

#### XIV. CROSSING OF SOCIO-ANTHROPOLOGICAL AND EPIDEMIOLOGICAL AXIS

- It was assumed that certain characteristics of interviewees could have particular influence on perceptions of mental health. Thus, in order to characterise these individuals, the questions of the identification questionnaire were used coupled with the appearance or otherwise of a disorder via the MINI questionnaire, and any likelihood of a particular approach to the field of psychiatry such as : knowing an "insane", "mentally ill" or "depressive" person among those close, having been in a psychiatric hospital or ward, having taken medication for nervous complaints, having received treatment for "depression" or having had "psychotherapy".
- However, the study of the various sites shows that generalisation of results is not really feasible, and certain differences noted can only be confirmed after study of a larger number of sites.
- **Axis crossing presented here concerns metropolitan France only**

##### 1. GENERAL REMARKS

The study of the perception of the "insane", the "mentally ill" or the "depressive" person according to wide socio-demographic criteria (gender, age, educational status, professional status, marital status, belief, migration) highlights few differences.

- The way "depression" is envisaged sometimes diverges between men and women. People between 18 and 35 are often more optimistic than the others with respect to cure and would more readily take in someone close.
- **People with higher education** seem to have a better knowledge of psychiatry. The other criteria do not influence responses sufficiently to be taken into account for the moment.
- **Knowing someone who is "insane", "mentally ill" or "depressive"** has an influence on the perception of certain behaviours, on the way people view likelihood of cure, taking someone in, and their knowledge of psychiatry and psychiatric facilities. This is coherent with the results of the studies conducted by Brockinton and Wolff quoted in part I of this report.
- For **people who stated they had been treated for "depression"** it was easier to envisage caring for a depressive person at home, his presence would not be a burden, and they also had greater knowledge of psychiatric care and facilities. They do not however have a specific view of depressive people.
- **People stating they had already taken medication for a nervous condition**, or had already been in a psychiatric facility or had had "psychotherapy" show no particular characteristic apart from those linked to the above.

## 2. THEMATIC STUDY

### A. BEHAVIOURS

Here we return to the analysis of behaviours and conduct showing qualification of the behaviours of people who are "insane", "mentally ill" or "depressive" as being normal or abnormal and dangerous or non-dangerous, as presented earlier in this report.

#### a. Perception of "depressive" persons

- Crying frequently and attempting suicide are widely recognised characteristics of people suffering from "depression" in metropolitan France (more than 75% of interviewees), as are, to a lesser degree, being isolated and withdrawn (from 55 to 66% of respondents).
- This proportion is higher among women respondents, about 5 points higher than for men. People who say they have received treatment for "depression" are more likely to consider that strange behaviour or speech, neglected, dirty appearance, and anxiety characterise "depressive" people. Finally, the people who proved to be "depressive" via administration of the MINI questionnaire also more commonly think that someone who is dirty and neglected, isolated and withdrawn, and shows anxiety is likely to be "depressive".
- It could be said that the fact that someone has suffered from "depression" improves their empirical knowledge of the illness, and leads to behaviours being attributed to, or re-qualified as "depression", which would not be so in first instance. The same observation was made by Ogden, who showed that patients who had personal experience of "depression" have a representation that is close to the medical profile<sup>102</sup>.
- Attention should be paid to this re-qualification serving as an excuse for entrusting the field of psychiatry with the ups and downs of life and ambient misfortune generally. Indeed, it is this very process of attributing or "re-qualifying" acts and behaviours that, in the Western world, at the end of the 19th century sent part of the prison populations into psychiatric hospitals, thus converting certain criminal acts into insane acts, and entrusting psychiatrists with those that had committed them.

#### b. Perception of "insane" and "mentally ill" persons

- It would appear that people who know someone in their close circle who is or has been "insane", "mentally ill" or "depressive" have a lesser tendency to characterise behaviours of the "insane" and the "mentally ill" by violence. Thus, for these subjects, a person who commits rape, incest or murder, or who regularly beats the spouse or children, is more frequently considered to be mentally ill. People who have had higher education also more frequently characterise these behaviours as belonging to the mentally ill.

#### c. "None of the three"

- Someone who takes drugs, who behaves strangely, or who shows anxiety is more often considered to be neither insane nor mentally ill nor depressive by people having had higher education.

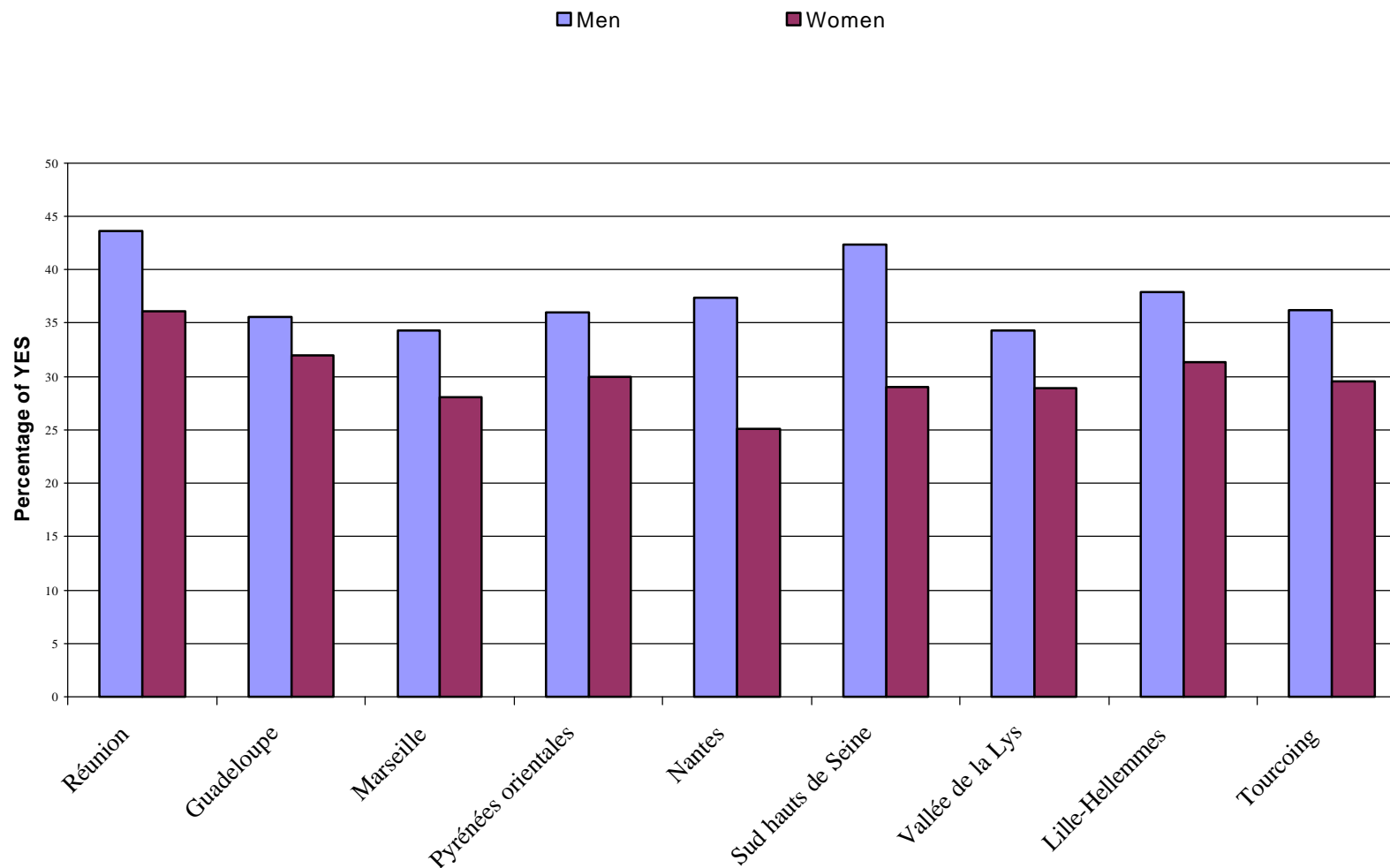
#### d. Normality

- People who proved via administration of the MINI to have drug or alcohol abuse problems tend to consider these behaviours to be normal.
- People who knew someone "insane", "mentally ill" or "depressed" tend more to consider that people who cry a lot, attempt suicide, use drugs or are intellectually deficient to be normal. Acquaintance reduces the distance from the "outsider" who is "insane", "mentally ill" or "depressive", and tends to normalise them. It could be said that the closer the state is to self, the more it is integrated into the intimate sphere, and the more it is considered by the subject to be normal.

## B. ILLNESS AND CURE

- The degree of responsibility attributed to a "depressive" person with respect to his/her state and acts is lower for women respondents than for men (see graph 37).
- **Men** appear more optimistic with respect to prospects of cure (see table 34), and men consider more frequently than women that an "insane" or "mentally ill" person can cure. Likewise the likelihood of curing any of the three categories without medication is seen as greater by men than by women. These results should no doubt be related to the sex-ratios observed for the different disorders identified by the MINI. Thus, as will be seen in the epidemiological section of this report, women more often present depressive or anxiety disorders, and they more often state they have used psychotropic drugs. This empirical knowledge of the disorders and medication in part explains the differences in representations.
- Likewise, **respondents between 18 and 39** are more likely to consider that an "insane" or "mentally ill" person can be cared for without medication, and that they can be cured.
- Among people with **higher education** the view that treatment can take place without medication tends to be more widely held.

**GRAPH 37 : PERCENTAGE OF MEN AND WOMEN THINKING  
A " DEPRESSIVE" PERSON IS RESPONSIBLE FOR HIS/HER CONDITION**



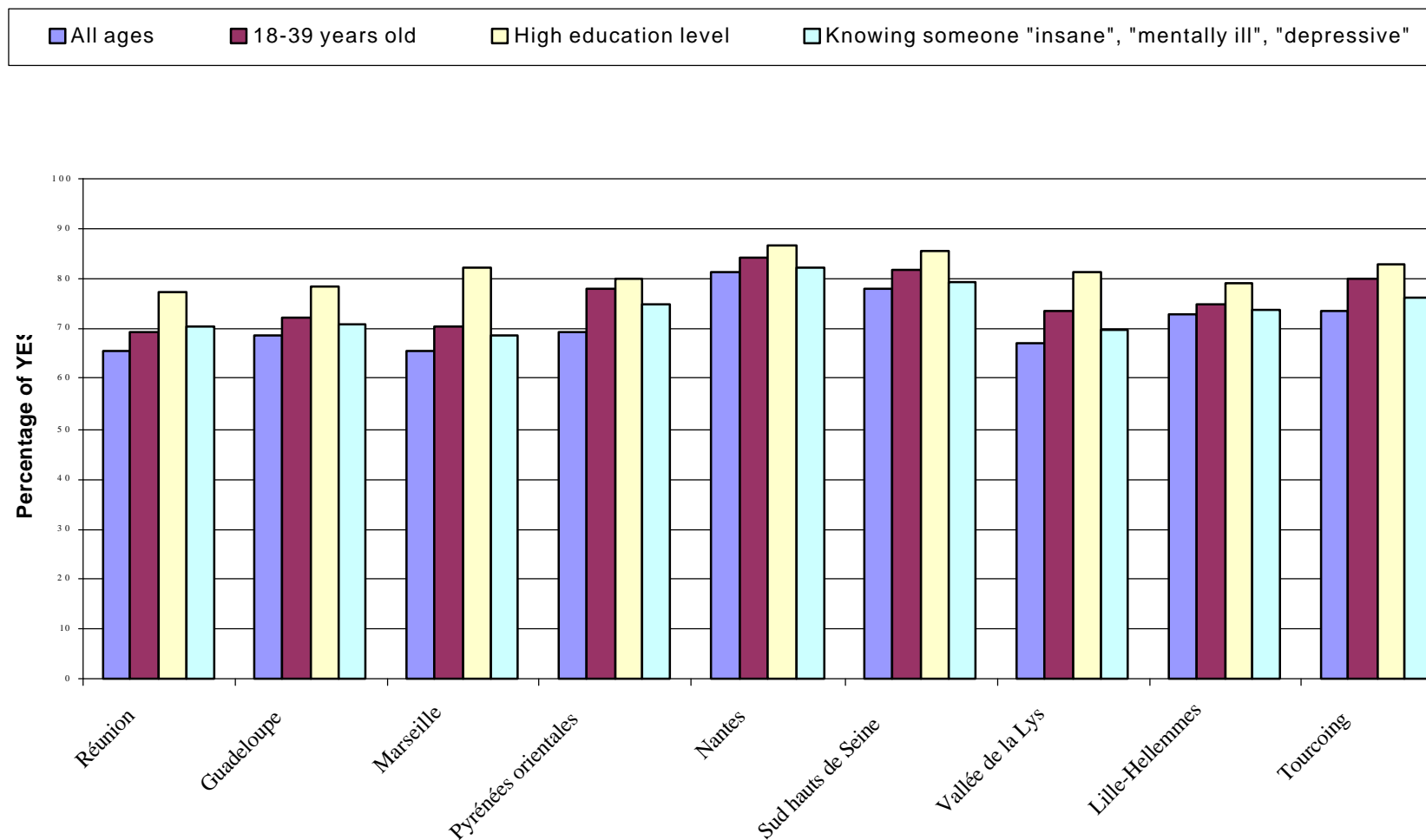
**TABLE 34 : PERCENTAGE OF MEN AND WOMEN THINKING BE CURED WITHOUT MEDICATION  
AND BE CURED ARE POSSIBLE**

	Can be cured without medication						Can be cured					
	"insane"		"mentally ill"		"depressive"		"insane"		"mentally ill"		"depressive"	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
<b>Réunion</b>	22,9	21,4	23,6	21,8	40,9	34,9	41,8	41	55,7	48,9	86,1	90,1
<b>Guadeloupe</b>	22,5	15,1	27,9	20	46,2	40,7	41,2	36	56,3	47,1	89,1	91,1
<b>Marseille</b>	23,6	17,2	23,2	20,2	45,6	41,5	35,2	27,4	51,8	41,9	94,1	95,5
<b>Pyrénées orientales</b>	20,9	13,1	17,5	13,3	40,1	31,9	24,8	22,4	38,2	33,3	90,3	93
<b>Nantes</b>	34	27,5	37,4	30	54,9	45,4	33	25,1	51,5	41,1	95,6	96,1
<b>Sud hauts de Seine</b>	33	19,5	35,6	21,2	50,5	40,7	45,9	30,9	62,7	53,5	96,7	96,9
<b>Vallée de la lys</b>	29,2	17	29,6	21,5	39,8	30	34	23,4	47,7	37,9	94,4	94
<b>Lille-Hellemmes</b>	29,4	23,9	35,1	31	49,6	37,4	38,7	29,4	53,5	48,8	92,9	94,8
<b>Tourcoing</b>	28,1	19,1	30,5	23,7	47,9	38,7	37,4	30,1	47,1	46,2	94,5	94,8

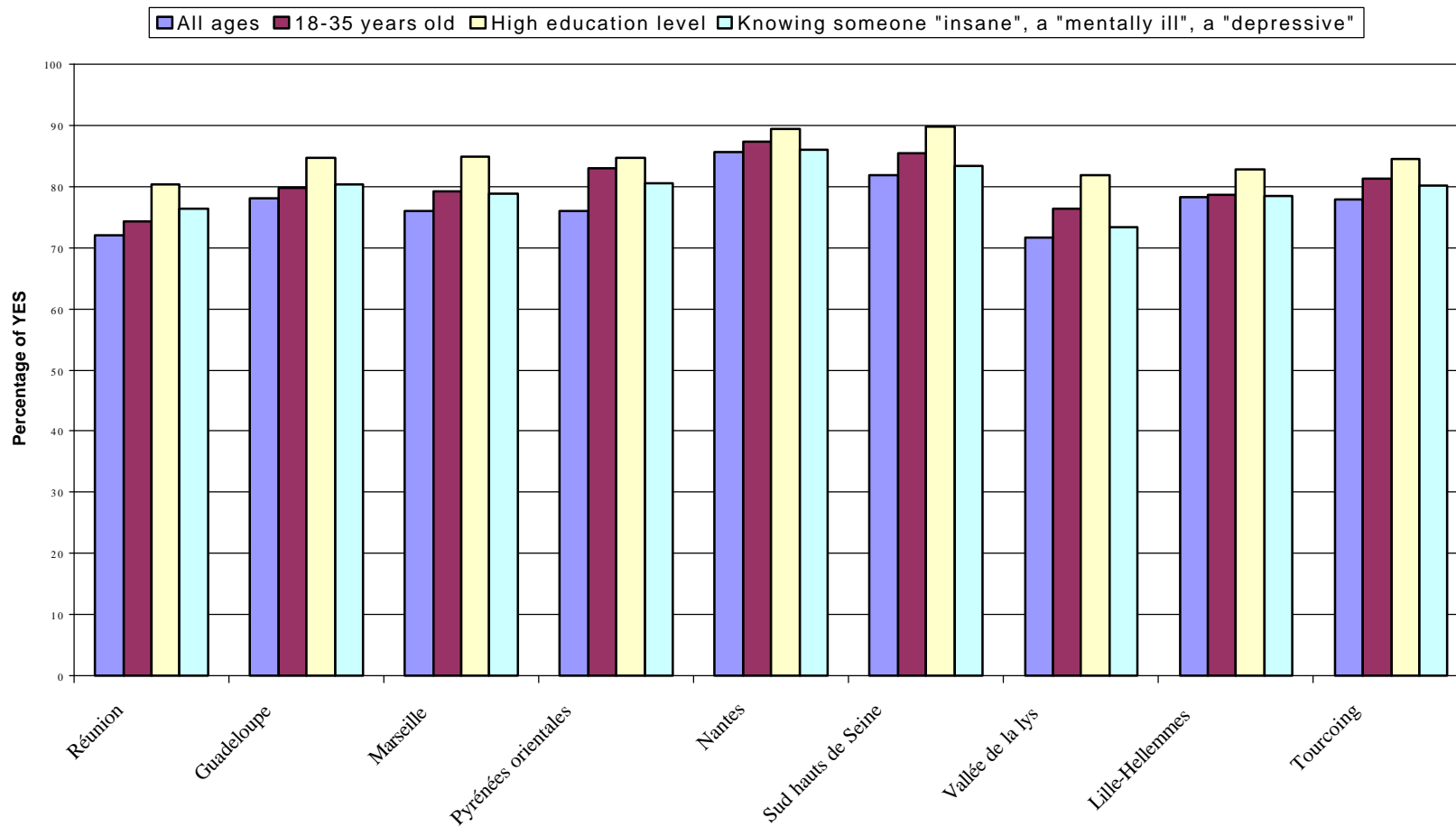
### 3. HOSPITALISATION AND TAKING INTO THE HOME

- **Respondents between 18 and 39** seem more inclined to take in a drug or alcohol addict, or a rapist who has had or is having treatment.
- **People who have had higher education** more readily state that they would take in people with disorders (child or adult who is "insane", "mentally ill", "depressive", drug or alcohol addict, rapist) after treatment or in the course of treatment. The difference is more marked for cases where the person is a drug or alcohol addict or a rapist after or in the course of treatment.
- Likewise, **people knowing someone in their close circle** who is or has been "insane", "mentally ill" or "depressive" are more liable to state that they would take in someone with these disorders who is cured or under treatment.
- It would appear that these same individuals would more readily tend to accept a child with psychological problems being admitted into the same facilities as other children.
- The tendency towards stating greater acceptance of the "insane", the "mentally ill" and the "depressive" among the under 35s and among people acquainted with such disorders in their immediate circle could indicate certain progress in mentalities (unless it is that people become more rigid with age...). This requires confirmation in the next phase of the survey.

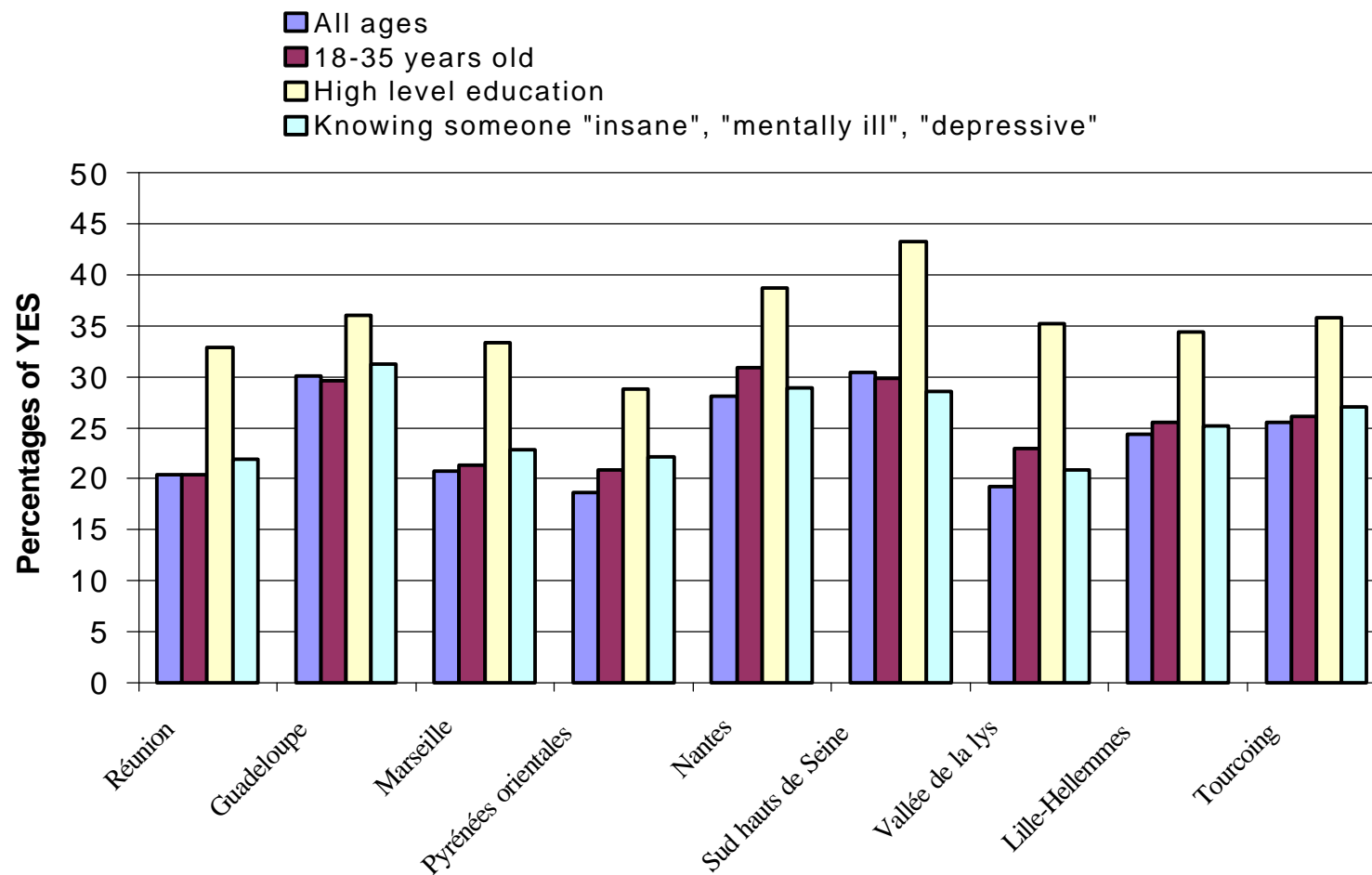
**GRAPH 38 : TAKE IN SOMEONE WHO IS DRUG ADDICT (AFTER TREATMENT OR IN THE COURSE OF TREATMENT) WITH RESPECT TO SOCIO-DEMOGRAPHICAL CRITERIA**



**GRAPH 39 : TAKE IN SOMEONE WHO IS ALCOHOL ADDICT (AFTER TREATMENT OR IN THE COURSE OF TREATMENT) WITH RESPECT TO SOCIO-DEMOGRAPHICAL CRITERIA**



**GRAPH 40 : TAKE IN A RAPIST (AFTER TREATMENT OR IN THE COURSE OF TREATMENT) WITH RESPECT TO SOCIO-DEMOGRAPHICAL CRITERIA**



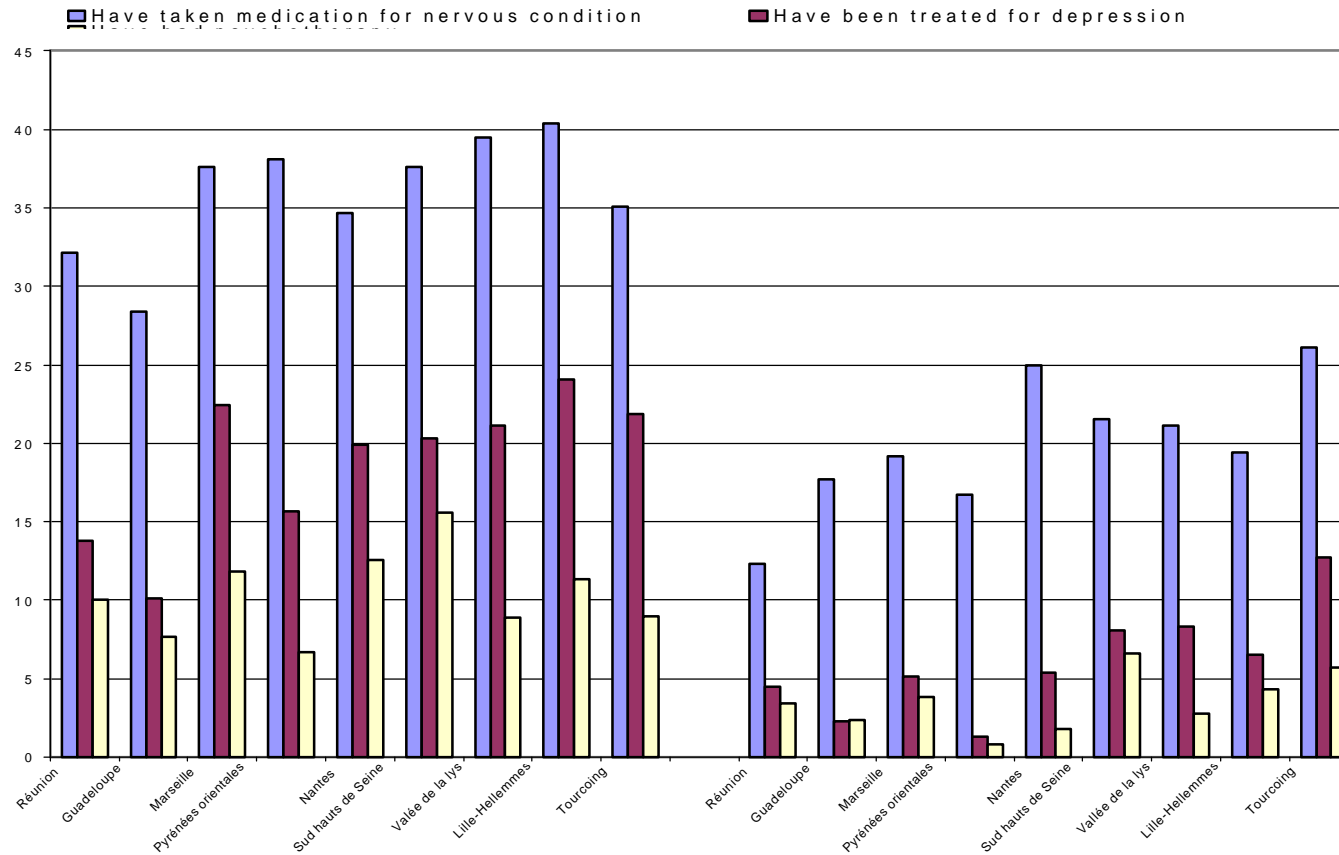
#### 4. ACQUAINTANCE WITH PSYCHIATRY AND PSYCHIATRIC FACILITIES

- People who know someone close who is or has been "insane", "mentally ill" or "depressive" seem more inclined to accept people with these disorders, and also seem to know more about psychiatry and psychiatric facilities : they more frequently know of some facility other than the psychiatric hospital to care for someone who is "insane", "mentally ill" or "depressive", and they have also more often themselves been in a psychiatric facility.
- However, these individuals have also been in more direct contact than others with psychiatry and psychiatric facilities : they more often state they have taken medication for nervous conditions, or have been treated for depression, or have had psychotherapy.
- Even so, someone who has been in a psychiatric hospital, or who has taken medication for a nervous condition, or who has been treated for depression , or has had psychotherapy is more likely to be found in these same groups.
- **Women** more frequently state that they have taken medication for nervous conditions, have been treated for "depression" or have had psychotherapy (see graphs in the following pages).
- **People who state they have a religious belief** also more frequently state they have taken medication for a nervous condition.

## GRAPH 41 and GRAPH 42

**KNOW SOMEONE CLOSE WHO IS "INSANE"  
"MENTALLY ILL", or "DEPRESSIVE"**  
with respect to following criteria

**DO NOT KNOW SOMEONE CLOSE WHO IS "INSANE"  
"MENTALLY ILL" or "DEPRESSIVE",**  
with respect to following criteria :



## GRAPH 43 and GRAPH 44

PERCENTAGE OF MEN WHO HAVE :

PERCENTAGE OF WOMEN WHO HAVE:

