COMMENTARY

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I am in entire agreement with Dr. May's paper, both in respect to the problems faced in arriving at an understanding of drinking in Indian communities and to the recommendations he makes for devising effective community-based prevention programs. In consequence, I will limit my comments to one area of concern to me: namely, that how the data on Indian drinking are presented shapes how the problem is perceived and, subsequently, has a negative influence on the chances of success for community-based prevention and treatment programs.

An increasing number of Indian communities are coming to the conclusion that only the community can eliminate alcohol abuse (Rhoades, Mason, Eddy, Smith, & Burns, 1988). This is in accord with Weibel-Orlando's (1989) assertion that the best Indian programs begin at the community level, are initiated by charismatic role models, maintain ongoing relationships with the "patients," and view themselves as an alternative to the drinking subculture. Since 1985, the Indian Health Service also has encouraged the development of prevention programs in Indian communities and schools.

For such programs to be successful, communities must maintain their energy and enthusiasm; in my opinion, this is only possible if the community has a positive self-image. Yet, as May has shown, the belief that Indians cannot hold their liquor is remarkably persistent among Indians themselves. Not only does this "firewater myth" predispose Indians to conceive of their problem in either/or terms, it also reinforces other beliefs that hold the Indian to be qualitatively different and in many respects inferior to Anglo Americans.

My concern here is the way in which even advocates of Indian causes perpetuate a negative view of Indians by: (1) presenting aggregated data that compare all Indians with national averages; (2) assuming a causal relationship between alcohol use and automobile accidents as well as several social pathologies such as suicide and homicide; and (3) allowing the lower morbidity and mortality rates of women drinkers to keep attention focused on male problems with alcohol. I will contend that as long as these practices continue, the self-esteem of Indian communities will be undermined and subsequent attempts to initiate community-based

programs will needlessly incorporate self-defeating attitudes. Finally, I will try to suggest some ways to mitigate these problems without going to the opposite extreme of arguing that Indian communities do not face serious problems and are not, in consequence, in need of increased budgets and special efforts.

Statistics Regarding Indians and Alcohol Use

From 1969 to 1971, the annual suicide rate in the Portland Indian Health Area was 28 per 100,000 population, somewhat higher than that of 23 for the national Indian rate (Shore, 1975). The regional rate, however, was considerably distorted because more than half of the suicides were committed by one tribe, the Shoshone-Bannocks, which had a rate of 122. When the suicides from this one tribe were omitted, the Portland Area rate was reduced to 14 per 100,000 population. One coastal tribe with a rate of 8 per 100,000 was considerably below the national average.

Similarly, although Hopi suicide rates were considerably higher than the national average after 1965, they were no higher than those of rural counties in the state that had few Indian residents (Levy & Kunitz, 1987). Hopi rates, for example, were 13.5 per 100,000 in 1966 and 23.7 in 1981. For the same years, Yavapai county had rates of 14.2 and 22.8.

Fatal traffic accidents are also said to be higher among Indians. In 1971, the age-adjusted Indian mortality rate was 96.5 per 100,000 population, more than three times the national average. In 1974, the mortality rate on the Navajo reservation was 91 per 100,000 (Katz & May, 1979). Katz and May note that while the state of Arizona has a traffic accident fatality rate higher than that of the nation, the Navajo rate is higher yet. In 1980, the motor vehicle fatality rate was 20.8 for the nation (Hacker, 1983, p. 71). The rate for Arizona was 35.43. This comparison, however, also tends to obscure the picture because, while Indians live in rural areas, Arizona has a large urban population; although urban traffic accidents are many, fatalities occur at a much lower rate than in rural areas.

When the rural populations in Arizona are compared, the traffic fatality differences between Indians and non-Indians are lessened considerably (Table 1). The counties with the largest proportions of Indians in the rural population (Apache 82%, Navajo 61%, Coconino 46%) have had an average annual fatality rate of 118.3 for the years 1979 through 1981. Thirty-two percent of the deaths (37.9/100,000) involved alcohol. By contrast, the seven counties with the lowest proportions of Indians (0%–8%) had an average annual fatality rate of 136, of which 42% (57.35/100,000) involved alcohol. Speeding, distance from medical facili-

Table 1
Rural Vehicle Average Annual Fatality Rates and Percent Involving
Alcohol in Arizona Counties Ranked by Proportion of the Rural
Population That Is Indian, 1979–1981

County	% Indian	Rural Rate	% Alcohol
Apache	82	107.3	32
Navajo	61	87.0	28
Coconino	46	138.7	36
Graham	17	42.0	32
Pinal	16	118.4	44
Oila	11	119.2	37
Pima	11	110.8	40
Maricopa	8	170.3	45
Mohave	6	160.6	37
Yuma	6	96.2	44
Yavapai	2	69.2	28
Greenlee	1	61.3	19
Cochise	1	71.5	42
Santa Cruz	0	53.8	73

% Rural Pop. Indian	Rural Fatality Rate	Rate Alcohol Involved
46–82	118.29	37.9
11–17	100.04	40.0
0–8	136.05	57.35

Source: Lohn (1991).

ties, and alcohol use combine to make traffic accidents a serious problem for rural populations regardless of race or ethnicity (Lohn, 1991).

The consequences of alcohol abuse most often include a group of social pathologies labelled as "alcohol-related" or, as in May's paper, "alcohol abusive." There seems to be little reason to doubt that intoxication leads to accidents rather than the other way around, but whether acts of violence are always and everywhere more frequent when associated with alcohol use is less clear.

Among the Navajo, for example, the proportion of suicides as well as homicides preceding a suicide involving alcohol increased after 1950 (Levy, Kunitz, & Everett, 1969). Yet suicide and homicide rates had not increased since the 1940s and the violence of the homicides had actually decreased. By contrast, alcohol-related homicides committed by Blacks and Anglos in Philadelphia were significantly more violent than those committed by either drinking Navajos or sober Philadelphians. Although

suicide and homicide rates were constant across the reservation, the incidence of alcoholic cirrhosis was higher in areas near the reservation boundary and, hence, nearer to sources of supply. Similarly, alcohol deaths were distributed evenly across the Shoshone-Bannock population, while suicides and murder victims were concentrated in five extended families and had been for some time (Levy, 1988).

Invariably the statistics show that women die from alcoholism and alcohol-related disorders less frequently than men. Yet Navajo women were at higher risk to become alcoholics than men. Though fewer Navajo women than men drink, a higher proportion of women become serious problem drinkers and a higher proportion of women who contract cirrhosis die from it than do men (Levy & Kunitz, 1981). Although the prevalence of fetal alcohol syndrome is not as high among Navajos as it is among some other Indian groups, it seems to be rising (May, Hymbaugh, Aase, & Smet, 1983). It appears that wives continue to feed their drinking husbands, but that when a woman drinks, the family tends to disintegrate and her journey into alcoholism is assured.

During the past decade more Navajo women have taken to drink, many from a desire to avoid being separated from their men. The social cost in broken families and the enormous costs involved in caring for children with fetal alcohol syndrome indicate that, despite women's lower mortality rates, alcohol programs must direct more attention to women's problems than heretofore.

By consistently presenting the higher prevalence of social pathology among American Indians, we foster the image of the Indian as sick and Indian communities as disintegrated. There is, however, considerable evidence that, despite the similarities between Indians and the rural populations surrounding them, the pattern and dynamics of Indian suicide, homicide, and drinking are often quite different. Navajo suicide, for example, is committed most often by married males between age 25 and 39 because of marital conflicts and sexual jealousy (Levy, 1965), while those at risk for alcoholism, suicide, and homicide among the Hopi are the children of parents who made disapproved marriages (Levy, Kunitz, & Henderson, 1987). Much Indian drinking involves periodic binges, often in public, rather than the steady, solitary drinking of the middle-class American alcoholic. Most male Navajo drinkers scored in a range that would indicate alcoholism, yet after age 45 or so, most are able to stop drinking entirely (Levy & Kunitz, 1974).

Despite the demonstrated cultural variability among different Indian groups, there has been little rethinking of the types of treatment programs appropriate to Indian needs. Suicide prevention programs are still predicated on the assumption that, as with Anglo-Americans, Indian suicide is always an *anomic* act of withdrawal. Alcohol programs are still mod-

elled after Alcoholics Anonymous programs, which hold that alcoholism is a disease for which the only effective treatment is total abstinence.

Programs that assume that Indian social pathology is only different in degree are almost invariably designed to target and treat individuals deemed to be most at risk. There are, in consequence, alcohol treatment, suicide prevention, and juvenile delinquency programs, all of which identify and thus label the individual before treatment can begin. Even prevention programs are predicated on the notion that the greatest effort must be to make contact with individuals thought to be the most at risk.

If the only way to fund programs is to demonstrate that Indians are sicker than Anglo Americans, the failure of community-based prevention programs is almost guaranteed. The idea that drinking is a learned behavior that can be changed in future generations by presenting new models of behavior can only be done by communities with the psychic energy, self-esteem, and confidence to innovate and experiment.

How, then, shall we steer a path between the Scylla of Indians being much like their neighbors and the Charibdis of their unique cultural differences? To argue, as I have, that many Indian groups are neither more nor less alcoholic, suicidal, or prone to violence than many non-Indian populations may be taken to mean that they are not in need of adequate funding and new programs. On the other hand, to emphasize their problems and cultural differences serves only to reinforce the notion that they are sicker and somehow less able to adapt to the modern world than their neighbors, a view that fosters a sense of inferiority and helplessness. By emphasizing cross-cultural similarities, we are led to develop programs based on Anglo-American definitions that utilize inappropriate treatment modes. By considering only the cultural differences we neglect those causes of social pathology that exist regionally.

The Need for Culturally Relevant Research and Prevention Programs

The solution to this dilemma, if one exists, involves two courses of action. One, already mentioned by May, requires that each Indian community conduct research into its own patterns of drinking: what is needed is research that investigates the culturally specific determinants of drinking behavior and makes regional comparisons. It is only from the findings of such research that problems may be accurately defined and understood and convincing programs designed. It would, of course, be possible that the aim of the program would be no more than to reduce the level of drinking in the community. In that case, evaluation research would not have to measure suicide, homicide, or cases of domestic violence. Other than a reduced proportion of motor vehicle accidents due to drinking,

however, other measures of success are difficult to define. Is total abstinence the goal or merely a reduction of drinking frequency, and how closely can individuals be followed to determine drinking levels? As demonstrations of the magnitude of drinking problems most often include the "alcohol-related" conditions that can be measured by reviewing death certificates and police records, it may not be wise to ignore such records entirely. If they are included, however, the research must be detailed, and realistic expectations must be established as to the expected reduction of incidence rate.

The second requirement is that prevention programs avoid identifying and labelling individuals at risk in order to avoid attaching the "sick" label to them and segregating them from their "healthy" peers. Noting that the individuals most at risk for alcoholism and suicide among the Hopi had already been labelled as deviant by the community because of their parents' transgressions, we felt that a wilderness adventure program would best avoid negative labelling, involve young people whether or not they were deemed at risk, and be economically feasible.

Such programs have enjoyed some popularity, both as programs designed specifically for delinquent youth (Vision Quest) and for general enrichment and confidence-building among freshman college students (Outward Bound). Such programs may incorporate prevention components such as education and counseling without seeming to do more than address the needs of adolescents generally. The effect of such an arrangement would be to create a "treated" group comprising all individuals in the program and an "untreated" group of those who had not joined the program. Both would include individuals thought to be at risk as well as those not at risk. Data could be collected on the entire age cohort year by year. Baseline data for a variety of social problems could be used to measure success as well as identify newly emergent patterns. In addition, stigmatization of individuals at risk would be minimized and troubled youngsters would benefit from interaction with well-adjusted youths with leadership skills.