**MENTAL ILLNESS IN MICRONESIA**

Presentation at the Interagency Conference on Childhood

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**Introduction**

• The mentally ill have become a common feature of the social landscape in Micronesia during the last decade or two.

• Description: wandering on the road, often garishly dressed (or undressed), stopping people to beg cigarettes and engaging them in bewildering conversation, usually in fluent English. Others skulk in their homes and have dealings with almost no one other than their most intimate relatives.

• Impression of many is that mental illness is a growing problem in society, particularly among the young. Mental illness threatened to be the paramount problem of the '80s and '90s just as suicide had been the scourge of the '70s. Mental illness was taking a heavy toll of Micronesian youth, including some of the most promising young men and women.

• Like suicide, psychosis was permanently disabling for the victim, since the hope of recovery, even with the help of the anti-psychotic medication already widely in use, was virtually nil.

**Goals of this presentation**

• present the epidemiological data gathered in a survey done by MicSem 1988-1990

• identify some sociocultural questions that the data raises

• offer this conclusion: mental illness, while it is certainly a medical problem, can also be regarded a social problem. Its etiology may lie in genetic and biochemical processes, but there is strong evidence that the social environment is a major contributing factor to the onset of psychosis.

**Necessary background**

Note: Bear with me. Some parts of this presentation are technical, and there is some numerical data to be absorbed. I am not an epidemiologist nor a clinical psychologist, but I'll do the best I can to make this relatively painless.

• *Schizophrenia*, a cognitive disorder, is actually a family of disorders. Schiz is by far the most common diagnosis for mental illness, especially in the US where a large majority of psychotics are diagnosed as schizophrenics.

• *Psychoses*, as defined in DSM-III, are "mental disorders in which impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or maintain adequate with reality." (DSM-III, 410)

• The *expectancy rate* (ie, lifetime risk) of schizophrenia in the US and Europe is estimated at 10/1,000 or 1 percent of the population. This indicates the percentage of the population that will manifest the illness at some time during their lives.

• The *prevalence rate* (ie, the presence of the disease at a given time) is lower. Studies show different rates, but the average is about 5-6/1,000. When we add to this other forms of psychosis, we get prevalence rates that may be about 8-9/1,000. (Murphy [1978:6] asserts that the average rate of psychosis in America, Europe and Japan is 9/1,000.)

• Some psychiatric researchers (eg, HBM Murphy) once held that the rates for psychosis in developed countries were much higher than in more traditional areas, but this proposition is less widely accepted today. Recent surveys with more sophisticated instruments are showing comparable rates of schizophrenia around the world.

**Micronesian survey methods**

• done by non-professionals using case records and key informants in the communities.

• criteria: those who have strange ("crazy") behavior, by the community's own norms, for a year or longer. We attempted to screen out personality disorders, those retarded from birth, those whose mental problems stemmed from trauma or physical disabilities, and those who suffer from severe but temporary problems (eg, depression). Borderline cases were also excluded.

**Findings in Micronesia**

[show Table 3 in Isla article]

• Total of 445 individuals suffering from psychosis in Micronesia. This yielded an overall prevalence rate of 5.4/1,000. This is similar to rates in many other part of the world, although slightly lower than prevalence rates for psychosis in modernized nations.

• The distribution, however, was very unusual. Very high rates in Palau (twice as high as Yap, the next highest place), with low rates everywhere else. The four island groups in the east showed rates of 6.4 to 3.2 per thousand.

• The biggest anomaly was male/female ratio of 3.4:1. Of all psychotics identified in the survey, 77 percent were male. This gender disparity showed up everywhere in Micronesia: in Palau and Yap, where the rates were highest, and in the areas where they were much lower. This is surprising because psychosis is not believed to be sex-linked, although the symptoms of males are usually worse, begin earlier in life, and respond less well to treatment.

**Explanation**

• Studies are now being conducted in Palau to explain its very high incidence of schizophrenia or schizophrenic-like psychosis. The current hypothesis is that genetic factors play a large part in its very high rate.

• The gender imbalance in psychosis, which appears to be real and not owing to muted symptoms in females, opens up some interesting questions on the degree to which mental illness is also a product of social environment. It also lays to rest some myths that are sometimes invoked to explain mental illness in island societies.

• Myth #1: Rising rates of mental illness are largely due to the disruption that occurs when rapid cultural change impacts on a society. The result is a breakdown of the societal rules (sometimes called anomie) that causes personal disintegration leading in some cases to psychosis. While there may be some truth to this, such a broad theory can not explain the gender imbalance seen in our rates for Micronesia unless women are somehow immune to social change.

• Myth #2: The increase in mental illness, like the suicide epidemic, is often blamed on the loss of self-esteem. This may be due to any number of blows, among them the shock of living in a world that one no longer understands and in which one can not hope to succeed. This explanation, betraying as it does a Western bias, ignores the fact that self-esteem for most islanders rests not on achievement but on the quality of interpersonal relations, especially with those most dear to them. It also raises the question why women remain relatively free mental illness and suicide compared to men.

**What we can learn from this?**

• If mental illness is partly genetic, its floridity and severity can be influenced by the social environment. We might therefore ask what elements in today's social environment may heighten the stress level for those most at risk.

• What elements in the social environment tend to protect women and put men at risk for full psychosis? There is a tradition in anthropological lore that social pressures on males have always been greater than on females. It doesn't take much insight to see that the traditional patterns of social organization in Micronesian cultures tend to shelter women, confining them to the home and keeping them from the public roles that bring men both greater satisfaction and greater stress. Men have always been subject to greater role changes and social dislocation than women. Could the explanation for the gender disparity in mental illness lie in this direction? Or can it be that women generally do not drink alcohol or use other drugs nearly as much as men in these societies? While drugs are not known to cause mental illness, they might trigger the onset of episodes and exacerbate morbidity.

• Whatever explanation we choose will have to account for the apparent gender imbalance in psychosis. We would do well to get beyond the old myths and look for more specific stresses--if indeed this is what is responsible for the imbalance. We are also forced to ask whether mental illness must be added to the long list of social problems--suicide, drinking and drug abuse, delinquency and violence--that are predominately male problems.

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