

XIII THE SOCIO-ANTHROPOLOGICAL LINE OF STUDY

1. REPRESENTATIONS RELATING TO THE "INSANE", THE "MENTALLY ILL PERSON" AND THE "DEPRESSIVE"

A. FIRST IMPRESSIONS : THE ANALYSIS OF THE OPEN QUESTIONS

- Three open questions are asked at the outset, they open the questionnaire and give a "raw" impression of representations. "In your opinion, what is an "insane person" ?" "In your opinion, what is a "mentally ill" person ?" and "In your opinion, what is a "depressive" person ?". So as to avoid systematic contamination of responses one by the other (e.g. someone who is "mentally ill " is not "insane") the order in which the questions occur is determined randomly from the subject's identification number (six possible combinations in all).
- The spontaneous responses of interviewees were noted in full by the interviewers. These responses were analysed using ALCESTE software, which enables a count of occurrences and an analysis of the context in which they appear. One of the issues at the start of the survey was to discover how far representations of the "insane", the "mentally ill " and the "depressive" people are differentiated in different socio-economic and cultural environments. The analysis of spontaneous answers throws some light on the question.

a. The "ALCESTE" analysis method

- ALCESTE (Analyse lexicale par contexte de segment de texte / lexical analysis from text segment context) is software developed by a CNRS team (French national scientific research centre) with the support of ANVAR (a national body supporting research). It highlights polarities in the use of words. These polarities are taken as so much raw data on which interpretation can rest. The programme is generally used to analyse interviews, open questions and sometimes for analysis of clinical discourse.
- ALCESTE is not a mere word/vocabulary counter. It also groups according to different themes. The creation of theme classes by the programme is not just a reflection of the overall idea of the theme concerned, it also enables identification of different thematic axes, in relation to which the questions asked are envisaged. The axes are then correlated to the groups that have been determined; in the case of this survey these are the survey sites.
- This computerisation therefore makes it possible to show that there is some sort of cohesion in social representations in certain sites. It should be recalled that each site is representative only for itself. There is no overall representativeness (in particular for metropolitan France sites). This representativeness will be achieved once the second phase of the survey is complete.
- Hence this programme makes it possible to demonstrate the link between culture and social representations. It will be seen that the theme groupings first follow a rough cultural distribution.

* All the terms between quote mark, refer to variables of the research questionnaire.

- The analysis of textual data or textual statistics is the method that aims to discover the essential information contained in a text. This type of analysis is derived from work by J.P. Benzecri. The hierarchical descending analysis as effected under ALCESTE is based on work by Max Reinert. The principle is as follows : I do not possess a single signifier to express my idea. Communication is not immediate. That is to say that to give a piece of information I use an association of signifiers in an utterance. But none ever reaches its actual goal. It approaches it in an asymptotic manner. The association of different pieces of information one with the other forms the discourse (speech). According to Reinert this dis/course is formed of breaks (dis) and continuities (course). Continuity is the repetition which makes is possible to reach the desired representation. Hence through repetition, there is an attempt at representation (as it can be conceived in psychoanalysis). In this discourse, the break is where one moves on from one idea to another. This reading can be performed at different levels of discourse. The ALCESTE methodology is based on this conception. One of the methodological problems is to capture this break. It is not always after a full stop, a comma, or even the end of a paragraph. In addition, the fact that there are different levels at which continuity can be read means that the problem is as yet not solved. Thus two distinct divisions are made through the text. It is the comparison of these two divisions that determines stable classes.
- The programme works on three types of units : words, units of context, and the corpus (the whole text under study). ALCESTE segments the corpus into units of context. It then studies the distribution of words within these units of context. The analysis is conducted using contingency tables (presence/absence). A comparison makes it possible to group the units of context comprising a maximum number of common forms. A first division is performed, and so on, moving towards a defined number of classes. From these contingency tables associative Chi 2 are calculated defining what proportion of items are attached to a class in a random manner. The higher the Chi2, the smaller the livelihood of a chance association. The Chi2 are not applied to a quantified probability, which would be meaningless in this type of work. The figures are given as an indication, as markers for the item/class link.

b. Problems encountered

- **Translation** : ALCESTE only functions in French so that is was translations that were studied for the **Comores**, Madagascar and **Mauritius** sites, and in some cases **Guadeloupe** and **Réunion** (the questionnaire was administered in French with the option of “switching” to Creole). The translation was performed by a small number of translators (generally only one per site); this reduces the scope of the vocabulary and hence increases the accuracy of grouping by the software. Certain words are probably not those used by all-comers in the survey : “existential” and “psycho-affective” for instance. They are noted in some sites where translation was required.
- **Cause or a consequence** : For certain items the forms taken by the responses made it impossible to determine if what is mentioned is the cause or the consequence of the disturbance cited. Cause-effect relationships are not identified in the textual analysis. Only systematic re-introduction of all the terms made it possible, in some instances, to identify cause-effect relationships, or to pose the problem of this relationship. Social representations are in themselves forms of knowledge. They are freed from all requirements of logic. Social representation can at once envisage the existence of an object as a cause or as a consequence.

- **Vocabulary** : the interpretation of certain words is problematic, since it is not known what exactly they cover. This mainly concerns scientific terms relating to intellectual function, intelligence, memory, the unconscious, consciousness. For instance, in French “*conscience*” often means “being conscious/aware of one’s acts, assessing their impact” (as in “awareness”).

c. "In your opinion, what is an insane person ?"

There are three coherent occurrence groups (see Tables 7 and 10) :

1. *Metropolitan France – Guadeloupe - Réunion* : " world ", " norm ", " reality ", "insanity".

What predominates here is the loss of the shared frame of reference.

- He is not adapted to the **world**[†], to **reality** or to **society**. His relationship with the **world** is different. He has lost the **sense** and **notion** of **reality**, of **real** objects, he lacks **markers**. He is **disconnected**, disjunct. He **sees** the **world** differently. Notions of **norms** or **society** also place the insane person in a social dimension. It is the place of the individual in his environment. He is on the **fringes** of society, set apart. He is not integrated. He is **different**. His **behaviour**, the **way he acts** is abnormal, not standard. He does not fit the **norm**.

This theme is preponderant in French metropolitan sites. Hence the "insane" here is someone who is outside all systems of reference.

- The reality of the "insane person" is not ours. The "insane" is someone who lives in another world quite detached from ours. He is outside society, because he is not in the same world as other people. He does not have the same frame of reference. The "insane person" is beyond frameworks and limits.
- Our hypothesis is that the "insane person" does not fit any of the patterns that organise the individual. He escapes understanding and laws that govern reality, whether human or natural. He is outside the laws of psychology, and even physical laws. Nothing can be said to a "insane person". Nothing can be understood about him. He does not relate to our patterns of thought. Just as he is unable to adapt to our world (he is in another world), likewise our world and its rules cannot adapt to the "insane person". The "insane person" cannot be understood, he cannot be known in any way. The only law that concerns the "insane person" is that he is not concerned by any law, whether legal, moral, psychological or physical.

This is the **paradox in representations of the "insane"**: we say that there is nothing to be said. It is the representation of the non-representable

- That is why the "insane person" is always another whom we do not know. If we get to know him, then he cannot be "insane person". Any act or gesture that cannot be understood, that is not seen as arising from reflection, thus becomes the act of an "insane person". Remarks such as "Are you insane ?", "sheer lunacy", concepts like "moments of madness" all characterise manifestations to which people cannot attach a meaning.
- If a patient says he is "going mad" it is generally in connection with acute anxiety. This fear without an object is by definition stripped of any meaning for the subject. Hence insanity is the loss of meaning.

The notion of danger is important.

- Dangerousness essentially appears through unforeseeability. The notions of **reaction**, and **moment** of insanity are related to the dangerous nature, the unpredictability of the insane person. These terms also recall passing madness. The "insane person" does however seem to be less in a state of transgression than in a state where the way he functions cannot be apprehended.

[†] In this part of the report, words in bold are those analysed via ALCESTE program.

- The “insane person” has a **problem**, an **imbalance**, an **illness**. Medical concepts appear only fleetingly. The “insane person” suffers from a disorder of his mental **faculties**. He **loses** his head, his reason, his abilities (he **cannot** or can no longer). He is **unreasonable** in his acts and thoughts. he has **lost his self-control**. He is **irresponsible**.

The "insane person" is mainly affected in his social dimension.

2. Comoros - Mauritius : "fatigue", "memory", "healthy", "spirit".

Both **Comoros** and Mauritius sites meet around representations of the "insane person" which can be defined by an alteration in function and manifestations of insanity.

- There is a **malfuction**, a **failure**, an **absence**, a **lack**, a **physical** and **mental** handicap. There is something that **affects** his state. He is not **healthy**. The terms seem to be looking for what it is that has been affected in his functions : **memory**, **intelligence**, **wits**, **morale**, the **head**, the **brain**. These function or organs are not **right**. Things are not right in his **head**, he can no longer **reason**. He does not **understand**. The functions mentioned should not be seen as those defined in medicine, but as representations of them.
- An attempt to explain emerges : **fatigue** (*mental, in the head*). This concept should be taken in a more global manner than simple fatigue or tiredness. It is a sort of dulling or slowing. In this case, this mental **fatigue** is also part of the malfuction, it is not simply the cause of the problem. This fatigue can have various causes : **worry**, substance abuse (**drinking alcohol**, taking **drugs**, **smoking Zamal** (cannabis). These elements are seen as a cause, but their representation as the consequence of insanity cannot be excluded either. The two coexist in the responses, and it often cannot be determined.
- The relationship to the norm appears : he is not **normal**. However this norm is not positioned in a social context, but in a context of deficiency. It is probably a physiological norm.

It is in **speech** that the "insane person" is perceived.

- He **talks** to himself, or talks nonsense; he is **talkative**.

But it is also in what he **does** that he is recognised. Everything carries the seal of **absurdity**.

- He is **incomprehensible** and **changeable**. It is violence in particular that shows through all of this. The "insane person" is a **violent** person verbally (**abuse**) or **physically** (**beating**). He is **brutal**, **throws stones**. He causes **damage**.

Here man is affected in his cognitive functions.

3. Madagascar : "naked ", "incapable", " walk " " eccentric".

The terms here are more descriptive of a concrete state of the subject, his appearance and his acts.

- The "insane person" is **naked**, **denuded**, he "no longer **wears clothes**", he has **stripped** and **goes around naked**, he dresses **eccentrically**. He is **dirty**. The themes of nudity and dress are predominant.

His behaviour also distinguishes him.

- His acts are **incongruous**. He **picks up** and **eats dirt** and **rubbish**. Strong moral connotations can be noted here, found in the various terms. The "insane person" can be **aggressive**, show verbal and/or behavioural **agitation**.
- The "insane person" is a person who is no longer **ashamed**, has no sense of **decency**, he is **unaware** of his **state**, has no ability for **self-criticism** : he **undresses** in public. He is **unable** to **distinguish** good and evil. He does **not know** what is **true**, **ignores** others, ignores conventions. He does not take advice. He has no **control** over himself. There is also the loss of contact with his circle of acquaintances.
- He no longer has any ties, he is **marginal**. He wanders through the streets, he is a **vagrant**. Here there are implicit notions of norms : **eccentric**, **dropout** (marginal), **antisocial**.
- The described subject seems to be an **animal, returned to the natural state**.

Following this there are a series of terms relating to **deficiency**.

- **Mental** function, the **psyche**, the mind is **damaged** and **altered**.
- The disorder relates to **reason** : he is **unreasonable**, **senseless**, **thoughtless**, he is **ignorant**, he is **unable**.
- He has **no control** over himself. He is **not aware** of his **state**. He is a **nutcase**.

It is his quality as a human being that is disputed. There is a sort of return to the animal nature of man. All of this is coloured with a pejorative moral connotation.

In conclusion, an overall concept of inability, inadequacy, incapacity and failure (default) is associated with the representation of the "insane" in all groups. However each group has its specific features :

- **In Mauritius and the Comoros deficiency is the most characteristic feature in the representation of the "insane". It is mainly a deficiency of function, a weakening.**
- **In Madagascar the deficiency relates to reason.**
- **In France (metropolitan and DOM) it is a lack of self control and self-awareness.**

TABLE 7 : ALCESTE ANALYSIS “ IN YOUR OPINION, WHAT IS AN INSANE PERSON? ”

CLASS 1			CLASS 2			CLASS 3		
SITES			SITES			SITES		
Sud Hauts de Seine Tourcoing Pyrénées Orientales Vallée de la Lys Marseille Nantes Lille-Hellemmes Guadeloupe Réunion			Comoros Mauritius			Mahajanga Tananarive		
Reduced Forms	Khi 2	Occurrence	Reduced Forms	Khi 2	Occurrence	Reduced Forms	Khi 2	Occurrence
world	104.18	166	fatigue	219.39	55	naked	669.56	142
norm	97.59	160	memory	197.48	71	incapable	352.47	98
reality	84.64	153	healthy	194.16	54	walk	308.09	70
insanity	77.01	96	mind	119.30	116	eccentric	242.85	61
society	75.63	189	to understand	114.14	66	vagrant	238.98	54
danger	70.72	160	word	72.21	23	eat	236.28	56
ability	50.53	117	intelligence	65.61	29	to wander	229.66	52
different	43.95	102	affect	56.63	16	shame	217.68	52
marker	32.43	40	head	52.72	163	unconscious	180.14	75
notion	24.76	55	worry	50.43	21	clothes	179.81	45

d. "In your opinion, what is a mentally ill person?"

Three new groups of representations that are well differentiated can be described (see Tables 8 and 10) :

1. *Metropolitan France, DOM* : " disorder", " psychological ", " affected ", " illness".

There is a marked medicalisation of the vocabulary.

- The person who is "mentally ill" is **affected** by or **suffers** from something. He presents a **problem**, a **disorder**, an **imbalance**, a **disturbance**, a **disruption**, a **malfuction**, an **illness**, a **pathology**. All of this is **linked** to **problems** of **psychological** or **psychiatric** nature. The **head**, the **brain** and the **psyche** are involved.
- Names of illnesses, medical causes are quoted : **depressive**, **neurotic**, **psychopath**, **neurological**, **psychiatric**. The people who deal with these conditions are given a name : the **psychiatrist**, the **psychologist**.
- The "mentally ill" person can or should be **cared** for in a **psychiatric** hospital.
- The notion of intellectual deficiency appears through that of **handicap**, and of mental and **intellectual abilities** and **faculties** being affected. The notion of congenital disorder is found : **genetic origins**, "**born with it**".
- The "mental ill" person is at the interface between the **psyche** and the **physical**.

The "mentally ill" person is **suffering** mainly from a mental **pathology**.

- It is not **suffering** in the sense of moral pain that is referred to, but the fact of having or being affected by a condition or an illness.

The person who is "mentally ill" lives in **a world of his own**.

- He does not **see reality** as others do. He loses contact with **reality**. He loses his **markers**, he is "**disconnected**", **out of touch**. He is apart. He does not **react** as others do. He cannot be like everyone else. He is not **adapted**, not suited to the **world** and **society**. He cannot live in society and cannot adapt to it. He **loses** his head, is "**a bit missing**". Things are not **clear** in his head. He is not right in his head. Something is wrong, or nothing is right in his head. He is **unable** to reason or to think. He cannot respond to questions. He **talks** nonsense. he is **unable** to **live** alone, he is not **independent**.

There is an attempt to determine the cause of the problem.

- It **arises** from severe **depression**, a **life** event, being **young**, relationships with **parents**. It can also be related to **trisomy**. Some form of illness is assumed.
- "Mental illness" is often noted as **depression** that got worse. The person who is "mentally ill" is also compared to "depressive" people. He is not at **ease** with himself. He is **pessimistic**. He broods over too many **questions**. The idea of suffering reappears here, an idea that is virtually absent for the "insane".

There is a meaning to "mental illness". It is not just a state to be accepted as such. "Mental illness" is at the interface between the psyche and the physical. There is a continuum with "insanity".

2. *Madagascar - Comoros* : "unable", "speak", "nutcase", "word".

- The "mentally ill" person positions himself clearly via his discourse : **speak, say, speech, discourse**. It is through his verbal expression the person who is "mentally ill" is recognised. He **talks** to himself, he **rants**, he **laughs** without reason.

He also positions himself to a lesser degree by his **acts** (what he **does**).

- He is **naked**, he no longer wears **clothes**, he does not **dress well**, or his clothes are dirty. He **wanders**, he is a vagrant who no longer feels **shame**. The person who is "mentally ill" shows **aggressiveness** in particular towards others. He is **highly** excitable.
- His speech and acts are described as **senseless, strange, abnormal**. The notion of the norm is found in this **eccentricity, marginality, abnormality**.

The term of "**insanity**" is reiterated, either down-graded or unchanged.

- It can be noted that the terms appear in attenuated form : he is not yet **naked**, he still **dresses** (this is not found in the analysis).
- He is often recognised as being **able** to **understand** the difference between good and evil, clean and dirty. Comparisons are regularly made with the "insane person", ". There is a proximity, even if it is sometimes denied. The "insane person" remains an important element of comparison.

The **mind** of the person who is "mentally ill" is affected qualitatively and quantitatively.

- There is a **deterioration**, an **alteration** in his mental psychic **state**,. He lacks ability (**incapable**), he lacks meaning (**senseless**), he lacks **consciousness (unaware)**.
- He is not **capable** of any intellectual functions (thinking, considering, understanding). He is **unable** to answer for himself. He lacks **reason**. He is not in **control** of himself, he is **not aware** of his **acts** or his **state**. He is **forgetful**.

In Madagascar, the person who is "mentally ill" is above all another insane person, but who is no longer able to apprehend morality. His behaviour is less marked by moral transgression, but his discourse is incoherent. In the Comoros, the notion of the person who is "mentally ill" does not really have separate individual status.

3. *Mauritius* : "fatigue", "affect", "stress", " alcohol ".

- **Mental fatigue** is at once the state in which the subject is, and the cause of this state. His state is affected, there is **malfunxion** : he cannot reason. He cannot make **decisions**.

- It is the **nerves**, the **nervous** system, the **head**, **mental** faculty, **morale** (more rarely) that are affected. Things are not right in his head. He has not all his wits.
- He is **unstable**. He has **attacks**. He is **nervous**. He is **sad**.
- Causes are suggested : **stress**, **worries**, **disappointments**. There is a relationship with the medical field. He has or **needs treatment**.

"Mental illness" is represented as mental fatigue, sign of irritability, related to life events. "Mental illness" is seen as treatable.

In all the sites there is a shift from the "insane " to the "mentally ill" person.

Before knowing what a "mentally ill" person is, we know what an "insane" is. This representation is quite obvious. The representation of the "insane" is a natural representation : it does not need science to exist. It refers to powerful ideas such as difference and fear of the other person. The distinction between the "insane" and the "mentally ill" requires access to quite precise concepts. The social representation of "mentally ill" transits through that of the "insane".

For the "mentally ill person", we are no longer in the "BEING" mode (TO BE insane) but in the "HAVING" mode (TO HAVE a mental illness).

- Jodelet had already noted this idea in her work. In a study on a community of "mentally ill" patients[‡], (she concludes that *"mental illness positions itself in the "being" mode, it does not articulate with the subject by "having" but by "being". They do not have an illness, they are ill. They are different"*). This is not a contradiction with what we have to say.
- As we underline above, when Jodelet talks about "mental illness", she is not making a differentiation between the "insane" and the "mentally ill" people as we have done. She notes that in social representations on the subject of patients in homes, their state is envisaged more as a manner of BEING in the world than as an illness. Even if the survey methodology used in the research is based on this differentiation – between the "insane person" and the "mentally ill person" -, we find throughout the results of this differentiation between "TO BE"- mostly linked to the "insane" person- and "TO HAVE".

[‡] She makes no distinction between mentally ill patients and insane patients

TABLE 8 : ALCESTE ANALYSIS “IN YOUR OPINION, WHAT IS A MENTALLY ILL PERSON ?”

CLASS 1			CLASS 2			CLASS 3		
SITES			SITES			SITES		
Sud Hauts de Seine Tourcoing Vallée de la Lys Pyrénées Orientales Marseille Nantes Lille-Hellemmes Guadeloupe Réunion			Comoros Mahajanga Tananarive			Mauritius		
Reduced Forms	Khi 2	Occurrence	Reduced Forms	Khi 2	Occurrence	Reduced Forms	Khi 2	Occurrence
to perturb	205.90	235	incapable	187.28	77	fatigue	101.34	97
psychological	160.09	230	to talk	187.11	95	affect	304.65	34
affected	144.53	166	nutcase	145.16	49	stress	173.82	23
illness	126.38	289	word	143.81	47	alcohol	146.23	22
level	124.58	119	act	137.76	94	to reason	140.84	45
problem	113.07	356	speech	129.52	51	nerve	123.02	24
psychic	86.33	164	senseless	117.25	43	to function	115.09	26
psychiatric	67.65	70	unconscious	108.41	50	to drink	113.39	13
to suffer	67.21	116	eccentric	87.90	29	mental	85.00	117
brain	63.50	210	naked	81.75	27	head	84.95	92

e. "In your opinion, what is a depressive person?"

Here, four groups can be distinguished (see Tables 9 and 10) :

1. *Mauritius* : "fatigue", "worry", "sorry", "affected"

The causes of "depression" are :

- social,
- external to the individual,
- generally caused by the social environment (work, unemployment, family).

These causes generate tension that is resolved by crisis and anger. This give rise to "depression", as it is classically described in these countries.

2. *Madagascar* : "life", "sad", "worry", "victim", "overwhelmed".

In a first analysis it was noted that there was a large number of non-responses in the two Madagascar sites, in the form of "I don't know" and "never heard of". Some even answered in terms of cyclones, storms and meteorological phenomena, or again in terms of illness related to the weather (the influence of meteorological catastrophes in Madagascar can be seen here).

In view of this, the non-responses were counted, and they amounted to 50% of responses for Madagascar, or some 900 non-responses. In the logic of the analysis this is a problem. The programme looks for the different themes touched upon, for a given subject. There needs to be unity of meaning for the question. The issue here is in fact social representations of "depressive" people. The "do not know" response is not one of them. This response is an inability for the interviewee to call up an association. It is different from saying "the insane person do not exist" as was encountered in the first question. In this case the subject positions himself on the non-existence of the concept.

The "depressive" person is a **victim** of the **events of life**

- He has had **misfortune, worries, disappointments, a shock, conflict**, which are qualified as **psychological** or **psycho-affective**. The verb **to become** signals a change in state under the weight of life events. The "depressive" person undergoes events, he is a **victim, overwhelmed**.

The "depressive" person is **constantly sad, chronically melancholic**.

- He is despairing, **overwhelmed**. He is easily **discouraged**. He is **unable to stand** the pace of **life**.
- He is **irritable (hyper-excitabile, hyper emotional)**.

Overall, if few have any representation of "depression", when it is represented, "depression" is quite distinct from the two other concepts.

3. *Comoros* : "act", "intelligence", "speech", " foolish",

The representation of the "depressive" person in the *Comoros* is distinct from the above two sites.

- The "depressive" person is identified by his **acts, behaviours, gestures**, and also by his **words (to speak)**. The "mentally ill" are **abnormal** (not **normal**), **different, strange**, they have no **meaning**. The "depressive" person does the **opposite** of other people. He is **dirty** and wears **dirty clothes**. He **threatens** to kill.
- But he is also lacking **deficient (defaulting, weakened, lessened, deficit)** Some functions are not **right**. This mainly applies to **intelligence (intellectual, foolish, stupid)**. He has **lost (lacking, absent)** his **reason**, his **memory**, his **awareness**, his **knowledge**.
- The **physical** and **psychological** state is affected (**brain, mind**). He is **deranged**.

The "depressive" person is often compared to the "insane person" to differentiate between the two, but he remains close to the "insane person" as well as to the person who is "mentally ill".

4. *Metropolitan France - DOM* : " see", " black", " sad", " life" .

The "depressive" person is described in part as a psychiatric manual could describe him.

Depressive psychology.

- A "depressive" person has a negative vision of **life** and of the **future**. Everything seems **black**. He **broods**. He has **gloomy thoughts**. He only looks at the **negative** side of things.
- He is **negative (pessimism)**. The "depressive" person lacks **self-confidence**. He has lost **hope**. He **no longer enjoys things**. He **no longer enjoys life**, he has **no desires**.
- He is **suicidal**.

The mood is sad

- A "depressive" person is sad, he is always weeping.
- He does not feel good, he is unhappy in himself, he is depressed, he is miserable.
- He is deeply disillusioned with life, profoundly sad.

A "depressive" person **cannot overcome** or **face** life's problems. He does not know how to **react** to things, he **lets things go**. His life is **empty**.

The dissemination of the "depression" concept via the media can be seen in the French sites. Today, the social representation of depression seems to embrace any psychological distress, beyond the strict psychiatric definition.

Social representation of the word “depressive” varies according cultures. There is an obvious link between the media effortand the social representation. In the Comoros site the "depressive" person is not well identified ; in the French sites, social representation of the word “depressive” allows the patient presenting confusion not to undergo the negative representations of the "insane" or the "mentally ill person”.

TABLE 9: ALCESTE ANALYSIS: “IN YOUR OPINION, WHAT IS A DEPRESIVE PERSON?”

CLASS 1			CLASS 2			CLASS 3			CLASS 4		
SITES			SITES			SITES			SITES		
Mauritius			Mahajanga Tananarive			Comoros			Pyrénées Orientales		
									Sud Hauts de Seine		
									Nantes		
									Tourcoing		
									Vallée de la Lys		
									Marseille		
									Lille-Hellemmes		
									Réunion		
Reduced forms	Khi ²	Occurrence	Reduced forms	Khi ²	Occurrence	Reduced forms	Khi ²	Occurrence	Reduced forms	Khi 2	Occurrence
fatigue	458.67	100	life	41.67	87	act	314.31	45	black	450.22	401
worry	376.37	86	sad	38.42	63	intelligence	285.11	37	to see	401.18	369
sorry	331.03	30	worry	33.34	55	word	213.18	28	sad	165.96	335
affected	289.37	33	victim	30.83	51	foolish	206.79	26	life	165.68	496
mental	263.83	100	stricken	28.95	48	abnormal	192.75	33	to cry	111.63	161
to disgust	141.98	14	misfortune	24.60	41	mind	184.62	39	negative	96.85	112
fact	117.08	86	time	21.15	47	reason	162.23	52	to brood	78.45	69
stress	114.66	57	psychological	20.32	42	to disturb	148.79	21	idea	70.31	95
to neglect	98.99	9	melancholic	20.29	34	memory	141.34	22	to go	70.14	112
frustrated	67.23	8	shock	18.46	31	clothes	125.65	17	taste	65.96	146

The "insane" person

- Conceptions are very different according to cultures, and the image of the "insane" can thus focus on human behaviours markedly different from each other. Although the notions of danger and violence are rooted in the representations, they are attributed to non-homogeneous cultural explanations.

The "mentally ill person"

- For the person who is "mentally ill" things are simpler in appearance. In France and the DOM sites, it is the medical sphere and its explanations that are predominant. Thus words become more accurate. The neurological gains the upper hand. Explanation is related to surrounding reality.
- In Madagascar and in the Comoros sites the signs of "mental illness" do not differ from those of "insanity". The person who is "mentally ill" is above all another "insane" person, but who is unable to apprehend morality; his behaviour does not bear the mark of moral transgression to the same degree, but his discourse is incoherent.
- In Mauritius, the aetiology is either internal or external (fatigue, stress, alcohol).
- The representations from the DOM and from metropolitan France are fairly similar. Medicalisation makes the "insane" person less insane, explainable, if not curable.

The "depressive" person

- In France social representation of the "depressive" person is a clear concept, close to what is described in a manual of psychiatry. This should obviously be linked with the awareness raised, that has been underway for some years in written and audio-visual media. In France, there is a certain conceptual distance from "insanity", and it is quite clearly replaced by "mental illness" and even more by "depression". Nevertheless, social representation of "depression" does not exactly fit with the psychiatric definition – but, being "depressive" remains "psychiatrically" acceptable.
- In the Mauritius site, the representation of "depressive" people that emerges, shows that this country knows depression. In Madagascar things are more uncertain (half the interviewees could not answer questions). In the Comoros it is not markedly differentiated from "insanity" and "mental illness". This non-differentiation can not be related only to translation problems.

To summarise, we can say that the "insane" person IS "insane", the "mentally ill" person HAS a "mental illness" and the (depressive) person IS SUFFERING from "depression". From this, it is easy to understand how "depression" is more curable in the social representation.

TABLE 10 : CULTURAL VARIATION OF SOCIAL REPRESENTATIONS
(from Kh^2 calculated with ALCESTE)

	<i>France (Métropole + DOM)</i>	<i>Mauritius</i>	<i>Comoros</i>	<i>Madagascar</i>
" INSANE "	WORLD NORM REALITY INSANITY	FATIGUE MEMORY HEALTHY MIND		NAKED UNABLE TO WALK ODD
" MENTALLY ILL "	TROUBLE PSYCHOLOGICAL STRUCK DOWN ILLNESS	FATIGUE AFFECTED STRESS ALCOHOL		UNABLE TO TALK TOQUE (CRAZY) WORD
" DEPRESSIVE "	BLACK TO SEE SAD LIFE	FATIGUE WORRY DESOLATE AFFECTED	ACT INTELLIGENCE WORD FOOLISH	LIFE SAD WORRY VICTIM

f. Discussion

The analysis of responses to open questions shows very marked inter-site conceptual differences.

In **France**, representations remain classic and homogeneous from one site to another :

- The "insane person" is not apprehendable; he is unpredictable and therefore dangerous
- The person who is "mentally ill" is situated in a mode of disorders and illness
- The person who is "depressed" sees everything in pessimistic manner.

For the **DOM**, the representations :

- are in the same group as France for "mental illness" (Guadeloupe for the "insane person")
- but differ markedly in representations of a "depressive" person, where the external social crisis aspect is stronger.

Inter-site differences are more marked in representations of the "insane person" :

- reason in the Comoros and Mauritius sites
- nudity in Madagascar

and "mental illness" :

- the illness is in words, what is said, speech for Madagascar and the Comoros
- biological causes (drug or alcohol abuse) or neurological causes for Mauritius.

- **The analyses of open questions on this theme converge with what can be noted from intensive qualitative surveys.** What can be retained is the strong symptomatic value of nudity in Madagascar, or the way in which qualifiers applied to "depressive" people make it possible to group the "Creole islands" (Guadeloupe, Mauritius, Réunion), reflecting the social conditions of psychological distress that anthropological studies have described (work by R. Massé in progress).
- For "depression" representations appear more confused in the Comoros. The differences between the "insane" person/ the "mentally ill" person and the "depressive" are not marked as they are in the other sites. These results require confirming in the analyses of the following questions. However, semantic problems can be underlined, those already encountered in the wording of questions, and one can wonder about the "degree of penetration" of the concept of disturbances/disorders in these societies. The prevalence rates for these disorders in the population will also need to be put in the perspective.
- These first results from spontaneous responses can also lead one to wonder if the establishment of psychiatric hospitals in the West 200 years ago, a corollary to prison for the "insane" person, has not left a mark on mentalities over a whole period (insane person = danger). Historically, France is the mother of all psychiatric asylums. With her European allies, she exported her care model throughout the world. It will be seen later that solutions provided for "insanity" in one way or another integrate the notions of care and internment in a psychiatric hospital. Even if those countries with no psychiatric hospital have another representation of the "insane person", who is not spontaneously described as being dangerous, this judgement will need adjusting subsequently. It can be recalled that Mauritius moved into psychiatry on the British model. This does not prevent Mauritius from having representations close to the DOM, the Comoros and Madagascar according to the

instance, or again from having a representation that is specifically its own, in particular with regard to “depression”. This data overall will be analysed for each site and each researcher.

B. MORE DETAILED REPRESENTATIONS

The semi-open and closed questions that follow are an attempt to approach representations of "insanity", "mental illness" and "depression" in the populations. It is therefore not surprising if an identical theme logic to that found in the analysis of the open questions is found. However, the questions here have the advantage of targeting the different aspects of representations more efficiently in relation to the following components :

- behaviours and conducts,
- dangerousness,
- causes attributed,
- responsibility,
- suffering,
- exclusion,
- role of family and relatives,

a. Behaviours and conducts (Tables 11 to 17)

- For the majority of interviewees a person who is "insane", a person who is "mentally ill" and a person who is "depressive" can be recognised "at first sight" mainly from his behaviour, his appearance and/or what he says. What behaviours, what conducts are involved ? The analysis of the 12 questions from 1a to 1r of the survey questionnaire provide some answers. It makes it possible to give a less subjective content (more detailed) than the raw representations obtained from the open questions.
- In these questions are included the twelve items highlighted by the INECOM[§] research co-ordinated by the anthropologist Gilles Bibeau, which aims to define mental disorders in different cultural sites. They are twelve behaviours or forms of conduct which in any given individual can suggest a disorder in the mental sphere. In our survey, for each of these behaviours or forms of conduct the interviewee is asked to indicate if this behaviour, in his/her opinion, it that of an "insane" person, a person who is "mentally ill", or a person who is "depressive", or "none of these three". It should be remembered in the reading of the results that there are four possible responses for each behaviour or conduct ("insane", "mentally ill person", "depressive", "none of these three"). Thus the mean response is 25% (and not 50%).
- For each of these behaviours or conducts the interviewee is then asked to say if he/she considers them to be "normal or abnormal", "dangerous or not very dangerous" (here the mean is 50%).
- The intention of the questions is obvious. We will not return here to the bias constituted by the fact of introducing oneself as a WHO interviewer, interviewing on mental health in the population. This indeed can lead to "biomedical" type responses. Representations are forced, indeed, but the bias is systematic in all sites. Hence all that can be done is to give it greater weight in the Comoros and Madagascar - though this requires confirmation from researchers in the field.

[§] INECOM "The International Network for Cultural Epidemiology and Community Mental" Summer 1993, Montreal WHO Collaborating Centre, Douglas Hospital, Montreal

EXTRACT OF THE QUESTIONNAIRE ON REPRESENTATIONS

1 CHECK ONLY ONE ANSWER FOR EACH QUESTION IN A - B - C

A

B

C

In your opinion, someone who :		insane	mentally ill	depressive	none of these three	normal	not normal	dangerous	little dangerous
1a	- is often crying, is sad most of the time, is :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1b	- attempts suicide, is :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1c	- is taking drugs (cannabis, heroin, cocaine, etc.) on a regular basis, is :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1d	- is drinking alcohol on a regular basis, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 ^e	- beats his wife, her husband, his/her children on a regular basis, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1f	- is violent against others, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1g	- is violent against himself, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1h	- suffers from delusion, hallucination, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1i	- is mentally deficient, retarded is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 **CHECK ONLY ONE ANSWER FOR EACH QUESTION IN A - B - C**

A

B

C

In your opinion, somebody who :		Insane	Mentally ill	depressive	none of these three	normal	Not normal	Dangerous	little dangerous
1j	- is having convulsions (falls, shivers, slavers, faints,...), is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1k	- shows a strange behaviour, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1l	- has senseless speech, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1m	- neglected, often dirty, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1n	-is isolated, withdrawn, looks for being alone is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1o	- is anxious is :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1p	- commits rape is :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1q	- commits incest, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1r	- commits murder, is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. *The "Insane"*

Transgressive acts are above all associated with the "insane person"(Table 11) :

- murder (31-59%)
- rape (28-50%)
- incest (26-54%)

except for Mauritius and Guadeloupe (17-36% for each item).

This representation is on the other hand very strong in Madagascar and the Comoros.

The responses from interviewees in the Madagascar sites include negative/antisocial behaviours in the concept of "insanity" :

- drug addiction,
- strange speech,
- violence to self,
- being dirty, neglect,

These results are in line with the analysis of the open questions.

It can be noted that delirium and hallucination are not considered to be a main component of "insane person", except in Reunion (37%).

In Mauritius, respondents considered the "insane" person to be principally someone with hallucinations (31%) or who is violent (34%).

Although marked tendencies can be seen, there is ***no international consensus on the subject.***

When in the questionnaire a transgressive act is proposed, it is put as a raw fact, in the absence of any accessible (approachable) meaning.

It is the act of a "insane" person.

2. *The "mentally ill person"*

The representation of the person who is mentally ill is composite (Table 12).

Is considered to be "mentally ill" someone who :

is delirious, has hallucinations (37-60%) - except in the Comoros (24%)

- commits incest (36-56%) - especially in metropolitan France (41-56%)
- commits rape (31-58%) - especially in metropolitan France (40-58%)

Likewise, is considered "mentally ill" someone who :

is intellectually deficient or retarded (47-64%) - except in the Comoros (19%)

- is violent towards himself or others (35-51%) - particularly in metropolitan France (39-50%)
- regularly beats his wife, her husband or his/her children (31-49%)
- has a strange discourse (32-50%) - a little less in Reunion (27%).

Rape and incest are considered to be more strongly connected with the "mentally ill" person (7 sites > 30% and 4 sites > 50%) than to the "insane person" (7 sites > 30% and 1 site > 50%). The same is true for violence towards others or self, beating the spouse or children.....

Having attacks or convulsions (48-49%) or showing strange behaviour (32-42%) are considered to be connected with "mental illness" in Mauritius and Mahajanga. In Mahajanga, someone who is isolated (33%), shows anxiety (30%) or weeps a lot (31%) is also considered to be a "mentally ill" person

Attempt to commit suicide are clearly not considered to be connected with "mental illness" in metropolitan France (6-11%), and the same is true for :

- drink (alcoholism) (5-9%)
- self neglect (3-7%)
- being isolated, withdrawn (1-5%)
- showing anxiety (1-4%).

Delirium, deficiency, strange speech, incest, rape, violence to self and others are related to "mental illness".

- **It could be said that representations here relate to "mental illness" as a medicalised form of "insanity". The person who is "mentally ill" has a biological disorder which explains his anti-social behaviour. It is striking to see the convergence of this analysis derived from the questionnaires with other more qualitative studies. In particular, a recent anthropology thesis from observations made in the South of France can be mentioned, in which the author shows how medical thinking, in coining the term "mental illness", has created a new attitude towards people with mental disturbances, and arrives at the conclusion that "medicine has created a new place for the mentally ill in the social imagination. But it would certainly be a mistake to think that medicine has altered the place that the insane occupy in our collective imagination"⁹⁸.**
- **This is not found with the "insane", where aetiology is not very convincing, and where visible manifestations are not well explained. Transgression of taboos, (mainly murder) is the main feature. The "mentally ill" person transgresses taboos that are intimate rather than external, less visible at first sight (rape, incest, violence in the home).**

3. *The "depressive" person*

Here there is a switch to a radically different sphere of analysis (see Table 13).

Following behaviours strongly represent the "depressive" person. Someone who :

Weeps frequently - especially in metropolitan France (85-91%) and in the DOM and Mauritius (71-76%), less so in Madagascar (38-39%)
attempts suicide - particularly in metropolitan France (76-84%) ; in the DOM and Mauritius (61-72%) - less so in Madagascar (36-38%).

- is isolated (45-66%) - rather less in Madagascar (28-29%).

A "depressive" person is also associated to a lesser degree with anxiety (except in Mahajanga). It will be seen that in Mahajanga anxiety disorders are very markedly present in the population.

In the Comoros site, an inversion of answers can be seen. Aside the murder item, other items related to the "mentally ill" person and the "insane" person are here related to the "depressive" person. As the word "depressive" does not exist in the Comoros language, it might have been translated in words close to "mentally ill" : that is our hypothesis (questionnaire translation validity is pointed out ; it was very hard to reduce the bias for logistical reasons).

There is a beginning of **international consensus** on "depression" as being a **withdrawal** of the individual from society and life. Percentages on key items are quite high : "someone who often weeps", "someone who attempts to commit suicide", "someone who is isolated or withdrawn, who prefers to be alone". A progressive integration of the concept of "depression" in the semantic landscape of the Indian Ocean can be clearly seen. If for France the process is complete, countries like Madagascar, Mauritius and the Comoros are "resistant" to the concept.

4. *"None of the three" (neither "insane", nor "mentally ill", nor "depressive")*

- Being dirty, drinking, having attacks, showing strange behaviour, taking drugs, showing anxiety, deficiency and withdrawal are behaviours that are not identified as being related to "insanity", "mental illness" or "depression", especially in France (Table 14). **It can be wondered if it is due to a "depathologisation" or a "depsychiatrisation" of certain behaviours in France.**
- This category assembles behaviours that have a qualification of their own ; "alcoholic", "drug addict", "epileptic", "anxious" and the unclassifiable in the three other categories : "dirty".
- It should be noted that in Mauritius "committing murder" belongs to this category rather by default. Someone who "commits a murder" is considered neither as "insane" person, nor as being "mentally ill" person, nor as "depressive", but as a murderer...

- The "mentally ill" and the "insane" are the ones who inspire fear; they are represented as being violent and dangerous. The figure of the murderer "fits" that of the "insane" person; the figure of the person who is "mentally ill" fits that of domestic danger; the figure of the "depressive" subject fits into a general atmosphere of misfortune and unhappiness.
- The item "none of the three" is an automatic recourse when the origin can be identified : drugs, alcohol, convulsions and even anxiety. The easier it is to find an aetiological diagnosis, the less likely it is that the behaviour will be related to "insanity" or "mental illness".

Following tables show the detailed answers for each site

They can be completed with the appendixes

**Graphs highlight variants and invariants related to "insane",
"mentally ill" and "depressive" representations.**

TABLE 11 : BEHAVIOURS AND CONDUCTS RELATED TO THE "INSANE"

"INSANE"	Comoros	MADAGASCAR		Mauritius	Réunion	Guadeloupe	Marseille	Pyrénées Orientales	Nantes	Southern Hauts de seine	Vallée de la Lys	Lille- Hellemmes	Tourcoing
		Tananarive	Mahajanga										
Someone who commits murder	59	53	62	17	36	24	49	47	37	31	45	41	42
Someone who commits rape	31	44	50	17	35	27	47	45	33	30	40	32	40
Someone who commits incest	38	51	54	19	36	26	45	42	30	27	39	31	37
Someone who regularly beats spouse or children	14	27	40	9	26	19	36	36	24	22	33	26	30
Someone who is violent towards others	8	31	30	26	30	34	33	34	28	20	31	28	27
Someone who is delirious, has hallucinations	32	19	22	31	37	27	28	32	28	23	22	28	30
Someone who is violent towards himself	18	38	35	34	28	30	26	28	20	17	25	22	21
Someone who has strange, meaningless speech	27	38	36	29	31	22	22	23	26	19	17	19	22
Someone who shows strange behaviour	12	28	31	14	24	15	16	19	14	8	14	11	13
Someone who regularly takes drugs	8	39	39	3	16	12	9	10	5	5	10	7	8
Someone who has attacks and convulsions	3	6	9	5	3	2	5	6	5	3	3	4	3
Someone who attempts suicide	31	20	20	5	5	6	6	4	2	2	4	4	3
Someone who is intellectually deficient, retarded	9	14	23	5	4	4	3	8	2	2	3	2	2
Someone who regularly drinks alcohol	7	18	23	1	6	3	3	5	2	2	3	2	2
Someone who is often neglected, dirty	13	39	26	12	6	6	3	2	2	2	2	3	1
Someone who is isolated or withdrawn, prefers to be alone	10	7	11	2	1	1	2	1	0	1	1	1	1
Someone who is anxious	5	6	5	1	1	1	1	1	0	0	1	1	0
Someone who often weeps	5	3	6	1	1	1	0	0	0	0	0	0	0

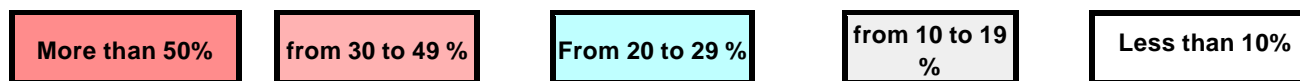


TABLE 12 : BEHAVIOURS AND CONDUCTS RELATED TO THE "MENTAL ILL"

"MENTAL ILL "	Comoros	MADAGASCAR		Mauritius	Réunion	Guadeloupe	Marseille	Pyrénées Orientales	Nantes	Southern Hauts de Seine	Vallée de la Lys	Lille- Hellemmes	Tourcoing
		Tananarive	Mahajanga										
Someone who is delirious, has hallucinations	24	38	54	46	37	46	47	54	47	56	52	46	47
Someone who commits incest	27	28	28	36	39	43	41	45	53	54	44	50	47
Someone who commits rape	31	31	25	33	40	41	40	43	50	56	44	52	45
Someone who is intellectually deficient, retarded	19	52	54	64	53	47	47	47	46	48	53	48	50
Someone who is violent towards himself	22	27	36	38	37	38	41	48	47	48	46	51	48
Someone who is violent towards others	26	29	35	41	27	35	39	41	45	49	44	41	44
Someone who regularly beats spouse or children	25	26	24	32	30	31	36	34	49	48	38	41	41
Someone who has strange, meaningless speech	32	39	50	36	27	35	33	38	35	40	33	35	36
Someone who commits murder	16	20	20	23	23	20	22	30	32	37	28	29	29
Someone who has attacks and convulsions	14	25	48	49	22	24	21	23	23	23	19	22	24
Someone who shows strange behaviour	25	37	39	42	22	21	17	20	16	17	19	16	19
Someone who regularly takes drugs	27	18	24	16	15	19	15	12	13	15	13	11	12
Someone who attempts suicide	23	26	27	21	14	12	10	9	6	8	9	11	8
Someone who regularly drinks alcohol	21	14	18	8	12	10	6	6	8	8	7	6	5
Someone who is often neglected, dirty	22	19	28	23	11	18	6	4	3	6	4	4	5
Someone who is isolated or withdrawn, prefers to be alone	22	16	33	11	8	6	5	4	1	4	3	3	2
Someone who is anxious	19	16	30	21	4	7	4	3	3	2	2	4	2
Someone who often weeps	17	19	31	8	5	2	1	2	0	1	1	1	1

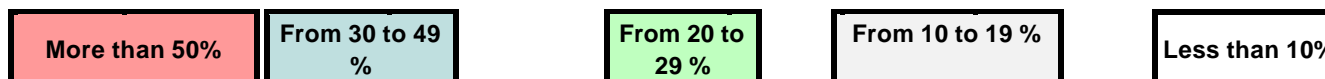


TABLE 13 : BEHAVIOURS AND CONDUCTS RELATED TO THE "DEPRESSIVE"

"DEPRESSIVE"	Comoros	MADAGASCAR		Mauritius	Réunion	Guadeloupe	Marseille	Pyrénées Orientales	Nantes	Southern Hauts de Seine	Vallée de la Lys	Lille-Hellemmes	Tourcoing
		Tananarive	Mahajanga										
Someone who often weeps	53	39	38	76	71	71	85	89	89	88	91	88	85
Someone who attempts suicide	38	36	38	61	71	72	76	77	82	84	80	78	82
Someone who is isolated or withdrawn, prefers to be alone	49	29	28	53	46	45	60	66	57	56	63	62	63
Someone who is anxious	49	29	19	49	41	40	37	38	29	40	41	40	41
Someone who regularly drinks alcohol	44	21	15	34	25	25	23	17	20	30	20	28	31
Someone who is often neglected, dirty	48	10	15	38	14	15	25	18	19	25	21	24	24
Someone who is violent towards himself	46	12	13	21	25	23	26	16	22	24	19	17	23
Someone who regularly takes drugs	42	14	10	32	24	20	22	18	18	22	18	21	21
Someone who is violent towards others	48	14	14	17	26	18	14	6	9	12	10	11	12
Someone who shows strange behaviour	48	13	10	17	13	15	13	8	8	10	12	13	12
Someone who has attacks and convulsions	58	13	10	14	19	17	13	6	7	9	9	9	10
Someone who is delirious, has hallucinations	29	12	12	13	11	15	13	5	5	9	12	10	9
Someone who regularly beats spouse or children	48	17	14	24	21	22	12	6	6	11	6	9	8
Someone who has strange, meaningless speech	37	9	8	12	7	7	9	5	4	7	8	6	8
Someone who commits murder	18	6	0	9	12	10	5	2	1	3	3	2	3
Someone who is intellectually deficient, retarded	54	8	8	7	3	3	2	1	0	1	2	2	2
Someone who commits incest	29	5	5	6	4	3	1	1	0	1	1	1	1
Someone who commits rape	31	7	8	7	5	4	1	1	0	1	2	1	1

More than 75%

From 50 to 74 %

From 25 to 49 %

From 10 to 24 %

Less than 10 %

TABLE 14 : BEHAVIOURS AND CONDUCTS RELATED TO "NONE OF THE THREE"

“ NONE OF THE THREE ”	Comoros	MADAGASCAR :		Mauritius	Réunion	Guadeloupe	Marseille	Pyrénées orientales	Nantes	Southern Hauts de Seine	Vallée de la Lys	Lille-Hellemmes	Tourcoing
		Tananarive	Mahajanga										
Someone who is often neglected, dirty	17	31	31	26	70	61	66	76	76	68	73	69	69
Someone who regularly drinks alcohol	28	47	44	57	57	62	68	73	71	60	70	63	62
Someone who has attacks and convulsions	25	57	33	32	56	57	62	65	65	64	69	65	63
Someone who shows strange behaviour	15	21	19	28	42	50	55	53	62	66	56	60	55
Someone who regularly takes drugs	23	28	27	49	45	49	54	61	63	58	59	60	59
Someone who is anxious	26	49	46	28	54	52	58	59	68	59	56	54	57
Someone who is intellectually deficient, retarded	18	27	15	24	39	46	48	44	51	49	42	48	46
Someone who has strange, meaningless speech	5	14	6	23	35	36	35	34	36	34	42	39	34
Someone who is isolated or withdrawn, prefers to be alone	19	48	28	33	45	48	33	30	41	39	33	33	34
Someone who commits murder	7	21	12	51	28	46	24	22	29	29	24	28	26
Someone who regularly beats spouse or children	13	29	22	35	24	28	17	24	21	20	23	24	21
Someone who is violent towards others	18	26	21	16	17	13	15	19	18	19	15	20	17
Someone who commits incest	5	16	12	39	22	28	12	12	17	18	15	18	15
Someone who commits rape	7	18	17	43	20	28	11	11	17	14	14	16	15
Someone who is delirious, has hallucinations	15	32	12	10	14	12	13	10	18	12	13	16	14
Someone who often weeps	26	39	25	15	23	25	14	9	11	11	8	11	14
Someone who is violent towards himself	13	24	16	7	9	9	7	8	11	10	10	10	8
Someone who attempts suicide	8	18	15	14	10	10	9	11	10	6	8	8	7

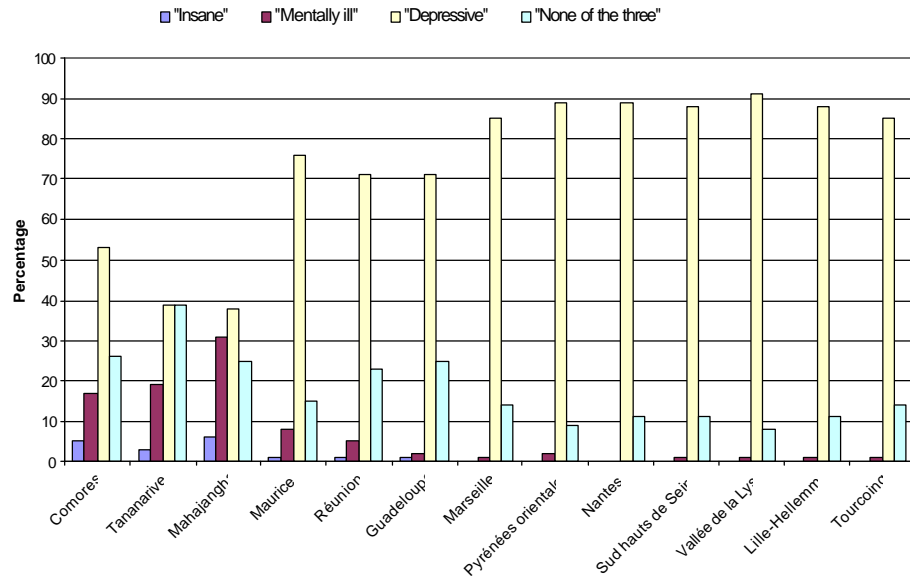
More than 50 %

From 25 to 49 %

From 10 to 24 %

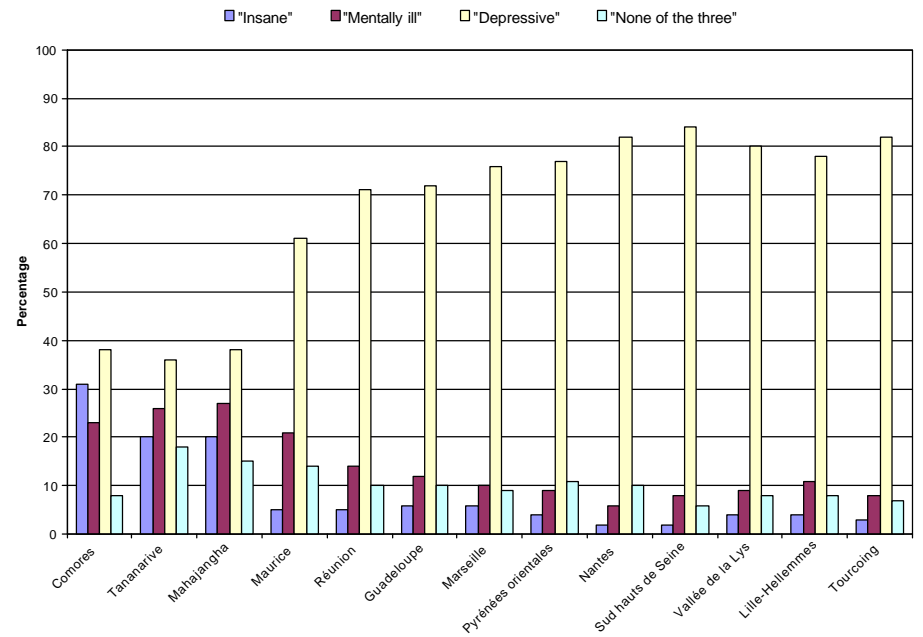
Less than 10 %

In your opinion, someone who often cries, and who is most of the time sad is :

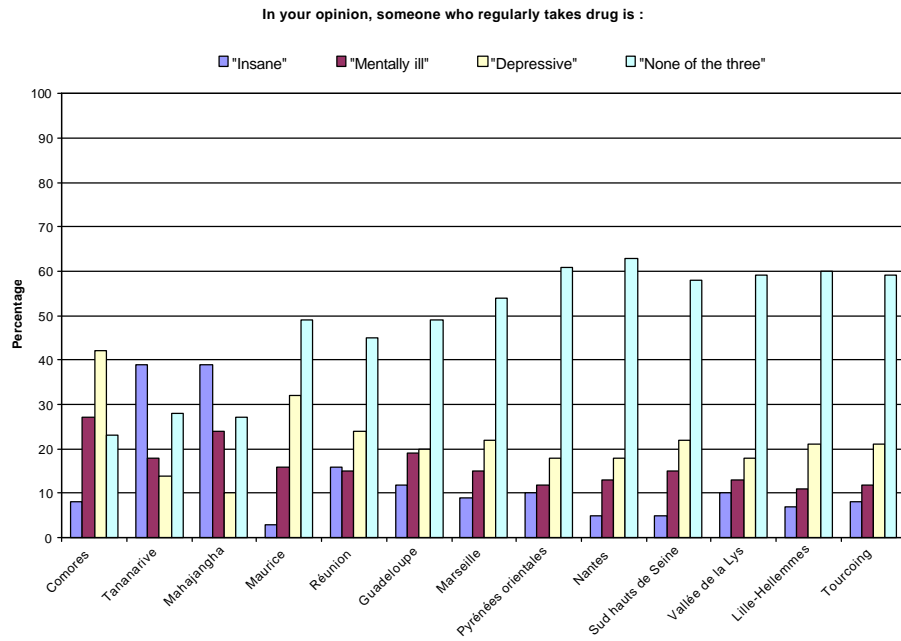


GRAPH 5

In your opinion, someone who attempts to commit suicide is :

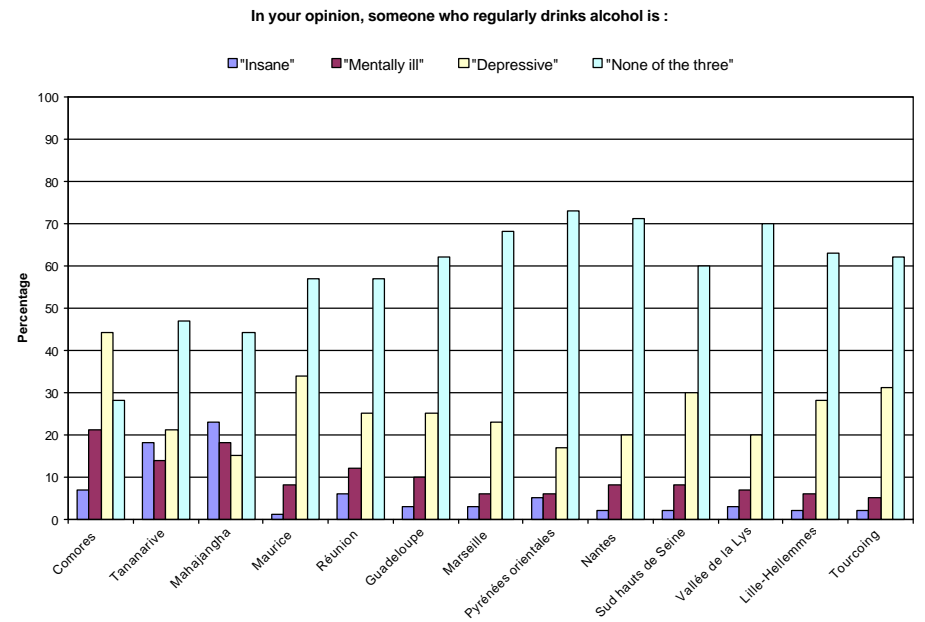


GRAPH 6

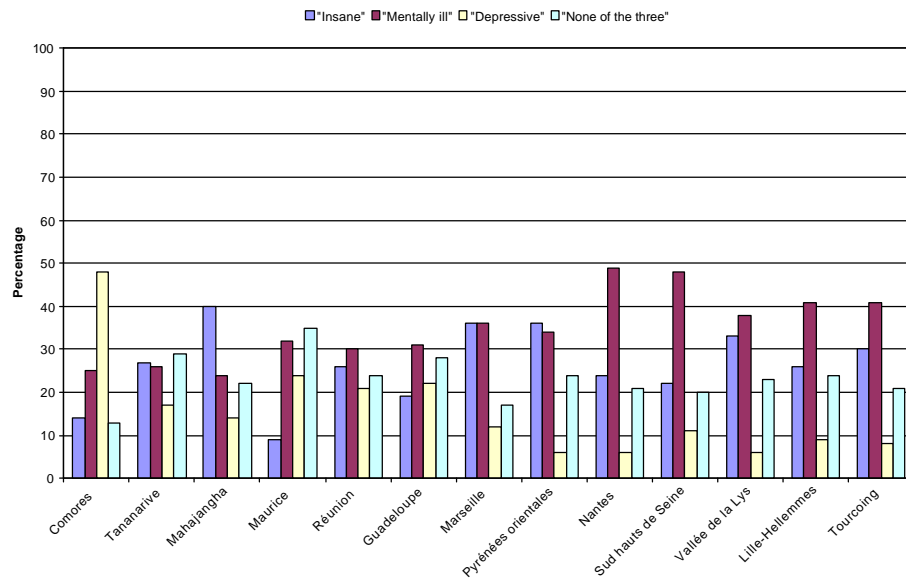


GRAPH 7

GRAPH 8

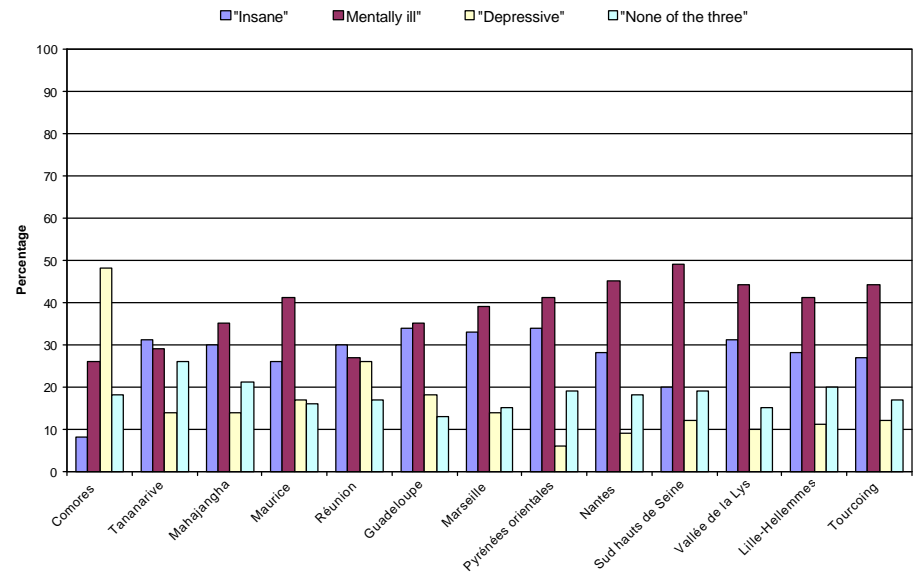


In your opinion, someone who regularly beats relatives is :



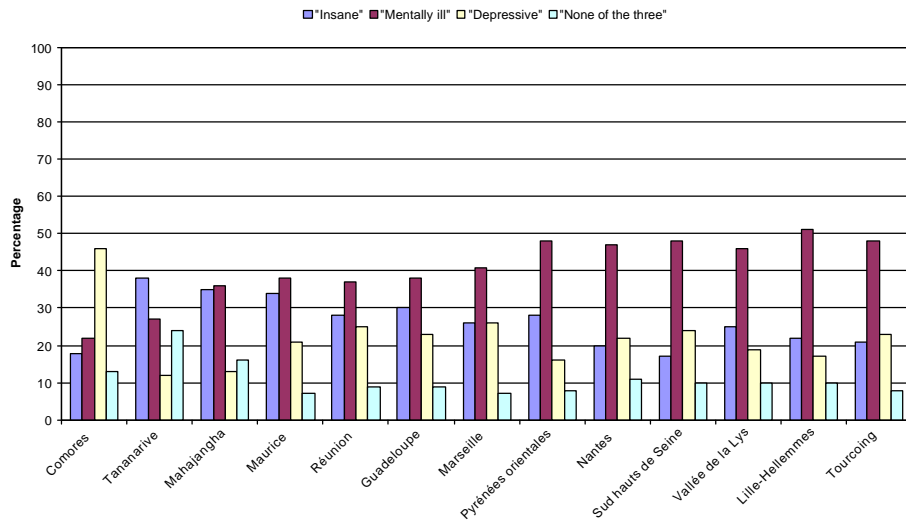
GRAPH 9

In your opinion, someone who is violent towards others and objects is :



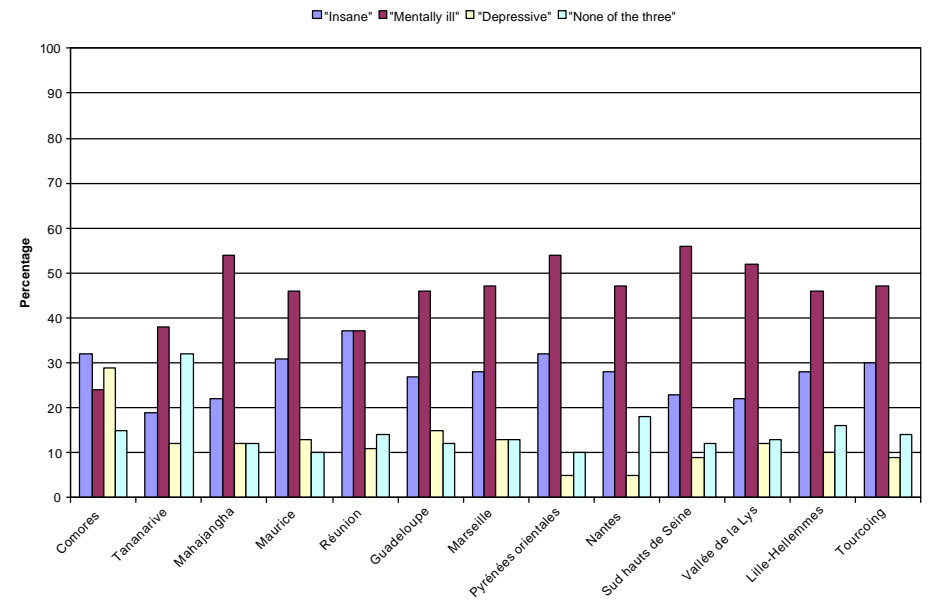
GRAPH 10

In your opinion, someone who is violent towards him/herself is :

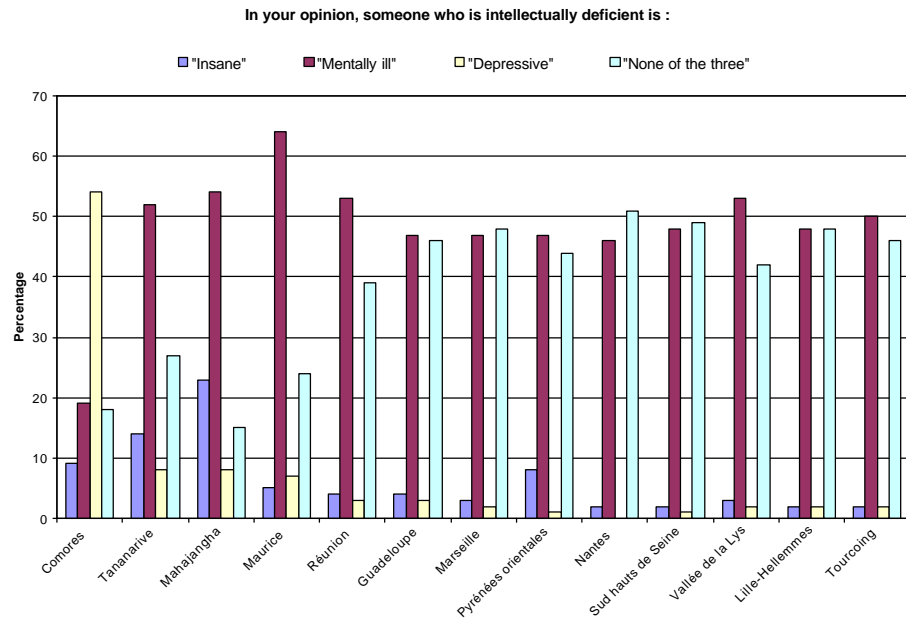


GRAPH 11

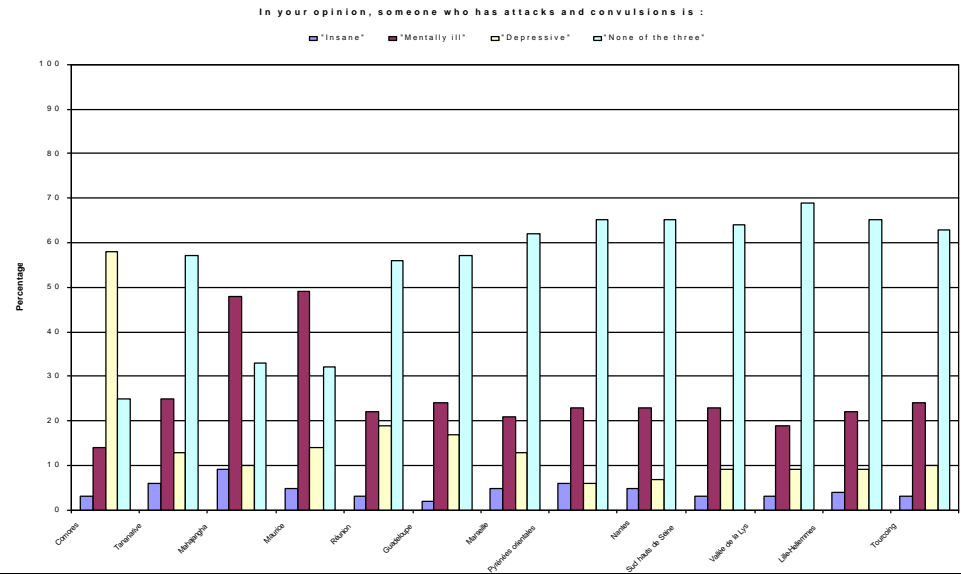
In your opinion, someone who is delirious, hallucinates is :



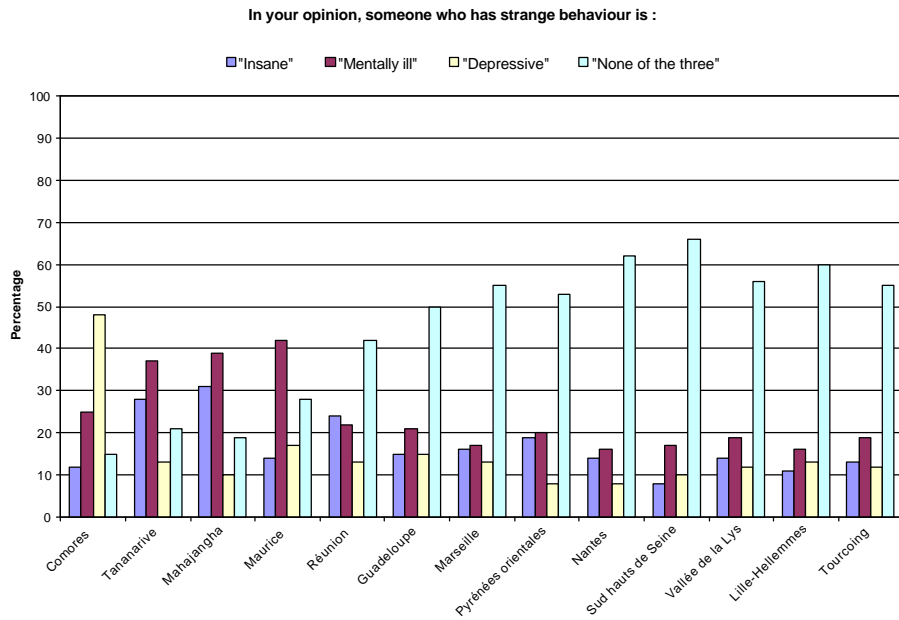
GRAPH 12



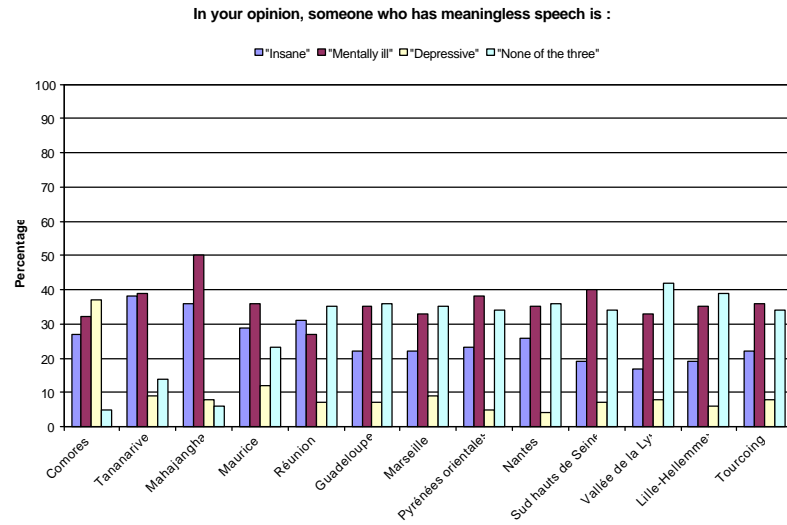
GRAPH 13



GRAPH 14

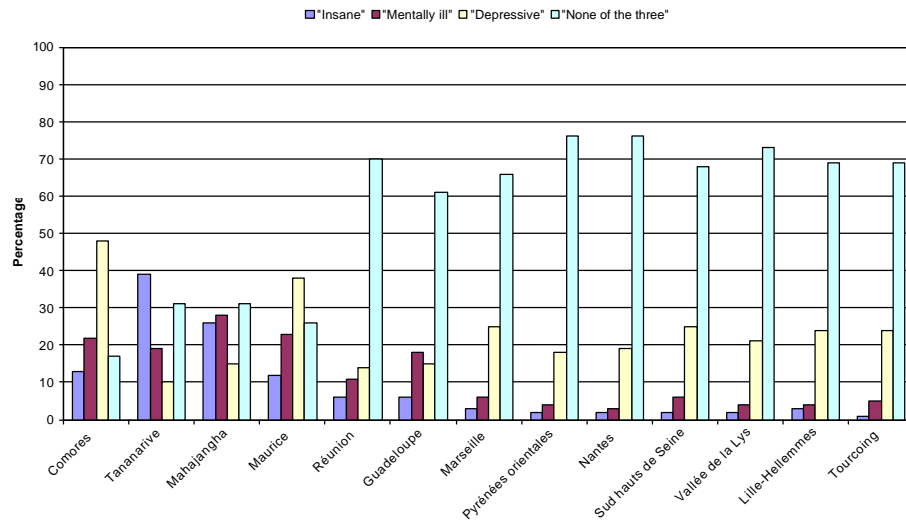


GRAPH 15



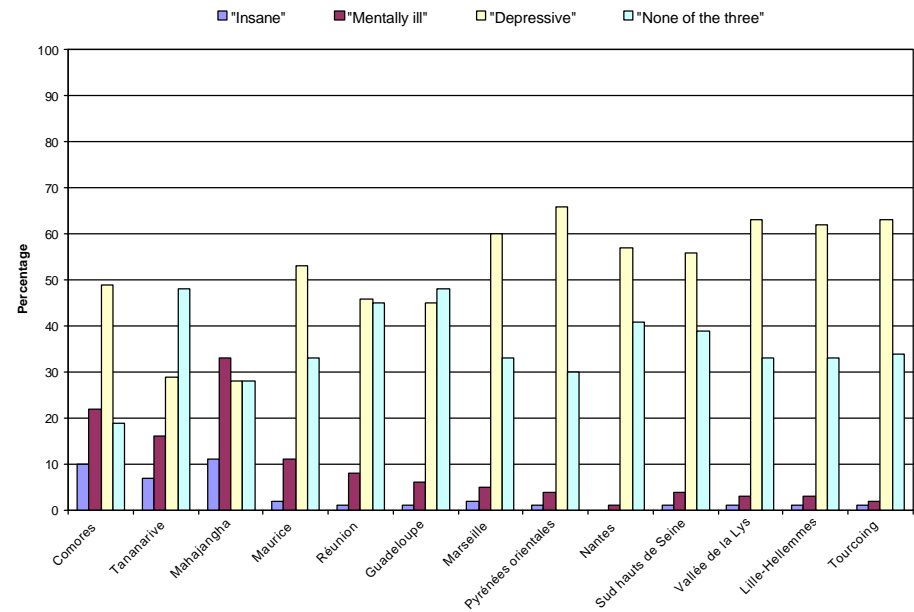
GRAPH 16

In your opinion, someone who is neglected, often dirty is :



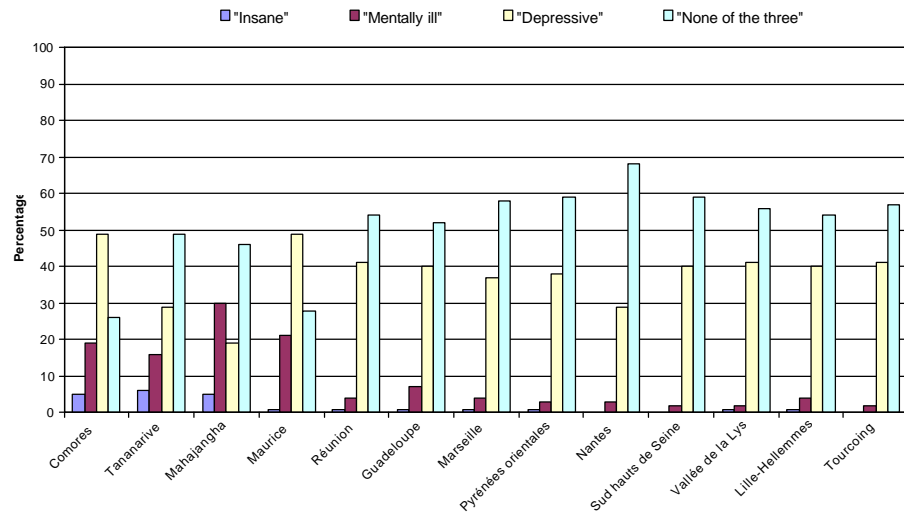
GRAPH 17

In your opinion, someone who is isolated, withdrawn is :



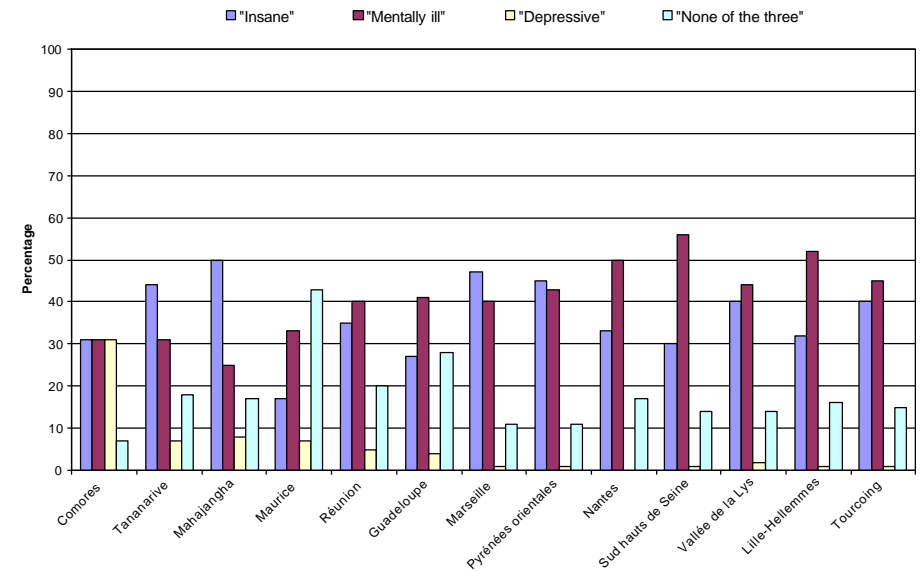
GRAPH 18

In your opinion, someone who is anxious is :

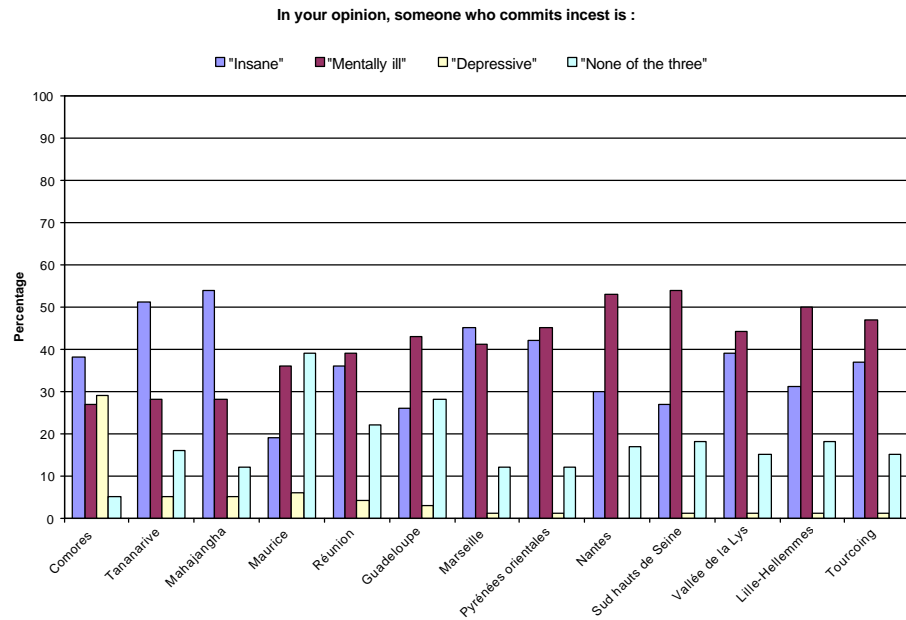


GRAPH 19

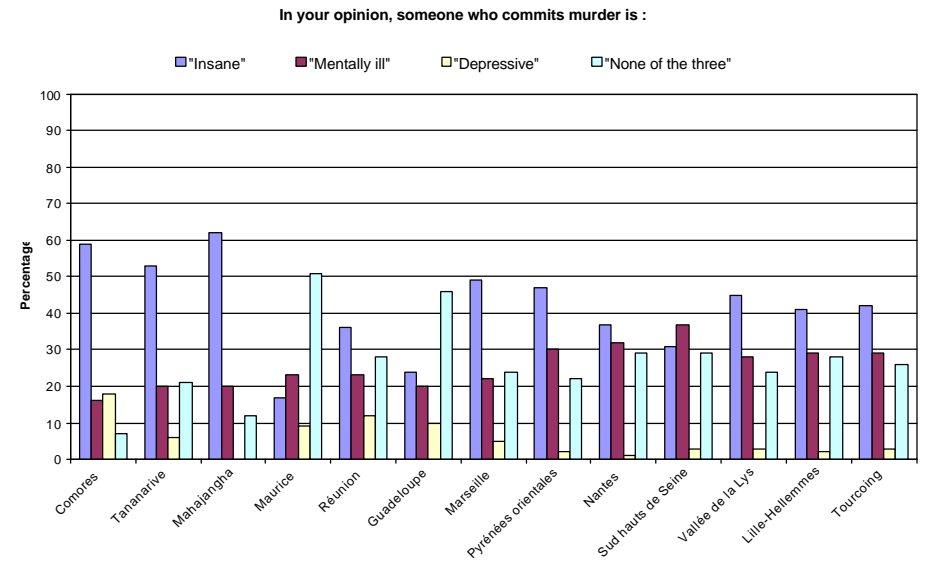
In your opinion, someone who commits rape is :



GRAPH 20



GRAPH 21



GRAPH 22

5. Normal / abnormal

- It can be regretted *a posteriori* that parallel to the very legitimate contrast "normal/abnormal" the contrast **healthy/pathological** can not also be highlighted. On several occasions in the course of interpretation, one is tempted to align "abnormal" and "pathological", terms whose equivalence is deceptive. Deviant behaviours in our societies, abnormal conduct appearing in individuals who are not recognised as being ill in other societies (attacks arising from possession for instance), also tend either to be pushed into the background or to be integrated into the order of pathology. The responses "none of the three" are no doubt a niche to escape the inability to position the non-pathological abnormal case, while this does not necessarily mean that it belongs to the sphere of "normal" occurrences.
- All the behaviours put forward are classified in the field of "abnormality", except for items for "depression": "being isolated", "weeping", "showing anxiety", which are generally considered to be "normal" (in metropolitan France in particular). It can be said that the more we understand, the more we can identify with these behaviours, the more "normal" they become (Tables 15 and 17).
- The **abnormality gradient** is rather interesting because murder a characteristic of the «insane» person comes only fourth after incest, rape and violence to relatives.
- Violence belongs to the field of "abnormality"; "delirium", "strange speech", and "substance abuse" tend to be considered more "normal" behaviours. This is however not the case in the Comoros and Mahajanga.

6. Dangerousness

Here again there is an international gradient (Tables 16 and 17) :

- In Mauritius, the DOM and France, non-dangerousness is associated with the following behaviours : being dirty, having strange speech or behaviour, having convulsions, being intellectually deficient.
- This is less true in Madagascar and the Comoros, where these behaviours, like the others, are all connoted with the notion of danger. This is in line with the results from the ALCESTE analysis which showed that in these sites, these behaviours were also more often associated with the image of the «insane» person or the "mentally ill".
- **The items linked to the semiotics of "depression" are not perceived as being "dangerous" either (being withdrawn, anxious, weeping, being sad). Here again the same rationale can be seen as for normality : the easier it is to identify with the behaviour, the less likely it is to be considered "dangerous".** The same reservation as above applies to Comoros and Madagascar sites. It can

also be recalled that, in particular in relation to the fact of being isolated/withdrawn, these behaviours can more easily be viewed as "abnormal" or even "dangerous" in a society where "the group takes precedence over the individual".

- **Delirium and suicide** are positioned in a dangerous area, but to an intermediate degree (except for the Comoros).
- **Alcohol and drugs abuse**, if not widely associated with representations of "insanity", "mental illness" and "depression", (see above) is however correlated to the notion of "danger" (for the health of the subject and for others). This association is particularly strong in Madagascar ; it should be related to the causes attributed to "insanity" and "mental illness".
- **The items connected with violence towards self and others are obviously identified as being "dangerous" (violence towards self and others, incest, beating spouse or children, murder, rape).**
- Apart from the transgressive items that are manifestly dangerous like murder, rape, incest, violence towards others, and to a lesser degree substance abuse, there is a relative degree of **dissociation between abnormality and dangerousness**. This is duly noted, with the regret that it is not possible to compare these results with others from similar studies.

- Overall, the "depressive" person tends to be considered to be "normal" and "not very dangerous", the "insane" "abnormal" and "dangerous", and the "mentally ill" as "abnormal" and "not very dangerous". For "mental illness", explicative medical concepts make their appearance.
- Abnormality relates to virtually all the behaviours used to describe the study entities, except for those associated with "depression".
- Dangerousness tends towards conducts involving substance abuse which are not considered to be related to "insanity", "mental illness" or "depression" - the outside cause being the substance identified, without asking the question of why there is abuse.
- The "depressive" person is given an environmental explanation (stress, unemployment, loss of someone close) as is "mental illness" (biological make-up, heredity, birth) but the "insane" and the other "deviants" in society are not.
- It will be clearly seen in what follows that the "insane" person is seen as being less curable than the others.

TABLE 15 : BEHAVIOURS AND CONDUCTS CONSIDERED AS "ABNORMAL"

"ABNORMAL"	Comoros	MADAGASCAR		Mauritius	Réunion	Guadeloupe	Marseille	Pyrénées Orientales	Nantes	Sud hauts de Seine	Vallée de la Lys	Lille-Hellemmes	Tourcoing
		Tananarive	Mahajanga										
Someone who commits incest	91	91	92	88	96	88	96	97	97	97	98	98	97
Someone who commits rape	90	90	92	84	95	88	96	96	97	97	98	97	97
Someone who regularly beats spouse or children	78	81	86	83	94	85	93	95	95	94	94	96	93
Someone who commits murder	91	91	95	85	93	76	91	92	92	95	95	96	93
Someone who is violent towards others	79	84	91	90	92	92	90	92	92	92	92	95	91
Someone who is violent towards himself	87	85	92	94	92	92	87	92	89	90	91	93	90
Someone who is delirious, has hallucinations	84	85	93	90	91	91	86	92	84	87	87	84	87
Someone who has strange, meaningless speech	92	89	95	79	80	78	76	76	76	78	77	77	78
Someone who regularly takes drugs	76	86	89	76	83	80	70	70	67	74	78	79	72
Someone who is intellectually deficient, retarded	91	90	95	77	72	76	74	75	70	70	76	71	72
Someone who has attacks and convulsions	93	84	91	76	69	76	61	61	66	70	66	74	66
Someone who attempts suicide	89	84	86	77	79	73	61	63	59	63	67	72	64
Someone who shows strange behaviour	84	89	90	79	77	69	62	63	56	56	68	63	61
Someone who regularly drinks alcohol	72	66	73	49	74	66	56	54	54	58	58	72	58
Someone who is often neglected, dirty	84	80	83	77	72	67	59	47	52	61	64	71	57
Someone who is isolated or withdrawn, prefers to be alone	80	59	78	62	54	48	44	40	43	48	53	56	44
Someone who often weeps	83	70	83	61	64	57	35	36	38	40	42	46	35
Someone who is anxious	78	59	67	65	45	42	28	21	23	29	34	37	29

More than 90 %

from 75 to 89 %

from 50 to 74 %

Less than 50 %

TABLE 16 : BEHAVIOURS AND CONDUCTS CONSIDERED AS "DANGEROUS"

"DANGEROUS"	Comoros	MADAGASCAR		Mauritius	Réunion	Guadeloupe	Marseille	Pyrénées orientales	Nantes	Sud hauts de Seine	Vallée de la Lys	Lille-Hellemmes	Tourcoing
		Tananarive	Mahajangha										
Someone who commits rape	95	91	92	95	98	95	98	98	99	99	99	99	99
Someone who commits murder	98	95	96	96	96	90	98	97	98	99	99	98	98
Someone who regularly beats spouse or children	91	83	88	90	95	90	97	97	99	97	97	97	98
Someone who commits incest	96	85	86	94	95	92	96	97	98	96	98	96	98
Someone who is violent towards others	98	83	84	95	93	91	93	95	96	91	94	92	96
Someone who is violent towards himself	89	77	87	91	85	81	77	82	77	77	78	77	82
Someone who regularly takes drugs	87	91	92	82	81	84	77	75	71	77	84	82	79
Someone who regularly drinks alcohol	84	69	65	57	77	69	65	64	70	72	68	77	74
Someone who attempts suicide	94	77	82	74	70	54	57	61	61	62	65	66	71
Someone who delirious, has hallucinations	82	59	80	55	58	47	49	55	55	47	51	47	52
Someone who has attacks and convulsions	81	63	79	54	39	22	28	34	38	37	41	38	37
Someone who shows strange behaviour	80	64	77	49	41	26	22	24	20	20	29	25	28
Someone who often weeps	76	50	63	28	26	12	13	11	15	16	17	20	18
Someone who has strange, meaningless speech	83	58	76	34	25	16	15	17	14	12	14	13	16
Someone who is intellectually deficient, retarded	79	50	68	31	19	12	12	14	13	9	13	12	12
Someone who is isolated or withdrawn, prefers to be alone	80	36	57	22	18	9	7	7	9	9	11	12	10
Someone who is anxious	75	36	45	20	13	10	6	4	5	6	6	8	7
Someone who is often neglected, dirty	79	49	50	24	16	11	5	5	4	5	5	6	7

More than 95%

From 90 to 95 %

From 75 to 90 %

From 50 to 75%

From 10 to 50%

Less than 10 %

TABLE 17 : GRADIENTS HIGHLIGHTED IN RELATION TO BEHAVIOURS AND CONDUCTS



7. Overview of responses to questions on behaviours and conduct of the "insane", the "mentally ill" and the "depressive".

The "depressive" person

- The attitudes of the "depressive" person are clearly characterised. Thus, in French metropolitan sites, it is someone who often weeps, or who attempts to commit suicide is "depressive" for more than 75% of respondents. Someone who is withdrawn and isolated is "depressive" for 50%. Conversely, items relating to violent behaviours (murder, incest, rape) or certain personality traits (strange speech, intellectual deficiency) are not often cited (< 10% in French metropolitan sites).
- In Mauritius, Reunion and Guadeloupe, a "depressive" state is less clearly characterised, but along the same lines.
- In the **Comoros** all the items set out are more or less cited as being indicators of a "depressive" condition. This should certainly be related to the difficulty in translating the concept, since it would appear not to cover the entity as perceived in the site. This would mean that all the questions are approached in an undifferentiated manner.
- The characteristics of the "depressive" person (someone who cries a lot, is isolated, withdrawn or anxious) tend to be considered as normal and above all "not very dangerous". However between 50 and 70% of respondents in France and Mauritius consider the person who attempts suicide as being "abnormal", and in a similar proportion as being "dangerous".

The "insane" and the "mentally ill" person

- Violent acts and behaviours (rape, incest, murder, beating in the home, violence towards others) often relate to "insanity" and "mental illness". Nevertheless, the "mental illness" concept is more often chosen by respondents than the "insanity" concept. These behaviours are consistently seen as "abnormal" and "dangerous".
- However certain attitudes, mainly associated with mental illness, such as delirium and intellectual deficiency are not considered to be dangerous. The definition of the "mentally ill" person seems wider than that of the "insane" person. The person who is mentally ill is characterised by states considered to be dangerous and non-dangerous, while the "insane" person is characterised only by states considered to be dangerous.

None of the three

- When respondents have mainly responded "none of the three" ("insane", "mentally ill" or "depressive") it may be because the description of the person was enough to classify him outside the three groups. For instance, someone who drinks alcohol regularly is not judged to be «insane» person or "mentally ill" or "depressed" : he is an addict. These behaviours are however considered to be "abnormal" and "dangerous".

b. Causes (Tables 18 to 20)

The results presented below relate to the analysis of the open questions : *"In your opinion, what can cause someone to be insane/mentally ill/depressive ?"*

The respondents give spontaneous answers which are then coded by the interviewer in **11** categories :

- physical cause : accident, illness, heredity, genetics, etc.
- "life event" causes : loss of someone close, aggression (rape, incest), strong emotion, childhood, etc.
- sentimental problems : breaking with someone, separation, disappointment in love, etc.
- "magical/religious" causes : spells, enchantment, spirits, etc.
- socio-economic causes : unemployment, poverty, precarious situations, lack of money, etc
- causes relating to social relationships : family, friends, those close, etc.
- society
- professional causes : problems at work, work, relationships at work, working conditions etc.
- causes connected with addiction : drugs, alcohol, sex, gambling, etc.
- other
- do not know

1. The "insane" (Table 18)

For metropolitan France people think that things that can make someone "insane" are first of all :

- life events (23-30%)
 - physical causes (20-30%)
- followed, to a lesser degree, by
- relationship problems (9-11% and drug or alcohol abuse (5-10%).

A few specific features appear in the DOM :

- for Guadeloupe "insanity" arises above all from relationship problems (22%)
- In Reunion, it is first drugs and alcohol abuse that can cause "insanity" (28%)

In Mauritius, physical causes are mentioned by 27% of respondents, followed by life events (23%) and addictions (15%)

In Madagascar the causes attributed to madness are first :

- drugs and alcohol abuse (30-42%)
- socio-economic problems (10-23%)

- magical or religious causes (10-15%), and
- life events (8-13%).

In the Comoros , after physical causes (20%) and life events (20%) come :

- magical and religious causes (14%)
- alcohol and drugs abuse (12%)
- socio-economic causes (11%).

Does the dispersion observed both within sites and from one site to another show that there is difficulty in finding a cause for "insanity" ? This explanation could echo the results obtained from the ALCESTE analysis.

2. *The "mentally ill" " (cf. Tableau 19)*

- Mainly **physical causes** are identified to explain "mental illness" in France (48-61%), the DOM (45%) and *Mauritius* (23%). **Life events** come next.
- In Madagascar, **socio-economic** causes come first (23-25%) and **addictions** (20%), to explain the "mental illness". Madagascar positions itself very differently from the other sites with regard to causes of "mental illness" as being mainly socio-economic. It can be relevant to consider that the socio-economic difficulties of the country over the last 20 years could influence this sort of response.
- In the Comoros, the dispersion of responses relating to the causes of mental illness is fairly equally spread over :
 - ✓ life events (18%)
 - ✓ physical causes (14%)
 - ✓ socio-economic causes (14%)
 - ✓ addictive substances (14%).

The importance given to addictive substances as a cause in the Indian Ocean sites (Comoros, Madagascar, Mauritius, Reunion) can be noted.

3. *The depressive person (cTable 20)*

- Responses from interviewees in French site concerning the causes of "depression" spread out as follows :
 - ✓ life events (23-31%)
 - ✓ relationship problems (14-21%)
 - ✓ socio-economic causes (8-17%).

The link with society and relationships is quite clear.

- responses in the DOM sites and Mauritius are equivalent to those from metropolitan France. However certain emphases should be noted :
 - ✓ relationships (21% and work (17%) in Mauritius
 - ✓ sentimental problems (22%) in Guadeloupe.
 - ✓ In Madagascar the same causes arising from relationships and social factors are attributed to "depression", here again with a particular weight for socio-economic factors (24-25%).

- In the Comoros site the responses are as dispersed as for the preceding questions :
 - ✓ physical causes (18%)
 - ✓ socio-economic causes (17%)
 - ✓ life events(16%)
 - ✓ addictions (12%)

In broaching the question of aetiology, the questionnaire comes up against a methodological problem that is virtually insoluble, connected, in many societies, with the complexity of the very notion of cause. Thus one can wonder if the wide dispersion of causal attributions emerging from the responses is not related to difficulties in finding a cause, or to the fact that the questionnaire " or any questionnaire " is not commensurable with reality.

However, some main tendencies are even so apparent :

For "insanity" : life events and physical causes (heredity or addiction); causes linked to magical or religious phenomena only appear in the Indian Ocean sites.

For "mental illness" : above all physical causes, and addiction in the Indian Ocean sites, and socio-economic causes in Madagascar and the Comoros.

For "depression" : causes are fairly homogeneous, they concern relationships and emotional and social factors, in addition to external or internal biological dimensions.

The scores for addiction in causes mentioned for "insanity" and "mental illness" may seem surprising. Someone who regularly takes drugs is not generally considered to be "insane", "mentally ill" or "depressed" in our first analysis. However, being subject to addiction constitutes a triggering factor that can explain the advent of "insanity", "mental illness" or "depression".

TABLE 18 : WHAT CAN CAUSE SOMEONE TO BE "INSANE" ?

	"INSANE"					
	Comoros	Madagascar	Mauritius	Réunion	Guadeloupe	Metropolitan France
Physical causes	20%	11%	27%	20%	16%	20-30%
Life events	20%	8-13%	23%	18%	21%	23-30%
Sentimental problems	9%	6%	8%	7%	22%	7-11%
Magical/religious	14%	10-15%	1%	1%	1%	0%
Social/economical	11%	11-23%	5%	8%	7%	2-4%
Relationship with others	5%	0,6-1%	10%	5%	5%	5-7%
Society	0,7%	0,2-1%	1%	2%	4%	5-7%
Employment	4%	1-2%	8%	2%	3%	0,6-3%
Addictions	12%	30-42%	15%	28%	10%	5-10%
Others	3%	3-4%	1%	8%	9%	10-16%

TABLEAU 19 : WHAT CAN CAUSE SOMEONE TO BE "MENTALLY ILL" ?

	"MENTALLY ILL"					
	Comoros	Madagascar	Mauritius	Réunion	Guadeloupe	Metropolitan France
Physical causes	14%	13-16%	24%	45%	45%	48-61%
Life events	18%	10-14%	17%	15%	14%	17-21%
Sentimental problems	13%	9-11%	9%	3%	10%	2-4%
Magical/religious	11%	5-8%	1%	1%	1%	0-0,3%
Social/economical	14%	23-25%	6%	6%	4%	1-2%
Relationship with others	4%	1-2%	13%	6%	6%	4-6%
Society	1%	0-1%	1%	1%	2%	2-3%
Employment	6%	5,5%	9%	2%	3%	0,2-1,4%
Addictions	14%	19-20%	17%	14%	6%	3-5%
Others	5%	5%	2%	7%	10%	6-14%

TABLEAU 20 : WHAT CAN CAUSE SOMEONE TO BE "DEPRESSIVE" ?

	"DEPRESSIVE"					
	Comoros	Madagascar	Mauritius	Réunion	Guadeloupe	Metropolitan France
Physical causes	19%	6%	4%	6%	6%	4-7%
Life events	16%	17-19%	18%	19%	22%	23-31%
Sentimental problems	11%	22-27%	15%	13%	22%	14-21 %
Magical/religious	7%	1,5-2%	0,6%	0,2%	0,1%	0,1%
Social/economical	17%	24-25%	10%	16%	10%	8-17%
Relationships with others	5%	3-4%	21%	13%	9%	6-12%
Society	2%	3-5%	1%	4%	5%	3-8%
Employment	5%	5%	17%	9%	10%	9-14%
Addictions	12%	4-5%	9%	6%	4%	1-2%
Others	5%	9%	4%	13%	12%	5-19%

c. Responsibility and awareness (cf. Tables 21, 24 et graphiques 23, 24 et 25)

In your opinion, is an insane person responsible for his/her condition ? In your opinion, is a mentally ill person responsible for his/her condition ? In your opinion, is a depressive person responsible for his/her condition ?

In your opinion, is an insane person responsible for his/her insanity ? In your opinion, is a mentally ill person responsible for his/her illness ? In your opinion, is a depressive person responsible for his/her depression ?

In your opinion, does an insane person know he/she is insane ? In your opinion, does a mentally ill person know he/she is mentally ill ? In your opinion, does a depressive person know he/she is depressive ?

- **Whatever the site, 80% of the subjects interviewed consider that the "insane" or the "mentally ill" are not responsible for their condition.** However, a smaller number of interviewees think that a "depressive" person is not responsible for his/her condition (30 to 51%), with Antananarivo (14%) and the Comoros (10%) even lower.
- Likewise, for more than 60% of respondents in sites in France, Mauritius and Reunion, the **"depressive" person is responsible for his/her acts.** Fewer think so in Guadeloupe (48%), Antananarivo (47%) and Mahajanga (41%), and a great deal fewer in the Comoros (9%) where once again no distinction is made between representations of the "mentally ill" and representations of "depressive" subjects.
- These two items once again raise the question of the responsibility of the "mentally ill" and the "insane". It can be noted that the sample population leans markedly towards non-responsibility, with all the problems that this involves in terms of image. The "insane", the "mentally ill", and to a lesser degree "depressive" persons overtake children and the demented who need supervision and control, and who are not able to take responsibility for their acts.
- It is obviously interesting to correlate these results with the question on awareness. Thus, **80% of respondents consider that an "insane" person is not aware of his condition** (only 65% in the Comoros), and around 60% consider that a person who is "mentally ill" is not aware of his condition, (75-80% in Madagascar).

The tendency is reversed for "depressive" people :

- In metropolitan France only 10 to 15% of respondents consider that a depressed person is not aware of his condition
- In the DOM and Mauritius there are rather more (22-25%)
- In Madagascar and the Comoros considerably more (42-63%)

The massive representation that emerges from these data is that the "insane" person is not aware of his condition, he is not responsible for his "insanity" or his acts.

The representation of the "mentally ill" person is fairly close, even if people consider he is more aware of his condition.

The representation of the "depressive" person is more qualified : he is aware of his condition, and therefore (?) perceived to be more responsible for his "depression" and his acts.

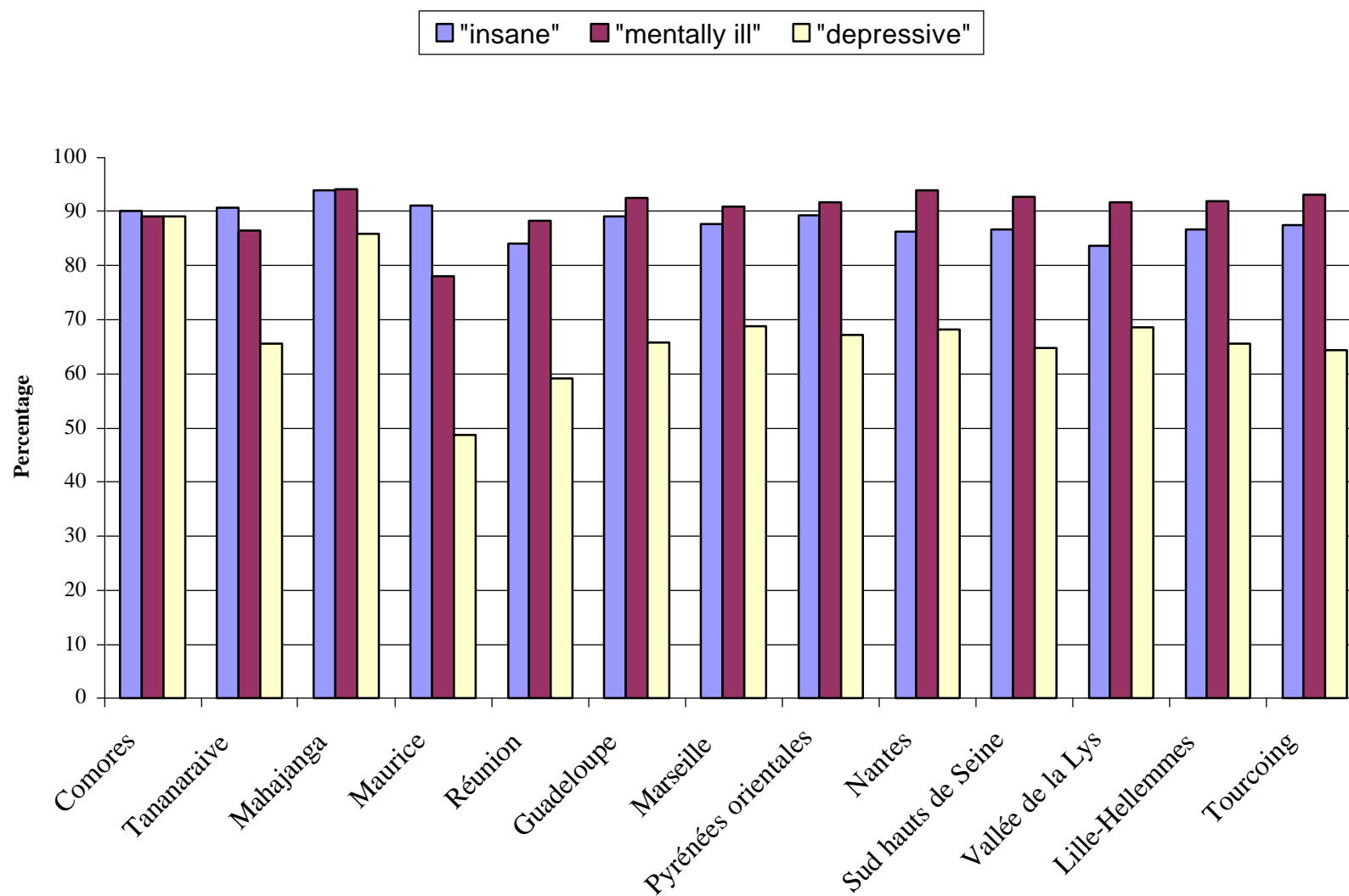
However, what does not emerge is the relationship between the notion of "awareness" of an act or a condition and the fact of being ill. In societies in which possession is an accepted fact for all, the dissociation is complete : an act committed or words said while possessed are in no way considered to be the words and acts of the person involved. However, this should not preclude cautious interpretation of these results.

TABLE 21 : RESPONSIBILITY

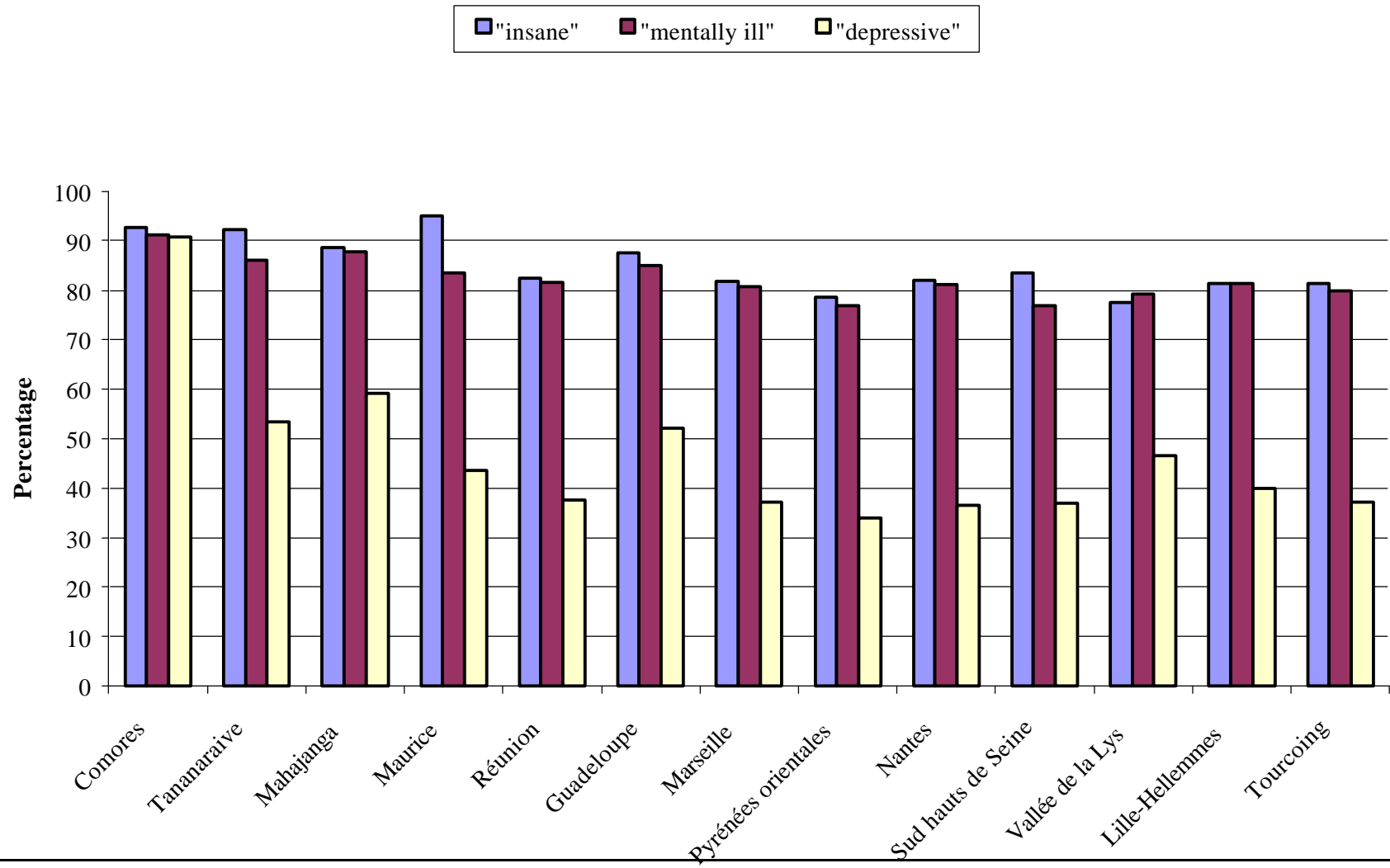
	Comoros	Madagascar	Mauritius	DOM*	Metro France
An "insane" person <u>is not responsible</u> for his insanity	90%	91-94%	91%	84-90%	84-89%
A "mentally ill" person <u>is not responsible</u> for his illness	90%	87-94%	78%	88-92%	91-94%
A "depressive" person <u>is not responsible</u> for his depression	90%	66-86%	49%	59-66%	63-69%
An "insane" person <u>is not responsible</u> for his acts	93%	89-92%	95%	82-88%	77-85%
A "mentally ill" person <u>is not responsible</u> for his acts	91%	86-88%	84%	82-85%	77-81%
A "depressive" person <u>is not responsible</u> for his acts	91%	53-60%	43%	38-52%	34-47%

* Réunion and Guadeloupe

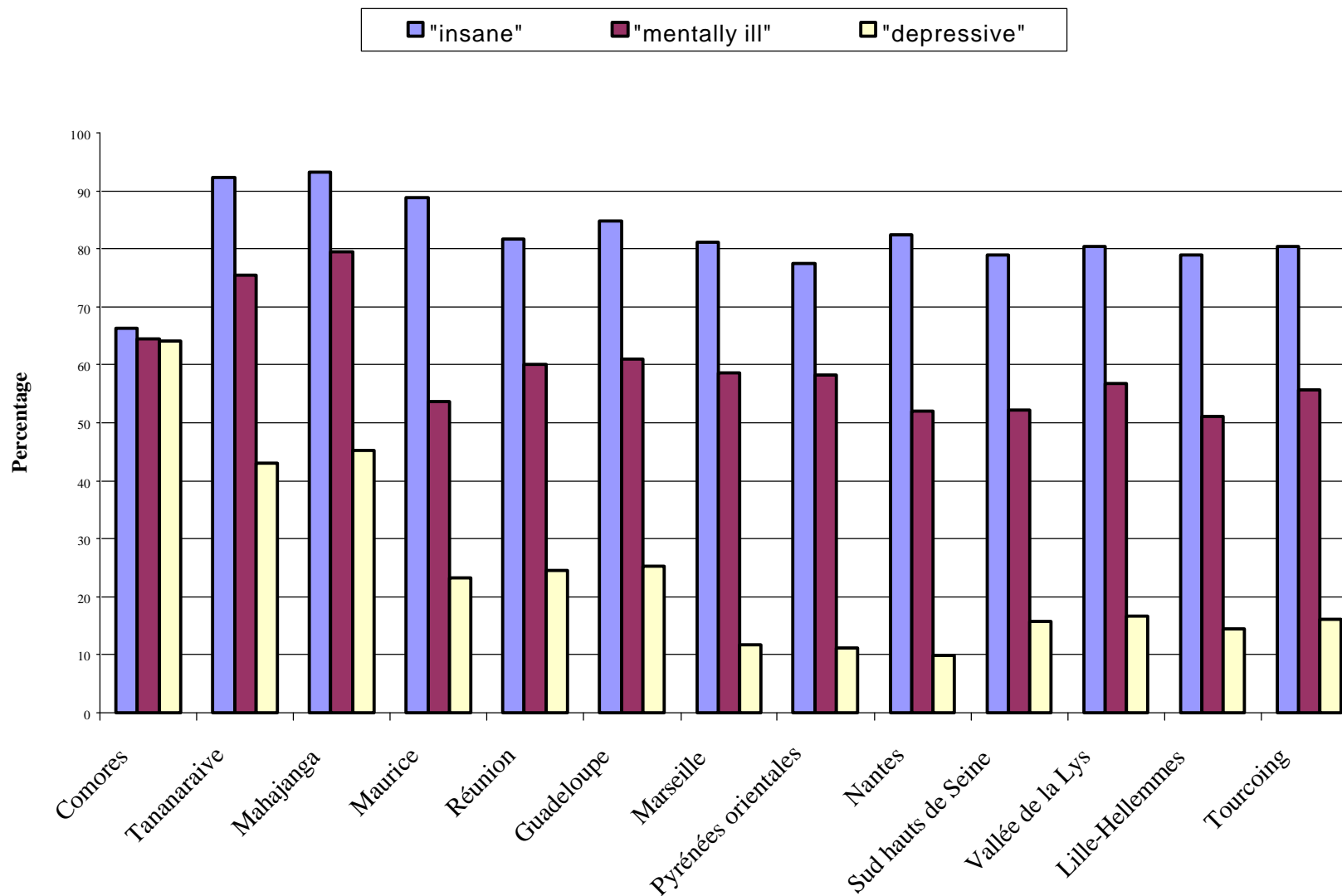
GRAPH 23 : NOT RESPONSIBLE FOR HIS/HER CONDITION



GRAPH 24 : NOT RESPONSIBLE FOR HIS/HER ACTS



GRAPH 25 : NOT AWARE OF HIS/HER CONDITION



d. Suffering (Tables 22, 24 and graphs 26, 27)

*In your opinion does an insane person suffer ? In your opinion does a mentally ill person suffer ? In your opinion does a depressive person suffer ?
In your opinion does the family of an insane person suffer ? In your opinion does the family of a mentally ill person suffer ? In your opinion does the family of a depressive person suffer ?*

- In line with the logic of what is said above, the respondents in French sites and Mauritius think that the "insane" person suffers less (only 49-69% of respondents thought that a lunatic suffers) than the "mentally ill" (81-86%) and "depressive" subjects (93-98%).
- In representations, suffering is correlated with awareness of the condition : people consider that **the more aware one is the more one suffers**. As expected there are lower figures for Madagascar, and identical figures for the Comoros where, as has already been seen, the distinctions between the "insane", the "mentally ill" and the "depressive" are less marked.

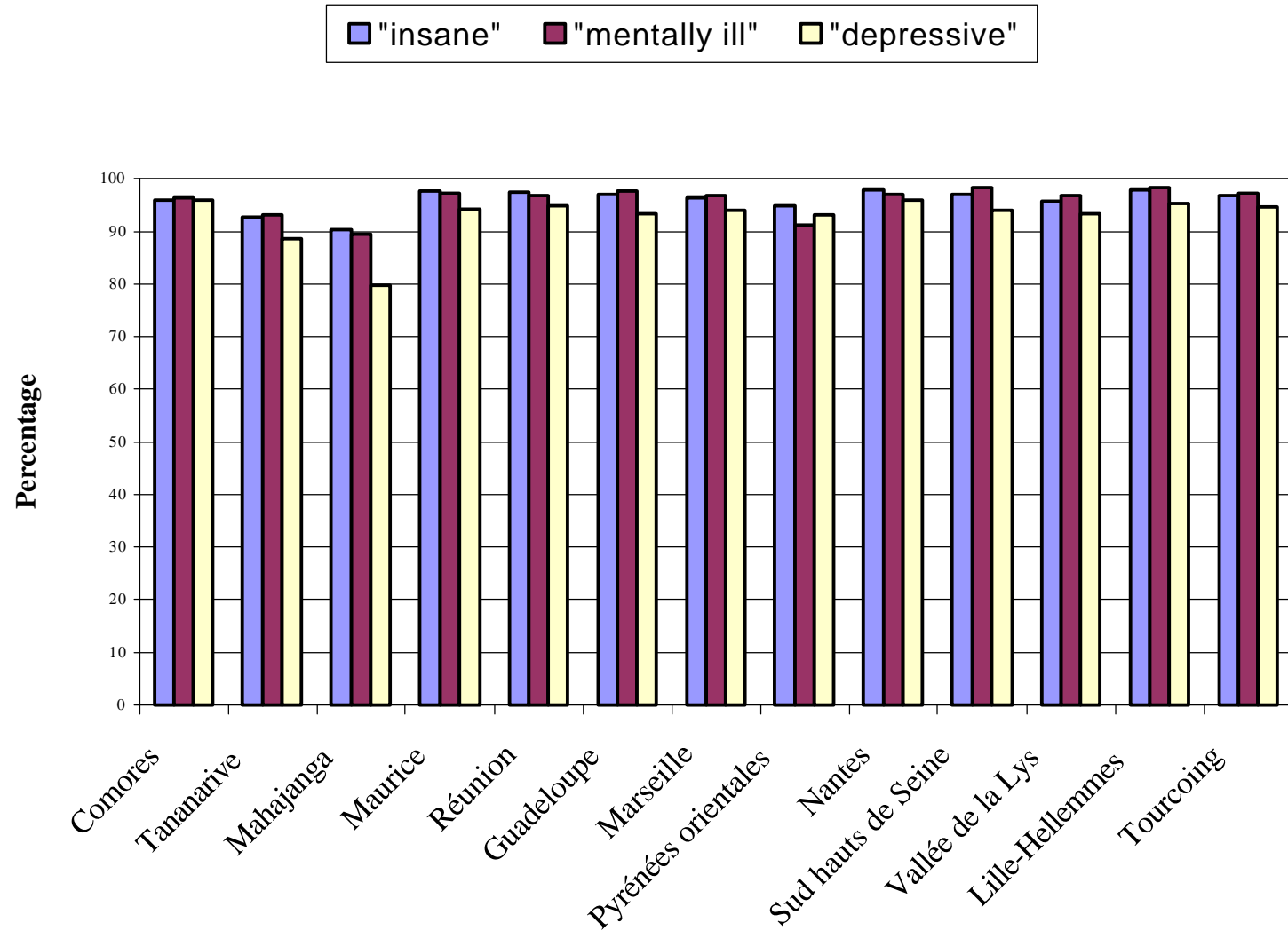
All agree that families, whatever the case, suffer. This does not vary whatever the qualifier "insane", "mentally ill", "depressive", and whatever the site, it is a constant factor in representations.

TABLE 22 : SUFFERING ?

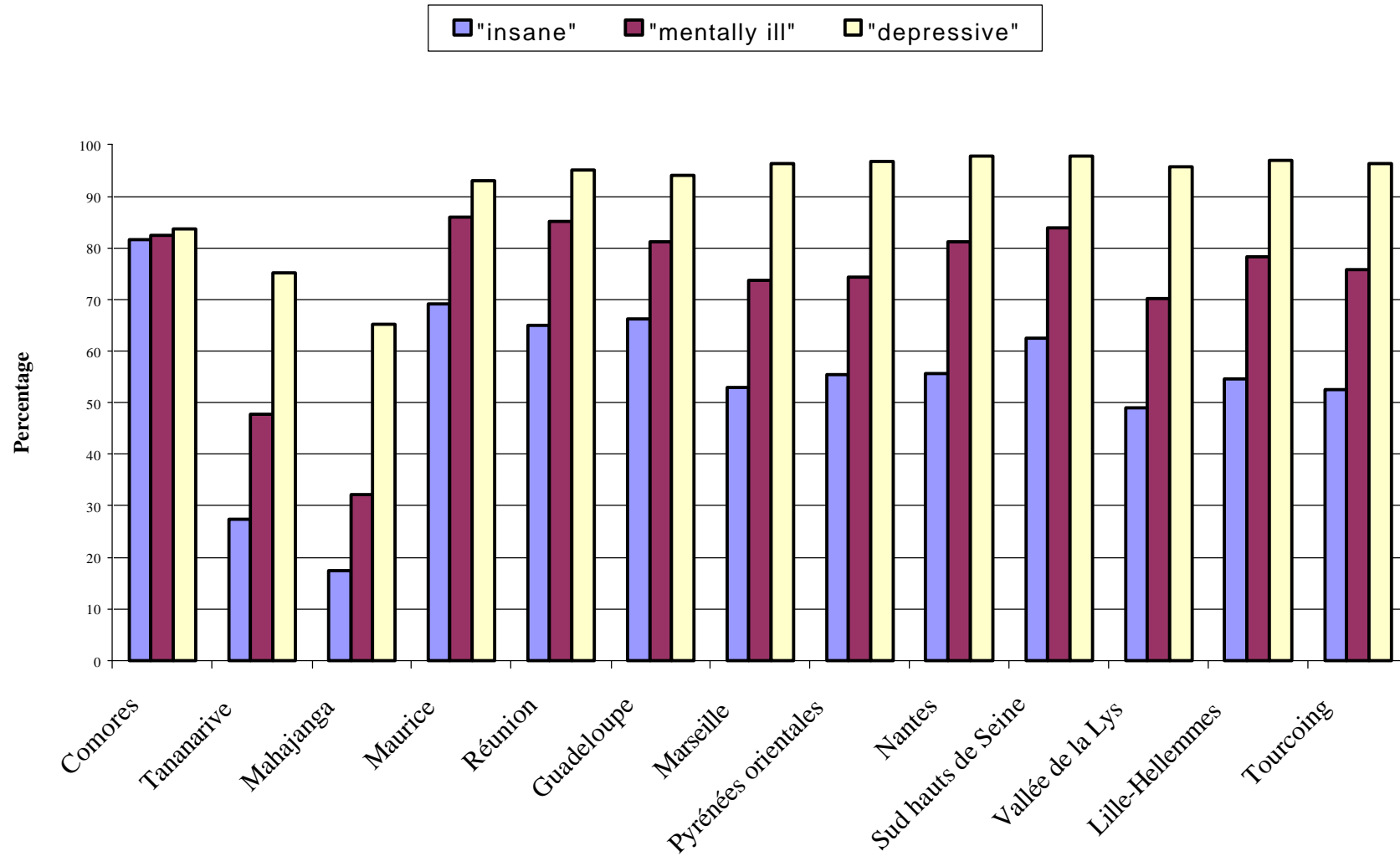
	Comoros	Madagascar	Mauritius	DOM*	Metro. France
An "insane" person suffers	82%	18-27%	69%	65-66%	49-62 %
A "mentally ill" person suffers	82%	32-48%	86%	81-85%	74-84 %
A "depressive" person suffers	84%	65-75%	93%	94-95%	95-98 %
The family of an "insane" person suffers	96%	90-93%	> 96 %		
The family of a "mentally ill" person suffers	96%	89-93%	> 96 %		
The family of a "depressive" person suffers	96%	80-89 %	> 92 %		

* Réunion and Guadeloupe

GRAPH 26 : SUFFERING OF THE PERSON



GRAPHIQUE 27 : SUFFERING OF THE FAMILY



e. Exclusion (tables 23, 24 and graphs 28, 29, 30)

In your opinion, is an insane person cut off from his/her family ? In your opinion is a mentally ill person cut off from his/her family ? In your opinion, is a depressive person cut off from his/her family ?

In your opinion is an insane person cut off from society ? In your opinion is a mentally ill person cut off from society ? In your opinion is a depressive person cut off from society ?

In your opinion is an insane person cut off from work ? In your opinion is a mentally ill person cut off from work ? In your opinion is a depressive person cut off from work ?

1. Exclusion by the family

In representations there is an "insane" > "mentally ill" > "depressive" gradient.

Exclusion by the family is seen in France and Mauritius as being considerable :

- 60-70% of respondents thought that an insane person was excluded or rejected by the family
- about 40% took this view for the mentally ill
- and 15-20% for depressive subjects, and a little more in Guadeloupe and Reunion (25-32%).

In the Comoros and Madagascar people consider that "insane", "mentally ill" and "depressive" people are not widely rejected by their families (20-30%). It may be that families are more tolerant and form the main bastion in these developing countries where other support structures are cruelly lacking. Family support appears to be very considerable : the family is the only link with reality in societies with no other option available. Elsewhere, the exclusion of the "insane" or the "mentally ill" seems quite clearly defined, inasmuch as special facilities have been established to cater for them. Conversely, the "depressive" are seen to a lesser degree as being excluded from their families, the family being viewed as a possible alternative for care, as will be seen below.

2. Exclusion from society

The same "insane" > "mentally ill" > "depressive gradient is found, with higher percentages.

People consider that they are more markedly rejected by society than by the family or the immediate circle.

The "insane" person is cut off from society for :

- 51% of respondents in Madagascar
- 70-80% in the other sites

The "mentally ill" person is cut off from society for :

- 42-45% of respondents in Madagascar.

- 67-71% people questioned in the other sites

"Depressive" people on the other hand are seen to be cut off from society for :

- 15-25% of respondents in Madagascar and metropolitan France
- 30% in Reunion
- 40% Mauritius and 63% in the Comoros.

The figures for Mauritius show a greater proportion than elsewhere of people thinking that people with "mental illness" are cut off from society.

- Representations associated with family **tolerance of children with psychological problems** show high levels of tolerance. Conversely, it is quite clear that things are not as simple when representations on admission of these children to normal school and leisure structures are considered.
- In metropolitan France, 75% of respondents consider that children with psychological problems should be taken into the same facilities (schools, kindergartens etc) as other children (a lesser proportion in Marseille and Pyrénées Orientales than in the DOM). Responses are difficult to interpret in Indian Ocean countries, as their relevance is correlated with the availability of social or education facilities mentioned in the question.

3. *Exclusion from work*

Exclusion in relation to work carries the strongest representation in the three categories.

More than two thirds of respondents consider that a person who is "insane" or "mentally ill" is cut off from his work. Here the difference between the "insane" and the "mentally ill" is less marked than with regard to the family and society. The "depressive" person is seen as being rather less excluded than the "insane" or the "mentally ill". However, a third of the respondents considered that a "depressive" person is cut off from his working¹ life.

In the **Comoros**, the perception of exclusion with regard to work is not different from that for the other exclusion categories.

The perception of exclusion shows a dual hierarchy : "insane" > "mentally ill" > "depressive", and society > close circle > family. In all, the family seems to be a fragile but a genuine bastion against exclusion. It is from the working world that the "insane", the "mentally ill" and the "depressive" are seen as being the most markedly removed.

The consistency of responses from one site to another is probably a positive indicator, in this domain as in others, of the genuine contribution of these questionnaires. It would be interesting, particularly in France, to determine the link between what emerges as quite a strong acceptance and policies that advocate recourse to "natural carers" in the family. Quebec has conducted some interesting research here, with detailed analysis of how the carer burden is spread differently among family members, or household members.

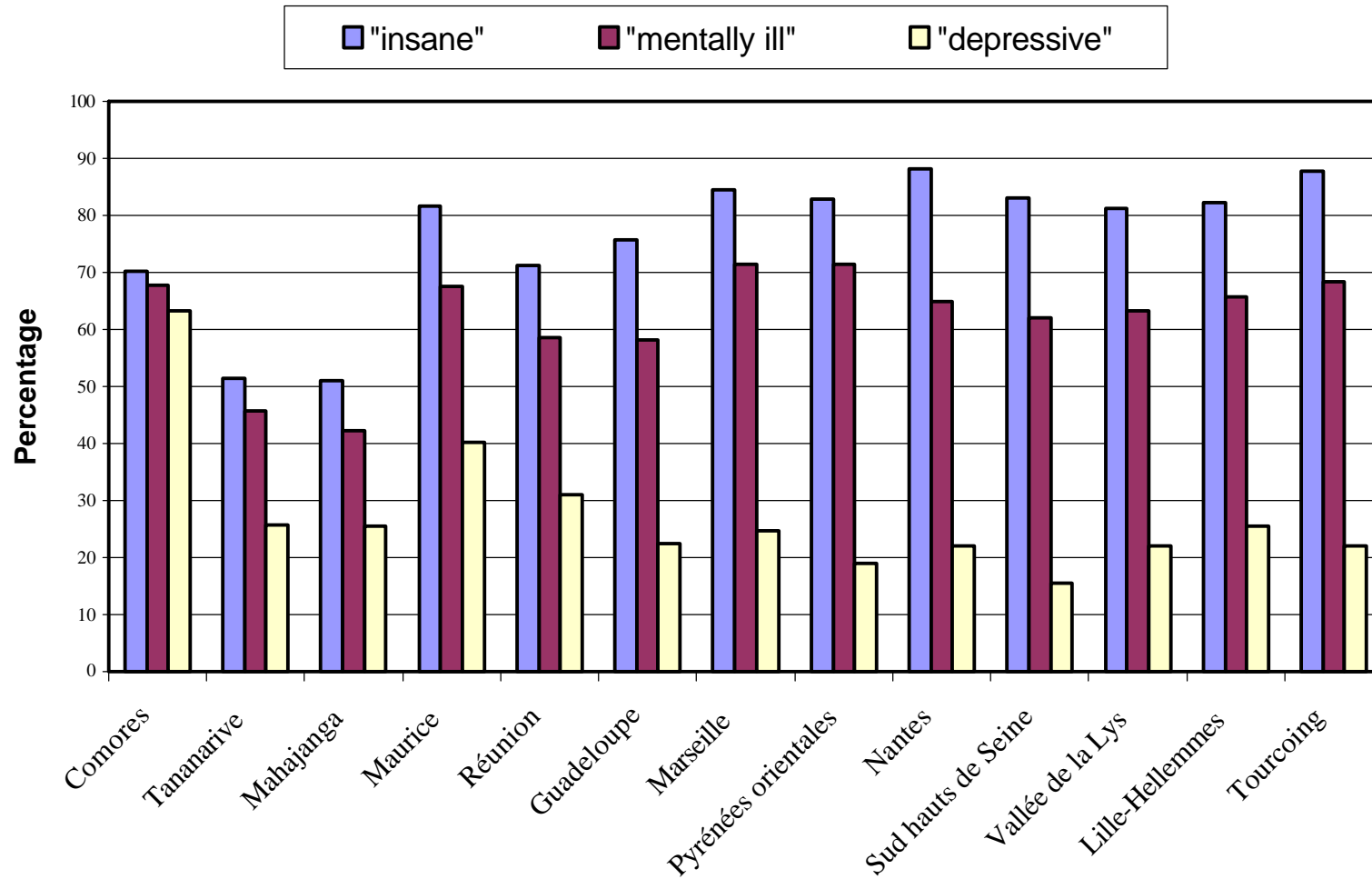
¹This perception is connected to occupational physicians present point of view about depressive workers (see Le retentissement professionnel de la dépression in "Itinéraires de déprimés" Rapport du groupe d'experts présidé par le Pr. P Parquet, janvier 2001)

TABLE 23 : EXCLUSION ?

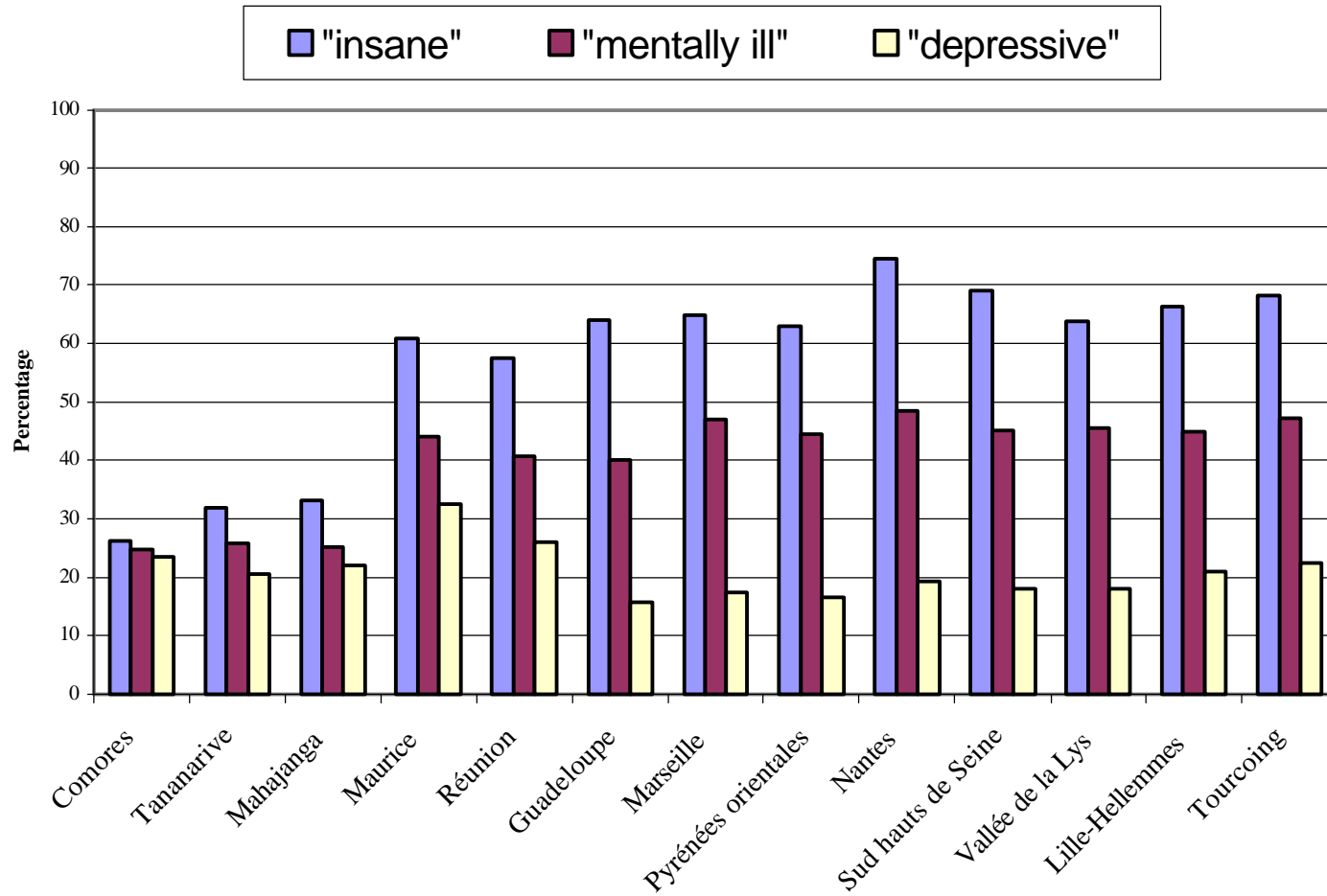
	Comoros	Madagascar	Mauritius	DOM*	Metro. France
An "insane" person is cut off from his /her family	26%	32-33%	61%	58-64%	63-74%
A "mentally ill" person is cut off from his/her family	25%	25-26%	44%	40-41%	45-48%
A "depressive" person is cut off from his/her family	24%	20-22%	32%	16-26%	17-22%
An "insane" person is cut off from the society	70%	51%	82%	71-76%	> 82%
A "mentally ill" person is cut off from the society	68%	42-46%	68%	58%	62-71%
A "depressive" person is cut off from the society	63%	25%	40%	22-31%	15-22%
An "insane" is person cut off from from the society	83%	84-90%	93%	90-94%	88-93%
A "mentally ill" is person cut off from the society	79%	78-87%	83%	78-85%	72-82%
A "depressive" is person cut off from the society	75%	45-60%	50%	38-54%	31-40%

* Réunion and Guadeloupe

GRAPH 28 : CUT OFF FROM SOCIETY



GRAPH 29 : CUT OFF FROM HIS/HER FAMILY



GRAPH 30 : CUT OFF FROM HIS/HER WORK

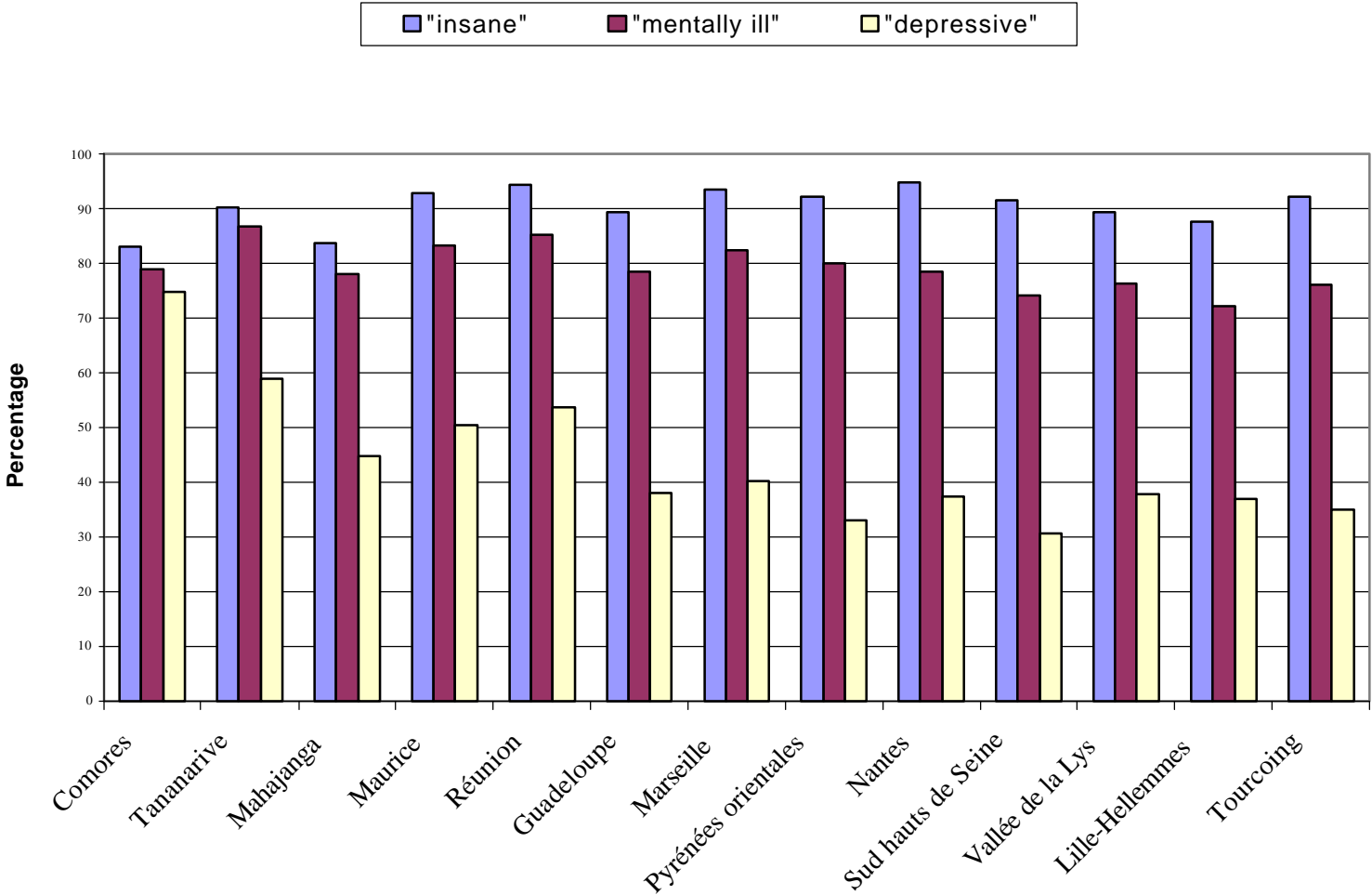
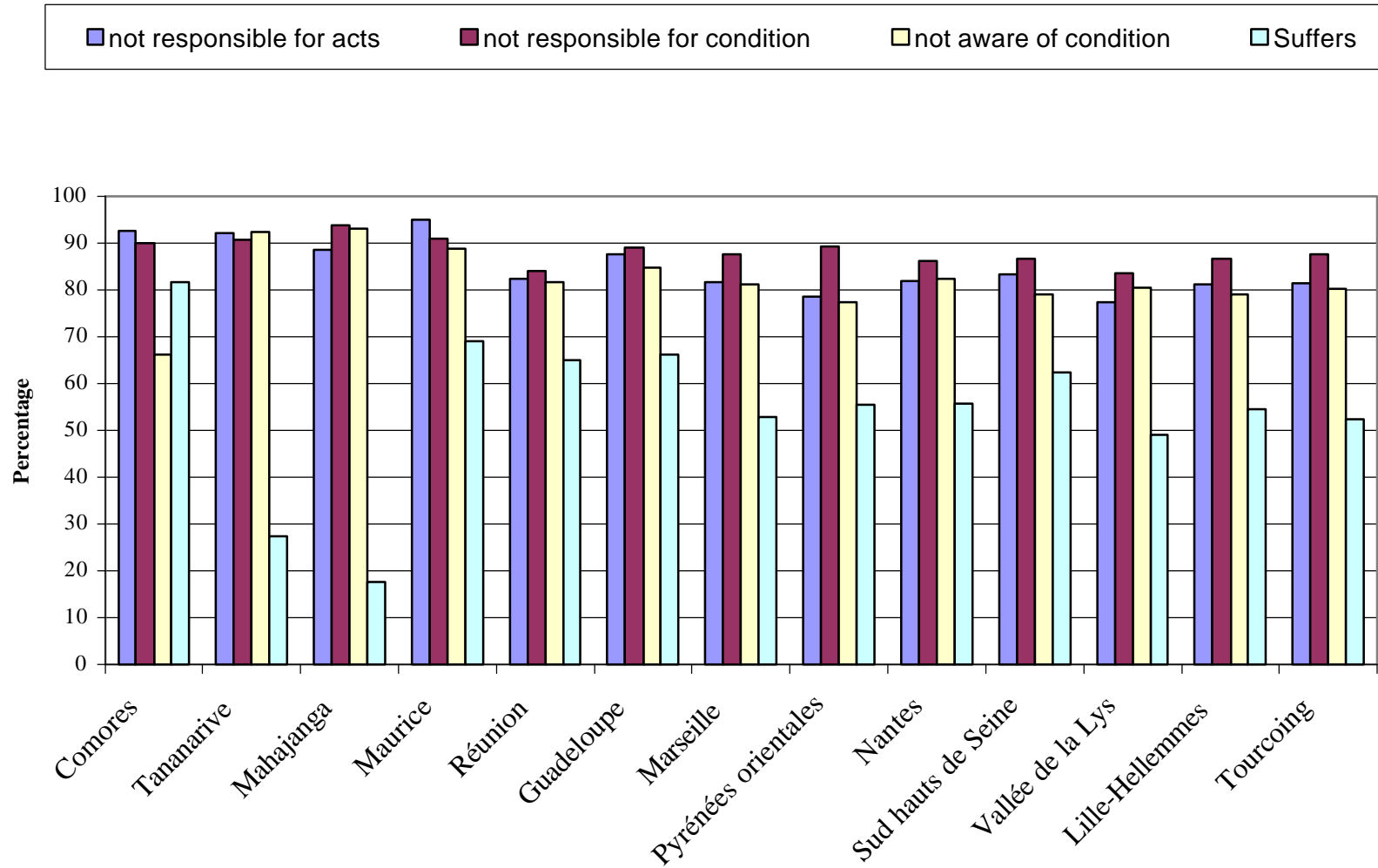


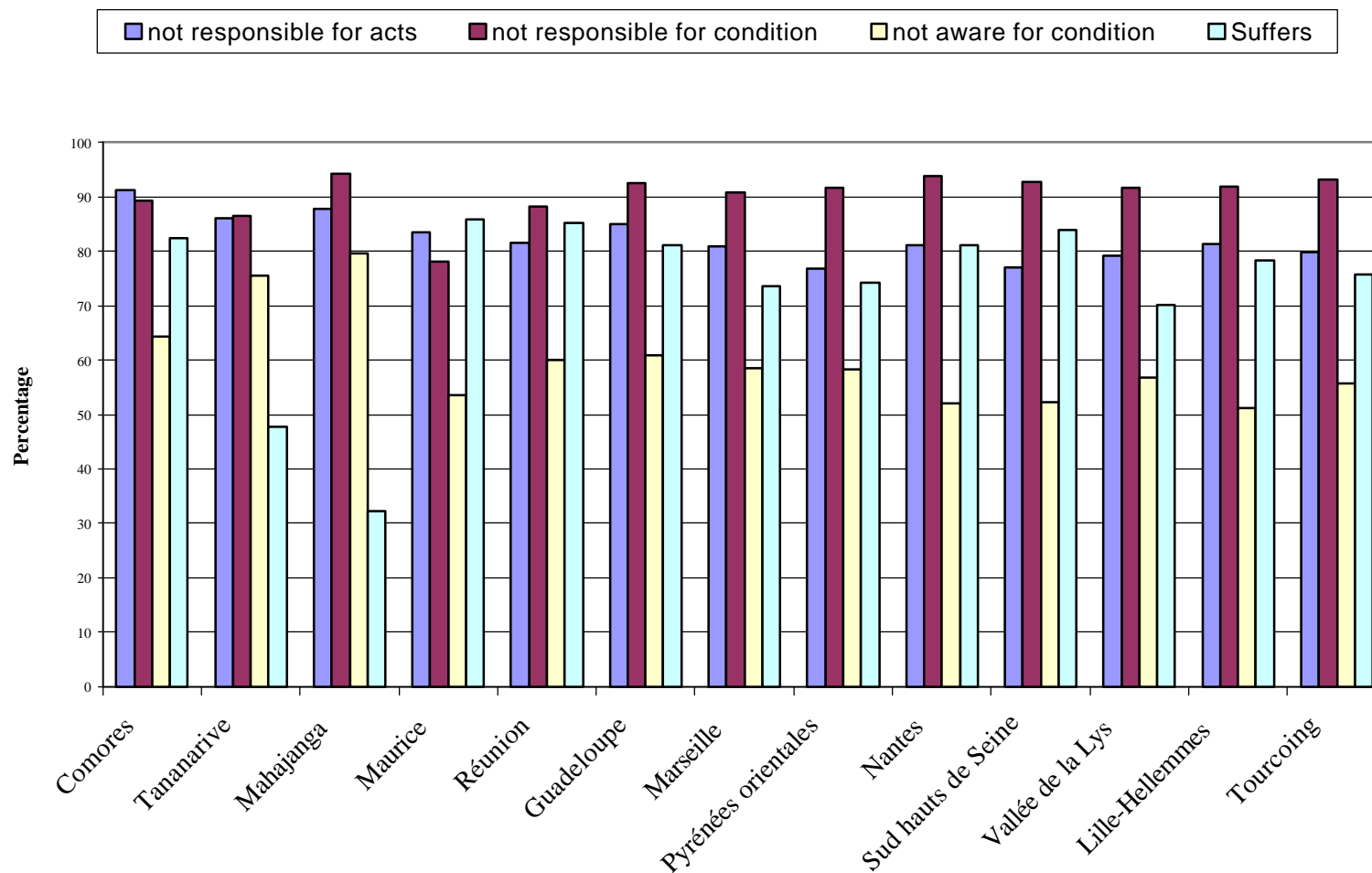
TABLE 24 : REPRESENTATIONS SUMMARY: RESPONSIBILITY/ AWARENESS/ SUFFERING/ EXCLUSION

" insane "	Comoros	Tananarive	Mahajanga	Mauritius	Réunion	Guadeloupe	Marseille	Pyrénées orientales	Nantes	Sud hauts de Seine	Vallée de la Lys	Lille-Hellemmes	Tourcoing
Not responsible for acts	92,69	92,2	88,52	95,09	82,35	87,57	81,78	78,62	82	83,44	77,49	81,29	81,49
Not responsible for condition	90,08	90,76	93,88	91,07	84,16	89,18	87,77	89,24	86,31	86,76	83,68	86,63	87,54
Not aware of condition	66,27	92,32	93,20	88,90	81,66	84,78	81,17	77,46	82,37	79,02	80,47	79,03	80,31
Suffers	81,62	27,45	17,52	69,08	65,00	66,24	52,88	55,38	55,70	62,43	49,06	54,56	52,40
Family suffers	96,06	92,66	90,30	97,77	97,46	97,07	96,30	94,91	97,82	97,11	95,68	97,85	96,89
Cut off from family	26,15	31,92	33,11	60,79	57,54	63,93	64,81	63,01	74,55	69,04	63,86	66,28	68,11
Cut off from society	70,20	51,40	51,10	81,60	71,20	75,80	84,60	82,90	88,30	83,07	81,40	82,20	87,90
Cut off from work	83,00	90,20	83,80	92,80	94,50	89,30	93,50	92,10	94,90	91,55	89,40	87,60	92,20
"mentally ill"	Comoros	Tananarive	Mahajanga	Mauritius	Réunion	Guadeloupe	Marseille	Pyrénées orientales	Nantes	Sud hauts de Seine	Vallée de la Lys	Lille-Hellemmes	Tourcoing
Not responsible for acts	91,28	86,16	87,83	83,54	81,63	84,99	80,81	76,81	81,06	76,95	79,16	81,36	79,84
Not responsible for condition	89,20	86,51	94,21	78,08	88,22	92,49	90,90	91,62	93,93	92,77	91,69	91,91	93,11
Not aware of condition	64,41	75,45	79,60	53,64	60,11	60,94	58,58	58,21	52,01	52,23	56,71	51,16	55,73
Suffers	82,49	47,83	32,14	85,97	85,12	81,24	73,65	74,32	81,19	83,98	70,11	78,28	75,75
Family suffers	96,28	93,09	89,42	97,33	96,80	97,78	96,86	91,17	97,08	98,33	96,78	98,35	97,34
Cut off from family	24,75	25,81	25,08	43,97	40,56	40,00	46,95	44,51	48,48	45,10	45,44	45,02	47,11
Cut off from society	67,70	45,80	42,20	67,60	58,70	58,20	71,50	71,40	65,00	62,14	63,40	65,80	68,40
Cut off from work	79,00	86,80	78,00	83,30	85,20	78,50	82,40	80,10	78,40	74,22	76,40	72,20	76,10
"depressive"	Comoros	Tananarive	Mahajanga	Mauritius	Réunion	Guadeloupe	Marseille	Pyrénées orientales	Nantes	Sud hauts de Seine	Vallée de la Lys	Lille-Hellemmes	Tourcoing
Not responsible for acts	90,84	53,48	59,18	43,53	37,7	52,12	37,09	33,94	36,62	37,00	46,56	39,90	37,22
Not responsible for condition	89,07	65,64	85,81	48,70	59,21	65,77	68,70	67,16	68,23	64,74	68,51	65,57	64,33
Not aware of condition	64,08	42,95	45,35	23,18	24,55	25,32	11,71	11,10	9,80	15,78	16,63	14,52	16,11
Suffers	83,70	75,23	65,25	93,08	95,06	94,02	96,41	96,83	97,82	98,67	95,67	97,03	96,33
Family suffers	96,06	88,56	79,71	94,10	94,92	93,33	93,95	93,21	95,88	94,00	93,35	95,22	94,67
Cut off from family	23,52	20,49	22,05	32,43	25,98	15,79	17,45	16,52	19,25	17,13	17,96	20,90	22,31
Cut off from society	63,30	25,80	25,40	40,20	30,90	22,30	24,60	18,90	22,00	15,37	22,10	25,40	22,10
Cut off from work	74,90	59,00	44,80	50,30	53,70	38,00	40,10	33,00	37,30	30,70	37,70	36,90	34,90

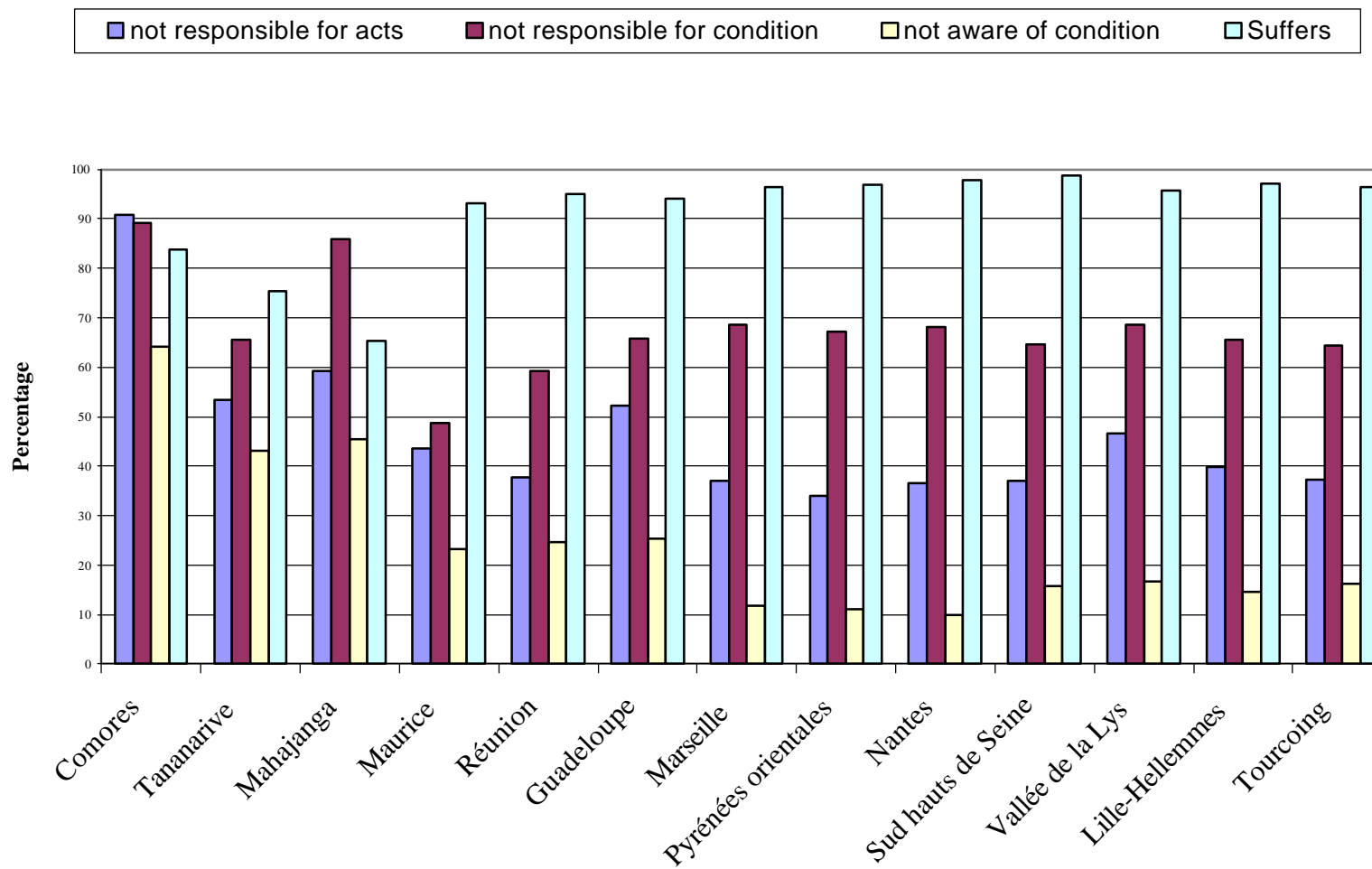
GRAPH 31 : "INSANE" PERSON SUMMARY



GRAPH 32 : " MENTALLY ILL" PERSON SUMMARY



GRAPHIQUE 33 : "DEPRESSIVE" PERSON SUMMARY



f. The role of the family (Table 25)

1. Tolerance

A very large majority respondents, whatever the site, considered that a family can take back a family member who is "insane" (70-92%), "mentally ill" (80-94%) and even more so "depressive" (>90%), either after cure or under treatment. The same gradient of tolerance is found as for the items concerning exclusion.

The positive view taken by interviewees with regard to family tolerance is surprising. In addition to the fact that it is in agreement with the perception of a lesser exclusion effect in the family than in society, it clearly shows the positive perception attributed to care and its function as an acceptance factor with regard to the disturbances for the family, and this is true of all sites.

If the "addict" is slightly less well accepted, he is also less present in representations of mental disturbance in the questions relating to qualification of behaviours.

Only 18-30% of respondents in metropolitan France could imagine taking a rapist back into the family, even after treatment; there is a much higher proportion in Madagascar and the Comoros (73%). Acceptance by the family is consistently stronger in these countries in taking back a family member who has been ill or committed an illegal act.

On the other hand, people did not consider, in France and the Comoros, that an "ill-treated child" should stay in the family, even if the family has psychological and social support. This is not the case in the other sites. This should also be seen in the perspective of availability of facilities and the perception of ill-treatment itself.

Responses alter as question become more personal, and the gradient becomes more discriminant. Thus, if interviewees state that taking in a family member who is "depressive" would not be a problem (70-88% would agree to provide care in the home), the case for a person who is "mentally ill" or "insane" is not so obvious (26-44% would agree).

It seems clear that care in the home is more easily envisaged in Indian Ocean sites than in France. But does this relate to greater tolerance, or rather to a lack of alternatives in sites where facilities are severely lacking ?

2. Resorting to outside support

At home, if a family member was "insane", his presence would be seen as a burden for more than 75% of respondents except in Mauritius where the proportion is 50%. Outside help would be sought if there was danger for others, especially in Madagascar (73-78%) and the Comoros, Guadeloupe and Mauritius (63-65%); following this, it would be sought if the subject were at risk (<24%), or if the day-to-day burden became too great (<20%). It can however be noted that this possibility is rarely mentioned in the Comoros (5%). This is in line with the preceding analyses.

2. REPRESENTATIONS CONCERNING SUPPORT AND CARE SYSTEMS

A. CARE

a. Obligation

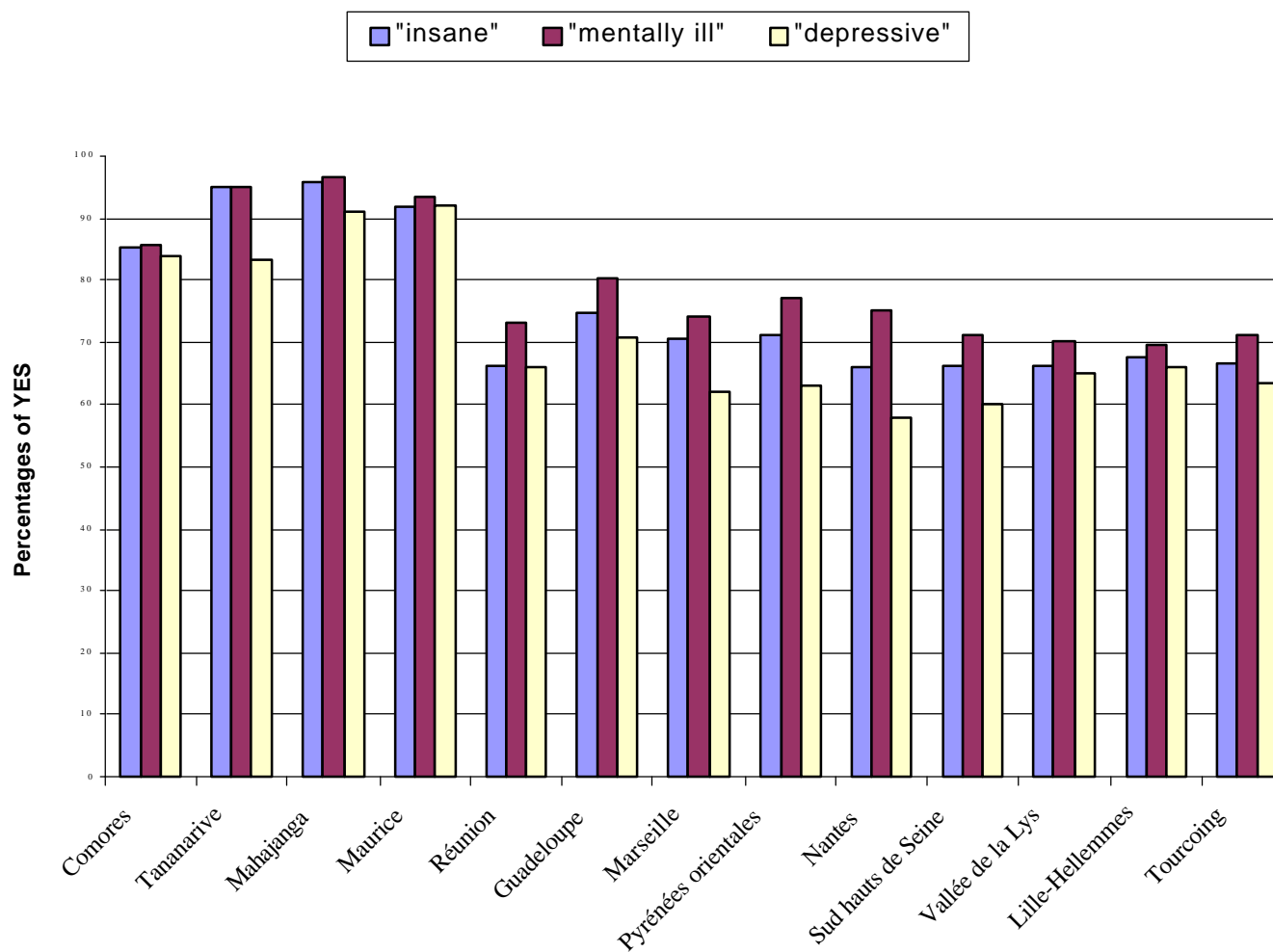
Do you think that an insane person should receive care even if he/she does not want it ?

Do you think a mentally ill person should receive care even if he/she does not want it ?

Do you think a depressive person should receive care even if he/she does not want it ?

- **Whatever the site, a large majority of respondents (>60%) consider that an "insane", "mentally ill" or "depressive" person should receive care even if they do not agree to it.**
- The hierarchy in compulsory care starts with the "mentally ill", then the "insane", and finally the "depressive", but variation is small (<10%). This tendency towards compulsory care is very strong in Madagascar and Mauritius (>90%) and in the Comoros site (>80%). In other words, it is in the sites where specialised facilities are the most lacking that people think the most strongly that care should be compulsory. In countries where facilities are lacking, disturbances are the burden of the family alone, with the concomitant socio-economic consequences. This could explain the importance given to compulsory care in these sites.
- These data should be related to responses on irresponsibility and non-awareness of disturbances. **The more the person is considered to be irresponsible and unaware, the greater the tendency to consider that care should be compulsory.**

GRAPHI 34 : SHOULD A PERSON RECEIVE CARE... EVEN IF S/HE DOES NOT WANT TO...?



b. Types of care

The questionnaire explores representations relating to types of care via open-ended questions ("How do you think an "insane" / a "mentally ill" / a "depressive" person should be cared for ?) Interviewees give spontaneous answers, which are then coded by the interviewer according to 11 categories :

- Treatment by medication,
- Hospitalisation : psychiatric hospital, general hospital or clinic
- Psychotherapy : individual, group, short, analytical...
- Consultation with general health professional : GP, nurse,
- Support from family, friends or close circle, being able to talk
- Social and educational care facilities : occupational therapy, support measures, rehabilitation...
- Religious practices : prayer, pilgrimage, retreat
- Magical or religious practices : sacrifice, exorcism...
- Cannot be cured/treated
- Do not know
- Other

More than 70% of respondents considered that **a person who is "insane", "mentally ill" or "depressive" cannot be cured without drugs**, except for Madagascar (+/-25%). Hence in Madagascar people consider that care should be compulsory (see above) but without drugs. The question is what this response conceals : would the recourse be to magical or religious practices, or herbal remedies ?

For "depressive" people however responses are more divided (40-60%).

For France and Mauritius the first therapeutic recourse cited is medication, whether for the "insane", the "mentally ill" or the "depressive". Second, for the "insane" and the "mentally ill", comes hospitalisation, followed by social support and psychotherapy.

For "depressive" subjects, social support is cited in second place, before psychotherapy and hospitalisation.

For the Comoros and Madagascar the therapeutic recourses quoted differ markedly : religious and magical practices are dominant. Whatever the type of mental disturbance noted and whatever the manner in which it is designated/stigmatised ("insanity", "mental illness", "depression") it is clear that such practices take the place of psychiatry (or else magical and religious practices are replaced by psychiatry in other sites ?). Nevertheless, despite the fact that there are no psychiatric facilities in the Comoros, a certain number of respondents state there they would resort to one in case of need.

This should be related to the existence of a Comoran diaspora in France, to globalisation of information, and the hiatus between statement (what I would do if...) and action (what I do...).

c Analysis

A detailed analysis of these results is required on account of the following reservations :

- In the analysis of the type of recourse, the main difficulty in interpretation is related to the organisation of the different types of recourse facilities into a coherent system or pattern within a society, or at least within a community in each society. **However the questionnaire does not make it possible to define what constitutes a system or pattern.** Therefore it is not possible to draw valid conclusions on the relationships between representation patterns and recourse patterns. Thus comparison with results from field studies is essential to complete or even validate the contributions from the questionnaire.
- The **place attributed to "magical and religious practices"** is probably under-estimated by the **response bias** arising from a survey labelled "World Health Organisation". Indeed, as for the question of cause, one can wonder how far the mention of this type of recourse is suppressed because the respondent has a fairly clear picture of what the "right answer" should be. Anthropological data indicate that this type of recourse is widespread in all the Indian Ocean countries taking part in the survey as well as in Guadeloupe. It also exists, but to a lesser degree, in metropolitan France. The results of the survey show that representations relating to such practices appear in a significant manner in the Comoros and Madagascar, but considerably less in Reunion and Guadeloupe. It is no doubt possible to hypothesise that once the "social desirability" bias towards the interviewer is removed, these representations would appear even more markedly in the Comoros and Madagascar, and probably also in Reunion, Guadeloupe and Mauritius.
- Going a little further along these lines of analysis, a distinction should be made between DOM (French Departments d'Outre-Mer) sites and the others. Indeed, these societies are not altogether comparable historically, culturally and socially. They are mixed societies in which strong cultural practices and beliefs coexist in daily life with Western lifestyle and socio-cultural markers originating from the links with metropolitan France. Thus it is possible to hypothesise that the under-statement or under-representation of magical and religious practices among respondents in the French West Indies and Reunion is in fact connected with a "right answer" effect. These results do not provide information on the actual practices so much as on the way in which these mixed cultures function.
- Another issue is to determine whether the questionnaire technique did not promote repression of information on magical and religious practices. Open-ended questions were prominent. One could wonder if the same results would have been obtained had they been direct closed questions, such as "*If someone close to you was mentally ill, would you advise him/her to see a marabou?*" Indeed, other studies have already evidenced recourse to religion and spiritism for depression for example⁹⁹.
- From the above it emerges that great caution should be exerted in interpreting responses on the subject of recourse to care of a religious type. Long experience in the field with the use of questionnaires shows that they can be deceptive in this area. The issue in particular is to determine (and this question is particularly relevant in Mauritius and Reunion) whether the differences between sites where this type of

recourse seems prominent and those where it does not relate to genuine differences in actual practice, **or differences in the willingness to talk about them**. Positive and negative responses can very well reflect different degrees of inhibition with respect to expressing conduct, rather than actual frequencies for such conduct. Further to this, a whole set of religious recourses deemed to be essential **but outside the scope of care escapes examination** : protection, guarantee against relapse, promises, vows and wishes. Observation of the importance of cults, sects and so on in the field of protection and care, and the importance of mental health issues among members shows that, by comparison, the results of the questionnaire evidence a genuine shortfall¹⁰⁰..

- Another bias to be taken into account is the gap between the reference categories suggested by the questionnaire ("insane", "mentally ill" and "depressive") and the lay-classification established for people, situations or problems that could benefit from recourse to magical or religious practices in a given society. Thus, under-representation of responses relating to magical and religious practices in sites where this is most characteristic could be connected not with under-statement (suppression to a varying extent) but with the fact that the categories given are not identified by respondents as being liable to benefit from such practices.
- Indeed, it can be regretted that on account of the grouping of spontaneous responses, **the semantic field for "medicine" is very wide**, while variations between sites can be very great. It should therefore be underlined that "medicine" can cover a fairly wide spectrum of products. As far as possible, it would be interesting at some stage in the future to relate findings here to anthropological studies on medication and remedies.
- Even so, as for the questionnaire overall, coherent general tendencies do emerge from the analysis of responses. There are differences and similarities in representations not only linked to cultural frames of reference and differing habits, but also differentiated according to the categories set out ("insane", "mentally ill", "depressive").

B. CURE

Do you think an insane person can be cured ? Do you think a mentally ill person can be cured ? Do you think a depressive person can be cured ?

In your opinion can an insane person be cured completely ? In your opinion can a mentally ill person be cured completely ? In your opinion can a depressive person be cured completely ?

Can an insane person be cured on his/her own ? Can a mentally ill person be cured on his/her own ? Can a depressive person be cured on his/her own ?

- **Irrespective of sites, interviewees overall (90%) agree that a "depressive" person can be cured. This representation of curability for "depressive" people is in line with medical knowledge that depression is a disease that is spontaneously reversible and curable.**
- **This tendency towards compulsory care is very strong in Madagascar and Mauritius (>90%) and in the Comoros. In other words, it is in the sites where specialised facilities are the most available that people consider most strongly that compulsory is necessary. In countries where facilities are lacking care remains the responsibility of the family alone, with the socio economic consequences this can entail. This perhaps explains the importance given to obligation of care in these sites.**
- **These data are to be related to the answers on irresponsibility and the not consciousness of the disorders. More the person is perceived as irresponsible and unaware, the more people consider compulsory care to be required.**
- **The same distributions are found for the question whether a subject can be "completely cured", but percentages fall to 10-20%.**
- **Whatever the site, interviewees overall (>80%) consider that a person who is "insane" or "mentally ill" cannot be cured on their own. However for "depressive subjects" it appears easier to envisage (30-40%).**
- **Here again there is a reservation with regard to these results : are differences in expectations with respect to cure connected with different etiological conceptions, or with differing definitions of what a cure might be ?**

TABLE 26 : CURE

	Comoros	Madagascar	Mauritius	DOM*	Metro France
An "insane" person can be cured	95%	86-92%	58%	39-42%	23-37%
A "mentally ill" person can be cured	96%	92-95%	77%	51-53%	35-57%
A "depressive" person can be cured	93%	90-96%	91%	89-90%	> 92%
An "insane" person can be cured completely**	83%	57-58%	16%	12-13%	8-14%
A "mentally ill" person can be cured completely**	87%	73-74%	44%	24-26%	17-32%
A "depressive" person can be cured completely**	84%	80-87%	80%	68-72%	71-81%
An "insane" person can be cured on his/her own	14%	7-8%	5%	7-8%	5-8%
A "mentally ill" person can be cured on his/her own	14%	12-15%	10%	6-8%	2-7%
A "depressive" person can be cured on his/her own	15%	41%	40%	31-35%	30-39%

*Reunion and Guadeloupe**

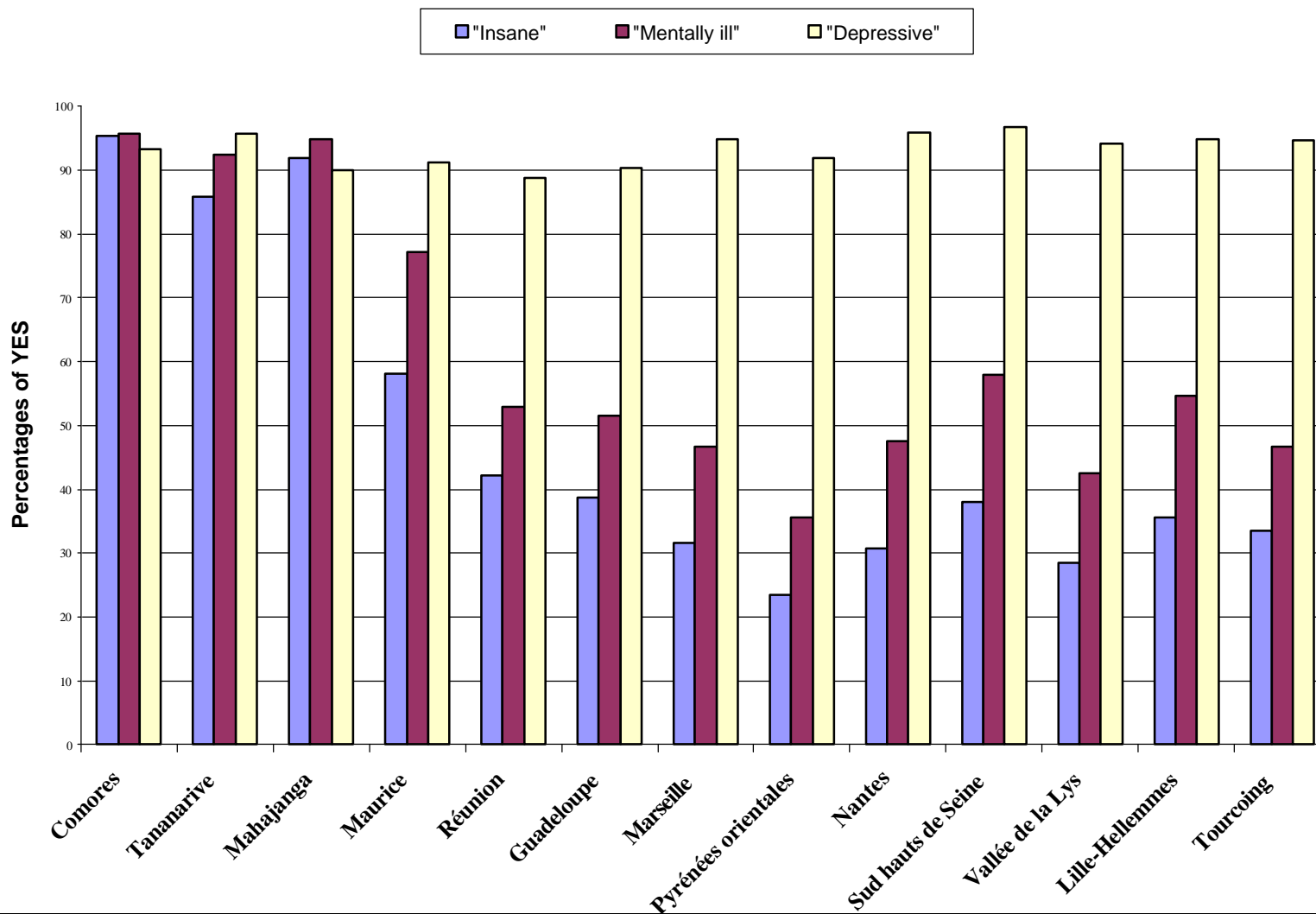
**North – South Gradient

TABLE 27 : CARE AND CURE

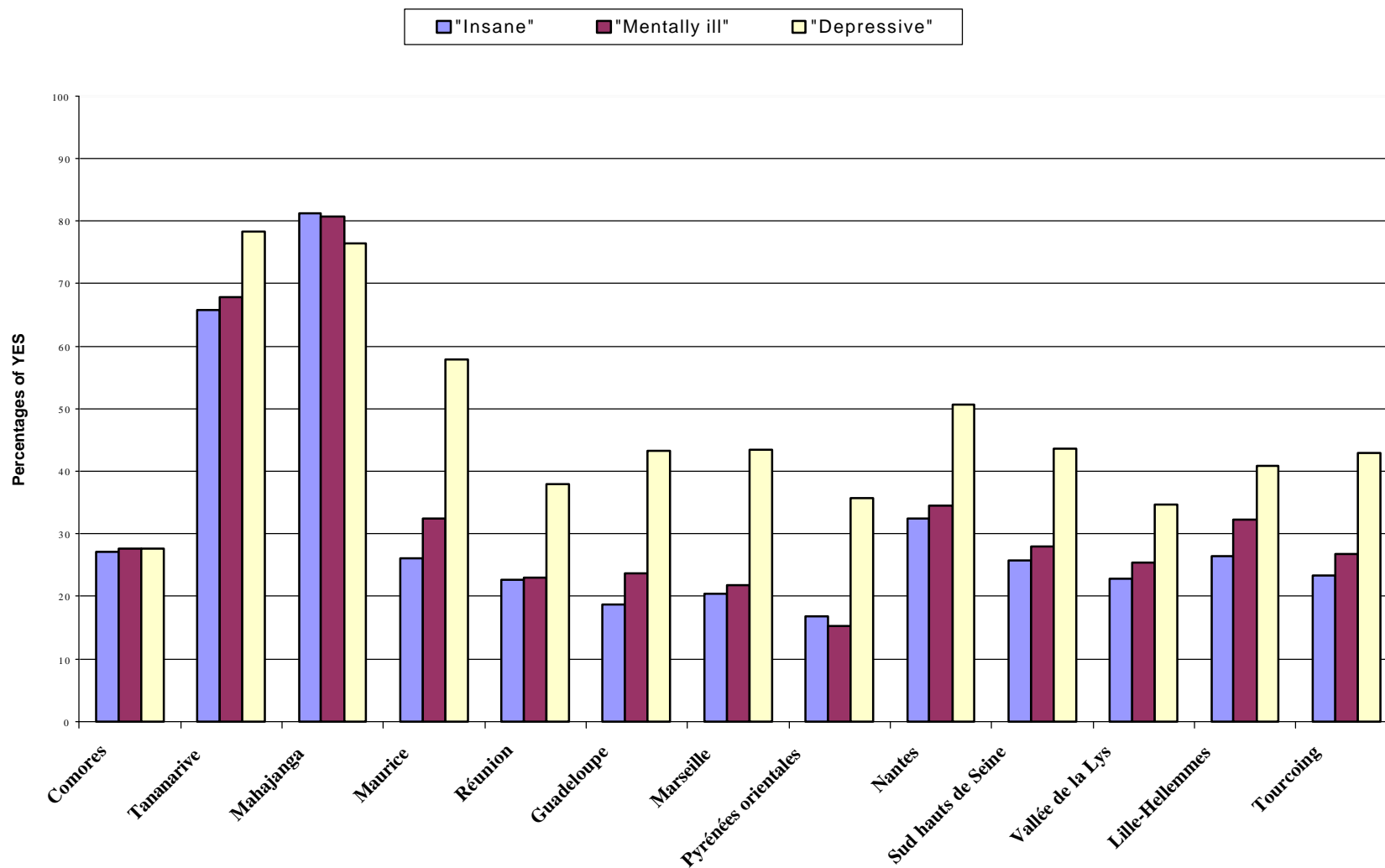
	"INSANE"	"MENTALLY ILL"	"DEPRESIVE"
WE HAVE TO CARE EVEN IF HE/SHE DOES NOT WANT PROVIDE IT*	65-95%	70-80%	57-70%
CAN BE CURED	30-43%	35-53%	89-93%
CAN BE COMPLETELY CURED	8-13%	17-32%	68-87%
CAN BE CURED WITHOUT MEDICATION*	16-23%	15-35%	28-58%
CAN BE CURED ON HIS/HER OWN	5-8%	3-8%	31-41%

* North – South gradient

GRAPH 35 : IS CURE POSSIBLE ?



GRAPH 36 : IS CURE WITHOUT MEDICATION POSSIBLE ?



MENTAL HEALTH IN GENERAL POPULATION : IMAGES AND REALITIES – ASEP – WHO – DIRM EPSM Lille Métropole – French Ministry of Health – French Ministry of Foreign Affairs, France – June 2001

C. REPRESENTATIONS OF THERAPEUTIC RECOURSE

a. The image of the psychiatric hospital

In your opinion, what sort of care is provided by a psychiatric hospital or clinic ?

Would you advise someone close to you who is insane should go to a psychiatric hospital ?

Would you advise someone close to you who is mentally ill to go to a psychiatric hospital ?

Would you advise someone close to you who is depressive to go to a psychiatric hospital ?

- It should be recalled that more than a third of the subjects in the sample said they had at some time been in a psychiatric hospital or a psychiatric ward. It is interesting to explore further the representations people have of psychiatric facilities. The items on care have already provided some information, which are clarified or confirmed here.
- In all sites except Madagascar, treatment by medication (drugs) is mentioned first as care offered in a psychiatric hospital or clinic. The majority of respondents in Madagascar state they do not know what sort of treatment is provided.
- **Psychotherapy is quoted second** in France (12 and 20%). Other treatment is quoted in Mauritius (electroshock).
- Irrespective of sites, people would advise someone close to them who is "insane" to go to a psychiatric hospital (>73%), and fewer in the case of someone close who is "mentally ill" (>58%). However, in France and Guadeloupe this advice would not be given to a "depressive" person. It should be recalled that in representations the person who is "insane" or "mentally ill" is another, while the "depressive" person could be oneself. Thus people would recommend the psychiatric hospital to a person who is "insane" or "mentally ill" but not to a "depressive" person (oneself). The vast majority of respondents think that a "depressive" person can be cured, even without medication. But opinions vary in sites in Reunion, Madagascar and Mauritius.

b. Image of other care facilities

Do you know places other than a psychiatric hospital to care for a person who is insane ? If so, what are they ?

Do you know places other than a psychiatric hospital to care for a person who is mentally ill ? If so, what are they ?

Do you know places other than a psychiatric hospital to care for a person who is depressive ? If so, what are they ?

- **In France, 70-80% of interviewees did not know of any place other than the psychiatric hospital caring for the "insane".** Only 20-30% could quote other types of facility. This percentage increases for other care facilities for the "mentally ill". Here 39 to 52% quote at least one.
- About the same alternatives are given for the "insane" and the "mentally ill" :
 - ✓ clinics, residential care facilities
 - ✓ day centres
 - ✓ family, for the "mentally ill"
- Alternative care facilities for the "depressive" are more easily evoked. More than 72% of respondents could quote at least one, except in Réunion (55%). **The first alternative is the home and the family**, which is in agreement with preceding responses : "depression" can concern self, it can be cured on its own, without drugs. The second alternative quoted concerns clinics and residential care facilities, care facilities under the psychiatric hospital are rarely cited for "depressive" subjects (see above).
- It is quite clear from these responses that psychiatric facilities based in the community are not a spontaneous recourse in stated attitudes on the part of respondents. This can no doubt be explained by a "contamination" of "small-scale" facilities (medico-psychiatric consultation centres set up in town) by the pejorative image of the psychiatric hospital ("that is for the insane ! I am not insane !"). This contamination is encountered in all the psychiatric professions, as will be seen later. Moreover, it can be said that other facilities than psychiatric hospital for the "insane" and the "mentally ill" are not quoted by interviewees ; nevertheless, a psychiatric hospital does not seem fit for "depressive" people.
- Mauritius constitutes a situation apart with relation to the other sites, probably correlated with the way psychiatric care is organised on the island (coercion until 1998 in the psychiatric hospital). Thus, nearly 90% of respondents are unable to quote any alternative to the psychiatric hospital to care for a person who is "insane" or "mentally ill". For "depressive" people, one third of respondents mentioned the family, residential centres or consultation centres.
- The picture is very different for the Comoros site and Madagascar where the majority could quote alternative places providing care for the "insane", the "mentally ill" or the "depressive" :
 - ✓ **catholic and protestant churches and missions**
 - ✓ **religious communities.**
- The paradoxical context of these responses is noticeable. There is indeed great disparity in facilities available to the various populations involved in the study, in particular for small-scale units (day centres, ambulatory care etc). Reference frames must also vary considerably through the study populations. It can however be recalled that in France 80% of the psychiatric sector budgets is still used for psychiatric hospitalisation facilities, while more than half of the patients are monitored outside the hospitals which even so occupy a prominent position.

- One issue is to determine whether apparently equivalent responses provided in very contrasted contexts have real significant equivalence, or whether they in fact correspond to different representations with respect to frames of reference. As a corollary, variations in responses from one population to another may reflect genuine differences in representation, or else arise from the disparities in the frames of reference.

- **For French sites it seems important to underline the lack of knowledge on the part of the general population with regard to alternatives to psychiatric hospitalisation. Only 5% of respondents in France can spontaneously quote a psychiatric care facility outside hospital. For a vast majority, psychiatric hospital is the only place to care for an "insane " and a "mentally ill" person**
- **Despite the promulgation 40 years ago of a law defining psychiatric "sectorisation" and the concomitant alterations in the care offer, spreading it into the community, the population still knows little of recourse facilities available. These results should lead on to clear recommendations for sector teams as a whole.**

TABLE 28 : DO NOT KNOW PLACES OTHER THAN PSYCHIATRIC HOSPITAL TO CARE FOR...

	Comoros	Madagascar	Mauritius	DOM*	Metro. France.
An "insane" person	39%	29 - 58%	91%	75 - 78%	71 - 81%
A "mentally ill" person	46%	24 - 60%	86%	61 - 69%	48 - 63%
A "depressive" person	50%	57 - 63%	70%	28 - 45%	15 - 24%

* Reunion and Guadeloupe

TABLE 29: OTHER PLACES TO CARE FOR AN "INSANE" PERSON

	Comoros	Madagascar	Mauritius	DOM	Metro. France.
Know places other than psychiatric hospital to care for an "insane" person	61%	42 - 71%	9%	22 - 25%	19 - 29%

Those who know other places quote :

Clinics, residential care facilities	16%	1 – 3,7%	12%	29 – 37%	18 – 32%
Day centres, GP, etc.	3%	0,2 – 0,7%	15%	18 – 32%	12,5 – 27,6%
Churches, mission, etc.	74%	92%	96%	1,6 – 4%	0,4 – 6,4%
Family, relatives	3%	1%	10%	10,3 – 20,6%	12,8 – 16,2%

TABLE 30 : OTHER PLACES TO CARE FOR A "MENTALLY ILL" PERSON

	Comoros	Madagascar	Mauritius	DOM	Metro. France
Know places other than psychiatric hospital to care for a "mentally ill" person	54%	40-68%	14%	31-39%	37-52%

Those who know other places quote :

	1,4%	0,1- 0,9%	28%	15 - 21%	20 – 37%
Clinics, residential care facilities	13,6%	0,9 – 3,4%	13%	25 – 29%	10 – 28%
Day centres, GP, etc.	3,4%	0,5 – 1,5%	16%	15,6 - 34%	15,7 – 25%
Churches, mission, etc.	70,6%	89 – 95%	11%	1,8 – 2,3%	0,4 – 1,4%
Family, relatives	8%	2 – 3,6%	8%	14 – 25%	14 – 19%

TABLE 31 : OTHER PLACE TO CARE FOR A "DEPRESSIVE" PERSON

	Comoros	Madagascar	Mauritius	DOM	Metro. France
Know places other than psychiatric hospital to care for a "depressive" person	50%	37 - 43%	30%	55 - 72%	76 - 85%

Those who know other places quote:

Clinics, residential care facilities	12%	17%	30%	34 – 45%	39 – 51%
Day centres, GP, etc.	11%	2 – 8%	11%	29 – 42%	17 – 37%
Churches, mission, etc.	3,5%	0,6 – 1,7%	14%	6,7 – 9%	6 – 15%
Family, relatives	68%	69 – 77%	5,7%	0,6 – 1,8%	0 – 0,7%

D. Referral of someone close or of the respondent him/herself

a. Referral of someone close

If someone close to you (family or friend) is insane, who would you tell him/her to see ?

If someone close to you (family or friend) is mentally ill, who would you tell him/her to see?

If someone close to you (family or friend) is depressive, who would you tell him/her to see ?

- In France and Mauritius, people stated that they would advise an **"insane" or "mentally ill" person close to them** first of all to see a psychiatrist, and in second position a general practitioner. The psychiatrist is seen as the person to take charge of serious pathologies.
- For **someone close suffering from "depression"**, the psychiatrist and the general practitioner are quoted to the same extent, and the close circle (family and friends) in second place.
- In Madagascar and the Comoros, whatever the category ("insane", "mentally ill", "depressive"), the person would first be advised to see a general practitioner, and second a religious figure in Madagascar and a magical-religious figure in the Comoros.
- **For a child** with mental disturbances, a general practitioner would be consulted first, and after these religious and magical-religious recourses in Madagascar and the Comoros.

b. Recourse for the respondent him/herself

Imagine that you do not feel good. You have problems in your life. You are not easy with yourself or the outside world. You no longer know where you stand. You do not understand what is happening to you. Things are not right in your head. Who would you go to see first ?

- In the case of psychological difficulties the majority of respondents said **they would first see someone close to them** (friend or family), then their **family doctor** (except in the Comoros where this order is reversed). These results are in line with results from other studies on representations of care. Thus the Australian study quoted in the methodological section shows that 83% of subjects consider that in case of psychological problems, a general practitioner is able to cater for them.
- In France and Mauritius the third recourse quoted for a personal problem is the **psychiatrist**.
- In the Comoros and Madagascar the third recourse is religious or magical-religious.

- **Thus people would readily advise someone close to see a psychiatrist, but would themselves consult one only as a last resort. The "insane" person is the other person, the psychiatric hospital and psychiatrists are for others.**


- **It is interesting to note that these responses are homogeneous irrespective of the site, hence also irrespective of availability of such facilities. This highlights the difference between intention, statement and action.**

c. Choice criteria

- On the subject of the person one would go to see in case of psychological difficulties, it is **personality criteria (confidence, listening abilities) and affective criteria (being intimate)** that take priority in the choice, before criteria of competence. Financial and geographical criteria are little involved.
- Obviously the same reservations should be applied to this data as for responses overall. **The statement should not override the reality of conduct.** The questionnaire is not intended, either, to reconstruct imaginary or real therapeutic itineraries. Anthropologists have studied raw results the "one would first advise him/her to see a psychiatrist/GP" type. They have shown that they are not really representative of actual conduct. Actual conduct is made up of complex and branching diagnostic and therapeutic itineraries, involving simultaneous applications to several sectors of the care system (vernacular, local specialists, bio-medicine, in various forms). In addition, there are considerable differences between care itineraries as reconstructed by questioning and those actually observed in follow-up.
- Even so, it is interesting to note the convergence effect of responses within geographical sub-sectors and the proposed categories ("insane", "mentally ill" and "depressive"). These elements will require consideration when recommendations are made to promote access to therapeutic facilities.

TABLE 32 : REFERRAL OF SOMEONE CLOSE TO...

		Metro. France.	DOM	Mauritius	Madagascar	Comoros
"INSANE"	1	Psychiatrist	Psychiatrist	Psychiatrist	General practitioner	General practitioner
	2	General practitioner	General practitioner	General practitioner	Religious	Magico-Religious
	3				Psychiatrist	Psychiatrist
"MENTALLY ILL"	1	Psychiatrist	Psychiatrist	Psychiatrist	General practitioner	General practitioner
	2	General practitioner	General practitioner	General practitioner	Religious	Psychiatrist
	3				Acquaintances Psychiatrist	Magico-Religious
"DEPRESSIVE"	1	Psychiatrist	Psychiatrist	Psychiatrist	General practitioner	General practitioner
		General practitioner	General practitioner			
	2	Acquaintances	Acquaintances	General practitioner	Religious	Psychiatrist Magico-Religious
3			Acquaintances	Acquaintances	Psychiatrist	



Magico-Religious

TABLE 33 : YOU DO NOT GOOD... WHO WOULD YOU GO TO SEE FIRST ?

	Comoros	Madagascar	Mauritius	DOM	Metro France
ACQUAINTANCES	23 %	46 – 47 %	43 %	37 – 40 %	36 – 46%
GENERAL PRACTITIONER	49 %	36 %	33 %	35 – 38 %	34 – 42%
PSYCHIATRIST	14 %	1 – 3 %	18 %	12 – 23 %	9 – 16%
RELIGIOUS/ MAGICO-RELIGIOUS	13 %	13 – 14 %	5 %	1,3 – 2 %	0,5 – 1,3%