined. However, suicide rates rose considerably through the 1970s to rates as high or higher than the national and New Mexican averages. Pueblo Indian rates were 27.8 per 100,000 but have been rising since 1972, as have the Apache rates. The authors conclude that the more acculturated (as measured by contact with the dominant society), the greater the suicide rates. Without opportunities for accommodative or integrative responses to increased contact with the dominant society, Apache and some Pueblos have suffered marginalization. Navajo, on the other hand, have continued a resistive stance, while slowly developing integration responses.

In traditional times, suicide among the Uto-Aztecan-speaking communities of the Sonora Desert region was almost unknown. The Pima, Papago and Yaquis were predominantly farmers who considered suicide and violent death to signal a breakdown of the “old ways.” Conrad (1972) and Conrad and Khan (1974) reported a suicide rate of 30 per 100,000 among the Papago for the years 1969–1971. Of an approximate total of 12,000 Papago, 7,000 lived on the main reservation, while most of the rest lived in urban areas, largely in Tucson. Reports of suicide for this population, from January 1969 through December 1971, were obtained from death certificates and by means of a 23-item questionnaire completed by Public Health nurses and workers. In addition, suicide and attempted suicide records were obtained from the Public Health Service. During this period, 9 of 10 cases of suicide were by men; there were 34 cases of attempted suicide, of which 20 were by women and 14 by men. Methods used in cases of completed suicides were firearms or hanging. The authors attribute these suicides to poor interpersonal relationships, with 41% of those who attempted suicide intending to change a relationship and 25% seeking revenge against a significant person. Quarrels precipitated 40% of completed suicides. Conrad and Kahn point out that many Papago men were in a deculturated and marginalized condition as a result of erosion of traditional male roles. Anglo priests and ministers have usurped the role of spiritual leaders; government physicians have replaced the medicine men; charity and welfare have supplanted the hunter’s role as provider. Loss of role definition is emphasized by the facts that 8 of the 10 suicides were by people living in or near urban areas, 8 victims were between age 20 and 29, 7 were known to be heavy drinkers, and 6 were known to be intoxicated at the time of their death.

It would appear probable that the Papago were in the crisis stage of adaptation to acculturative stress at the time of the study. Those who committed suicide, mainly alcohol-abusing young men with impaired interpersonal relationships, may have been struggling unsuccessfully with intense acculturative stress. The young men especially were vulnerable to a profound sense of powerlessness and hopelessness, and a sense of their psychocultural marginalization, in their contacts with the dominant Anglo urban society. This population was in high contact but low identification with the dominant society and, thus, at higher risk for suicide than the Navajo and other more rural groups, who had low contact, low identification, and lower levels of acculturative stress.

**PUEBLO INDIANS**

The Pueblo peoples represent at least eight different language stocks. They are commonly grouped together because they build the same type of adobe construction, live in closed communities, and share a common culture and history. Because of the closed nature of most of these communities, accurate suicide rates have been difficult to assess.

The Pueblo Indians of the southwest, like the Navajos, manifest overall low suicide rates, although rates vary from reservation to reservation (Levy and Kunitz, 1965; Sieversen, 1975). Reservations where the rates tend to be high are distinguished by dissolution of the traditional family structure, high levels of unemployment, inadequate job training programs, significant alcoholism, and a high index of other self-destructive behaviors such as accidents.

Among eight Pueblo groups reviewed by Levy and Kunitz (1965), suicide rates over a 10-year period varied from more than three times the national rate to the low rate of 2.4 per 100,000 in the Santo Domingo pueblo. Considering only those tribal groups with a population exceeding 1,000 Levy and Kunitz found that groups
TABLE 11
Crude Suicide Rates per 100,000 and Level of Acculturation for Pueblo Tribes in New Mexico, (1957–1979)

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Rate</th>
<th>Level Acculturation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laguna</td>
<td>45.2</td>
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</tr>
<tr>
<td>Isleta</td>
<td>41.3</td>
<td>High culture contact</td>
</tr>
<tr>
<td>Taos</td>
<td>35.6</td>
<td>Transitional</td>
</tr>
<tr>
<td>Zuni</td>
<td>31.4</td>
<td>Transitional</td>
</tr>
<tr>
<td>San Felipe</td>
<td>21.3</td>
<td>Traditional</td>
</tr>
<tr>
<td>Acoma</td>
<td>15.8</td>
<td>Traditional</td>
</tr>
<tr>
<td>Jemez</td>
<td>13.2</td>
<td>Traditional</td>
</tr>
<tr>
<td>Santo Domingo</td>
<td>2.4</td>
<td>Traditional</td>
</tr>
</tbody>
</table>

Source: Van Winkle & May (1986)

in greatest contact with the dominant society had higher suicide rates than those whom they termed “traditional.”

Van Winkle and May (1986) conducted a similar analysis for the period 1957–1979 and found the same patterns of suicide associated with high contact with the dominant society. Their study also showed increasing rates for all pueblos but Santo Domingo during this period (see Table 11).

A general pattern of suicide among the Pueblos cannot be described, however, because they do not represent a unified group for whom generalizations are meaningful, and because studies of these rather small communities are limited.

PACIFIC NORTHWEST INDIANS
Suicide rates of Tlingit Indians between 1950 and 1974 varied between 20 and 30 per 100,000 (Kraus & Buffler, 1975). These rates were similar to those of the Northwest Coast Indians in the Seattle area, 28 per 100,000 (Shore, 1972).

Suicide in traditional Northwest Coast societies was not unknown, but it was negatively sanctioned. Among the Tlingit, suicide was utilized as a method of obtaining revenge. It was resorted to in order to harass and burden others and as a bluff to get one's way (Jones, 1914; Krause, 1885; McClellan, 1954; Olson, 1967). Among the Nootka, the suicide victim was often left near the place where the suicide occurred, rather than being buried with the other dead. This may be consistent with beliefs of the Bella Coola, who felt that the body, being made up of life and spirits, could not be divided into these elements, and the spirit could not reach the afterworld, if the death had resulted from a suicide. Tribal mores among Indians of the northwest were thus opposed to suicide (Drucker, 1951; McIlwraith, 1948).

INTERMOUNTAIN INDIANS -- NORTHERN PLAINS
Pine (1981) reviewed suicide as it occurred in traditional Indian societies and pointed out that, among the Plains Indians, suicide was thought to occur as infrequently in traditional times as it does today. He cited the work of Fletcher and LaFleshe (1906), who stated that the Omaha Plains group believed suicide caused spiritual death, and that it was therefore used infrequently as a last resort when all other means of resolving a conflict failed. Pine argued that traditional attitudes toward death by suicide were key factors in low rates of suicide among Plains Indians. He pointed out that an emphasis on the concept of masculinity prevails even today, with aggression more likely to be turned toward others than toward self as suicide.

Hoebel (1940) discussed several cases of aged Mandan people who committed suicide because they were ashamed of their non-conformity to behavior appropriate to their age. Mandan suicide was very infrequent, but when it did occur, it often followed love problems or insult pertaining to one's honor.

Barter and Weist (1970), Sindell and Stuart (1968), and Pambrun (1970) reported significantly higher suicide rates for the Northern Plains tribes, including Northern Cheyenne and Blackfeet. Dizmang (1968) discovered rates as high as 100 per 100,000 among the Shoshone-Bannock; this is consistent with studies conducted in this region during this period in their history (see Table 10).
According to Resnick and Dizmang (1971), in traditional times, the Shoshone lived in the Great Basin deserts of Nevada, Idaho, and Utah in extended family-sized bands. They foraged for plants and small animals, adapting some of the Plains culture, but did not have access to the large Buffalo herds. Now the Shoshone are found on small reservations in Idaho, Wyoming, and Nevada. The Shoshone still live a marginalized existence, lacking in employment opportunities, while the non-Indians living in their area have greatly increased in both number and influence.

Resnick and Dizmang (1971) discussed sociocultural factors producing higher suicide rates on Shoshone reservations during the 1960s. Among the most important factors were the breakdown of traditional values, patterns of behavior resulting from enforced residence on reservations, geographic isolation, widespread unemployment, and a high incidence of alcoholism. The sociocultural determinants applied so strongly in this case that the authors felt that theories of individual dynamics or neurochemistry alone could not account for the high incidence of depression and suicide. High infant mortality rates (50% higher than US norms), early death (average life expectancy of 44 years), a birth rate twice that of the general population, high unemployment (about 40%; more than 10 times the national average), inadequate housing, and gross overcrowding contributed to severe acculturative stress at the crisis stage and cultural marginalization.

May and Dizmang (1974) and Watson (1969) have found that 70% of Indian youths who completed suicide, compared with only 15% of a control group, had more than one significant caregiver during their childhood and adolescence, which may be another indicator of marginalization of both household and community. In recent years, suicide among the Shoshone has decreased, correlated in part, perhaps, to improved living conditions. From 1977 to 1986, there were only one to two suicides per year, and they were exclusively male (Gregory, 1986).

Another factor contributing to higher rates of suicide among Intermountain groups may be continuities of traditional attitudes. Among some Intermountain area tribes, suicide was apparently common among women in contact times, but relatively infrequent among men (Cline et al., 1989). A common motive for suicide among the Shoshone was shame. Among the Washo, suicide was not uncommon and occurred with equal frequency among males and females (D’Azvedo et al., 1963). Among the Paiute, a group which has manifested very high rates recently, suicide was infrequent in pre-contact times (Kelly, 1934); when it did occur, it was attributed to problems in marriage or with a lover.

**BOREAL FOREST INDIANS**

Even more than the Arctic coast, the Boreal forests of Canada and Alaska are among the most climatically severe environments that support human life. In traditional times, the Native groups inhabiting these regions lived as nomadic subsistence hunters and trappers, resting and fishing during the long winter months, and preparing for the hunting season of the short summer. The extreme winter cold in these regions requires family and clan members to live in close quarters with one another. Schavinsky (1974) has reported that the confinement of the winter months is a time of particular interpersonal stress.

While low rates of suicide in several of these groups had been reported by Westermeyer and Brantner (1972) and Butler (1965), Kraus and Buffle (1976) calculated alarming increases in Alaskan Athabascan groups between 1965 and 1974. They related this escalating suicide pattern (80 per 100,000 in 1974) to a rapid increase in alcohol use and its attendant social problems.

Ward and Fox (1977) found alcohol intoxication to be a major factor in seven cases of suicide they investigated among Cree Indians in Northern Ontario. They also studied the social and psychological characteristics of the victims; all had a negative sense of self-esteem and showed a striking absence of intimacy in their interpersonal relationships. Social isolation was commonly found, often existing since early childhood. These individuals appeared to lack social skills even within their peer group, and seemed to suffer problems of identity confusion and cultural marginalization. Those who completed suicide were described as noncommunicative; they did not express their feelings directly, nor did they respond in
traditionally expected ways to abuse or rejection by members of their community and family. Though characteristic of their culture, their internalization of feelings was carried to an extreme. Their main mechanisms of coping with family and cultural conflict were escape, withdrawal, internalization, and alcohol abuse, which tended to isolate the victims further, rendering their lives hopeless and meaningless.

The association of suicide and the social markers of marginalization becomes a familiar pattern, as more remote groups are brought into closer culture contact with the dominant society. Berry et al. (1982) detailed the struggles of acculturation among the Cree of the Boreal Forests of northern Quebec, focusing on changes in acculturative stress and adaptation among youth during the period 1965–1980. They noted a change from marginalization, associated with unsuccessful efforts at assimilation and intense identity conflict among youth in the 1965–1973 period, to cultural integration and separation accompanied by identity consolidation and reduced intergenerational conflict among youth in the period 1973–1980. This change reflects increased intragroup cohesion and economic and political strength achieved during years of forceful negotiation between the Cree people and the Governments of Quebec and of Canada over land rights and use of the natural resources of their region.

Suicide was known among the Boreal forest Indians during traditional times. As Barnouw (1950) noted, they institutionalized the practice of suicide, sanctioning the act as a response taken when marital problems seem insoluble or as an appropriate act of mourning when feeling the loss of a loved one. Present day patterns of suicide, however, are not sanctioned and are more often associated with alcohol abuse and other signs of acculturative maladaptation.

ARCTIC

Among the Inuit, suicide was traditionally sanctioned when individuals became a burden to the group (Klausner & Foulks, 1982). Suicide was considered culturally acceptable, even appropriate, for individuals with chronic illness or infirmity due to age, which prevented them from hunting or keeping up with the demands of the nomadic way of life. Two primary motives for suicide were infirmity and the death of kin. When individuals became socially or physically disabled and a hardship on the community, they would sense the group's growing dissatisfaction. Ultimately, relatives might encourage them to do away with themselves. Rasmussen (1927) mentioned a young man who was told by his foster father, "I wish you were dead! You are not worth the food you eat." The young man took off his clothes, lay in the snow, and froze to death. DePoncin (1941) told of a suicide by an older man as a result of criticism about his inadequate hunting skills. In most situations where persons have been disabled through infirmity and age, it is unlikely that the group would be so openly ungenial. Nonetheless, the individuals would be well aware of their liabilities to the group, feel ostracized and shamed in many subtle ways, and become suicidal.

Among Inuit, who were especially prone to fear of separation death of a loved one also frequently led to suicide. The loss of friends and kin through death threatened one's social integration. The Inuit depended on kin and friends not only for food, clothing and comfort, but also for an emotional sense of well-being. Separation by death of a loved one, therefore, engendered a profound sense of vulnerability and social worthlessness. Others would even assist people in such a situation in committing suicide, since they desired to see them relieved of the burden they imposed on the community. It was felt that a person who committed suicide or died violently fared better in the hereafter than those who died through natural causes. Immersion in the frigid sea was a common method of committing suicide. Another was wandering out on the Arctic tundra and perishing by exposure to the cold.

Leighton and Hughes (1955) analyzed 44 cases of completed suicide on St. Lawrence Island and found that the traditional pattern of suicide persisted. Those who died by suicide were predominantly elderly (mainly men, but some women). Occasionally a younger person would hang, shoot, or stab himself with the assistance of relatives. Suffering brought on by an illness and loss of
productivity and prestige were the most common motivations for suicide. It was commonly believed that a suicide might save the life of another, such as a sick child; thus, suicide was considered altruistic and was positively sanctioned. For the individual who had lost esteem and prestige, the act offered a way to regain social approval.

Balikci (1961) collected data on 50 suicidal persons in Pelly Bay, Canada, over the preceding 50 years. Of these, 35 committed suicide, 4 made abortive attempts, and 11 expressed suicidal intentions. Twenty apparently committed suicide because of personal suffering from illness or misfortune. Marital disharmony appeared to have precipitated six suicides. Only four persons took their lives because of old age and infirmity. Recently, there has been a marked decline in suicide among the elderly and an increase in suicide among the younger age groups (Kraus & Buffler, 1975).

Nachman (1969) described an epidemic of suicide attempts in Bethel, Alaska, during the winter and spring of 1968. Following one completed suicide, 15 abortive attempts were made during the following 60-day period. Similar but milder "outbreaks" of suicidal behavior were described in the towns of Barrow and Kotzebue. Most of those cases involved women in their teens or early twenties who had experienced a rebuff or loss of friendship, and most attempted suicide by taking a drug overdose.

Drugs and alcohol have provided the acculturating Inuit the medium by which to escape psychological pain and obtain momentary relief through psychosocial "time out." For those under more intense psychological pain, suicide under intoxication has offered a lasting escape. The traditional dissociative trance state served similar psychological functions for the Inuit. The dynamic central to each of these behaviors involves escaping feelings of social worthlessness and depression engendered by feelings of frustration and anger.

The suicide death rate of the Inuit is below that of the Athabascans and Aleut among the Alaskan natives and higher than that of the Tlingit and Southwest Eskimo. The suicide rate for the Inupiat is about 2 times as high as the Alaskan native average and about 6½ times higher than the United States average (see Figure 4).

Kraus and Buffler (1975) found escalating suicide patterns among the Inuit and Yuit, which parallel patterns they discovered among the Athabascans of Alaska. The suicide rates increased from 30 per 100,000 to almost 70 per 100,000 between 1965 and 1974. Suicide was associated with alcohol use in almost all cases. The victims were young, of both sexes, and usually died while intoxicated.

Klausner and Fouks (1982) have related increasing suicide rates and alcohol problems in Native Alaskans to the rapid social and cultural changes experienced during the past decade of major exploitation of energy resources in the Arctic. They reported that about 30% of the population were relatively well prepared for shifts in their way of life through generations of family contact with traders, missionaries, and United States government representatives. This group has adapted to the acculturative stress by means of
cultural and psychological integration. The majority of the Inuit population, not so well-prepared by historical circumstances, however, has experienced great distress in trying to cope with the process of rapid acculturation in their region. They have become victims of alcohol abuse, depression, and in some cases, suicide. Their lives have been marked by self-doubt and the lack of direction that we have called identity confusion and marginalization.

**DISCUSSION**

While there is great variation in geography, culture, language, history, and socioeconomic circumstances among Native American groups, and while this variation is a factor in the disparate rates of suicide reported, there nevertheless emerges a definitive pattern of self-destructive behavior which can be generalized to all groups. Despite the wide variation in suicide rates by region, by time in history, in character, and in extent of culture contact, the majority of Native American suicide victims are young people who suffer family discord, social disintegration, and culture conflict. Levy (1969) points out that "the young male is bearing the brunt of the stresses in the society due to his immediate involvement in the economic and role changes taking place at present and . . . due to the lesser degree of stability or integration afforded him in his society."

Acculturative stress is intense for the young adults in Native American communities. Indian youth experience not only the personal identity crisis of adolescence, but also the additional burden of the adaptational crisis of their culture. The psychological helplessness and increased feelings of hopelessness engendered by such circumstances sometimes make a self-sought death seem an acceptable solution. For an individual caught up in cultural crisis, suicide can offer a sense of gaining control over constant anxiety. Demographic factors associated with marginalization, such as family breakdown, parental loss, and early separation, contribute to depression and suicide in later years.

Alcohol abuse has also proven to be a major factor in Native American suicide. Drinking has contributed to the disintegration of family life in many groups, and has resulted in child neglect, abuse, and other forms of intrafamilial and community violence; all these are indices of cultural disintegration. Such tragic personal histories are frequently implicated in the cases of completed suicide.

Health problems, educational disadvantages, and poverty have been major factors in Native Americans’ struggle for consolidation of their cultural identity. Integrationist and assimilationist responses to acculturation require that paths of opportunity be open in the dominant society. Educational, economic, social, and political opportunities have been severely lacking and have forced most Native American groups into other forms of adaptation, particularly separation and marginalization. Because of historical factors, such as isolation and habitation in their indigenous lands, some Native American communities have been able to maintain separationist responses to acculturation pressures. These responses strengthen both cultural and psychological identity. Separationist responses consolidate psychological identity formation based on traditional cultural values and practices, and reduce vulnerability to the kinds of self-doubt and self-criticism that can lead to suicide among those whose coping skills are weakest. Groups that have maintained separationist responses, such as many of the Southwestern Pueblos and the Navajo, have experienced lower suicide rates than other Native Americans faced with the combined pressures of modernization, technological change, and acculturative stress. Where groups are located near medical emergency rooms, the lives of individuals who have attempted suicide might be saved. Some Native American communities, such as the Inuit with a long history of contact, the Cree, and the Northwestern tribes living on the Warm Springs Reservation, have adapted to acculturative stress by forms of cultural, economic, and political integration with the dominant society. This integration has enabled them to provide adequate supports for the identity consolidation of their youth and young adults and, thereby, has reduced the risk of suicide among them.

Where traditional lifestyles and values have been eroded by displacement, disease, persistent unemployment, poverty, and religious and educational efforts to discourage “old ways,” separationist and integrationist adaptations tend to break down. Many Native
American groups have endured this situation for generations; with pathways to assimilation to the dominant society blocked, they have slipped or been forced into cultural marginalization. These groups have lost many essential values of traditional culture and have not been able to replace them by active participation in American society in ways that are conducive to enhanced cultural and psychological self-esteem. The feelings of loss, alienation, self-denigration, and identity confusion engendered by this situation are reflected in the escalating rates of suicide witnessed in many Native American communities.

While many stubborn problems remain, current social forces may modify acculturative stresses and reduce vulnerability to suicide. Considerable progress has been made in reducing mortality and morbidity from communicable diseases and in lowering infant mortality rates. Each year, more American Natives are attending high school and college, and scholarship assistance is more readily available. This has resulted in the emergence of a cadre of articulate and respected young adult leaders who now represent for Native American youth a model of successful cultural and psychological integration. Pan-Indian awareness has contributed to pride, local decision making, and local responsibility in facilitating effective political participation. Such self-determined political participation resulted, for example, in the formation of the Alaska Federation of Natives (Klausner & Foulks, 1982). This Federation was instrumental in negotiating the Land Claims Settlement Act of 1972, and helped form corporations to manage the resources provided by the Settlement. Similar developments have characterized the contemporary history of the Cree Indians in the James Bay region of Quebec, the Navajo, Pueblo and other Indian tribes of the Southwest, and the Yurok and other Northwest tribes.

In Alaska, development of land corporations resulted in an increase in per capita income and rights to land which have great potential for economic development. Subsequently, many communities have taken over the management of their own educational, safety, health, and welfare programs and have become less dependent on government-provided services. In the process, jobs have been generated for Native Americans, and individuals have learned the administrative, business, and political skills needed to represent their people in dealings with the dominant society. The role models that these people provide for contemporary Native American youth may be of great importance to the future of their people and to the reduction of acculturative stress among groups and individuals.

Most mental health efforts of the past were directed at secondary and tertiary programs; primary prevention programs have been developed only recently. Shore et al. (1972) describe the development of a suicide prevention center on a Northwest Reservation. Dinges and Yumori (1987) provide conceptualizations of preventive mental health issues that aim directly at promoting psychological health and competence. Maintenance and enhancement of self-esteem have broad disciplinary acceptance as a unifying concept for understanding the prerequisites of positive mental health. Iscoe (1974) identified the characteristics of the competent community as providing a repertoire of possibilities and alternatives, knowing where and how to find resources, self-esteem, and power. The last element, power, is construed as the right to self-determination and is linked to recent cultural revitalization movements—bicultural attempts by Native American communities to erect meaningful frameworks for operating vis-à-vis the dominant US society (Medicine, 1981). Manson et al. (1982) have called for a major departure from past lines of inquiry regarding the mental health of Native Americans by focusing instead on ethnological definitions of psychological health, maturity, and competence, and on causal linkages of these elements in the context of a systematic theory of human adaptation.

The past decade has witnessed a movement toward integration and assimilation by Native Americans. As more educational, occupational, and economic opportunities become available, the cultural and psychological adaptations of rejection and marginalization are likely to decrease. While Pan-Indianism has created increased political cohesion and a national awareness among the many ethnically diverse Native American groups, it has also generated local pride and identification with traditional values. The new generation of Native Americans affirms its traditional ethnic identity,
while accommodating and adjusting to the demands and prerequisites of living in a technological, changing nation.

At this process unfolds, the identity confusion, self-denigration, and despair often observed in Native American communities, and associated with social disorganization, alcohol abuse, and family violence, may give way to a positive bicultural self-development consistent with cultural and psychological integration. While this process can create tensions and social problems of its own, the risk of identity confusion and suicide of youth and young adults is much reduced. Primary prevention of Native American suicide is predicated on continued development of effective social, economic, and political institutions and the accompanying communal and personal internalization of a sense of control.

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4

SUICIDE AMONG THE CHINESE AND JAPANESE

Linguistic custom in the United States tends to group all peoples who have migrated from the Far East under the label “Asian-American,” just as we group a variety of Latin Americans as “Hispanic-Americans” or “Hispanics” (see Chapter 5). However, it is important to keep in mind that Asian-Americans consist of immigrants and their descendants from different countries, with diverse ethnic backgrounds, speaking different languages, and coming from widely disparate cultures. As a group, Asian-Americans include Chinese, Japanese, Koreans, Filipinos, Southeast Asians, Indians, Pakistanis, Sri Lankans, Pacific Islanders, particularly the Samoans, a substantial number of whom have recently migrated to California, and others. Some, such as the Japanese, have lived in the United States for generations (Yamamoto & Wgatsuma, 1980). Others, like the Chinese, include both recent arrivals and those who came to this country in the nineteenth century. Still others, like the Southeast Asian refugees fleeing from the consequences of the Vietnam War, have arrived in large numbers in the last two decades. The Asian population as a whole is one of the fastest growing ethnic groups in the United States; it has doubled in number in the last 10 years.

In a report on suicide in ethnic groups, it would be desirable to examine suicide rates and their causes for all these groups. From a public health point of view, it would be particularly desirable to review the situation for the Southeast Asians. It is well known, for example, that the Cambodians have suffered severely from high rates of post-traumatic stress syndrome as a result of their experiences under the Pol Pot regime. Many of them have undergone atrocities at the hands of the Vietnamese invaders; some have had devastating pirate attacks following their escape from Cambodia. It would have been helpful to compare the reactions of these survivors with those of the Koreans, who are well-known for their high motivation and economic success in the US. Similarly, it would have been interesting to review the suicide rates for the Filipinos, most of whom are Catholic and consider themselves closer to the culture and traditions of the United States, and for whom the stress of acculturation following migration to the US would therefore presumably be less severe.

Unfortunately, such examinations have been impossible because of the lack of reliable data on suicide among these groups. The most consistent data on Asian-American groups are on Chinese- and Japanese-American populations. This chapter will, therefore, focus on these two groups. There are, additionally, some particular advantages in comparing the two groups. One is the fact that some suicide data exist for the Chinese and Japanese in their countries of origin, providing some insight into the consequences specific to their migration and acculturation. Another is the striking difference in the attitudes toward suicide in the countries of origin. As will be described below, ritual suicide in Japanese culture has been a socially sanctioned practice, fostered in obedience to the Emperor or as an honorable solution to certain social dilemmas (Benedict, 1946; Iga, 1986). In contrast, Chinese tradition has not codified suicide as socially acceptable. These contrasting traditions are reflected in patterns of suicide demonstrated by these groups in their adjustment to American society.

ACCULTURATION EXPERIENCES OF CHINESE-AMERICANS AND JAPANESE-AMERICANS

During the mid-nineteenth century, Chinese laborers were recruited to provide low-paid manual labor for building railroads, for mining, and for farming in the western United States. Because of the Boxer Rebellion and for other political reasons, the Chinese were never treated with the same courtesy accorded immigrants from European nations. There is a long history of both official and unofficial discrimination against them. Official discrimination accounts for
the fact that there were two basic waves of immigration. The first began during the Gold Rush years in California in the 1850s and continued until the passage of the Oriental Exclusion Act in 1924.

Chinese immigrants experienced strong discrimination and bias that prevented them from working toward an integrationist mode of adaptation to culture contact with the dominant society, and that enhanced their proclivity to maintain separate communities resistant to close contact with the surrounding majority population. Racial, linguistic, and other cultural differences made early attempts at integration almost impossible (Cheung, 1978). Most of the Chinese who came to Hawaii and the West coast of the United States were recruited from peasant backgrounds. They came as sojourners hoping to make a fortune and return with money to their families. Discriminatory legislation reinforced their sending money home, since it became illegal for Chinese men to bring their wives over during their work stay in the United States.

Chinese civilization is old and long influenced by the teachings of Confucius, which emphasize harmony in the home, propriety between husband and wife, and a traditional, sexist, hierarchical society. Transition to the U.S. communication-oriented, individualistic society is a very major and stressful change.

At the turn of the century, Japanese workers were also recruited from peasant communities. However, despite the anti-Oriental attitudes which prevailed at that time in the Western United States, Japanese men were allowed to bring their wives with them and to settle. They were treated with more respect, probably because of Japan’s naval victory over Russian forces during this period. From 1924 to 1965, however, the Oriental Exclusion Act prohibited further legal immigration of Asians into the United States. Since immigration law was reformed in 1965, large numbers of Chinese, Filipinos, Koreans, Japanese, and Southeast Asians have come to America. Most of the Asian population (56%) is still concentrated on the West Coast (US Bureau of the Census, 1981).

The second wave of Chinese immigration began in 1965 with the reform of the Immigration Act and the provision for 20,000 new immigrants from each nation. Since there are Chinese in Hong Kong, Taiwan, the People’s Republic of China, many Southeast Asian nations, and the Philippines, there has been a remarkable increase in the number of ethnic Chinese who have immigrated to the United States. In contrast to the early immigrants, the recent Chinese, mainly from Hong Kong and Taiwan, are primarily from affluent backgrounds. Among post-1965 Chinese immigrants to the US, 71% have had a high school education or above and 37% are college graduates. Many are professional people. This higher socioeconomic status is exemplified in the Monterey Park area of California, where businesses are burgeoning and upper-middle-class developments are expanding (US Bureau of the Census, 1983).

According to the 1980 census, 59% of the total Asian/Pacific Islander population are foreign-born (US Bureau of the Census, 1983). Japanese-Americans, in contrast, are for the most part third- and fourth-generation Americans (only 28% are foreign-born). Third- and fourth-generation Japanese-Americans are, like recent Chinese immigrants, generally well educated; 82% have been to high school or above and 26% have completed college. Japanese-Americans have the highest family income levels, averaging $27,354. The Chinese-Americans are not far behind with average family income of $22,559. There are over 3,500,000 Asian-Americans currently living in the United States, with a median age of 29.4 years, in contrast to 31.2 for the total US population. Given the rising rates of youth suicide in the United States as a whole, the younger age of this population might be a factor in predicting high suicide rates.

One index of the acculturation process is religion. Despite two to three centuries of active American and British Christian missionary efforts in China and Japan, conversion to Christianity in the homelands was relatively uncommon. Within the United States, however, there has been a trend toward giving up such traditional religions as Taoism, Buddhism, and Shintoism and turning to Christian churches. At first glance such movement could appear to be assimilationist. However, on closer inspection, many of these Christian churches are specifically designated as Asian-American.

TRADITION OF SUICIDE IN JAPAN

Altruistic suicide has been a time-honored practice in the history of Japan, as in the story of The Lady Tekona, a beautiful woman
highly sought after by two young men. Both young men proposed marriage to her, but she could not choose between them, nor could she refuse either one. She resolved her dilemma in a way to avoid embarrassing either of her suitors, by committing suicide. Immediately thereafter, one of her suitors followed her in suicide; shortly thereafter the second suitor also killed himself (Yamabe & Takahashi, 1981). Today, there is a shrine to honor The Lady Tekona and a Shinto temple to memorialize this woman who, even to this day, is honored as one who exemplifies the importance of saving face in interpersonal relationships.

Another famous story concerns the 47 samurai who plotted together and finally killed the persons responsible for their master’s death. All 47 of them then committed suicide in the ritual manner of seppuku (also called kara-kiri), thus atoning for the crime of killing all those who had wronged their master.

A more recent example is the case of Admiral Nogi, who led Japanese naval forces to victory over the Russians at the turn of the 20th century. Miserable because so many of his men died in battle, Admiral Nogi wanted to atone and commit suicide. His Emperor prevailed upon him not to precede him in death. Thus, Admiral Nogi waited to commit suicide until after the Emperor had died of natural causes.

The traditional methods used in Japan for committing suicide not based on seppuku (which was for warriors) were hanging, cutting, jumping off high places, drowning or suffocating (Yamamoto, 1976). Certainly, the powerful ethos among Japanese that one must be of use to one’s society, and must achieve in order to be worthwhile, leads to feelings of worthlessness and shame when achievement has not been attained. In some cases suicide is an honorable alternative to failure.

CURRENT SUICIDE IN JAPAN AND CHINA

Suicide is not uncommon today among highly competitive Japanese schoolboys and schoolgirls following failure of college admissions examinations. This is regarded by Japanese authorities as a serious social problem. In the current atmosphere, even mature Japanese men, depressed by the materialistic competitiveness of their economy, frequently choose to kill themselves in order to escape the “rat race” (Matsugi, 1986).

Yap, writing on suicide in Hong Kong, (1958a, 1958b), emphasized many of the dynamic issues in the precipitation of both suicide attempts and completed suicide, but he did not comment on the degree of social acceptability of suicide in Chinese culture. We can therefore assume that Yap viewed suicidal behavior as related to intrapsychic and interpersonal factors and not as culturally acceptable behavior.

Yap also compared rates of suicide between Chinese in Hong Kong and Japanese in Japan. He found Japanese rates to be 23.4 per 100,000, compared to 14.2 for the Hong Kong Chinese. Similarly, Japanese rates are also higher in comparison to rates of Chinese in Taiwan (Kato, 1981; Yeh, 1981). From 1977 to 1980 the rates were approximately 17.8 per 100,000 in Japan versus 9.8 per 100,000 in Taiwan (Yamamoto & Kato, 1982; Yeh, 1981).

SUICIDE AMONG JAPANESE-AMERICANS AND CHINESE-AMERICANS

From 1970 to 1975, suicide among Japanese-Americans was 9.7 per 100,000 and among Chinese-Americans, 8.9 (Frederick, 1978). During this period the rate among Americans generally was 12 per 100,000. Thus, both Asian populations manifested rates lower than other Americans, despite the relative youthfulness of the Asian-American groups. Women continue suicide in a much greater proportion among Chinese-American and Japanese-American populations than among the non-Asian population, especially after the age of 55. Nevertheless, their rate remains lower than the rate of Asian-American males (Liu & Yu, 1985b). The rate of suicide among Asian-American women tends to increase with age, as shown in Table 12. Above the age of 45, the rate for Chinese-American women becomes higher than for White American women (13.9 vs. 11.2). The rate for Chinese-American females continues to increase until, for those 85 years of age and older, it is 49.9 per 100,000. In contrast, among White American women, the rate for those 85 years and older declines to 4.9.
<table>
<thead>
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<th>Age Group</th>
<th>Total</th>
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<th>Female</th>
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<td>Age-adjusted</td>
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<td>12.28</td>
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<td>12.34</td>
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<tr>
<td>65-74 years</td>
<td>24.35</td>
<td>25.85</td>
<td>22.61</td>
</tr>
<tr>
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<td>33.51</td>
<td>21.82</td>
<td>44.32</td>
</tr>
<tr>
<td>85+</td>
<td>56.13</td>
<td>64.10</td>
<td>49.93</td>
</tr>
</tbody>
</table>

Sources: Liu & Yu (1985a, 1985b)

Japanese women have lower rates of suicide than White women overall, but considerably lower than among Chinese women, in every decade after age 35. By age 85 and over, the suicide rate has declined by 3.5% per 100,000 per year. Among people aged 65-84, the Japanese rate of suicide is lower than the Chinese. Both increase with age, however, peaking at the age group 95 years. In 1985, the male/female combined rate for the Chinese was 19.76 per 100,000. For this age group, the combined rate for the Chinese was 56.13 per 100,000. Among those aged 85 years and over, the Japanese rate of suicide is lower than the Chinese.
be taken care of in their old age. Traditional Asian women will perceive such a shift of values as a lack of filial piety and respect, and as the ultimate rejection. In this situation, some might choose suicide as an honorable alternative.

Substance abuse is relatively uncommon among Asian-American populations; however, it is not unknown. During World War II, kamikaze pilots sacrificed their lives in the traditional samurai spirit. Their acts were facilitated by the use of amphetamines and sake (rice wine) to bolster their courage and maintain their resolve. The role of chemical substances in facilitating an altruistic suicide in an elderly person is a subject requiring further exploration. There are no data to suggest that this is a significant problem. In any case, Asian-American suicidal behavior is not associated with impulsive acts following substance abuse, but rather is planned with considerable forethought and organization.

Yamamoto and Iga (1975) cited several recent examples of such contemplated long-term planning for the suicide act. The famous Japanese author, Yukio Mishima, committed suicide after haranguing the Japanese self-defense forces (army) about the need to return to samurai values. Shocking people not only in Japan but all over the world, he committed suicide by ritual seppuku (abdominal disembowelment) in the classical samurai manner using a sword, and was immediately decapitated by his friend and trusted companion (Abel, 1978; Lifton, 1982; Yamamoto & Iga, 1975). Yamamoto gave another example when a chef of a major Japanese airline committed suicide because the food he had prepared had resulted in passengers becoming ill from food poisoning.

The suicide rate among Asian-Americans is, for most age groups, relatively low compared to other Americans. The figures no doubt reflect the relatively high socioeconomic and educational status of these populations and the relative success of integrative and assimilative acculturation modes. A smaller proportion of the overall Asian-American population, however, has maintained a separationist or resistive acculturation position. This group of traditionalists seems to function relatively successfully until their elderly years, when the new cultural values of the greater society begin to clash harshly with traditional Confucian values. People become isolated and alienated from their younger, integrated or assimilated fam-

ily members and, adhering to their cultural ideals, commit suicide in the manner and for the reasons found in the old country.

Group figures, however, provide us only with averages; they tell us nothing about an individual case. From this point of view, it may be helpful to include an illustrative vignette.

In 1984 in Los Angeles, a Japanese woman attempted to commit suicide. She was 35 years old, married, and distraught because her husband was having an affair with another woman. She became progressively more depressed and dysfunctional. On a bright spring morning she went to see a doctor because one of her two young children was ill. Because of the long lines of patients waiting to see the doctor, she left and went to the beach. There she bought lunch for herself and the two children (one still nursing, one 4 years old). She then walked into the ocean with the two children in order to commit family suicide. The attempt was only partially successful; she survived, but tragically, the infant and the 4-year-old drowned. Subsequently, the mother was confined to jail and accused of murder. In response to this legal process, there was a large outcry from the Japanese-American community. They were sympathetic to the motivations of a Japanese mother attempting to solve her dilemma through suicide including her children. In traditional Asian communities, the family is the unit, not the individual. This was Japanese suicide, not American murder (Iga, 1986; Reese, 1985).

**DISCUSSION**

This discussion of suicide among Asians/Pacific Islanders is limited to the two groups for whom there are data available in the United States: the Chinese and the Japanese. There are many other Asians in the United States who are very important members of this minority group.

A contrast between the Chinese and Japanese is of interest because of the difference in acceptance of suicide as a solution to life's problems. In Japan, for the last several hundred years, suicide has been considered an acceptable solution to certain problems; there are heroic stories of suicides for altruistic purposes. In China, this has not been true. Among the Chinese there is no modern tradition of suicide as a socially acceptable response to particularly
troublesome circumstances. In fact, there is a traditional expectation of troubles as fate that must be borne. It is not surprising then that the overall rate of suicide is relatively low. We hypothesize that these differences may result in suicide being more frequent among the Japanese than Chinese. As we have demonstrated, suicide rates in Hong Kong and in Taiwan are lower than in Japan. Unfortunately there are no recent suicide rates available for mainland China.

Suicide rates among Chinese-Americans, though generally lower than those for White Americans, are similarly distributed by age, with peak rates among those aged 65 and over. The ratio of male-to-female rates is particularly distinctive among Chinese-Americans, with slightly higher overall rates among females because of the high incidence of suicide among older Chinese-American women.

The acculturation experience of Chinese-Americans is relevant to the phenomenon of suicide. The earliest Chinese immigrants to the United States were peasants brought over to work as laborers in the 19th and early 20th centuries, prior to the Oriental Exclusion Act of 1924. There were relatively few women among this group of early migrants. Not until 1965, when the Exclusion Act was repealed, did the majority of Chinese-American women have the opportunity to immigrate.

Thus, some of these new immigrants to the US from China are elderly females, unable to speak English and unable to cope with the majority society. They maintain a separatist mode of acculturation, many living in the Chinatowns across the United States. They may become depressed because they lack traditional familial support. Feelings of worthlessness and psychological isolation in older years may be important factors in the high rate of suicide in this cohort.

Although more of the recent Chinese immigrants are affluent, a substantial proportion is impoverished. This includes many older women, most of whom possess few marketable skills. Poverty, combined with conflict between traditional Chinese values that emphasize the importance of the family (with its central female role) and those of the dominant culture (which espouses greater equality between the sexes), places greater stress on traditional Chinese-American women. As they survive as widows, this source of stress is reflected in the relatively high rates of suicide among women, particularly aged ones.

The combination of value conflict and economic pressure, in the absence of the support expected in traditional families, may contribute to relatively high rates of suicide among aged males as well. That is, for elderly Chinese females and males experiencing acculturative stress, traditional culture and identity are of value and to be retained; whereas, positive relations with the larger dominant society are not sought. The result is separatist or resistive acculturation.

Among the Japanese there is a tradition of suicide as a way out of difficult circumstances. Consequently, suicide rates in Japan are consistently higher than for the general population of the United States. “Since 1950, the suicide rate of Japanese older persons of both sexes has been decreasing significantly (males aged 65–74, 45; ages 75+; 79; females 65–74, 51; ages 75+, 54). In 1950, the suicide rate of those aged 65–79 was 80.6 per 100,000. In 1982, it was 42.4 per 100,000, a decrease of approximately one half in about 40 years... But it is very hard to explain why the suicide rate of older women only is higher in Japan” (Maeda et al., 1988).

However, rates among Japanese-Americans are generally lower than those of White Americans. The distribution of suicide rates by age for Japanese-Americans also differs from that of White Americans. Among Japanese-Americans, there is a minor peak among young adults and a major peak among the elderly. Unlike the case for White Americans, however, there is no consistent increase in rates concomitant with increasing age. Among Japanese-Americans, the ratio of male-to-female suicide rates is approximately 2.2 to 1.

The relatively high socioeconomic status that characterizes Japanese-Americans today must be taken into account when looking at suicide rates. Japanese immigrant peasants prior to 1924 included a substantial proportion of women, and the majority of Japanese-Americans today are descended from this original immigrant group. Acculturation has been ongoing through two, three and four generations. Thus, the acculturative stress is of a chronic nature.

In viewing the age of Japanese-American suicides, it is important to realize that the distribution is bimodal, that only the most elderly over the age of 75 would be first generation (Issei). There is a minor peak of suicide among young adults and a major peak
among the elderly. The peak among the youth and young adults may be explained, in part, by the fact that the age cohort of Japanese-Americans represent a highly educated and culturally integrated group, for whom the psychosocial issues leading to suicide are similar to their age cohort in the majority population. Even among the elderly Japanese-American females and males, most are second or third generation. Instead of the separation mode of the seri, the second and third generations have adopted the integration mode of adaptation to the stress of acculturation. This would explain how the pattern of suicide among Japanese-American females is generally lower than among White American females, with the exception of those 75 years and older.

There are three possible explanations for the lower suicide rates of Japanese-American women younger than 75 years old compared to White American women: 1) acculturation overrun—becoming more American than Americans; 2) positive integration in the American culture with socioeconomic adaptation; and 3) strong family ties that continue into the second and third generations.

The comparison of the Chinese and Japanese suicides in the United States is not of the same generation or of cohort of English-speaking Asian immigrants. On the contrary, many of the Chinese have come recently to the United States. Although many of these recent immigrants are more affluent, well educated, and with intact families, nonetheless, they are mixed statistically with the original cohort of Chinese immigrants, who were mostly males who were not permitted to bring their families to the United States. The Japanese, on the other hand, are mostly descended from the original cohort of immigrants prior to 1924. There are many more Japanese than Chinese who are American-born, in the second or third or fourth generation, speaking English, educated in the United States, and adapting with an integrative mode of acculturation.

The cultural dynamics in this case—and in our analysis of suicide rates among Chinese-Americans and Japanese-Americans—bring us finally to the questions of public health policy, which will be discussed more fully in the last chapter. Should the United States pursue a multicultural and multiethnic policy in regard to health as it does in education? Should we attempt to nurture self-and ethnic confidence? Should we try to promote intergroup sharing? If such policies reduce acculturative stress, it is likely that they would also reduce the incidence of suicide. This is a matter that requires thoughtful consideration from public policymakers.

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5

SUICIDE AMONG HISPANIC-AMERICANS

The relative paucity of information about suicide among the Hispanic population in the United States, together with the diversity of Hispanics, has led us to limit our attention in this chapter to Puerto Ricans and Mexican-Americans. These two ethnic subgroups comprise two-thirds of all Hispanic-Americans in the United States. While there are differences among the Hispanic groups who have immigrated to this country, the groups nevertheless share a number of sociocultural attributes.

In this chapter, we shall present data concerning these two subpopulations of Hispanics living in the United States. We shall also characterize these groups by outlining special sociocultural features that distinguish them from each other and from non-Hispanics. Then, we shall review the available data on suicide in these Hispanic subgroups in order to compare them to the suicide rates and patterns in their places of origin.

DEFINITION OF THE POPULATION

The US Bureau of the Census reported that the total Hispanic-American population of the United States was nearly 17 million people in 1985, representing 7.2% of the total US population of over 234 million. The largest proportion of Hispanic-Americans (42.8%) was living in the West, 30.6% lived in the South, 17.8% in the Northeast, and 8.8% in the North Central area of the country (US Bureau of the Census, 1982-A). Mexican-Americans were the largest Hispanic subgroup (60.6%), followed by Puerto Ricans (15.1%) and Cuban Americans (6.1%). Other Hispanic-American groups, such as Salvadorans, Colombians, and Dominicans, combined represented 18.2% of the estimated Hispanic population of the US in 1985. Recent estimates (US Bureau of the Census, 1987) indicate that there are approximately 2 million undocumented Hispanics in the United States.

Two groups of Hispanics were excluded from these figures. Puerto Ricans actually living in Puerto Rico were not included. Most of them cannot be said to have been exposed to the effects of migration; although many have moved back and forth between Puerto Rico and the mainland. The Cubans who recently arrived in this country in the “Mariel” exodus, numbering about 125,000, were excluded from the 1980 census because their migration occurred in the spring of that same year (Queralt, 1984).

Table 13 gives the latest demographic data on social characteristics of Hispanic-Americans, comparing them to the total US population, as well as to the population not of Hispanic origin. This table shows that Hispanic-Americans are younger, with a lower median age and a lower percentage of people aged 18 years and over. Hispanic-Americans have a slightly higher percentage of single people and a lower percentage of married and widowed people than do either the total US population or the non-Hispanic population.

In education, Hispanic-Americans lag significantly behind the non-Hispanic population. Over 13% of adult Hispanic-Americans have had fewer than five years of school, compared to 2% of non-Hispanics. Less than half of adult Hispanic-Americans have had four years of high school or more, compared to more than three quarters of the adult non-Hispanic population. Only 8.5% of adult Hispanics have had four or more years of college, in comparison to more than twice that proportion of non-Hispanics.

Hispanic-Americans also differ from the non-Hispanic population in family size and composition. As can be seen in Table 13, not only are Hispanic-American families larger than non-Hispanic families, but they are more likely to be led by a single parent.

Table 14 serves to contrast the economic profile of Hispanic-Americans with that of non-Hispanics and that of the total US population. It can be seen that unemployment is higher among Hispanic-Americans than among non-Hispanics, and that, among
TABLE 13
Selected Social Characteristics of All Persons
and Persons of Spanish Origin in the US, 1985

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total US Population</th>
<th>Total US Hispanic Pop.</th>
<th>Mexican-American</th>
<th>Puerto Rican</th>
<th>Non-Hispanic Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (in thousands)</td>
<td>234,066</td>
<td>16,940</td>
<td>10,269</td>
<td>2,562</td>
<td>217,126</td>
</tr>
<tr>
<td>Percent</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Under 5 years</td>
<td>7.7</td>
<td>10.7</td>
<td>11.7</td>
<td>10.6</td>
<td>7.4</td>
</tr>
<tr>
<td>5-17 years</td>
<td>19.0</td>
<td>25.3</td>
<td>27.4</td>
<td>26.5</td>
<td>18.6</td>
</tr>
<tr>
<td>18-64 years</td>
<td>61.8</td>
<td>59.2</td>
<td>56.8</td>
<td>60.3</td>
<td>61.9</td>
</tr>
<tr>
<td>65 years plus</td>
<td>11.5</td>
<td>4.8</td>
<td>4.2</td>
<td>2.7</td>
<td>12.0</td>
</tr>
<tr>
<td>Median age (years)</td>
<td>51.4</td>
<td>25.0</td>
<td>28.3</td>
<td>24.5</td>
<td>31.9</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total, 15 years and over (in thousands)</td>
<td>182,316</td>
<td>11,776</td>
<td>6,814</td>
<td>1,774</td>
<td>170,540</td>
</tr>
<tr>
<td>Percent</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Single (never married)</td>
<td>26.2</td>
<td>31.2</td>
<td>31.0</td>
<td>37.5</td>
<td>25.8</td>
</tr>
<tr>
<td>Married</td>
<td>59.2</td>
<td>57.9</td>
<td>59.6</td>
<td>50.1</td>
<td>59.3</td>
</tr>
<tr>
<td>Widowed</td>
<td>7.4</td>
<td>4.7</td>
<td>4.9</td>
<td>4.2</td>
<td>7.6</td>
</tr>
<tr>
<td>Divorced</td>
<td>7.2</td>
<td>6.2</td>
<td>5.4</td>
<td>8.2</td>
<td>7.2</td>
</tr>
</tbody>
</table>

Education
Total, 25 yrs and over (in thousands) | 143,524 | 8,755 | 4,755 | 1,241 | 155,070 |
Percent completed—
   Less than 5 yrs of school          | 2.7     | 13.5  | 17.1  | 12.8  | 2.0     |
   4 yrs high school or more         | 73.9    | 47.9  | 41.9  | 46.3  | 75.5    |
   4 yrs college or more             | 19.4    | 8.5   | 5.5   | 7.0   | 20.1    |
Med mean school years completed     | 12.6    | 11.5  | 10.2  | 11.2  | 12.7    |

Type of Family
All families (thousands)            | 62,706  | 3,939 | 2,251 | 621.0 | 58,767  |
Percent                             | 100.0   | 100.0 | 100.0 | 100.0 | 100.0   |
Married-couple families             | 80.3    | 71.7  | 75.7  | 52.0  | 80.9    |
Female householder, no husband      | 10.2    | 23.0  | 18.6  | 44.0  | 15.7    |
Male householder, no wife           | 5.6     | 5.3   | 5.8   | 0.0   | 3.4     |
Mean number of persons/family       | 3.2     | 3.9   | 4.2   | 3.6   | 3.2     |

Source: US Bureau of the Census (1985)
### TABLE 14
Selected Economic Characteristics of All Persons and Persons of Spanish Origin in the US, 1985

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total US Population</th>
<th>Total US Hispanic Pop.</th>
<th>Mexican-American</th>
<th>Puerto Rican</th>
<th>Non-Hispanic Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Labor Force Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total, 16 yrs and over, (in thousands)</td>
<td>178,587</td>
<td>11,466</td>
<td>6,625</td>
<td>1,721</td>
<td>167,121</td>
</tr>
<tr>
<td>In civilian labor force</td>
<td>114,256</td>
<td>7,362</td>
<td>4,427</td>
<td>882</td>
<td>106,894</td>
</tr>
<tr>
<td>Percent in civ. labor force</td>
<td>64.0</td>
<td>64.2</td>
<td>66.8</td>
<td>51.2</td>
<td>64.0</td>
</tr>
<tr>
<td>Percent unemployed</td>
<td>7.6</td>
<td>11.3</td>
<td>11.9</td>
<td>14.3</td>
<td>7.4</td>
</tr>
<tr>
<td><strong>Males, 16 yrs and over</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(in thousands)</td>
<td>85,132</td>
<td>5,643</td>
<td>3,402</td>
<td>754</td>
<td>79,489</td>
</tr>
<tr>
<td>In civilian labor force</td>
<td>68,365</td>
<td>4,427</td>
<td>2,773</td>
<td>504</td>
<td>58,938</td>
</tr>
<tr>
<td>Percent in civ. labor force</td>
<td>74.4</td>
<td>78.5</td>
<td>81.5</td>
<td>66.9</td>
<td>74.1</td>
</tr>
<tr>
<td>Percent unemployed</td>
<td>7.8</td>
<td>11.8</td>
<td>12.5</td>
<td>15.0</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Females, 16 yrs and over</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(in thousands)</td>
<td>93,455</td>
<td>5,823</td>
<td>3,223</td>
<td>967</td>
<td>87,532</td>
</tr>
<tr>
<td>In civilian labor force</td>
<td>50,891</td>
<td>2,935</td>
<td>1,654</td>
<td>378</td>
<td>47,966</td>
</tr>
<tr>
<td>Percent in civ. labor force</td>
<td>54.5</td>
<td>50.4</td>
<td>51.3</td>
<td>59.0</td>
<td>54.7</td>
</tr>
<tr>
<td>Percent unemployed</td>
<td>7.4</td>
<td>10.5</td>
<td>10.9</td>
<td>13.3</td>
<td>7.2</td>
</tr>
</tbody>
</table>

### Occupation

<table>
<thead>
<tr>
<th></th>
<th>Employed males, 16 yrs and over</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(in thousands)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent</td>
<td>58,430</td>
<td>3,906</td>
<td>2,426</td>
<td>429</td>
<td>54,524</td>
</tr>
<tr>
<td>Managerial and professional</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Technical, sales, admin. support</td>
<td>19.8</td>
<td>14.6</td>
<td>12.3</td>
<td>21.6</td>
<td>20.2</td>
</tr>
<tr>
<td>Service occupations</td>
<td>9.9</td>
<td>14.9</td>
<td>14.1</td>
<td>19.9</td>
<td>9.5</td>
</tr>
<tr>
<td>Farming, forestry, fishing</td>
<td>4.3</td>
<td>6.0</td>
<td>8.7</td>
<td>0.8</td>
<td>4.2</td>
</tr>
<tr>
<td>Precision production, craft, repair</td>
<td>20.3</td>
<td>23.3</td>
<td>24.8</td>
<td>17.4</td>
<td>20.1</td>
</tr>
<tr>
<td>Operators, fabricators, laborers</td>
<td>20.5</td>
<td>29.6</td>
<td>31.6</td>
<td>27.8</td>
<td>19.8</td>
</tr>
<tr>
<td>Employed Females, 16 yrs and over</td>
<td>47,120</td>
<td>2,625</td>
<td>1,474</td>
<td>327</td>
<td>44,405</td>
</tr>
<tr>
<td>(in thousands)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Managerial and professional</td>
<td>23.7</td>
<td>12.6</td>
<td>11.2</td>
<td>14.3</td>
<td>24.4</td>
</tr>
<tr>
<td>Technical, sales, admin. support</td>
<td>45.7</td>
<td>42.7</td>
<td>43.5</td>
<td>42.1</td>
<td>45.9</td>
</tr>
<tr>
<td>Service occupations</td>
<td>18.1</td>
<td>22.3</td>
<td>22.4</td>
<td>22.8</td>
<td>17.9</td>
</tr>
<tr>
<td>Farming, forestry, fishing</td>
<td>1.0</td>
<td>1.3</td>
<td>2.1</td>
<td>0.6</td>
<td>1.0</td>
</tr>
<tr>
<td>Precision production, craft, repair</td>
<td>2.3</td>
<td>3.5</td>
<td>3.8</td>
<td>2.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Operators, fabricators, laborers</td>
<td>9.1</td>
<td>17.7</td>
<td>17.1</td>
<td>17.9</td>
<td>8.6</td>
</tr>
</tbody>
</table>

### Family Income in 1984

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Median income in (dollars)</td>
<td>26,433</td>
<td>18,833</td>
<td>19,184</td>
<td>12,371</td>
</tr>
</tbody>
</table>

### Below Poverty Level in 1984

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Families (in thousands)</td>
<td>7,277</td>
<td>991</td>
<td>541</td>
<td>260</td>
</tr>
<tr>
<td>Percent below poverty level</td>
<td>11.6</td>
<td>25.2</td>
<td>24.1</td>
<td>41.0</td>
</tr>
</tbody>
</table>

Source: US Bureau of the Census (1985)
those who are employed, there are considerable differences from
the non-Hispanic population with respect to the types of jobs held.
Among employed Hispanic-American males, only about 12% hold
jobs that are managerial or professional, compared to more than
twice that proportion of non-Hispanic males. Employed Hispanic-
American females are doing only slightly better than this with
respect to the same quality jobs. There are higher percentages of
both male and female Hispanic-Americans in service occupations,
farming and related endeavors, and repetitive manual labor, in
comparison to those in the non-Hispanic population. Accordingly,
the median income of Hispanic-American individuals and fami-
lies is considerably lower than that of the non-Hispanic population.
Indeed, the percentage of Hispanic-American families below the
poverty level is more than twice that for the total population of the
United States.

VARIABILITY OF THE POPULATION

While sharing a common language, the Mexican-American and
Puerto Rican populations have traditionally represented a study
in contrasts.

Social and Economic Differences

It can be seen from Tables 13 and 14 that there are significant
differences between Puerto Ricans and Mexican-Americans in
several of the social and economic categories already discussed.
The percentage of married Mexican-Americans is higher than the
percentage of married Puerto Ricans, who have more single and
divorced individuals (Table 13). Not surprisingly, there is a 25%
difference between the two groups when it comes to families
headed by a married couple. Many more Puerto Rican households
are headed by a single female. Mexican-Americans have larger
families, easily a function of the differences in marriage and
divorce between the two groups. Puerto Ricans have a slight edge in
education, with a lower percentage of people with less than five
years of school, and with higher percentages of people who are
high school and college graduates.

There are also important differences between the economic
profiles of the two groups (Table 14). Mexican-Americans have a
higher percentage of people aged 16 years and over who are in
the civilian labor force, and a higher percentage of these are employed.
The results of these differences are obviously cumulative, as can be
seen by the markedly higher median income of Mexican-Americans
and the much higher percentage of Puerto Rican families below
the poverty level. The differences in education and geographic
location are reflected in the higher percentage of Mexican-Americans
employed in farming and related occupations, in contrast to Puerto
Ricans, who have higher percentages in managerial and professional,
technical and sales, and service occupations.

Cultural Differences

Mexican-Americans have a greater degree of Indian heritage than
Puerto Ricans. The Indian population of the island of Puerto Rico
was quickly decimated by the Spanish colonists; however, in Mexico,
Indian resistance to colonization and the high social organization
of the Indian population facilitated survival of many aspects of the
Indian culture. On the other hand, Puerto Ricans represent a
greater mix of black and white populations, due to the extensive
history of black slavery on the island. During many years, there was
considerable mating between African female slaves, mostly brought
from West Africa, and Spaniards. This resulted in a large Puerto
Rican population of mulattoes. In Mexico, however, mating of
Spaniards with Indians predominated, resulting in the persistence
of a very strong Indian presence in the Mexican population, which
can be generally characterized as mestizo.

Puerto Ricans are American citizens by virtue of the common-
wealth status of Puerto Rico, while immigrant Mexican-Americans
have had to achieve naturalization status. Many Mexican migrants
to the United States remain undocumented.

Much of the West and Southwest of the United States, including
Texas, New Mexico, Arizona, and California, was originally part of
Mexico and became incorporated into the US following wars and treaties in the 19th century. Hence, Mexican-Americans overall have deeper roots in the United States than Puerto Ricans, as the immigration of the latter was largely a 20th century phenomenon.

With regard to language, Puerto Ricans on the island speak Spanish, though many of them also speak English to some degree. On the mainland, most are bilingual, and those in the more recent generations speak primarily English. In Mexico, many indigenous languages continue to be spoken, either as the principal language or in addition to Spanish. Many Mexican-Americans, particularly second and third generations, speak only English and occasionally use Spanish as a second language.

The religion of most Puerto Ricans and Mexican-Americans is Catholic; however, some are Protestant, particularly Pentecostal. Some Puerto Ricans also practice espiritismo, which stems from a belief that one can communicate with the spirits of the dead (Comas-Diaz, 1981; Ruiz, 1979). Mexican-Americans have been known to practice curanderismo, which is based on traditional folk beliefs in supernatural healing rituals (Kiev, 1968; Martinez, 1977; Ruiz, 1985).

Both Puerto Rican and Mexican-American immigration have led to the establishment of rural and urban subgroups in the United States. It appears that Mexican-Americans have had a stronger attraction to rural areas because of the availability of agricultural jobs and active recruitment by farm owners in the part of the country they inhabit. Puerto Ricans, on the other hand, have settled mostly in the Northeastern cities, perhaps due to their higher familiarity with urban life, as well as better access to the region.

REVIEW OF SUICIDE RATES AND PATTERNS

Few authors have attended to the subject of suicide among Hispanic-Americans in the United States. The small body of literature available has focused on small-scale, localized (New York City) studies for the Puerto Rican population and on regional (Southwestern states) studies for the Mexican-American population. There is a need for more comprehensive and detailed scrutiny of self-destructive behavior among these ethnic subgroups as such behavior would seem to be a reliable indicator of stress.

Suicide Rates in Puerto Rico

Figure 5 depicts suicide rates in Puerto Rico in 1975 and 1980, broken down by age and sex. In both time periods, it can be seen that the suicide rates for males exhibited a distribution quite different from that of females. Male suicide rates peak in the 35-44 age range, then once again in the 75+ range. Females, on the other
hand, do not exhibit any peaks; across the board, they have much lower rates of suicide than males.

Puerto Rican Suicide on the Mainland

Monk and Warshauer (1974) looked at rates of attempted and completed suicide in Whites, Hispanic-Americans, and Blacks in the East Harlem area of New York City. They recorded all completed suicide and suicide attempts that occurred in the area during a three-year period from 1968 through 1970. There are a few interesting trends evinced by the data (Table 15). First, the suicide rate for each of the three ethnic groups was considerably higher than the national rate of 11.8 per 100,000 in 1970. Rates for females in all groups were remarkably high, with the rate for White women, surprisingly, slightly higher than that for White men.

Puerto Rican males had the highest suicide rate of all groups, being more than 40% higher than rates for Black or White males in the same area, and almost three times higher than the rate for Puerto Rican males living in Puerto Rico in that same time period (Figure 5). The suicide rate for Puerto Rican women on the mainland also exhibited a threefold elevation when compared to the rate for women living in Puerto Rico. Puerto Ricans who committed suicide did so at an earlier median age than did Whites or Blacks, reflecting the fact that Hispanic-Americans are a younger population overall. It is also interesting that the overwhelming majority (87%) of Puerto Ricans who committed suicide had been born in Puerto Rico, compared to 13% who were born in New York State. Also, 68% of Puerto Rican suicide victims had been living in New York City for 15 years or more, compared to 21% who had been living there 5–14 years and 11% who had been there less than 5 years (Monk & Warshauer, 1974).

Suicide Rates in Mexico

Table 16 displays suicide rates in Mexico, broken down by age and sex, compiled at three different times, the last time being 1975 (World Health Organization, 1973). Evident in looking at this table is the uniformly low suicide rates for all sectors of the population. Women's suicide rates are considerably lower than men's rates, by a factor of one-half to one-third. More recent suicide rates (United Nations, 1985) do not deviate from this pattern, showing rates of 2.6 for men and 0.7 for women, for a joint total of 1.7 suicides per 100,000. The very low suicide rates for both male and female Mexicans would suggest that there are some positive factors in Mexican culture that mitigate against suicide. It should also be mentioned, however, that suicide might be underreported among Hispanic populations due to fear of stigma and religious sanctions.

Mexican-American Suicide Rates

A recent study on suicide among Mexican-Americans (Smith et al., 1985) focused on over 36,000 suicides that occurred over a five-year period in the states of Arizona, California, Colorado, New Mexico, and Texas. Data on suicide were broken down by age, sex, and race, with significant comparisons drawn between Mexican-Americans and non-Hispanic Whites (referred to as “Anglos” in the study). The data from this study, presented in Table 17, are also depicted graphically in Figure 6. As can be seen, there was a peak incidence of suicide (33.1) among Mexican-American males in the age group 20–24. The suicide rate then declined from age 25 on, with the exception of a mild peak in Mexican-Americans over the age of 70. Thus, suicide risk among Mexican-American males seems to be highest in young adulthood.
### Table 16
**Mexico: Suicide Rates per 100,000 Persons**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5-14</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>15-24</td>
<td>2.9</td>
<td>3.4</td>
<td>2.5</td>
<td>1.9</td>
<td>1.0</td>
<td>1.3</td>
<td>1.9</td>
</tr>
<tr>
<td>25-34</td>
<td>2.8</td>
<td>4.1</td>
<td>1.5</td>
<td>2.0</td>
<td>3.3</td>
<td>0.8</td>
<td>1.2</td>
</tr>
<tr>
<td>35-44</td>
<td>2.9</td>
<td>5.0</td>
<td>0.9</td>
<td>2.2</td>
<td>3.7</td>
<td>0.8</td>
<td>1.2</td>
</tr>
<tr>
<td>45-54</td>
<td>3.0</td>
<td>5.4</td>
<td>0.9</td>
<td>1.8</td>
<td>3.2</td>
<td>0.4</td>
<td>1.2</td>
</tr>
<tr>
<td>55-64</td>
<td>2.8</td>
<td>4.5</td>
<td>1.1</td>
<td>3.0</td>
<td>5.0</td>
<td>0.9</td>
<td>1.4</td>
</tr>
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<td>4.6</td>
<td>0.3</td>
<td>1.7</td>
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<td>8.4</td>
<td>5.6</td>
<td>3.7</td>
<td>7.7</td>
<td>0.3</td>
<td>1.6</td>
</tr>
<tr>
<td>All Ages</td>
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<td>1.0</td>
<td>1.1</td>
<td>1.8</td>
<td>0.5</td>
<td>0.7</td>
</tr>
</tbody>
</table>


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**Table 17**

**Suicide Rates per 100,000 Persons in Five Southwestern States: 1976-1980**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
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</thead>
<tbody>
<tr>
<td>0-14</td>
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<td>15-19</td>
<td>27.5</td>
<td>32.8</td>
<td>20.7</td>
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<td>20-24</td>
<td>38.6</td>
<td>49.1</td>
<td>29.5</td>
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<td>25-29</td>
<td>47.2</td>
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<td>38.5</td>
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<td>30-34</td>
<td>56.7</td>
<td>68.4</td>
<td>51.2</td>
</tr>
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<td>35-39</td>
<td>57.4</td>
<td>69.1</td>
<td>51.1</td>
</tr>
<tr>
<td>40-44</td>
<td>67.1</td>
<td>80.2</td>
<td>61.0</td>
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<td>45-49</td>
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<td>75+</td>
<td>142.0</td>
<td>160.7</td>
<td>131.3</td>
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Source: Smith, Marsh, & Warren (1980)
similar to results obtained by Smith et al. (1985). The suicide rates for Mexican-American women were consistently lower than for Mexican-American men, but they did show a five- to tenfold increase, in comparison to Mexican women still living in Mexico. Along these same lines, the suicide rate for Mexican-American men was elevated to similar proportions, when compared to the rates for men in Mexico.

DISCUSSION
Puerto Ricans
The most salient finding in Monk and Warshauer’s (1974) study of suicide in East Harlem is an inordinately high suicide rate for Puerto Ricans. This stands out despite the fact that all groups in this area showed high suicide rates. It is probable that the socioeconomically marginal status of all the subgroups living in East Harlem influenced the suicide rates in this geographically discrete locale. For Puerto Ricans who live on the mainland, suicide is a phenomenon of the young adult population; the rate is substantially higher than that of those who continue to live in Puerto Rico.

Another interesting finding from this study is that, among Puerto Ricans who committed suicide, two-thirds had been living in the United States for 15 years or more; thus, the risk of suicide appears to have increased with the amount of time spent on the mainland. Being of Puerto Rican birth, versus mainland-born, was also seen as increasing the risk of suicide.
The acculturation experience of Puerto Ricans living on the mainland is a unique one. Since Puerto Rico is part of the United States, Puerto Ricans are faced with a foreign culture while still at home. In Puerto Rico, it is easier to ignore this foreign influence; at home, Puerto Ricans can choose whether or not to take in the Anglo culture. Migration to the mainland, however, produces stress in a number of ways. The adjustment to a new life is rendered more difficult by the need to use a new language daily. It has already been mentioned that Puerto Ricans compare quite poorly to the general population in degree of schooling. The impact of physical changes, such as the change in climate and the move to crowded, inner-city settings, is further deleterious. New strategies for obtaining the necessities of life must be acquired. Even though ghettos such as Spanish Harlem exist, the choice of avoiding the dominant culture can result in social isolation, not to mention economic failure, as even negotiating the public assistance system requires contact with the dominant culture.

Dressler and Bernal (1982) studied a group of 67 Puerto Ricans living in a low-income neighborhood in Hartford, Connecticut. They examined the relationship between signs of emotional and physical stress and variables of psychosocial supports and length of residence in the area. There were positive correlations between length of residence in the area and number of (presumably stress-related) health problems. This was significantly mitigated by the psychosocial resources available to the individual, whether these resources came from their own culture or from the dominant culture. Although the number of subjects studied was low, the data implied that the worst stress outcomes occurred in “those persons who have been in the Anglo cultural environment the longest, but who do not have the resources for coping with that environment.” This is consistent with Monk and Warshauer’s (1974) finding that a very large proportion of Puerto Rican suicides occurred in people who had been born in Puerto Rico, and that two-thirds of suicide victims had been living in the United States for 15 years or longer.

The findings mentioned above are of interest, in light of a study by Fernandez-Pol et al. (1985). They studied a population of Puerto Rican-born alcoholics in a New York City ghetto and compared their adherence to traditional values with that of a control group of non-alcoholic Puerto Ricans from the same area. There seemed to be a positive correlation between traditional values and alcoholism, especially in males. The number of years residing in the area, while having little effect on the subjects’ adherence to traditional values, also seemed to have a positive correlation with alcoholism. Thus, the amount of time spent living in the dominant culture and the attempt to continue to adhere to traditional values both seem to act as psychocultural stressors associated with an increased incidence of alcoholism among members of this acculturating group.

The traditional family support system also seems to be suffering the stress of migration. The US Census data (1985) reveal clearly that Puerto Ricans as a group have a much higher proportion of families headed by single females. Not only does this tend to place more responsibility on the single parent, but the absence of a successful male role model in the home can also make it more difficult for children, particularly adolescents, to develop a sense of identity. Children learn the new language and culture far more quickly than adults, and are consequently used by their parents as “culture brokers” to help them in their dealings with the dominant culture. The resulting added stress on children is compounded by their increasing perception of the female parent as ineffective and, thus, a questionable role model. In addition, being a single parent leads to increased stress on Puerto Rican females to provide an income while attempting to maintain a family structure that is already endangered.

In summary, the limited data available point to a great increase in suicide rates in Puerto Ricans who live on the mainland United States, compared to Puerto Ricans who remain in Puerto Rico. A number of stressors impinge on Puerto Ricans who live on the mainland. Undoubtedly, migration exposes Puerto Ricans to a different set of stresses not encountered in the Island such as language barriers, dissimilarities in value systems, and the like. Such stressors contribute to the increase in suicide rates seen on migration.
Mexican-Americans

The studies of suicide among Mexican-Americans concurred on two major points. Both studies found markedly increased suicide rates in all Mexican-Americans, in comparison to the rates in their country of origin. Both studies also found peaks in suicide for Mexican-American males in young adulthood, as well as some increases for elderly Mexican-American men. Although increases were also seen for Mexican-American women in relation to women residing in Mexico, these increases were fairly uniform across the age spectrum; no age group showed a high proclivity toward suicide.

To explore possible explanations for the differences in suicide rates it is helpful to look at the intercultural differences that an individual would face upon migrating from Mexico to the United States. Similar to Puerto Ricans, Mexican-Americans must deal with the stress of the language barrier, discrimination, poverty, low education, and the limited ability to communicate with the dominant culture that results from all of these factors. Unlike Puerto Ricans, Mexican-Americans are hardly confronted with an American influence prior to migration, which implies both a more stable cultural environment while in Mexico and a more marked change upon migration.

The fact that many Mexican-Americans belong to the second or third generation might mitigate some of the stressors that act more acutely, such as language, but they might provide more insidious, chronic problems. The erosion in the United States of traditional family values, which are very strong in Mexico, has led to Mexican-American families that are less extended than in Mexico, although still somewhat larger than the average US family. Children leave the home earlier, leading perhaps to increased stress both on the offspring, due to diminished family support, and on the parents, due to a diminished sense of family. It is possible that the decline of the extended family is a factor in the dramatic rise in suicide among elderly Mexican-American males, with acculturation leading to less of the respect traditionally bestowed on grandparents. Poverty can lead to the family viewing the elderly more as financial burdens than as revered figures of authority. Low adaptability and tolerance for change, fairly common in the elderly, can also strain intergenerational communication and result in further alienation of the older Mexican-Americans. Mexican culture being typically patriarchal, it is easy to see how these changes would affect the elderly males more strongly than the females, the latter being accustomed to a more submissive role.

It is interesting to note that, despite these stressors, the Mexican-American family has remained a more stable unit than the Puerto Rican family, as evidenced by the much lower proportion of single-parent Mexican-American families. An intact nuclear family unit may be an important factor in providing support for Mexican-American females, allowing them to remain more within their traditional family roles, even while working outside the home. This is consistent with the relative sparing of Mexican-American females in the suicide statistics.

Recent literature on Mexican-Americans has alluded to the stresses of migration and acculturation. Vega et al. (1985) found that at least one subset of the Mexican-American population—farm workers—is “experiencing psychiatric symptom levels which place them at extraordinary risk”; acculturative stress is likely to be responsible for this. Montgomery and Orozco (1985) found sizable differences between Mexican-American and non-Hispanic college students and attributed the majority of these to acculturation. Burnam et al. (1987) found that the group of Mexican-Americans they defined as “more acculturated” had increased lifetime rates of phobia, alcohol abuse or dependence, and drug abuse or dependence. In addition, they also discovered that US-born Mexican-Americans had a significantly higher prevalence of major depression and dysthymic disorder than those born in Mexico. They attributed this, in part, to increased stress associated with “frustrated status expectations.” It is also well known that Mexican-Americans severely underutilize mental health services available to them, and this is attributed to problems with acculturation (Wells et al., 1987).

In summary, there are marked differences between the rate of suicide in Mexico and that of Mexican-Americans. Rates of Mexican-Americans are higher overall, and there are peaks of suicide in
Mexican-American young adults and elderly males which are not seen in the population in Mexico.

The Mexican-American population seems to be exposed to a series of stressors resulting from migration such as language barriers, cultural barriers, forced family separation, and the like. In view of the above, we would expect to find a higher incidence of affective-spectrum psychiatric disorders in Mexican-Americans. It is also not surprising to find a higher suicide rate, especially among young adult and elderly males, given the degree of stress to which this population is exposed, compared to the population that has remained in Mexico.

CONCLUSION

Acculturative stress seems to be an important factor in the uniform increase in rates of suicide by Hispanic-Americans in the United States, compared to the suicide rates of their places of origin. Young adult males seem to be particularly strongly affected by the stress of acculturation, as reflected by their inordinately high suicide rate. Although these rates still compare favorably with the suicide rates of non-Hispanic Whites in the US, the increase in suicide with migration seems to be a real indicator of stress.

Caution dictates that certain sources of potential error be kept in mind. It is quite possible that there has been selective under-enumeration of Hispanic-Americans, resulting in inflated estimates of their suicide rates. It is unclear how many Puerto Ricans living in the Northeast routinely travel to (and may temporarily reside in) Puerto Rico, and Mexican-Americans who live in close proximity to Mexico may do the same. Undocumented Mexican-Americans may or may not be counted in the census, and this may affect suicide estimates either way, depending on what proportion is counted.

Suicide rates in Mexico are remarkably low, which, in a predominantly Catholic country, may mean that there is a potential for underreporting of suicide by the population and, more importantly, an avoidance of the act of suicide based on the teachings of the Catholic church. Suicide is considered a sin by the Catholic church.

The differences between the suicide rates of Puerto Ricans and Mexican-Americans need further exploration. The geographic differences, and the urban/rural split between the two groups cannot but promote different levels of stress of all kinds. Adherence to traditional values may be beneficial to an individual within an intact family but might be detrimental to one with less family support. There is clearly an urgent need for research on this growing population.

REFERENCES


SUMMARY AND DISCUSSION

In the preceding chapters we have reviewed the available data on suicide among four major ethnic groups in the United States. In this final chapter, we wish to draw together the thematic threads observed in several of the groups we have studied. We also wish to point out thematic differences in the suicide data among the four groups studied and the possible significance of these differences.

The most striking common theme that emerges from the analysis of suicide data for the four ethnic groups is the finding that suicide occurs most frequently among youth and young adults, and predominantly among young men. This is the case for Blacks, Native Americans, Puerto Ricans, and Mexican-Americans. The data for Japanese-Americans, showing a minor peak of suicide in young adulthood, allow some consideration of this general theme for this ethnic group as well. A notable exception is the Chinese-American group.

A second major theme is the low rate of suicide among Black, Native American, Puerto Rican, and Mexican-American women, compared with males of this age group and compared with the majority population. Here, too, Chinese-American women are a dramatic exception, with peak suicide incidence occurring in older women.

A third common theme is the comparatively low rate of suicide among older people in three of the four ethnic groups: Blacks, Native Americans, and Hispanics—both Puerto Ricans and Mexican-Americans.

There are important differences in frequency of suicide between the majority population and the ethnic groups, but these differ-
ences are not consistent for the four ethnic groups studied. Most dramatic are the substantially higher aggregate rate of suicide among Native Americans than that which occurs among the majority population and the lower rates among Blacks, Puerto Ricans, and Mexican-Americans. The rates for Chinese- and Japanese-Americans are lower than the national figures, but not strikingly dissimilar. It is important to highlight the notion that no explanatory theory by itself accounts in a consistent way for the differences in suicide rates between the majority, White US population and the four ethnic groups we have studied.

SUICIDE AMONG YOUNG ADULTS

Epidemiologists have demonstrated that within the general population of the United States, a family history of suicide, unmarried male status, and presence of an Axis I psychiatric disorder are primary risk factors associated with death by suicide (Klerman, 1987). Research based on collating life history information of individuals who have committed suicide (psychological autopsy) has revealed that the majority of individuals who ultimately commit suicide, in addition to having other symptoms of depression or schizophrenia, had experienced feelings of hopelessness, despair, pessimism, and helplessness prior to their suicide. Another general risk factor for suicide is the age cohort of "youth." Between 1960 and 1980, youth suicides increased by 150%. In this "baby boom" generation, clinical depression has also been on the rise (Klerman, 1987).

Psychological autopsy studies in this age group have also shown that suicides are usually accompanied by substance abuse and early-onset affective disorder, as well as by a history of previous suicide attempts (Klerman, 1987). This is consistent with our findings for Blacks, Native Americans and Hispanic-Americans with respect to alcohol and substance abuse and history of previous suicide attempts, although specific data on early-onset affective disorder are limited for these groups as well as for Asian-Americans.

Some differences in the pattern of suicidality in bipolar and unipolar patients have been found. In patients with unipolar affective disorders, suicidality usually occurs early in the course of illness and intensifies, with increasing severity of symptoms of agitation and major depression. In bipolar patients, suicide most often occurs later, in the course of a single depressive episode, and becomes an increasing risk with each subsequent relapse. An additional factor is the effect of social contagion in the precipitation of "suicide experience" among young people.

Increasing rates of suicides in youth is a phenomenon that has also transcended national boundaries. Increased rates have been reported in Canada, Australia, the United Kingdom, and Western Europe, in addition to the United States. We have found similar trends in our investigation of suicide among youth and young adults of minority groups in the United States (Table 18). Increased rates of suicide among minority group youth may be considered a reflection of general national and international factors affecting this age group. On closer inspection, however, we have identified unique problems in identity formation and acculturative stress in minority youth that require more focused consideration. We believe the finding that the incidence of suicide peaks among young adult males in Black, Native American, Puerto Rican, and Mexican-American populations is partially accounted for by factors integral to their mode of adaptation to acculturative stress.

To understand better the significance of these findings, we need to concentrate further on the concepts of self-esteem and identity formation, because they relate directly to how individuals cope with and adapt to stress.

Identity has been defined by Erikson (1968) as an internal sense of sameness and continuity over time that can be recognized by the individual as well as by others. He considers youth to be the stage of life that extends from early adolescence until the achievements of adult status in a society, a status associated with achievement of occupational role and independent living. Instrumental in the development of Erikson's theoretical perspective was a cross-cultural perspective, with observations drawn from American Indian tribes as well as from the dominant White society. Identity, in his view, can therefore be understood to include the component of ethnic identity: that part of one's sense of self that recognizes one's ethnic
heritage and cultural continuities, even in the face of attempts to deny their importance.

Youth as a normative period of psychosocial moratorium has been considered by many social historians to be a uniquely mid-twentieth century development in Western societies; formal education has become longer and longer, delaying achievement of occupational role, independent living, and establishing a family of one's own. In more traditional societies—in hunting cultures, for example—adult status is assumed earlier in the life cycle, allowing only a short time for what Erikson has described as the psychosocial moratorium of youth. This is a time for testing values and behavioral modes, prior to the internalization of those that will congeal into a sense of identity with sameness and continuity over time.

But whether youth is a protracted or contracted stage of the life cycle of a given culture, it is always that time of testing positive role models for identification. These can be parents, extramural racial heroes, or others from outside the culture. Negative models for identification also exist within and beyond the community or cultural confines.

We can combine these concepts of identity development with those of modes of adaptation to acculturative stress. Identity conflict normal to the stage of youth may be successfully resolved by what Winthrop and Sindell (1972) have defined as "identity synthesis," a form of identity consolidation that involves a cohesive blending of elements of one's culture of origin with those of the dominant society—elements such as customs, language, beliefs, and behaviors of both cultural groups—while maintaining a strong and secure primary ethnic identification. This is consistent with the outcome of acculturative stress described here as "cultural integration."

Youth and young adults who have achieved identity synthesis are usually those who have recognized the value of participating in the dominant society's formal educational process and have succeeded in it. They have done so with the intention of using their education and knowledge of the ways of the dominant society to serve the interests of their people and to work for their communal good. They are the new generation of leaders, committed to reclaiming or maintaining control over communal institutions and neighbor-

### Table 18

<table>
<thead>
<tr>
<th>Age Group</th>
<th>White M</th>
<th>Black M</th>
<th>Hispanic M</th>
<th>Japanese M</th>
<th>Other M</th>
<th>Total M</th>
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<tr>
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Sources: Lina & Yu (1966a, 1966b) and Smith et al. (1985)
hoods; to assuming total control of economic development and resisting outside exploitation; to ensuring the viability and continuation of traditional ways of life that preserve the dignity and valued role of the elder, less acculturated generation of their people. They are committed to negotiating with regional, state, and national authorities to maintain the long-term rights and interests of their people.

The negative pole of this form of resolution of identity conflict is identity confusion, Erikson's "role diffusion" combined with cultural marginalization. This is the combination we hypothesize to be associated with the greatest risk of suicide. Individuals experiencing identity confusion are usually those who have or have had aspirations of leadership that they have been unable to achieve. They have tried to live in the communities in which they grew up, but have found the way of life to be too traditional in attitudes and activities for them to identify with or adapt to it. They have found the geographic and cultural isolation to be too great and the opportunities for social and occupational satisfaction too limited. They are the generation that has drifted from their communities of origin to the urban centers, only to find that they lack the educational background and technical skills required to achieve their aspirations of urban middle-class success. They have attempted to leave behind the unhappy experiences they had trying to fit into the community they knew as children. But when they returned to their community as young adults, they found much changed. They are the people who become dissatisfied with themselves whether they are "at home" or "in town." They feel part of neither community and become emotionally distant and alienated from both. They drift back and forth from their community of upbringing to the inner city, less sure of themselves and more marginal with each move.

We hypothesize that cultural separation or withdrawal (or resistive acculturation) as an outcome of acculturative stress may be associated with either identity consolidation or continuing identity conflict, depending on the degree of intragroup commitment to separation, the availability of successful role models with whom to identify, and the amount of peer group support the individual receives. The dominant society may facilitate this process or retard it through policies of discrimination and unequal opportunities. However, for cultural separation to result in enhanced cultural coherence of the group and identity consolidation for the individuals involved, the ethnic minority group needs to achieve and maintain control of communal institutions, neighborhoods, and natural resources. There needs to be a cadre of leaders capable of preserving and developing those resources for the well-being of the group. This in turn requires leaders who are knowledgeable about the political and economic currents of the larger society and capable of negotiating with outside agencies to respect and preserve the uniqueness of their way of life, so that its uniqueness is accepted as a valued part of the whole in a multicultural society. Not only must there be respect for cultural diversity in order to achieve this outcome of acculturative adaptation, but there must also be a critical mass of individuals who, by their life example, demonstrate for youth and young adults that their communal way of life can adapt to changing times while still preserving its respect for the traditions of their forebears.

We hypothesize that assimilation as an outcome of acculturative stress, as it relates to youth and young adults, is likely to be associated with continuing identity conflict and identity confusion, since it requires such a strong identification with another ethnic group and a negation of one's own cultural heritage. This kind of striving would be quite characteristic of the early and middle phases of youth, but not consistent with mature self-acceptance and successful resolution of identity conflict.

Each of the ethnic groups we have studied has been involved during the past two decades in a collective struggle to define themselves as distinct and distinctive components of the fabric of the larger society. For each group, this struggle has involved difficult and frequently painful change from separate and unequal status, involving political, occupational, and social discrimination, to greater involvement, recognition, and authority in a multicultural society. Progress has been neither continuous nor automatic; rather, it has been marked by resistance and struggle.

Native American communities, for example, have varied greatly, and still do, in the extent to which they have achieved internal cohesion, common goals with respect to political and economic
integration with the dominant society, maintenance of traditional values and beliefs regarding interpersonal and intergroup relations, acceptance of technological and educational changes, and many other concomitants of adaptation to acculturative stress. There has been great variation also in the degree of pressure that has been exerted on Native American communities by the surrounding or impinging dominant society and its institutions. However, no tribe and no community has been free from acculturative stress, and all have had to work out communal adaptations. Much internal conflict has resulted, in some cases reaching the communal straining point of social and psychological crisis. Many Native American tribes and communities are at that point now, and the greater the communal stress, the greater the individual conflict as well.

Youth and young adults in Native American communities can reasonably be considered "the point men" for acculturative stress, since it is people of their age who generally have the closest contacts with the dominant society at school and at work. They have shared in the "culture of youth" over many years at school. They have experienced the intergenerational stresses that accompany inevitable changes in values and aspirations between modernizing youth and their more tradition-oriented parents. Furthermore, this population of youth and young adults increasingly loses the knowledge and skills necessary to live the more traditional lifestyle of the older generation with any degree of personal satisfaction. They are most aware of and sensitive to the past and present discrimination their people have experienced. And they are striving to achieve a way of life for themselves that combines what they are as Native Americans of a particular tribe and community with what they are as members of a larger society characterized by rapid social and technological change. Therefore, we contend, youth and young adults can reasonably be assumed to be that component of the minority population most intensely affected by acculturative stress. These youth and young adults must strive to resolve issues of ethnic identity as an inescapable and integral component of their personal identity, in a way that majority youth and young adults do not.

Many Native American communities have experienced great turmoil in the face of intense acculturative stress during the past two decades. In the age cohorts of youth and young adults, some have evolved a separationist mode of adaptation. Some have achieved this by forming an intense identification with Native American traditions and causes, contributing to a "cultural revitalization" of the indigenous community institutions as well as to a pan-Native American movement. Others have withdrawn as much as possible from contacts with the majority population, adopting a confrontational position in dealings with the agencies and institutions of the dominant society, which are perceived to be jeopardizing their communities' independence, autonomy and distinctiveness. Resolution of the ethnic identity component of the normative psychosocial conflict of identity consolidation appears to be a central theme for individuals in this group. Among those individuals experiencing greater identity confusion than consolidation, there is substantial risk of self-destructive behavior through alcohol and substance abuse, acts of violence, and suicide.

The risk is even higher for those individuals whose mode of adaptation to acculturative stress is marginalization. These are youth and young adults whose identification with their ethnic heritage is intensely ambivalent and predominantly negative. They have been neither accepted by nor integrated with the majority culture. They have a sense of being disconnected from both their own and the majority culture, of not having a secure and accepted place within their family or the community in which they grew up. They are often the focal point of intense intergenerational conflict related to their interpersonal relations, values and lifestyle, and are rarely members of a supportive social peer group or cross-generational network. Among economically disadvantaged minority youth and young adults, language problems, as well as negative stereotyping, contribute to lower levels of school performance, higher rates of school dropout, and difficulties finding and maintaining stable jobs. These factors all contribute to a sense of marginalization, demoralization and depression among minority youth and young adults. They are, for these reasons, the group at greatest risk of contributing to the statistics for substance abuse, accidents, social violence, and suicide.

Another factor that strikes us as highly relevant to understanding the correlation between ethnic minority status and the high rate of
suicide among youth and young adults is the much higher rate of unemployment and underemployment among minority youth and young adults than is the case in the majority population. The effects of unemployment and underemployment on erosion of self-confidence and self-esteem, and the relationships between these and increased incidence of alcohol and substance abuse, antisocial behavior, and even violence, have been well documented. The association between youth and young adult alcohol and substance abuse, accidents and violence has been particularly prominent among Native Americans, for whom a link to suicide has also been documented (Berlin, 1985; May, 1987).

Analysis of these issues among diverse Native American tribes and communities suggests that as role models become more common, as more adults who have successfully achieved an integrationist mode of adaptation to acculturative stress achieve leadership roles within their communities and within the dominant society and bring social and economic gains to those communities, psychological and social turmoil has decreased among youth and young adults (Klausner & Foulks, 1982; May, 1987; Sack et al., 1987; Wintrob et al., 1982).

We hypothesize that the case we have outlined for Native American youth and young adults may be generalized to include Black, Puerto Rican and Mexican-American youth and young adults. However, we acknowledge that only a limited body of literature addresses these issues. There is empirical evidence in support of the links between unemployment and underemployment, alcohol and substance abuse, accidents and social violence in these groups, as there is with Native Americans. The experience of youth and young men living in Black, Puerto Rican, and Mexican-American communities has been much the same as that of Native Americans with respect to negative stereotyping and discrimination. The intensity of acculturative pressure has varied by community, as with Native Americans, with the most intensive acculturative stress occurring in large urban areas of the Northeast, Midwest, and West, and the least in the rural areas of the South and Central states.

The minor peak of incidence of suicide among Japanese-American men in young adulthood may be an example of what we hypothe-
minorities makes these age cohorts strikingly comparable to the majority culture, for whom the incidence of suicide among youth and young adults has shown a steady increase over the past two decades (Holinger & Ofer, 1986; Klerman, 1987). At the same time, as Weissman (1987) has recently shown from analysis of the epidemiological literature on depression during the past 50 years, the median age range at which depression is most commonly encountered has been steadily decreasing. The result is that those age cohorts born since 1950 are now at highest risk of experiencing major depression, and major depression is a primary risk factor for suicide. It is only among youth and young adults, in fact, that suicide rates for minority and majority populations are similar. This similarity suggests that the “convergence hypothesis” we have described is useful in understanding the significance of these findings. For this segment of the population, there is a strong correlation in minority and majority communities between rising rates of alcohol and substance abuse, social violence, and suicide (Klerman, 1987).

SUICIDE AMONG WOMEN

In three of the four ethnic groups for which we have reviewed data on suicide, the incidence of suicide is remarkably low for women (see Table 19). This is the case for Black, Native American, and Hispanic women. On the other hand, suicide data for Chinese-Americans show a peak incidence for older women.

Two factors seem to us to be particularly relevant to understanding the significance of low suicide rates among minority women. First, women may be less exposed to the more stressful effects of acculturative change because there is less internal community pressure on women to give up or greatly modify traditional role expectations related to household and family maintenance. This is not to suggest that there is no wish for change. Substantial changes are being made by young women of these ethnic groups, but at the same time there is more support for traditional roles. To the extent that this is the case, young women living in these ethnic minority communities experience less frequent and less stressful interaction with individuals and agencies of the dominant society. Child-rearing and family maintenance continue to be highly valued roles for women, especially in rural settings, and such traditional roles do not engender the ambivalence or sense of futility more commonly encountered among young women of the majority culture.

A second factor that can help in understanding the comparatively low suicide rates, especially among younger women of the ethnic groups we studied, is the much lower rate of unemployment and underemployment among the segment of the population of minority women who seek jobs outside the home. For all the groups under consideration, jobs in the service sector and in factories seem to be more readily available for women than for men of similar age. While young men expect to hold a job, and the community, too, expects it of them, the same expectations do not apply to women. Young men experience erosion of their self-esteem when they are unemployed or underemployed, but young women can find alternative roles at home, which do not have that deleterious effect on their self-esteem. These two factors—better job opportunities for young women and less communal and famil-

<table>
<thead>
<tr>
<th>Age Group</th>
<th>White</th>
<th>Black</th>
<th>Native Amer.</th>
<th>Hispanic**</th>
<th>Japanese</th>
<th>Chinese</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>6.2</td>
<td>2.6</td>
<td>4.6</td>
<td>4.0</td>
<td>5.9</td>
<td>8.0</td>
</tr>
<tr>
<td>15-24</td>
<td>5.0</td>
<td>2.7</td>
<td>7.0</td>
<td>4.4</td>
<td>4.5</td>
<td>4.7</td>
</tr>
<tr>
<td>25-34</td>
<td>8.0</td>
<td>4.8</td>
<td>9.1</td>
<td>6.1</td>
<td>7.8</td>
<td>5.7</td>
</tr>
<tr>
<td>35-44</td>
<td>9.9</td>
<td>4.3</td>
<td>6.2</td>
<td>6.3</td>
<td>6.4</td>
<td>9.1</td>
</tr>
<tr>
<td>45-54</td>
<td>11.2</td>
<td>2.7</td>
<td>6.1</td>
<td>6.1</td>
<td>8.2</td>
<td>13.9</td>
</tr>
<tr>
<td>55-64</td>
<td>9.6</td>
<td>3.0</td>
<td>0.8</td>
<td>4.5</td>
<td>7.8</td>
<td>15.5</td>
</tr>
<tr>
<td>65-74</td>
<td>7.5</td>
<td>2.5</td>
<td>1.3</td>
<td>3.7</td>
<td>2.2</td>
<td>22.6</td>
</tr>
</tbody>
</table>

*Age adjusted, per 100,000 population
**1976-1980 cumulative data of five southwestern states
Sources: Liu & Yu (1985a, 1985b) and Smith et al. (1985)
SUICIDE AMONG THE ELDERLY

The third common theme (shown in Table 20) to emerge from our study of suicide among the elderly is the comparatively low rate of suicide among older Blacks, Native Americans, Puerto Ricans, and Mexican Americans. This finding was unexpected and particularly striking in the data for Native Americans since this aspect of the demographic data has been overlooked in the wake of the focus on the substantially higher aggregate rate of suicide among Native American youth and young adults.

Older Chinese-American women seem to constitute an example of the psychosocial hazards of acculturation to the stress of cumulative adversity. They are predominantly first-generation United States immigrants who lack access to the social and emotional supports for validation of their traditional roles within their families and communities and as tourists. Chinese-American women may serve as a buffer for the maintenance of adequate self-esteem in the face of cumulative stress.

TABLE 20
Suicide Rates in the Later Years
According to Ethnicity and Sex, 1980*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>White M</th>
<th>White F</th>
<th>Black M</th>
<th>Black F</th>
<th>Native Amer. M</th>
<th>Native Amer. F</th>
<th>Hispanic** M</th>
<th>Hispanic** F</th>
<th>Japanese M</th>
<th>Japanese F</th>
<th>Chinese M</th>
<th>Chinese F</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>19.4</td>
<td>6.2</td>
<td>11.6</td>
<td>2.6</td>
<td>24.2</td>
<td>4.9</td>
<td>17.8</td>
<td>4.0</td>
<td>11.1</td>
<td>5.0</td>
<td>7.9</td>
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<tr>
<td>55-64</td>
<td>26.5</td>
<td>9.6</td>
<td>12.4</td>
<td>3.9</td>
<td>20.1</td>
<td>0.8</td>
<td>19.9</td>
<td>4.5</td>
<td>12.4</td>
<td>7.8</td>
<td>9.4</td>
<td>15.5</td>
</tr>
<tr>
<td>65-74</td>
<td>32.4</td>
<td>7.5</td>
<td>11.4</td>
<td>2.5</td>
<td>6.4</td>
<td>3.7</td>
<td>24.0</td>
<td>3.7</td>
<td>11.2</td>
<td>2.2</td>
<td>25.9</td>
<td>22.6</td>
</tr>
</tbody>
</table>

*Age adjusted, per 100,000 population
**1976-1980 cumulative data of five southwestern states
Sources: Liu & Yu (1985a, 1985b) and Smith et al. (1985)
Similarly, low rates of suicide apply for older Blacks, especially for
older women. Data from the major study of suicide among Anglos
("Anglo" is a word used in the Southwest to distinguish English-
speaking non-Hispanics from the Mexican-descended, originally
Spanish-speaking population) and Hispanics in the Southwest also
demonstrate the comparatively low rate of suicide among older
Mexican-American women.

We hypothesize, on the basis of these findings, that members of
ethnic minority communities who have lived through the stages of
youth, young adulthood, and the middle years have, over many
years of experience in the crucible of culture contact, learned to
cope with acculturative stress without the kind of serious erosion of
self-esteem that would lead to suicide. In that process, older mem-
bers of the ethnic minority communities have come to be figures of
intrafamilial and communal stability, maturity and wisdom, sources
of support for younger people and for each other. Their more
tradition-oriented values have, it appears, been robust enough for
them to maintain adequate self-esteem during the acculturative
stress they had previously experienced. The negative stereotyping
and discrimination that prevented movement toward a multicultural
society, and that required a separationist mode of adaptation among
ethnic minorities in previous decades, also had the effect of strength-
ening institutions of mutual support and cohesion within ethnic
minority communities—most notably by indigenous religious, fami-
liar and social institutions. In each case, these indigenous commu-
nity institutions gave positive recognition to older people as bearers
of respected traditions of the group, capable of providing guidance
and a steady influence to both family and community when these
institutions experienced acculturative stress. This line of
reasoning applies equally to older men and women in the minority
ethnic communities up to the present time.

It seems reasonable to hypothesize, however, that as ethnic minor-
ity populations become more integrationist in a society that evolves
toward multiculturalism, the "convergence model" would apply.
That is, if we can envision a time when ethnic minority communi-
ties more closely resemble the social and familial organization of
the majority population, older people may, at that time, become
more isolated, less emotionally, socially and financially secure, less
supported and cared for by their families and the surrounding
community, and more prone to the sense of disconnectedness, iso-
lation, devaluation and futility that are found to be associated with
high rates of suicide in the older age cohorts of the majority popu-
lation. We expect this formulation would apply to the already
increasing rates of suicide among older Blacks.

POLICY IMPLICATIONS

If the psychocultural model of acculturative stress and its outcome
for groups and individuals is useful for understanding the com-
plex phenomenon of suicide among ethnic minority communities
in the United States, it should have implications for health and
social policy aimed at decreasing social stress and, ultimately,
suicide. During the past several years a working group was brought
together to address these issues under the auspices of the World
Health Organization. The focus of the WHO Working Group was
family health in circumpolar regions, where acculturative stress is
an issue of primary importance. The recommendations of the
group (WHO, 1985) focused on measures that could help com-
nunities, families, and individuals adapt to the pressures of accul-
trative change without experiencing erosion of internal cohesion
and direction.

The WHO Working Group emphasized the importance of ena-
brling communities to determine for themselves the direction they
take in accepting and internalizing technological changes and in
maintaining control over their natural resources, health and social
welfare institutions, educational facilities, and economic develop-
ment programs. In this process, consultation with regional and
national government agencies was encouraged, in order to coordinate
planning and development efforts. The Working Group empha-
sized the importance of community leadership and the posi-
tive influence of an indigenous leadership structure on youth and
young adults, who could identify with the aspirations and achieve-
ments of somewhat older cohorts of leaders experienced in the
ways of the majority population, but at the same time be commit-
tended to maintaining the strength and continuity of indigenous traditions and ethnic identity.

The Working Group recognized that cultural integration was the outcome of the process of acculturative stress that has the greatest potential for maintaining community cohesion and for lowering the risks of intergenerational conflicts over values and social behavior patterns. The outcome of integration was felt to offer the best hope for youth and young adults to maintain adequate self-esteem as members of distinct indigenous communities, yet to realize their aspirations for occupational lives that would incorporate advanced education, commitment to the well-being of their families and communities, and respect for their unique cultural traditions.

The degree to which the recommendations of the Working Group could become reality for communities experiencing acculturative stress depends, in very large measure, on the commitment of the majority culture to support the validity of minority ethnic groups' integrity, distinctiveness, and positive contribution to the national society. Cultural integration can be encouraged or impeded by the attitude of the majority population.

Progress toward cultural integration cannot be mandated by legislation but certainly can be influenced by government policy. Support for the principles of a multicultural society needs to be internalized by communities, by families, and by individuals. The principles need to be established by the actions of national institutions and authority figures, exemplified in the collective behaviors of communities, and modeled by individuals. The lack of progress in this direction can be measured by the disorganization of communities and individuals and by a rising tide of social violence and personal despair, particularly among youth and young adults.

In this report, we have used national aggregate data on suicide to develop the "larger picture" of the possible relationships between acculturative stress and suicide among ethnic minority populations in the United States during the past two decades. Suicide is, however, most of all an individual phenomenon. In this report we have not been able to examine the details of individual cases of suicide, to determine the particular social, familial, interpersonal, and intrapsychic factors that led these individuals to end their lives. There is a compelling need to have this type of data available for analysis, to provide the kind of fine-grained psychodynamic understanding of suicide necessary to enrich and deepen our understanding of the complex issues involved in each individual contribution to the nation's aggregate suicide data we have considered in this report. We hope that the findings and hypotheses of this report will help guide the way for further study of this subject.

REFERENCES


APPENDIX

ACCULTURATION AND ACCULTURATIVE STRESS: A THEORETICAL FRAMEWORK

Acculturation has been defined as culture change which results from continuous first-hand contact between two distinct cultural groups (Redfield et al., 1936). Anthropologists developed the concept as a means of studying group-level phenomena, but the concept has been increasingly recognized as an individual-level psychological phenomenon, one that has been termed "psychological acculturation" (Jessor et al., 1968; McFee, 1968). Accordingly, this report focuses on the consequences of intercultural contact and intergroup relations for individuals involved in and affected by the process of acculturation. This process has been described in detail by Berry and Kim (1988).

The range of changes that may result from acculturation is great. Ecological changes may occur such as being displaced from one's ancestral homeland or region, increased population density, or radically different types of housing and transportation. Biological changes may occur such as genetic changes resulting from intermarriage among culturally diverse groups, introduction of diseases previously unknown to or rare to one group, or the introduction of new medical technology. Cultural changes necessarily occur and are at the core of our definition of acculturation; preexisting political, economic, technical, linguistic, religious, and social institutions become altered as new ones take their place. Finally, interpersonal and psychological changes occur as individuals attempt to cope with and adapt to the changes that have altered their environment and their way of life.

Historically, acculturation has often resulted from colonial expansion, wars, forced migration or resettlement, economic development of remote areas, and efforts at religious conversion. These circumstances meant that the two groups coming into contact were usually not equal in size, resources or influence, and the less dominant groups could usually be categorized as native peoples, refugees, or immigrants. Groups have varied greatly in attempting to cope with such changes, from being overwhelmed and paralyzed by the scale of change to resisting change actively or passively or adapting to and voluntarily adopting changes. Within a particular group experiencing such acculturative changes, individuals may vary greatly in their personal coping strategies, resulting in different psychological outcomes.

The term "acculturative stress" implies that persistent intercultural contact brings stressors to bear on the less dominant group, inducing a state of tension in the group and anxiety in its component individuals. Given the context of description to this point, it is not surprising that for many years the view held by most observers of acculturative stress was that negative outcomes were virtually inevitable for the less dominant group. Further, it was thought that tensions and individual anxieties produced by the acculturation situation would result in a deterioration of the mental health status of the individuals involved. However, studies (Berry et al., 1987; Chance, 1965; Inkeles et al., 1970; Murphy, 1965) have demonstrated that the outcome of acculturation for both groups and individuals depends on a number of interacting factors: the phase of acculturation, the mode of acculturation, the type of acculturating group, the nature of the more dominant cultural group or society, the sociocultural characteristics of the less dominant group, and the psychological characteristics of the acculturating individuals.

PHASES OF ACCULTURATION

In the precontact phase, there exist two independent cultural groups with characteristic sets of customs, beliefs and behavior patterns, each comprised of individuals with a range of psychological characteristics, including levels of mental health. In the contact
phase, the groups interact and new stressors appear. Cultural and behavioral changes begin. In principle, the concept of acculturation allows for cultural exchange in either or both directions, but in practice, the predominant exchange is from the larger, more dominant society to the less dominant or acculturating group, placing more and more serious stressors on that group. Usually, but not inevitably, a conflict phase appears, in which tension builds and pressures are experienced by the less dominant group to change their way of life. The greater the resistance to change by that group, the greater the stress of acculturation. If conflict and tension are notable, a highly stressful crisis phase may occur, for which some resolution is required. Finally, an adaptation phase may take place, during which intergroup relations become more stable. These varieties of adaptation may or may not bring about an adequate resolution of the conflict and crisis or a reduction in the stress.

Whether conflict does or does not occur is a crucial issue. Here, intragroup and individual psychological conflict must be distinguished, but both may jeopardize the mental health status of the acculturating group. Intragroup conflict may create threats to person and property, while psychological conflict (even without social conflict) may create uncertainty and demoralization. The crisis phase represents the peak of conflict, and is often associated with the overt behaviors so often identified with social disintegration in acculturating peoples: increased alcohol and substance abuse, increases in all forms of intrafamilial neglect and abuse, and increased incidence of social violence of all kinds. This last includes fatal accidents, violent crime, assault, homicide, and suicide.

Forms of social and psychological adaptation that perpetuate the phase of conflict and crisis are likely to be associated with deteriorating mental health status, while those that reduce or resolve conflict and crisis could be expected to lead to improvement in mental health status.

The time frame for each of these phases in the acculturation process varies considerably, depending on the internal cohesiveness or cultural integrity of the less dominant group, the nature and intensity of contact between the groups, and the degree to which the less dominant group resists or accepts change. Thus acculturation may proceed over generations, in some circumstances, or it may occur at a rapid rate in one generation.

MODES OF ACCULTURATION

Acculturation has been widely misunderstood to be a linear phenomenon, the end point of which is the cultural assimilation of the less dominant group. It was assumed that acculturating individuals would inevitably lose—even wish to lose—virtually all of those characteristic customs, beliefs and behaviors that made their traditional or precontact culture distinct from the more dominant culture, and would be absorbed into the mainstream of the dominant society. The tendency for this to occur is greatest in societies where there is an assimilationist or culturally homogeneous ideology, but it is not inevitable.

It is possible to differentiate modes of acculturation according to how discrete minority groups and individuals cope with and resolve the central issues inevitable to all acculturation experiences (Berry, 1980). While “mode of acculturation” is viewed here as the position taken by the minority group, it is influenced by both the nature of the minority population and by the degree to which the dominant society accepts or rejects the acculturating minority population. These two issues can be represented as two crucial questions confronting groups and individuals: 1) Is my cultural identity of value and to be retained? 2) Are positive relations with the larger, dominant society to be sought? In this manner, four distinct outcomes of acculturative stress can be identified: assimilation, integration, separation, and marginalization. These outcomes are shown schematically in Figure 8.

In assimilation, cultural identity is relinquished and the characteristics of the dominant society are adopted. In integration, cultural integrity is maintained while moving to become an integral part of a larger societal framework. Thus, cultural identity is valued and retained, while positive intergroup relations are encouraged and strengthened. Integration involves a number of ethnic groups, all cooperating within a larger social system. This has been described as “cultural pluralism” or “cultural mosaic.”
Answering no to the question of establishing or maintaining positive relations with the larger society leads to the outcomes of separation and marginalization. Separation refers to self-imposed withdrawal from the larger society. When separation is imposed by the dominant society, the outcome is some form of segregation. Thus, maintaining a traditional way of life outside full participation in the larger society may be due to a group's desire to lead an independent existence, as in the case of "separatist" or "cultural regeneration" movements, or may be due to the restrictive discriminatory powers of the dominant society, which exclude people from full societal participation, as in racial segregation.

Finally, there is marginalization. This outcome of acculturative stress is accompanied by the persistence of marked collective and individual tension, anxiety, and ultimately identity confusion. Individuals have lost essential features of their culture of origin, without replacing them by active participation in the way of life of the larger society. Feelings of loss, alienation, self-denigration, and identity confusion are characteristic of such individuals. They are out of cultural and psychological synchrony with both their traditional culture and the larger society.

The point of this analysis is to illustrate the various ways in which groups and individuals may experience acculturation and acculturative stress. All result in cultural and psychological changes following intercultural contact, but the extent and nature of the changes vary greatly.

Change in mental health status of individuals can be expected to be equally variable across these four modes of outcomes of acculturation, both as a function of the mode itself and as a function of the congruence between an individual's psychological adaptation to acculturative stress and that of the majority of his or her group. However, to take account of intragroup variation fully, the two questions relating to racial/ethnic identification and interethnic contact would need to be continuously scaled from a point of strong agreement to the opposite pole of strong disagreement.

The concepts of phase and mode of acculturation may be combined in the form of a schematic diagram. Figure 9 illustrates the relationship between phase (on the horizontal axis), mode, and the relative amount of cultural and psychological change experienced by an individual (on the vertical axis). Variations in acculturative stress are also suggested (below the horizontal axis).

One may hypothesize that for individuals involved in this process of coping with acculturative stress, marginalization is likely to be associated with the most protracted deleterious effects on mental health status, and thus is likely to be the situation associated with
the highest risk of suicide. At the opposite pole of risk would be integration, since it could be expected to engender the least conflict with either the individual's cultural group of origin or the dominant society. Whether integration and separation would be conducive to decreased or increased individual turmoil would depend on two factors: 1) the degree of support from the group for that mode of adaptation; that is, to what extent has the group moved toward that outcome of acculturative stress; and 2) the degree to which the dominant society encourages or seeks to prevent group integration or separation. Case examples of acculturative stress engendered by the tensions between integration and separation include anglophone-francophone relations in Canada, French-Walloon relations in Belgium, Maori-pakeha (White) relations in New Zealand, and Andean Indian-mestizo relations in Bolivia and Peru.

The point here is not to make exact predictions about the mental health status of individuals who are to be found at various places in the diagram, but to suggest that it is reasonable to expect mental health variations during acculturation which are a function of the phase and mode variables.

TYPE OF ACCULTURATING GROUP

Some groups voluntarily seek out culture contact experiences, while others have it forced upon them. Some remain in their ancestral areas (initially surrounded by an intact society and traditional resources), while others experience contact far from home. For some groups acculturation may be a time-limited experience, lasting only one or two generations. Likewise, for some individuals the process may be temporary, a part of one's life experience. In most cases, though, the process is ongoing and continuous, unlikely to be reversed. Based on the circumstances of intergroup contact and the group's precontact history, four groups pertinent to this report can be distinguished: immigrants, refugees, native peoples, and ethnic groups.

Immigrants may be viewed as voluntary and migrant. In contrast, refugees are involuntary and migrant. Distinct ethnic groups in a plural society are differentiated from immigrants and refugees on the basis of the size of the group and its history of participation, or exclusion, in the country to which they migrated. A parallel distinction can be made between ethnic groups in a multicultural society and native peoples. While both are nonmigrant, native peoples have usually had acculturation forced on them, whereas ethnic groups have established themselves more or less willingly in a new society.

Categorizing these distinctions another way, we see that migrant peoples—immigrants and refugees—may not be able to find out about the traditional resources and social support networks which are available to nonmigrant peoples—native peoples and ethnic groups. To the extent that they lack effective social support systems, individuals' mental health status may be jeopardized by their experiences of acculturation.

Taking these two issues together, one would hypothesize that of these four types of groups undergoing acculturative stress, established ethnic groups would experience the least deleterious effects on their mental health and refugees the most, while the mental health effects on immigrants and native peoples would be intermediate between established ethnic groups and refugees.

NATURE OF THE LARGER SOCIETY

The dominant society exerts acculturative influences in a variety of ways. One important consideration is the society's degree of cultural pluralism (Murphy, 1965). Culturally pluralistic societies, in contrast to culturally monistic ones, are likely to be characterized by two important conditions. One is the availability of a network of social and cultural groups that can provide support for groups experiencing acculturative stress; the other is a greater tolerance for or acceptance of cultural diversity. This latter is termed "multicultural ideology" (Berry et al., 1977). Taken together, one might reasonably expect the mental health status of persons experiencing acculturation in pluralistic societies to be better than that of those living in monistic societies.
SOCIOCULTURAL CHARACTERISTICS OF THE ACCULTURATING GROUP

What social and cultural qualities of the acculturating group influence their coping abilities, and consequently the mental health status of individuals, during acculturation? One cultural factor of importance to this process is the group's traditional settlement pattern. Nomadic peoples, who are usually hunters, gatherers or pastoralists (herdsman), may suffer more negative consequences of acculturation than peoples who are sedentary prior to contact. Nomadic peoples inhabit relatively large territories with low population densities, and function in loosely structured sociopolitical systems characterized by consensual decision making. During acculturation, sedentarization into relatively dense communities with more structured authority systems is typically required, and this places relatively greater stress on nomadic peoples than on others.

Social status is another relevant factor, even when one's origin is in a relatively stratified society. For example, "entry status" into the larger society is often lower than "departure status," and this relative loss of status is inherently stressful. Status mobility in the larger society, whether to regain one's original status or just to keep up with other groups, may also be a factor. In addition, some specific features of status, such as education and employment, provide the necessary resources to deal effectively with the larger society and are likely to affect one's ability to function and cope effectively in the new conditions of life.

Several standard sociodemographic characteristics, such as age and gender, may also play a role. Older people tend to be less adaptable to change, as are those who lack immediate family or close friends to provide material and psychosocial support. Another important consideration is fluency in the language of the country to which one migrates.

Perhaps the most comprehensive variable in the literature on adaptation to acculturative stress is social support. Included here are strengthening elements such as ethnic associations, residential enclaves with people of one's own group, extended families, availability of one's original cultural group (including visits to, viali-

PSYCHOLOGICAL CHARACTERISTICS OF ACCULTURATING INDIVIDUALS

Here again, it is useful to differentiate between those characteristics that were present prior to contact and those that developed during acculturation. Certain precontact variables may predispose one to function more effectively under acculturative pressures. These include prior knowledge of the dominant society's language and culture, prior intercultural encounters of any kind, motives for the contact (whether voluntary or involuntary), and attitudes toward acculturation (positive or negative). Other prior attributes relevant to the outcome of acculturative stress are achievement motivation, personality rigidity or flexibility, and cognitive style.

Another variable, the sense of cognitive control an individual has over the acculturation process, also seems to play a role. Those who perceive the changes as opportunities they can manage experience less turmoil than those who feel overwhelmed by them. In essence, then, the attitudinal and cognitive perspectives suggest that it is not the acculturative changes alone that determine psychological outcome, but how one sees them and what one makes of them.

A final variable is the degree of concordance between expectations of cultural contact and actual experiences. Individuals for
TABLE 21
Variables Which May Affect Relationship Between
Acculturation and Mental Health Status

<table>
<thead>
<tr>
<th>Category</th>
<th>Variable Affecting Relationship</th>
</tr>
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<td>Phase of Acculturation</td>
<td>Precontact</td>
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<tr>
<td></td>
<td>Contact</td>
</tr>
<tr>
<td></td>
<td>Conflict (stress induction)</td>
</tr>
<tr>
<td></td>
<td>Crisis</td>
</tr>
<tr>
<td></td>
<td>Adaptation</td>
</tr>
<tr>
<td></td>
<td>Integration</td>
</tr>
<tr>
<td></td>
<td>Separation</td>
</tr>
<tr>
<td></td>
<td>Marginalization</td>
</tr>
<tr>
<td>Modes of Acculturation</td>
<td>Assimilation</td>
</tr>
<tr>
<td></td>
<td>Integration</td>
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<tr>
<td></td>
<td>Separation</td>
</tr>
<tr>
<td></td>
<td>Marginalization</td>
</tr>
<tr>
<td>Type of Acculturating Group</td>
<td>Immigrants</td>
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<tr>
<td></td>
<td>Refugees</td>
</tr>
<tr>
<td></td>
<td>Native peoples</td>
</tr>
<tr>
<td></td>
<td>Ethnic groups</td>
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<td>Sojourners</td>
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<td>Congruity between expectations and actualities</td>
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Source: Berry & Kim (1988)

whom there is a discrepancy, such as those whose aspirations and expectations of acculturation are much higher than is possible for them to achieve, can be expected to experience more intense conflict and be more susceptible to feelings of alienation, demoralization and despair than those whose aspirations are within reach during the acculturation process.

Table 21 lists some of the variables identified in this outline of the impact of acculturation and acculturative stress on groups and on individuals.

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—Armando R. Faviaza, M.D.
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University of Missouri-Columbia

"This concise, well-organized report should fill in the gaps of knowledge about suicide in ethnic minorities. . . . For any clinician working with ethnic minorities, for any researcher interested in suicide statistics, for the community leader considering integration versus assimilation, for any policy maker concerned with the rising suicide rate in many minority young adults, or for anyone who is intrigued by the complexity of suicide or cultural heritage, there is something of value here. Why, I wouldn't even be surprised if the suicide rate of ethnic minorities decreased after this report is published."

—H. Steven Moffic, M.D.
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