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Véronique Petit

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- 1 This article reports on the situation of certain migrants returning to their country of origin, Senegal, due to mental illness, despite the fact that this return is neither anticipated nor desired by the actors involved. It provides insight into forced returns regardless of how repatriation occurs, the migrant's failure to complete migration or their scheduled return. We use original data to question the impact of mental health on migratory routes and what it reveals about the investment of family solidarity in the implementation of the migration project. The observations and stories question the strength of migrant status in Senegalese society and point towards its possible erosion, since migrants are accorded the status of "very important persons" and embody one of the major representations of success. Migrants affected by mental illness may return on their own or be repatriated for health reasons to be treated in Senegal when their mental state deteriorates. The pathology may exist before the migratory departure, but the latter may provide a context favourable to its emergence or to the worsening of the migrant's state of health due to their daily living conditions.

- 2 We focus on the early stages of return to Senegal and the questions raised by the therapeutic care of the migrant for families facing the following dilemma: how can the moral duty to care for the migrant who contributes to the family's resources be reconciled with the desire to limit the duration of treatment in order to encourage the migrant to resume the path of migration as soon as possible? The families' decisions must be placed in a specific social and therapeutic context: the stigmatization of madness in Senegalese society, the financial cost of care as well as the duration of treatment. The confrontation between the migrant's state of health and the multiple expectations that weigh on him also raise the question of acknowledging his status as patient and the legitimacy of the complaint; however, the migrant must constantly renew the proof of his performance as a body at work. The data come from a larger ongoing survey on individuals' access to mental health care in Senegal, with international migrants constituting only one group within the general population.
- 3 Older studies have already mentioned the negative consequences of migration on mental health and intra-family dysfunctions that emerged as early as the 1960s in emigration countries around the Mediterranean Basin (Charbit and Bertrand, 1985). In the case of Senegal, mention should be made of the study by Henri Collomb and Henri Ayats, who referred to "a pathology of return" when describing the situations of migrants "who, without reaching psychotic upheaval, have difficulty reintegrating their home group. They are linked more to a sense of fault, a consequence of non-observance of group rules, than to profound disorganization" (Collomb and Ayats, 1962: 595-596). We do not refer here to the use of psychiatric services by the children and wives of migrants, whereas observations show that they too are affected by the living conditions (absence, waiting, secrecy, dependence) imposed by the migratory experience on those who remain and are excluded from circulation. The return, or more precisely an ever-delayed return for personal reasons or because of the effects of migration policies, has morbid effects on the migrant's family back home. These situations remain to be studied in sub-Saharan Africa regardless of the cases of refugee populations or forced repatriations of young sub-Saharan Africans who have failed to reach the European Union. These complex family configurations deserve to be treated in depth, but they are clearly complementary to those described in this article.
- 4 Let us also briefly recall the importance of migration and mobility in Senegalese society. Historically, Senegal's geographical location (Atlantic coast on the margins of the African kingdoms) made it one of the trade centres linking Europe, Africa and America before the colonial period. From 1895 onwards, colonization and inclusion in French West Africa (FWA) led to the mobilization of different categories: men recruited into the regiments of Senegalese riflemen, the education of civil servants within the FWA, traders and sailors. After independence in 1960, emigration took on a new dimension and flows were directed towards France and African countries (Ghana, Ivory Coast, Gabon, Democratic Republic of Congo) in a favourable economic and political context. The demand for external labour is fuelled by the crisis in the rural world and the parallel conversion of the brotherhood of the Mourides (Diop, 1980, 1981). Thanks to international trade and investment through the diaspora and its networks, the brotherhood has become a central actor in migration. The oil crisis and its economic and political consequences, and the closure of some African destinations led from the late 1970s to a reorientation and diversification of migratory flows to Italy, Spain, the United States, Canada, and the Gulf Emirates, with some migrants remaining trapped in

the Maghreb countries unable to reach the European Union. Migrant profiles have diversified, involving more women, students and graduates. Due to investment and remittances, emigration plays a major socio-economic role. Nor is it completely definitive, since according to estimates, half of Senegalese emigrants return home after ten years of living abroad (Lessault *et al.*, 2015).

Theorizing the Relations between the Migrant and his Family during the Migration Process

- 5 While the decision to migrate has been widely theorized, the question of return has been less so or remains latent in theories. Undoubtedly because initially theorists implicitly adopted the point of view of the northern immigration countries (America, Europe), and because it was important for them to model the motivations of migrants in order to understand what their contributions to economies and their “integration” capacities could be, particularly through professional activity in the societies they joined at that time of growth. This decision making is a calculation, a comparison that puts into perspective the benefits and costs of staying or leaving (Lee, 1966; Harris and Todaro 1970). From this perspective, the migrant - an individual actor - is a rational being, a *homo oeconomicus* who reacts to the structural determinants (differentials in wage levels, employment opportunities) that guide migration flows from the perspective of social mobility. The migrant maximizes his interest by choosing a destination that allows him to satisfy his expectations and enhance his human capital (Schultz 1961; Becker 1964).
- 6 From the 1990s onwards, the new migration economy, based on the micro-economy of families (Becker 1992), led to the renewal of this theoretical framework. International migration is no longer analysed as a strategy for maximising gains, but as a strategy for diversifying risks in order to minimise them. Since the mid-1970s economies have entered a period of crisis and instability. Actors must therefore make their decisions in an economic, socio-political and environmental context characterized by a high degree of uncertainty. Costs and benefits must be calculated, as well as the probabilities of failure or success, for the whole household and not just for the migrant individual. Migration itself is a risk management strategy (Stark, 1984, 1989). Another theoretical advance is that the decision-making process to migrate and thus the nature of the migration project are no longer considered as a purely individual initiative, but rather as a project developed and decided at the family level. The family is described by Thomas Faist (1997) as “*the crucial meso level*” and becomes decisive in international migration research through the analysis of networks and diasporas. Family structure, gender roles in work organization and kinship relationships broaden this decision-making context. Subsequently, the family plays the role of an institution that makes the choice of a migrant actor and then supports the implementation of the migration project by mobilizing its multiple resources, whether in the countries of departure or arrival. By adopting the internal perspective of families, we can understand why the migration of some of their members is more desirable than others.
- 7 Solidarity (redistribution and reciprocity) and the links between migrants and their families are conceived within the framework of a moral economy defined “as a system of exchanges of goods and services, articulated” with “a system of norms and obligations that guide judgments and acts, distinguishes what is done and what is not

done” within a community of belonging (Fassin, 2009: 1243). The migrant is indebted to his or her family, which has mobilized to make it possible to carry out the migration project through the redistribution logic that has been put in place around him or her. Through the different forms that migration rent can take, migrants contribute to the health, education and economic activities of their relatives. This rent, even if the term may seem abusive because of its regularity and dependence, implies that the return must be anticipated (real estate investments, land, professional activity, business creation, etc.). Upon return, the migrant is expected to capitalize on the material and immaterial resources he or she has acquired and accumulated during his or her migration experience. In this perspective, their return is expected, legitimized and celebrated, because it is anchored in a dynamic of success and social promotion. Nevertheless, while this vision of return as a logical step in the migration process corresponds to the profiles of some migrants (entrepreneurs, trained students, pensioners), others escape this ideal or idealized process for various reasons.

- 8 In this perspective, C. Z. Guilmoto and F. Sandron (2001) defined the notion of a migration contract between the family and its migrant, the former investing in the latter, which must return the investments made in a deferred manner. This contract is atemporal, its implicit and tacit nature makes it possible for stakeholders to renegotiate life in migration progresses according to the constraints and opportunities in the regions of departure and arrival. The transfers made guarantee the migrants a “right to return” by allowing them to retain access to land, the matrimonial market and political life (Stark 1984; Stark and Lucas 1988). From an anthropological perspective, Hamidou Dia (2009) formulated the notion of the “aesthetics of lies” in order to describe the mirror game of family actors here and there who distort the reality of their lives, on the side of migrants in order to resist the multiple demands they are constantly subjected to, and on the side of their relatives in order to take the best advantage of the migratory rent generated.
- 9 In the context of the economic crisis mentioned above, solidarity is becoming increasingly selective and chosen in developing countries (Calvès and Marcoux 2007, Marie 2007; Leimdorfer and Marie 1997). At the same time, as a result of demographic transition and socio-economic changes, family structures are changing, with the extended family disintegrating in favour of the nuclearization of families and the promotion of individualisation processes. The integration of the meso level also provides an explanation of the increase in migration within societies, in which it becomes a model of success, and its reproduction through the emergence of a migration culture. The desire for migration and migratory imaginaries is fuelled by the stories related by migrants and their practices upon their return (Massey *et al.*, 1987). Far from curbing international migration, development also contributes to the expansion and diversification of forms of mobility (De Haas and Fokkema, 2011; De Haas, 2005; Skeldon, 2008), as more people have the capital needed for emigration. This theoretical framework is designed in the context of “successful” and regular migration, in which the migrant integrates socially through the labour market. This enables him to make remittances that allow them to repay the investments they have benefited from in order to emigrate, maintain links with their family and prepare for a possible return to their country of origin. Through their policies, states and institutions promote the migrant as a development actor.

- 10 During an anthropological demographic survey (Petit, 2013; Petit *et al.*, 2019) on access to and adherence to mental health care in Senegal in psychiatric care units, we encountered the situation of several returning migrants in hospital either directly, or indirectly through accounts of situations comparable to those we observed. Their stories came from different categories of caregivers, administrative staff, the patients themselves and their parents. The frequency of these situations is not quantifiable due to the lack of statistical data and the social context that leads to their concealment.
- 11 The data presented here relate to fifteen Senegalese migrants interviewed in several care units. The vast majority of them are in a regular situation with salaried employment in France, Italy, Canada, the United States and Belgium. Three of them are students and employed in parallel with their training. Most often they are single or alone, having left their wives in Senegal. They are employed in catering, services (guarding and security, office cleaning), and construction. Affected by a mental illness, they often prefer to use traditional treatments initially with immigrant marabouts (Hamès, 2003) or, through their networks, they are sent medicines and , charms fabricated by traditional practitioners. Some decide to consult a psychiatrist alone, others are referred by their general practitioner or are pushed by an influential relationship to do so. In other cases, they are hospitalized in a crisis situation.
- 12 Their pathological condition has an impact on their economic and social situation, which is deteriorating due to the lack of regular psychiatric follow-up and adequate family support. In Senegal, as in the case of migration, the assignment of the status of “madman” or “mentally ill” leads to a form of social distancing. Finally, they are repatriated by health services either at their request or at the request of their family, which is concerned, particularly when hospitalization is prolonged, with no relative assisting the patient over a long period. What is more, the illness results in a loss of income. It is not always easy in discussions to clearly identify who makes this decision, as it is more of an exchange process than a one-off act. Other patients who have started psychiatric treatment wish to return to Senegal in order to continue their treatment with a Senegalese psychiatrist. They consider that a Senegalese doctor will have a better understanding of their health problems because of a socio-cultural proximity that they do not share with psychiatrists in the countries of arrival, due to differences in representations and interpretations of the disease (Storper-Perez, 1976 ; Zempléni, 1985 ; Ortigues et Ortigues, 1966)¹. Sometimes it is the psychiatrists who follow them to Europe, especially doctors from the Maghreb, who encourage them to return home, arguing that they will be better surrounded by their families and that warmth and family solidarity will contribute to their recovery. This vision of simultaneous idealization of therapeutic care and family solidarity in Senegal is contested by all the stakeholders. For sick migrants, “*doctors in the North do not know the realities of families here [i.e. in Senegal], mental illness isolates you, cuts you off, even us who are from a family of educated people, with teachers, intellectuals*” (woman, university, 46 years old). However, some migrants clearly express the desire to return home to be cared for by their families during this morbid episode, faced with the difficulties they encounter in assuming and combining their professional and therapeutic obligations in a context where their social environment is crumbling in the face of representations linked to madness. In all these cases, the return home had not been anticipated since it did not represent a short-term intention, but the psychological situation and its multiple socio-economic consequences require it. The management of the disease and the therapeutic

choices affecting the migrant's future are therefore a powerful indicator of family dynamics.

Psychiatric Context in Senegal and Investigation Mechanism

Cultural Psychiatry

- 13 Senegal's mental health supply has been inherited from French colonization². France was the first state in the world to establish legislation, the law of 30 June 1838, to protect society and guarantee the rights of sick people. The effects of this law were not identical in metropolitan France and in the colonial empire, and differences emerged between the colonies over time. At the beginning of the 20th century, colonial physicians noticed that the health system in the French colonial empire was lagging behind that in the British and Dutch possessions. Before 1897, persons designated as insane in the French colonies were subject to judicial proceedings, as the administrative authority had the power to intern any person deemed to disturb public order. The medical opinion requested in the case of persons presented as insane did not involve any of the social and therapeutic considerations related to the 1838 law applied in metropolitan France. This judicial practice of confinement showed its limits, and from 1896 onwards the colonial administration pragmatically chose to exile madmen to asylums in metropolitan France. In 1912, the *Report on the Alienated in the Colonies*, written by Drs Reboul and Régis, denounced the health situation in the French colonies. They strongly defended the idea that France had a moral duty to provide care for the insane in the colonies. This care included indigenous people, as they emphasized that madness has local expressions. Medical assistance concerned indigenous people, the European group, the army and criminals. Reboul and Régis proposed different modes of action to improve the healthcare system in Algeria, Tunisia, Madagascar, Indochina and AOF. These modes of action included the promulgation of the French law of 1838 by adapting it to local conditions, the construction of asylums in localities strategically located with regard to communication infrastructures and mobility in the regions concerned, the creation of a specialised medical corps, the stopping of sending indigenous patients to asylums in France where they frequently died, the revision of the conditions for the repatriation of civilians and soldiers, prevention through general prophylaxis and hygiene measures, and finally the fight against prejudice in local cultures and the education of European populations.
- 14 The implementation of these recommendations was not carried out in the same way in Algeria and in the AOF, since these regions were subject to specific investments by the State. The First World War and then the inter-war period did not allow significant progress in terms of health facilities and improved care for patients in AOF due to a lack of resources and real political will. During the 1920s and 1930s, various projects to install asylums were presented, but none of them were successful. The asylum model was not as vigorous as in the Maghreb, where it was fought by medical and intellectual circles, beyond the emblematic figure of Franz Fanon (Keller, 2001 ; Cooper et Stoler, 1997). Indigenous psychiatric assistance (API) was established on 28 June 1938, a century after the metropolis. The Second World War slowed down the introduction of

the plan and it was not until 1956 that the first psychiatry department was created in Dakar.

- 15 The French doctor Henri Collomb held the first chair of psychiatry at the University between 1959 and 1978. It involved collaboration between physicians, traditional practitioners and anthropologists to understand the representations and beliefs associated with madness. They developed therapeutic practices (the *pencil*, the accompanying person, the therapeutic villages) that implemented his precepts according to which “you are always crazy in your culture” and that the psychiatric hospital must not be cut off from society. This conception of a “cultural” or “social” psychiatry remains a demand from Senegalese psychiatrists that they formulate individually with some nuances. After independence, Act 75-80 of 9 July 1975 on the treatment of mental illnesses, defined the legal framework for psychiatry in Senegal. The country’s only psychiatric hospital was established in Thiaroye in the industrial suburbs of Dakar. In Dakar, the Centre hospitalier national universitaire (CHNU) and the hôpital militaire Principal offer psychiatric services. Other therapeutic units, much smaller and lacking in financial and human resources, are being set up in Saint-Louis, Ziguinchor (mobile consultation in Kolda) and Tambacounda. In Thiès and Fatick (itinerant consultations in Louga and Diourbel), the Dalal Xel Catholic Mental Health Centres are linked by an agreement to the Ministry of Health and Social Action (MAAS). Psychiatric supply remains insufficient and is very unevenly distributed throughout the country, with the Dakar region accounting for 80% of resources.

Investigation System

- 16 There are no national statistics to measure the prevalence of mental illness in the population in Senegal and even fewer in specific³sub-populations. Routine data (consultation register, hospitalization register) from psychiatric services do not provide information on migration status, which is not included in the socio-demographic characteristics of patients (gender, age, marital status, occupation, residential location, ethnicity, educational level). In the case of foreign patients, the place of residence allows them to observe therapeutic mobility. For example, the Emile Badiane centre in Ziguinchor is known to receive patients from Guinea Conakry, Guinea Bissau and Gambia. They represent about 7% of the patients who come for consultations. In the psychiatric centres of Thiès and Tambacounda, patients from Mauritania and Mali are reported. This fact reveals the existence of complex transnational therapeutic pathways, partly explained by the low availability of mental health care in West Africa. As far as Senegalese international migrants are concerned, it is most frequently their residence in Senegal that is recorded, because if they are on holiday or on an occasional return to the country the illness is declared by the accompanying person and the duration of this return is unclear.
- 17 A patient’s migration history can be understood by reading his medical file. Indeed, during the clinical interview with a patient and his companion the psychiatrist establishes the “*medical picture*” by looking for “*antecedents*”. Through questions, the psychiatrist tries to reconstruct the biography (education, training and profession, migration experience, family environment, religious and cultural environment) of their patient. The psychiatrist always and first and foremost addresses the patient directly; if he is not in a position to answer, the doctor then turns to the person(s) accompanying

him. During the consultations we attended or discussions with practitioners at their desks, they often spontaneously suggested that we examine patients' medical records to explain their medical approach and the difficulties of therapeutic follow-up. Apart from obvious ethical issues, the exploitation of medical records is difficult for several reasons: often illegible writings, abbreviations, medical vocabulary, etc. Medical records, while not providing in-depth details of patients' histories, nevertheless demonstrate that international migration is a recurrent feature in patients' family histories, whether they are themselves migrants, returning migrants or relatives of migrants. Monitoring sheets are drawn up by the administrative services for those who are part of a medical repatriation organised between a hospital in the north and the CHNU de Fann in Dakar. We did not have access to them, although they would have allowed us to have more systematic information on these situations, but without allowing access to these patients.

- 18 The survey, which combines demography and anthropology, has been conducted since 2015 in various Senegalese psychiatric services: in Fann (Moussa Diop clinic, day clinic and Ker Xaleyi child psychiatry centre), Thiaroye psychiatric hospital (emergency and child psychiatry service), the Dalal Xel Catholic mental health centre in Thiès and its mobile consultation unit in Louga, and the Emile Badiane mental health centre in Ziguinchor. Observations were made at the reception desk of the care units, in the emergency rooms, in the waiting rooms, and in the patients' living areas (rooms, gardens, corridors, etc.). In several departments (Thiaroye, Louga, Thiès, Ziguinchor), we were able to attend the consultations alongside the doctors, which made it possible to understand the interactions between the carers, the patient and the accompanying person, as well as between the members of a family. In parallel with the observation sequences, semi-directive interviews were conducted with the agreement of the heads of department and administration with carers (psychiatrists, interns, nurses, carers, pharmacists, psychologists), sick people at the time of an appointment or during hospitalisation, and traditional practitioners (marabouts, healers, exorcists). Psychiatrists and psychologists were also interviewed in their clinics and private practices. Several people undergoing treatment were also met outside the medical units in a place chosen at their convenience (homes, cafés-restaurants, religious areas).
- 19 Sick people must have an "accompanying person" (Kilroy-Marac, 2014; Koundoul, 2015) i.e. a relative designated by the family to remain at the patient's side at all times during their hospitalisation. This relative must take care of the patient (toilet, clothing, food, keeping the room clean, assisting with follow-up appointments and medical examinations). He or she attends discussions with the psychiatrist and is responsible for making the link between the medical institution and the family. Nevertheless, some families choose to pay someone from outside the family to perform this function because of changes in lifestyles. Doctors then speak of "*mercenary companions*" and interpret it as a form of abandonment of the mentally ill to the institution.
- 20 The semi-directive interviews were conducted either directly in French or in Wolof, Diola or Creole with the help of a caregiver and an investigator-interpreter trained in health anthropology. The central themes of these exchanges were: representations of madness, interpretation of mental illness, nosology, stigmatization of patients, therapeutic pathways and therapeutic pluralism, adherence to psychiatric treatment, and the effects of the disease on the patient's family and social situation. A very positive reception was given to us in all the institutions requested. There were two

main reasons for this. First of all, doctors spontaneously presented themselves as Henri Collomb's heirs, by referring to his collaboration with anthropologists and sociologists, which still legitimizes the presence of social science researchers in psychiatric units today. Second, patients and their carers spend long periods of time waiting in a hospital setting where they feel lost, sometimes abandoned and helpless. Boredom, misunderstanding, apprehension about the future and social isolation encourage people to share a situation experienced as a disaster or drama. This need to talk is all the stronger within the care units, as mental illness outside these walls remains highly stigmatized.

- 21 This survey has two limitations. Private mental health provision has so far been little investigated, while the most favoured and educated migrants can obtain it when they return occasionally or have resettled in the country. The clinics and medical practices offering psychiatric or psychological consultations are all located in Dakar. A consultation with a specialist costs at least 25,000 FCFA (about 40 euros) while a consultation in a public service costs about 5,000 FCFA (about 7.50 euros). The latter also provides access to cheaper tests and medicines and certain payment facilities, while such services can be obtained free of charge in Catholic centres. The use of private sector consultation can be explained by (supposed) better quality of care, but also because patients seek absolute discretion in order to preserve their reputation in a social context where, regardless of their social affiliation, everyone fears being associated with madness. The question of social differentiation does not only arise through the alternative of recourse to private or public provision, since even within the latter there are significant differences in the conditions of care and treatment that patients and their families can afford. Despite changes in the societal context, the discourse about the erasure of disease and patients from public space remains recurrent: *"If you could tie patients to a stake wherever you want, even in the hospital, and no longer let them out, it would be better if they were no longer seen or heard"* (request addressed to a psychiatrist from Fann during a public intervention). It should be recalled that the first psychiatric care structures were installed in Senegal to replace lazarettos, leproseries and morgues.

A Broken Migration Path: The Return of the "very very VIP"

Stigmatization

- 22 Mental illness affects not only the sick person, but also all those around him or her. It constitutes a social explosion that shakes up family organization, and just as the migrant's success reflects on his or her family, so too does the shame associated with madness fall on it. Indeed, when looking at the representations of apparently benevolent African societies towards their "madmen" more closely, it can be seen that people designated as mad by their entourage as well as those conducted to psychiatric services⁴ are subject to strong stigmatization. They are excluded from commensality and are subjected to physical and symbolic violence (restraint, chaining, confinement). They lose their status, authority and power; their word is discredited. Sometimes they are left to their fate on the street (Diagne, 2016). For families, mental illness is strongly associated with shame and dishonour, because the patient's behaviour transgresses

social customs and codes of civility by being too agitated and noisy, or on the contrary by being plunged into silence and prolonged depression. It disrupts relationships within the family and with the neighbourhood. Unable to carry out a remunerative activity with constancy, the sick person constitutes a burden for his relatives who must maintain them and seek care.

- 23 In a context of considerable therapeutic pluralism, the analysis of therapeutic pathways shows that the use of psychiatric services is almost always a last resort when other alternatives have been exhausted. The “ordinary” patients are taken in crisis into psychiatric units, often under duress because the neighbours or the family itself have called the police or fire brigade in urban areas, or the gendarmerie in rural areas. After years of therapeutic quest, when the patient is tossed around between various traditional practitioners (marabouts, healers, exorcists, etc.), a course taken whatever the religion of the families and therapists, the patient’s condition worsens. The treatment of the (mental) patient depends on other family imperatives, the resources of the moment, the economic and social context, and the calendar of religious holidays (Fassin, 1992). People who are ill frequently report a sense of insecurity and lack of trust in their families, saying that they have not respected their wishes, imposed other therapeutic solutions on them, or stopped funding their medical treatment. These family tensions are exacerbated by certain symptoms that lead to misunderstanding, fear and shame. The expression of these symptoms (delirium, agitation, aggressiveness, exhibitionism) breaks social codes: does not a Wolof proverb declare, “*he is telling the truth, is he crazy?*” (“*dof la*”). The way families feel the symptoms of mental illness contributes to the demands placed on caregivers: “The focus is on visible signs, generating shame in relation to others, rather than the patient’s intimate experience, their subjective experience, even if it is painful for the patient. The dissolution of relationships is also reinforced by a lifestyle perceived as dysfunctional, deviating from social norms. [...] On the other hand, signs of great psychological suffering of the patient such as depressive moods, motor inhibition, excessive guilt, attract little attention from the family and are considered ‘normal’, less disturbing for the entourage and more consistent with the social values of the *kersa* (modesty, timidity, deference) and *sutura* (discretion, respect for intimate life) much appreciated by the family group” (Sylla *et al.*, 2009: 69-71).

“A society of shame”

- 24 Repatriated medical migrants arrive at Dakar airport where an ambulance awaits them and usually takes them to the CNHU in Fann, which can then dispatch them to other psychiatric units at the family’s request, depending on where they live and the cost of hospitalization. Those who return on their own are welcomed by their families, who also take them as quickly as possible to Fann in the first instance, as it is not desirable for the sick migrant to be seen by the neighbourhood. His state of weakness or incapacity must not appear publicly and give rise to rumours that would damage the honour (*jom*) of the family and cover it with shame (*rus*). Young people accompanying or visiting (brothers, cousins, friends of hospitalized migrants) say how difficult, almost unbearable it is to be confronted with the physical and mental decline of their migrant relative. Sitting on the bed in front of his older brother lying on his bed, a high school student testifies:

"I would like to be hidden so that he doesn't see it, so that he doesn't see me, because it hurts to see my brother, it's... it's humiliation... someone tall like him, enterprising, there... dazed, with his eyes fixed, he drools... almost an animal, a beast, eh!... He no longer recognizes us, he has forgotten his own mother, he no longer knows my name... The patients here, they walk like robots. They stare at you. It's a world apart."

- 25 This transformation, partly related to the side effects of the treatment, is felt as a forfeiture all the more painful as it affects an individual who had succeeded and enjoyed the recognition of his or her family. If the project of the departure can be hidden because of the weight of superstitions in order to avoid spells, the return, if not glorious, is kept secret. Shame appears repeatedly in interviews. Anything that is considered a failure or failure to meet social expectations is a cause of shame *"encysted deep within individuals"* (G.B., psychiatrist, HP Thiaroye) that we seek to hide. Psychologists and psychiatrists unanimously refer to a *"society of shame"*, built:

"Not on guilt, but on processes of guilt. [...] People are educated 'with the cane', a whole process of inhibition is launched so as not to create, not to think, not to question, but to control, to control oneself, to control the other." (KT, psychologist, private practice, Dakar)

- 26 Successive generations learn that *"in society you have to be generous, that is to say, to have nobility whatever your social rank..."* nobility is understood as the greatness of the soul, the readiness to be upright and to be generous:

"But how can you have nobility when you are in poverty, misery, destitution? Shame is eating away at these people because they have to manage to live, so they can steal, manage, collapse. It's a little like Jean Valjean of the Misérables, but without the part where things get a little better. They are the miserable ones, I can only say that." (KT, psychiatrist, CNHU Fann)

- 27 Shame is anchored in very strong conformism linked to this social appearance, where one must avoid any attitude or words that go against the current:

"In society, you have to behave, you have to be prepared, you have to be stilted. The investment in clothes, trinkets, accessories, the fact of being dressed by your father during the big holidays is not insignificant. [...] We are, we remain glued to each other to fight against the anguish of collapse. We must not mismatch. We get stuck." (KT, psychologist, private practice, Dakar)

"We want to show that we are well according to a defined value system. But it is as if, at the end of the day, we don't care what we do, intrinsically. The most important thing is that others know that we are good. [...] Yes... [says in a breath] to be oneself... Yes, because the group has something reassuring, I think: to go in the same direction, not to differentiate, not to draw attention to oneself... Because it costs to draw attention to oneself every day, it costs to have all these acts judged every day. Because when you go in the direction of the big group, you do things the way everyone else does, right? We have this security of being the one who does not distinguish himself." (AS, psychiatrist, HP Thiaroye)

- 28 The family provides advice in order to decide urgently on the type of therapeutic remedy and the contributions of each party to its financing. The father, mother, brothers and wife of the migrant intervene within this improvised council according to their degree of proximity to the migrant and the arguments they have to put forward (social capital, level of information, financial resources). While for non-migrant patients, discussions may drag on between those who support a traditional option and those who support a biomedical solution, psychiatry is the choice for international migrants. Indeed, despite the fear and shame associated with attending psychiatric institutions, biomedicine is perceived - at least for a time - as the most effective way to

restore the situation, i.e. to avoid the discontinuance of migration income and thus the collapse of the projects that depend on it.

- 29 Tearful mothers explain that they had already helped their sons to migrate, and that in this desperate situation, they will sell their jewellery, mobilize their resources to pay for medicines and hospitalization as long as their child can “*get up*”, an expression that contrasts with “*we are here, we are sitting*” meaning the absence of a remunerative activity and means. In Senegalese society, mothers are held responsible for the success of their children. Safietou Diack thus refers to a Wolof expression “*liggeeyu ndeyu ndey, anu doom*”, which she translates as “the mother’s work is the child’s lunch” (Diack, 2017: 265). The education given by the mother produces the value of the child; by succeeding through this attention the child will strengthen the prestige and pride of his mother. She will receive recognition from her family and in-laws when her child gets married. Individual honour is strongly intertwined with family honour. A child internalizes that he must honour himself (*suturaal*) and his family (*teral*) through success, of which migration is one way. The link between the migrant son and his mother is often stressed:

“Just look at the relationships between mothers and their boys, they decide everything, the mother decides for the woman, she decides everything. She decides on her son’s marriage, she moves in with him, and if she wants to break him, she breaks everything.”(KT, psychologist, Dakar)

- 30 Far from the virtues of knowing how to bear responsibility, of having the courage to endure (*mun*) with modesty in order to preserve honour and avoid shame, emotions and feelings are externalized as if the psychiatric service were a place apart, a profound upheaval not only for the patient, but also for all those who accompany him. Observations show migrants arriving framed by uncles, brothers and cousins while women often walk behind collapsed and grieving. The migrant is not accompanied by one or two people as is usual for other patients, it is a family delegation that introduces itself, which quickly puts verbal pressure, almost physical since expressed by a group, on the doctors. Even before any diagnosis is made, family representatives ask to “*silence*” their patient, to “*rehabilitate*” him or her with “*injections and tablets*” that have the almost instantaneous power to change the patient’s condition in the desired direction (Petit *et al.*, 2014). The request is very explicit: psychiatrists must restore the migrant’s good health as soon as possible, because the objective is that he or she should be able to re-migrate as soon as possible. Since the migrant’s return was not “*on the agenda*” and “*not calculated*”, it cannot last, because it affects the global family economy by calling into question the redistribution linked to migration remittances. The migrant during this phase is totally excluded from family discussions. He is in a way divested of the migration project, because as the disease has broken the migration contract, it is no longer the subject of negotiations. Whereas success makes the migrant a central figure in the family, mental illness creates discomfort and distance. What is true for all patients is even more so for migrants, revealing how much their status is linked to success. Hospitalized at the Fann University Hospital and wondering about his future, a migrant (38 years old, employed in a supermarket in France and a wife in Senegal) who came back to be treated here explains: “*If you have nothing, you are nothing... the Wolof family is not generous*”. A second respondent reminded us that, if in the past during presentations it was customary to take an interest in the person in order to know his social rank, today we ask a foreigner what he does, which is a

roundabout way of estimating his resources. Economic success thus becomes an essential criterion for social determination.

A Specific Therapeutic Path: “Restoring the migrant to a state of health”

- 31 Comparisons show that international migrant status provides rapid access to psychiatric services, unlike the long and chaotic treatment paths of other patients. However, the intensity of investment in the migrant’s mental health is subject to the evolution of the disease. In Senegal, the migrant is one of the major figures of success. If in the 1950s and 1970s, social promotion was symbolized by success in education and access to the civil service, from the 1980s onwards, following structural adjustment plans, international migration became a new model of success: “*the migrant is a very very VIP here*”.

Caregivers in a Difficult Position

- 32 Psychiatrists explain that they must face and resist family injunctions, because therapeutic imperatives immediately come up against the logic of migration rent. Mental illness involves a period of hospitalization and observation in order to make a diagnosis and treatment takes a long period of time. This does not match well with the requirements of the multiple investments made in the migrant. Some doctors also point out that families are in denial of the patient’s psychological suffering: “*they ask us to be effective, to restore him to his normal state*”. Doctors forthrightly question the cost of the migration experience, relegating social appearance to the background. Psychiatrists explain that it is they who must remind, sometimes with severity, the parents who have come to urge them to make their sick migrant perform well, that he or she has experienced remoteness, isolation, the “greatest loneliness”⁵, “the intensity of the relational deficit” (Collomb and Ayats, 1962: 596), difficult living conditions and the burden of the responsibilities that the family places on him or her. The doctors put themselves in a position of protection and defence of the sick migrant while the families express a more ambiguous position. Some patients realize the painful fact that some family members no longer embody the protective and reassuring world they are supposed to embody, by dissociating themselves from their suffering. In their view, this constitutes a serious breach of the moral contract that governs their mutual obligations.
- 33 In the late 1970s, sociologist Danièle Storper-Perez already referred to a “universe of contradictions” (1976) to describe the difficulties that individuals experience in locating themselves in a society in transition. She also noted that the emergence of mental disorders among family members forces them to update their relationships. More recently, a psychologist (NK, Ker Xaleyi Centre, CHNU Fann) reported on the difficulty individuals have in assuming and articulating the sometimes contradictory roles they perform (being a “good son”, “a good migrant”, “a good Muslim”, a modern husband, etc.), because they confront them with dilemmas and contradictions. These choices are difficult to make because they have direct consequences for family and social relationships. Individuals realize with the help of psychiatrists and psychologists that emancipation is a painful process, which involves more than speeches⁶, decisions,

actions and a form of personal coherence. Practitioners repeatedly point to “*the lack of communication*”, “*the very slow circulation of communication within families*”. For a psychiatrist at Thiaroye HP, their role is to “*help patients to be themselves*”, while social control pushes “*people to go in the same direction; it’s as if there were a routine behaviour to adopt with everyone and it can go very far...*”. Throughout their lives, social juniors have been confronted with decisions imposed on them by heads of households, without being justified or explained, even though they have a direct impact on their lives. Family relationships are therefore characterized by “*the weight of the unspoken*” and the difficulty “*to differentiate oneself from uneasiness*” and “*family magma*”. During the interviews, migrants rarely named their parents, they refer to “*they*” and “*them*” who embody family authority. For their part, psychiatrists, by implicitly criticizing the obligation of the carer, recount the very significant difference in the patient’s expression when he is alone with his therapist and when his speech is constrained by the look of his carer. During consultations psychiatrists always ensure that their patients have the first opportunity to speak and that they are not interrupted by their companion(s). Compliance with this therapeutic order in speaking remains difficult for family members to respect as it contravenes social rules, thus it requires the full authority of the doctor who threatens to exclude reluctant carers so that it can be applied. The production of the individual narrative – including migratory narrative – and its confrontation with the family narrative are key issues in family relationships.

Moral Dilemmas within Families

- 34 While the status of international migrant allows for psychiatric care, the comparison between the temporalities of treatment and those of family requirements mentioned above reveals the moral dilemmas of the actors within the family. When families express very strongly their desire for their migrant to regain his or her performance as quickly as possible, they are not only driven by a utilitarian feeling. Through words, gestures of attention and affection, forms of recognition and loyalty are expressed towards those who have made the family’s well-being possible through their work. Although doctors point out that migrants and their families frequently come from the urban world and that their experiences in the Western world have brought them closer to psychiatry, they do not share the same discursive universe as psychiatrists. They express a traditional or Muslim interpretation of the outbreak of the disease: a spirit (a *jinn*, a *seytaane*, a *rab*) has attacked the patient or he is the victim of a maraboutage (*liggéey*). The causality of the disease remains external. According to Sow (1977), in the African conception, the sick individual appears both as a victim and as an informant of the danger facing the group. Families are primarily looking for relief and relief of symptoms in psychiatry; the interpretation of the disease and its etiological imputation are not biomedicine. According to secular beliefs, a madman never heals. Families frequently use the expression: “*dof du wér day tane*” (“*the madman does not heal, but is better*”), in order to justify the interruption of treatment or poor compliance.
- 35 On the side of the patients, the speeches express the ambivalence linked to the ideology of the *tekki*. This term expresses the will to untie knots, break dependency, and get out of poverty in order to ensure a path to success and recognition of one’s group. This thought is very present in the culture of urban and Wolofized youth. In interviews conducted in Fann, young hospitalized migrants said in the same sentence “*to want to manage on their own*” and acknowledge that “*the family is always there behind*”, expressing

the tension between a strong desire for emancipation and a need for powerful recognition. All the more powerful because it is underpinned by a mystical investment in work for those who adhere to Mouridism. It is painful for sick migrants to return to a situation of dependency on their elders, even though they have conquered a position of family breadwinner, but at the same time they express the obligations that their parents have towards them. The painful nature of this situation is exacerbated by the fact that the patient is denied in his individuality and suffering, his parents speak and decide in his name without systematically giving him explanations in return. While the legitimacy of asking for help varies with the degree of success of the migration, the distance involved, the desire to “save face” (Pian, 2009), it appears as a legitimate counterpart to migrants who have made transfers until the onset of the disease. This social logic appears in the survey through expressions that come up again in the course of the discussions: “it is *their turn*”, because parents “*must*” (implying taking care of the sick migrant).

- 36 Mental illness and the family crisis it generates transform the principles at work in the moral economy by putting them to the test. It is no longer a question of espousing a rhetoric of duties and obligations, but of positioning oneself and acting very concretely alongside the patient. Several patients during this investigation, whether migrants or not, expressed the idea that beyond suffering, this ordeal is also an opportunity to recognize the true bonds of affection that unite them to others.⁷ The notion of a migratory contract mentioned in the first part offers an interpretation of the dynamics of the links between the migrant and the family institution. Erving Goffman, referring to the question of social cohesion and the requirements of institutions, reminds us not only that every contract has an implicit part, but that “to enter into a contract is to affirm oneself as an individual with a personality and a precise existence. The most insignificant contract, which meticulously defines the rights and duties of an individual, is therefore sometimes based on a considerable number of assumptions about that individual’s personality. [...] The question then arises as to how the individual assumes the definition of himself implied by these links” (Goffman, 2010: 230-231). He pointed out that individuals have several limit options (openly failing in their obligations, breaking the link, rejecting the implications of their commitment without their refusal manifesting itself openly, complying exactly), but that in practice individuals choose the least costly path for them, refusing extreme positions while expressing their reluctance, but *in the end* fulfilling their major obligations.
- 37 In the situations that hold our attention, migrants are no longer able to comply with their parents’ expectations, while conversely, the parents no longer feel so strongly obliged towards the patient, because the illness has changed the latter’s personality and therefore the tacit expectations of the contract. From the parents’ point of view, mental illness affects the ability of sick migrants to have predictable and continuous behaviour that guarantees the permanence and consistency of the social bond. Investing in a brother “*who is no longer recognized and who no longer sees us as essential* [implying that they neither identify nor name their own]” then becomes a question of procrastination, since reciprocity will be imagined in a temporality considered too distant, in a darkened horizon. Expressions of solidarity and the weight of the gestures expressing distance between the patient and his or her family provide a measure of the intensity and sacredness of emotional ties. If the trading system is reduced to economic aspects, the migrant who becomes ill has everything to lose.

- 38 The challenge for psychiatrists is to get both the patient and their family to adhere to the treatment, and that together they build a “*therapeutic alliance*”. Despite the fact that psychiatric treatment is the emergency recourse for the migrant’s return, doctors find it difficult to elicit from the family what mental illness and the meaning of recovery means to it. Parents implicitly want biomedicine to have the same power as they usually believe that traditional medicine has (to cure everything at once), while psychiatrists want to get families to question the meaning and reality of healing. What does it mean to be healed? Is it an erasing of symptoms, the end of the crisis, the beginning of treatment, stabilization, a return to social life, a return to active life with follow-up? Questions that all refer to the way in which the patient’s future is envisioned. Psychiatrists go through a process of “psychological education” with the patient and his or her carers, involving a work of semantic convergence. Dispensing this pedagogy is a necessary but dangerous exercise, because the psychiatrists must avoid the pitfall of a discourse that could corroborate the belief that a madman never really heals and prepare families to change their point of view on the migrant’s future. Family members are generally quite reluctant to express themselves and to be in some way “*included in the problem, i.e. the disease*” (AK, psychiatrist, Ziguinchor) through the psychiatric approach. This step can be critical regarding the patient’s entourage. Indeed, its implications are hardly compatible with the family’s expectations: the therapeutic temporality is too long and requires precise adherence to treatment and attention to living conditions, while the type of healing desired (the recovery of health allowing re-migration) is by no means guaranteed. The reflexive questioning on the psychological and emotional cost of migration comes up against “*the denial of families who are not ready to hear the suffering of their migrant. They do not want to know the cost of what they own*” (FB, psychiatrist, CNHU Fann). Also, if the migrant does not recover quickly, there is a family discouragement leading to the cessation of psychiatric treatment in favour of traditional treatment, or even a complete cessation of any therapeutic quest, which may subsequently resume in the event of a crisis.

Mouridism, Presence in the Migratory Quest, Presence in the Therapeutic Quest

- 39 Among the remedies that sometimes succeed psychiatry, it is worth mentioning, in view of the importance of Mouridism⁸ in Senegalese international migration, the fact that some marabout healers claim a form of specialization in the treatment of madness. Some marabouts build what they call “therapeutic villages”, abusively using the name of the therapeutic experimentation initiated by Henri Collomb. Patients undergoing psychiatric treatment were entrusted to a village community and cared for by a nurse sharing the same ethnic and local origin (Collignon, 1983). The rural “*environment*” is considered by psychiatrists to be healthier, as it is closer socially and less stressful for patients than the urban context described as pathogenic. This capture of Collomb’s legacy can be interpreted as an attempt to legitimize the psychiatric institution with which the marabouts wish to create a partnership. It is part of a broader strategy according to which marabouts integrate biomedical practices (drugs, medical analyses, patient files with a diagnosis sometimes including psychiatric nosology), so that they can be listed in both religious and scientific medical registers.

40 Observations and interviews were conducted in January and July 2017 in the concessions of Serigne Dame Dieng in Tobor village, and Abdul Karim Sane in Mawa village near Ziguinchor, in Casamance. These two marabouts have acquired a solid reputation because they treat mental illness and welcome patients to their concession for long-term treatment, especially when families completely relieve themselves of it. While the Emile Badiane mental health centre in Ziguinchor — the only centre in Casamance — has the capacity to receive about thirty patients for a psychiatrist and an intern in training, the marabout Serigne Dame Dieng welcomes about sixty patients who have been abandoned by their families or whom he takes in as they wander the streets. The housing and living conditions provided are certainly basic. In order to accredit the social and therapeutic role of its action and to request subsidies from the State and NGOs, it has created the *Association for the Reintegration of Mentally Retarded Children and Children in Difficult Situations*, recognized by the Ministry of General Affairs and Territorial Administration. Despite this title, it overwhelmingly welcomes adults, especially young men, including former migrants. These people are supervised by former patients who present themselves as being healed thanks to the mystical treatment (baths, prayers, amulets) provided by the marabout or the miracles he performed thanks to the baraka. They agree on the “path” that the newcomer must take: he must comply with the discipline of the place, thus becoming a “good patient” if he wants to see his condition improve:

“In life nothing is free: you have to fight, never give up, even if it is an illusion that goes away, even if a pain hurts your eyes. You must always have the way, the patience, the will.” (Bassirou, disciple of S. D. Dieng)

41 Although the treatment is not presented as a conversion to Mouridism, the patient must respect the therapeutic prescriptions established by the marabout (mystical cure, sometimes supplemented by biomedical prescriptions for patients who have consulted a psychiatric ward), have a physical activity while working in the fields (peanut growing and market gardening) and comply with the organization of the concession regardless of his religious beliefs. According to the marabout, relayed by his disciples, the work requested is adapted to the patient’s condition and skills. Work ethics, once oriented by migration activity, is now applied to self-care:

“Here you always have to do something; what we are interested in here is health, healing. You have to do physical exercises, sports. We just finished the market gardening, the onions. We cultivate, we sell. To maintain his strength, the patient must work. He has to do this. It’s not good to sit around and do nothing, sleep without doing anything. They must be stimulated. The body, the mind. We do workshops in sewing, welding, carpentry, checkerboard, play. Television. We do this together.” (Bassirou, disciple of S. D. Dieng)

42 Individual discipline is part of a collective organization where everyone has a well-defined place and role. Physical activity allows the patient to contribute to the economy of the concession, which has the virtue of providing a sense of utility and social recognition, and thus improving self-awareness and mental health. Patients must therefore work to improve physically, morally and psychologically at all times. This “mystique of work” (Bava, 2003) is described as life-saving. The migrants who arrive here are in a situation of failure and almost total abandonment, with migratory exile being followed by family exile, thus these steps become trials whose meaning here is found in the reconquest of oneself and one’s destiny.

43 The marabout, his disciples and the patients with whom we exchanged uniformly repeat a discourse that opposes “the community” with the outside world. Mouride

iconography is present in many rooms, and former migrants already imbued with Mouride doctrine say that they find themselves “at home” (Bava, 2005). A migrant who returned from Catalonia three months ago and was left by his family who no longer financed his treatment insists: “Here we are one big family. We’re holding on. Here, there, we are people”. Whether by presenting the concession as a “large family” or “a therapeutic village” or “a place where dogs and birds are not hunted”, meaning that everyone can find their place, its members insist on the importance of the link between individuals and the feeling of being considered as human beings. This insistence is to be understood as a thinly veiled criticism of psychiatric units and families who “treat them like animals (and) do not respect them”, like the fear of no longer being anything. Lovell *et al.* recall that a “double thread then weaves the social relationship of mental illness: a lateral affinity between those who experience abnormalities [...], a social distance between users and inhabitants of the ‘normal’ world” (Lovell, 2009: 214).

“We are in solidarity. We support each other. You always have to have love for what you do. In Africa we have our beliefs. Some things with modern treatment it can’t do it, with traditional treatment it can pass. The Main Hospital [Dakar], the Regional Hospital, the Peace Hospital [Ziguinchor], in Kenia [Mental Health Centre in Ziguinchor] you do tests, but they [the doctors] did not see anything. They can’t explain it to you. The marabout provides clairvoyance, the listiqar. The mother, she gives the name of the migrant to the marabout, the marabout, he can know, he knows. The migrant comes during the holidays, or we send treatments via a relative. Other emigrants come here directly. Others, families say they will give 30,000 CFA per month, but they forget their emigrant for months, years.” (El Hadj, disciple of S. D. Dieng)

“We are a rehabilitation centre. Our satisfaction is to free the sick. We must be able to see how the patient evolves, understand the cases, how he lives. It is the marabout who gives the care, he knows if he is fit to return to society. We do everything we can for him. Some of them come from Europe. Him, over there, he went through a psychiatric centre in Spain. His family threw him out. The other, Chérif went to Cameroon, Libya, Italy. Abo, Ivory Coast. El Hadj, Germany and America. Landing was taken from an HP in France, after Switzerland. How should one behave towards society? With regard to one’s neighbour? Behave as a healthy person. You have to be with them all the time. Don’t let them think. A healthy mind in a healthy body. With exercises they regain their minds. It takes patience.” (Marabout Serigne Dame Dieng)

- 44 The concession allows you to visit the rooms that single patients share (separated men and women) and those of couples. The marabout also celebrates marriages in order to regularize the relationships that can be established between patients and the births that result from them. These practices raise ethical, therapeutic and judicial questions, since the marabout replaces the country’s political and medical institutions. However, as some psychiatrists point out, no authority in Senegal challenges these questionable practices, because these marabouts fill the void left by institutions due to a lack of will and effective mental health policies.
- 45 Although the institutions concerned (the family, the psychiatric medical institution, the Mouride organisation) seek to distinguish themselves from each other, seeing things from outside invariably reveals that they share common expectations towards the patient expressed in specific registers, whether or not he is a migrant: on the one hand, he must do his job by adhering to the treatment that the institution “offers” him, he must also show his gratitude by being a “good patient”; on the other hand these institutions share the idea that the patient must readapt to society and express the desire to play his role in the social game. Goffman points out that “psychiatrists readily see this system as a kind of social greenhouse in which the patient enters a state of

infantilism and from where [...] he leaves as an adult rehabilitated in society". The patient is thus pushed to act, "to constantly think according to the success or failure of his self", to work on "his own recovery" by accepting the version that the institution gives him of his disgrace (Goffman, 2010: 219-220).

Conclusion: The Shift from the Figure of Success to that of the Madman

- 46 The experience of mobility changes relationships within the family by changing the relationships of dependence and authority through redistribution processes. If successful, the migrant gains access to or strengthens a new family or social position, benefiting from greater recognition and prestige. The confrontation with mental illness shows that this migrant status is only momentarily beneficial by allowing him/her to gain access to psychiatric care more quickly. This difference from non-migrant patients is not negligible since in the case of the latter, the use of psychiatry is generally postponed as long as possible. The cost of treatment is only one explanatory element among others, while the effect of healing beliefs, and discursive and semantic proximity to other therapeutic alternatives should not be underestimated. Each family will postpone the migrant's entry into a psychiatric unit for as long as possible, since it will mark the patient and consequently his family with an indelible seal. Faced with shame and dishonour, a powerful motive is therefore required to lead a patient to a psychiatric unit: love (filial, conjugal, fraternal, friendly) and interest, since these two motivations are not mutually exclusive. In the case of sick migrants, these two motivations can be exacerbated: migration rent is a major challenge in a society still marked by poverty and inequality. Initial investments and then redistribution crystallize the links between the migrant and his or her family. The migrant, who derives his legitimacy and prestige from economic success, sees his status shaken by mental illness because in his fall he leads his relatives down a more visible, brutal and undoubtedly more unthinkable path than a normal patient. While he had achieved varying degrees of success, recognition, autonomy and emancipation, he suddenly found himself brought back to a worse situation as a result of the disease than that which preceded his migration experience. He is deprived of the right to speak, all decisions are made for him, he depends totally on the goodwill of his family. The hero slips towards becoming his antinomic figure, that of the madman. The family's psychic economy is therefore durably affected, because in addition to the violent, contradictory and ambivalent emotions generated by the direct confrontation with the disease, this situation reconfigures intra-family relationships and their expressions.
- 47 This emotional and symbolic repositioning, felt as a "*loss of humanity*" by all patients, is especially acute for migrants. It reaches its peak when, after having experienced a phase of lucidity and well-being thanks to psychiatric treatment, migrants see their treatment interrupted or, worse, themselves abandoned by their families at the homes of marabouts. We are then faced with a tragic situation, since many young migrant men have emigrated while being driven by the values of the Mourides. The necessary success through work, the constant investment in this migratory project and the pressure it implies have contributed to the disruption of their psychological balance: overwork, fatigue, stress, depression (Ebin, 1990). On returning home to be treated or to continue medical treatment initiated in Europe or North America, they finally fail

under the control of an ideological representative who may have contributed to their situation. Whereas Mouridism drove them in their quest for prestige, it now accompanies them in a singular quest for psychological survival as their families, society, the State and NGOs lose interest in them.

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NOTES

1. This is not the purpose of this work, but interviews with interns and psychiatrists would make it possible to highlight the evolution of the positions in relation to the heritage of Henri Collomb and Fann's school beyond a rhetoric of deference.

2. On the history of colonial psychiatry in the AOF and the creation of the Fann School, refer to the work of Collignon (2006) as well as to the *Revue de psychopathologie africaine*. See also Gueye (1995) and Lachaise (2014).

3. In Senegal, as in most developing countries, mental health is not a priority in public health despite the burden of disease it represents and its impact on the country's development (Charlson *et al.*, 2017; Lund *et al.*, 2011; Patel *et al.*, 2007).

4. The psychiatric institution secretes an image that gradually transforms the traditional images of madness far beyond the consensus of those around it. It turns it into a disease. The madman who is no longer assumed by the social and cultural consensus is rejected to the psychiatric hospital of the former colonizers to be treated, at least locked up, guarded, relegated (cf. Storper-Perez, 1976). "The introduction of a new culture, and rapid and profound social transformations inevitably change the status of the patient and the image of mental illness. This upheaval can be to the detriment of the patient" (Collomb and Zempléni, 1965).

5. To repeat the title of the book by the writer-psychiatrist Tahar Ben Jelloun (1977) Paris, Seuil.

6. During an informal exchange, René Collignon described Senegalese society as "a society of commentary, one comments on the commentary".

7. This idea was raised by Egrot (2007) in the case of people living with HIV.

8. A great deal of work has been done on Mouridism. In addition to Bava (2003 and 2005), Diop (1980 et 1981), Copans (1980), Riccio (2003) and Salem (1981).

ABSTRACTS

This article describes the situation of Senegalese migrants returning to their country of origin because of a mental illness that appeared during the migratory experience. While the international migrant embodies a figure of success, the effects of illness and the temporality of treatment alter his status as a hero. In the context of a moral economy, the family is gradually faced with the dilemma of remaining loyal to the migrant by bearing the cost of his health or giving up investing in a migrant considered more and more as a patient with no productive future. In a context where mental illness is a source of shame and dishonor, some sick migrants are abandoned by their families. They find refuge with murid marabouts specialized in the treatment of mental illnesses. In accordance with the doctrine of labor mouride, the physical and psychic activities deploy therapeutic virtues and are salvatrices. The sufferings of exile and the hardships linked to the disease make sense in the therapeutic work undertaken.

Cet article expose la situation de migrants sénégalais de retour dans leur pays d'origine en raison d'une maladie mentale apparue au cours de l'expérience migratoire. Alors que le migrant international incarne une figure de la réussite, les effets de la maladie et la temporalité du traitement modifient son statut de héros. Dans le cadre d'une économie morale, la famille est progressivement confrontée au dilemme de rester loyale au migrant en prenant en charge le coût de sa santé ou de renoncer à investir sur un migrant considéré de plus en plus comme un malade sans avenir productif/performatif. Dans un contexte où la maladie mentale est source de honte et de déshonneur, certains migrants malades sont abandonnés par leur famille. Ils trouvent refuge chez des marabouts mourides spécialisés dans le traitement des maladies mentales. Conformément à la doctrine du travail mouride, les activités physiques et psychiques déploient des vertus thérapeutiques et sont salvatrices. Les souffrances de l'exil et les épreuves liées à la maladie prennent alors sens dans le travail thérapeutique engagé.

Este artículo describe la situación de los migrantes senegaleses que regresan a su país de origen debido a una enfermedad mental aparecida durante la experiencia migratoria. Mientras que el migrante internacional encarna una figura de éxito, los efectos de la enfermedad y la temporalidad del tratamiento cambian su condición de héroe. En el marco de una economía moral, la familia se enfrenta gradualmente al dilema entre permanecer leal al migrante soportando el coste de su tratamiento médico o renunciar a comprometerse con él, considerándolo como un enfermo improductivo. En un contexto en el que las enfermedades mentales son fuente de vergüenza y deshonor, algunos migrantes enfermos son abandonados por sus familias. Éstos se refugian en los marabús murides, especializados en el tratamiento de enfermedades mentales. De acuerdo con la doctrina muridista del trabajo, las actividades físicas y psicológicas están dotadas de virtudes terapéuticas y salvan vidas. Los sufrimientos del exilio y las dificultades asociadas con la enfermedad cobran sentido a partir del trabajo terapéutico realizado.

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