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VISIBLE SAINTS: SOCIAL CYNOSURES AND DYSPHORIA IN THE MEDITERRANEAN TRADITION

ABSTRACT. "Visible saints" are individuals in the Mediterranean culture area who lead lives of heroic, exemplary and public suffering. This paper offers an analysis of visible saints as social cynosures as a means of exploring critical cultural psychiatric issues. We examine the changing nature of saintly suffering in the culture area and look at the media through which familiarity with the saints and their passions is developed and maintained. A detailed clinical case study is presented of "Madame Lorca," identified by her peers as a "saint." We focus on a particular illness episode which proved to be an amplification of symptoms of long standing. Psychiatric diagnostic instruments were administered and indicated the presence of severe clinical depression. However, our research suggests that Mme. Lorca's symptomatology reflects culturally specific methods of coping with dysphoric affects and chronic illness. The paper concludes with an exploration of the nature of personal illness as it relates to a wider cultural system of meaning. The findings demonstrate that the visible saint and her symptomatology are part of a cultural system which generates, promotes, patterns and frames the experience of dysphoric affect in a cultural complex quite distinct from that of clinical depression.

INTRODUCTION

This paper focuses on the local community members in the Mediterranean culture area who are known and referred to as "saints." We consider these people, whom we call "visible saints," to be social cynosures.1 This concept allows us to explore critical cultural symbolic themes and meanings so as to extend our understanding of the cross-cultural variations in and the patterning of dysphoric affect. The paper is intended as a contribution to cultural psychiatry inasmuch as it examines a critical facet of the relationship of the individual and his/her internal experiences to society. It examines this relationship through a consideration of the central problem of cultural psychiatry, the study of the interface between the paired problems of normality and abnormality on the one hand, and the key anthropological concept of culture on the other (Devereux 1980a). The research employs a multidisciplinary approach which draws from several fields within anthropology and psychiatry as well as from history.

The presentation is divided into three major sections. In the first section the concept of the social cynosure is explained and compared to other approaches to group psychology. We then turn to a consideration of the role of the saints in, and central characteristics of, the Mediterranean culture area.2 This is followed by an examination of the changing nature of saintly 'suffering' in the culture area and a look at the media through which people become familiar and maintain familiarity with the lives and persons of the saints.

The second section of the paper is devoted to a detailed case study of a visible saint whom we call, "Madame Lorca." We focus on a particular illness episode that appears to be clinical depression. The symptoms of her episode and the high number of somatic and other complaints recorded among her and her peers lead us to examine the relationship of cultural conceptions and experiences to depressive symptomatology and clinical depression. Clinical instruments were employed to assess the clinical nature of the problem(s). The instruments included the Zung Self-Rating Depression Scale, the Research Diagnostic Criteria and the criteria of the Diagnostic and Statistical Manual, Third Edition of the American Psychiatric Association. The validity of the instruments' findings is questioned.

The paper concludes with a discussion of the disconfirmation of the findings of the clinical instruments through the application of the cultural understandings generated by our multidisciplinary approach. We explore the nature of personal illness as it relates to a wider cultural system of meaning. The findings demonstrate that the visible saint is part of a cultural system which generates, promotes, patterns and frames the experience of dysphoric affect in a cultural complex quite distinct from that of clinical depression.

I. SAINTS, CYNOSURES AND THE MEDITERRANEAN TRADITION

Social Cynosures

Definitions

In 1946 Weston La Barre published an article entitled Social Cynosure and Social Structure. His formulation of the social cynosure was an important and promising one, but that promise seems to have gone unfulfilled. This article points out the utility of the conception for cultural psychiatric research. La Barre stated that a social cynosure is that individual "who achieves the most attention, who is the cynosure of all eyes" (1946:535). The point was stressed that the cynosure was a culturally arbitrary and historically conditioned phenomenon.

It was shown that the majority of the advertisements of the time utilized the cynosure for two purposes. First, they represented the reality of the cynosures' existence. Second, they appealed to action, specifically those actions which assist one in the real or fantasized achievement of aspects of the cynosure ideal (p. 536–537). Further, the status of the cynosure is not always a blessing and may entail negative aspects.

Two other key points concerning the cynosures of cultures are summarized as follows: 1) "The cynosure of a society may be an individual, an age and or sex group, a class, caste-, or occupational-group, such that some individuals, and not others, receive the bulk of attention, gratification of narcissism, and public prestige. One may be born to the status of cynosure, one may achieve it, and one may in some cases lose it: 2) Not all individuals in a given society are permitted to achieve success, within the culture's definition of success; therefore some individuals must be emotionally disenfranchised for the benefit of those others" (La Barre 1946:538). Ideally societies should possess a variety of cynosures and there are or should be various paths to the status of cynosure; an individual need only reach old age in a gerontocracy, for instance, or simply become a parent as among the Chinese (p. 539). When we consider Mme. Lorca, our visible saint, the characteristics of the cynosure mentioned here will be much in evidence.

Social Cynosure and Group Psychology

The formulation of the social cynosure stands apart from other attempts to grasp and conceptualize significant aspects of group psychological differences. Various means have been developed to apprehend and interpret psychological characteristics of various cultures. Reacting against the atomistic notions of behaviorism and associationalism, early researchers modeled their work on notions from Gestalt psychology and early psychiatry. They sought to understand cultural wholes, cultures seen as integrated elements organized into unique "configurations" and "patterns," as posited first by Sapir (see Bock 1980) and later developed by Benedict (1946a, orig. 1934).

Psychoanalyst Kardiner (1939), working with ethnographic data provided by anthropologists Linton, DuBois and West, formulated the notion of Basic Personality Structure (BPS). Believed to be a precipitate of uniform cultural experiences, the BPS was said to be a common psychological substrate of all members of a particular society. DuBois (1944) argued against this construct, developing a contrasting formulation, the Modal Personality (MP), seen as the statistically most frequent personality in a particular society. Wallace (1952) later went on to see cultures as organizing diversity, in contrast to those such as Mead and Benedict who saw cultures as replicating uniform personalities.

During the war years, researchers were moved to consider group psychology at the national level. It was hoped that such work would yield understandings of past and future actions of allied and axis powers during and after the cessation of hostilities. Research on national character included Benedict's The Chrysanthemum and the Sword (1946b), the best known of this genre of anthropological research, as well as Mead's work on America (1942), and Gorer and Rickman on Russia (1949).
Advantages of the Concept of Social Cynosure

There are several advantages in the formulation of the social cynosure making it preferable to other attempts at apprehending group psychological differences. One principal advantage is that the social cynosure is a figure that members of the culture under study have themselves selected as a focus of attention. As such, cynosures serve as keys to unlock central cultural themes, values, roles, behaviors, aspects of worldview and ethos and the relationship of these to one another. The conception of the cynosure also avoids the utilization of ethnocentric descriptions and psychological constructs (e.g., BPS, MP). The recognition of a culture’s social cynosures avoids the tendency toward the effacement of cultural differences in a search for universals as it does not posit any necessary uniformity of psychological organization among members of a culture.

Cynosures are at once ‘types’ which receive attention but also may be viewed as central, key or core symbols (Turner 1974; Ortner 1974). As such they may be seen as symbols of and for social action, as vehicles for central concepts, as vessels of meaning (Geertz 1973) and as exemplary figures (in the Weberian sense, as examples for others). It may be that the lack of utility of the notion of social cynosure in the post-war period may have had something to do with the lack of attention and understanding of symbolic forms outside of psychoanalysis and a lack of concern for the analysis of meaning in all fields of anthropology. In the following section, we explore the cultural context of our study.

The Mediterranean Culture Area

The Mediterranean tradition encompasses areas which are both physically contiguous with that body of water and those whose culture is strongly influenced by that area, usually through colonization, e.g., Latin American and Mexico (see Tousignant 1984). It is now generally recognized that the Mediterranean culture area exists as a cultural (i.e., ideological and behavioral) system, not as a set of common material conditions or circumstances such as modes of production (Arensberg 1963; Gilmore 1982), relation(s) to putatively more developed areas (Gilmore 1982), climate (Braudel 1972), ecology, geography or social structure (see Bailey 1971; Boissevain 1979; Davis 1977; Gaines 1982a; Gilmore 1982; Peristiany 1966; Pitkin 1963). It could not be otherwise for the tradition is clearly not confined to the northern or southern littorals of the Mediterranean Sea.

A host of cultural similarities in the lands of this tradition have been noted recently. Gilmore (1982) summarizes some 15 different ideological commonalities of the groups of the culture area including authoritarian religion, dotal marriage, “camanelismo” (a sort of ardent parochialism), machismo, “structural dualism” (i.e., ambivalence), strong sexual segregation, familism, the honor-shame complex and others. This paper adds several more, including the notion of the visible saint itself, though the “cult of the saints” is known for the area at large (Crapanzano 1973).

Saints

Sadness, grief and anguish appear to be common to all cultures. However, the sources and ways in which these and other dysphoric affects are managed clearly differ across time and culture. One determinant of “coping styles” in a culture will be the existence of individuals who demonstrate, through their behavior, how culture-mates are to bear misfortune — exemplary sufferers, to paraphrase Max Weber in his work on types of prophets (1963). Throughout much of the Mediterranean culture area, such exemplars or paragons of suffering exist in the form of canonized Roman Catholic, Eastern Orthodox and Islamic saints. Indeed, for many centuries, death as a result of “exquisite tortures bravely borne” was the unique means of achieving sainthood. These saints are celebrated widely, but others are locally-known. In Catholic lands, there are saints as yet unrecognized by Rome although their feast days are celebrated and their miracles or martyrdom regularly commemorated, i.e., they are traditional.

Visible Saints

There is, however, a third form of saint upon whom a great deal of attention in daily life is focused in the Mediterranean world. These are the “visible saints,” who, unlike their more hallowed and honored counterparts, are flesh and blood. As actual contemporary members of their respective communities, they provide more immediate examples of life paths of suffering and the appropriate manner in which to travel such paths. Often, as we shall see, visible saints take their cues from canonized and local saints (and may represent an early stage in a process which may lead to officially sanctioned apotheosis).

In the Mediterranean culture area, individuals known to suffer at the hands of an “unjust” fate but who persevere in approved cultural roles in the face of adversity are candidates for lay canonization, for “visible” sainthood. In the tradition, life is seen as a constant struggle against overwhelming odds. In this struggle, ‘one has no one but one’s own to depend on’ (Campbell 1964; Cornelissen 1971; Wylie 1957; Bailey 1971; Gilmore 1982; Peristiany 1966). Visible saints simply endure more of life’s burdens than others but their goodness is confirmed by their passion which goes beyond the bounds of normalcy.

In the tradition, suffering is ennobling. Visible saints exemplify the connection
between suffering and social status and do so publically. They demonstrate the veracity of the view of life as suffering by serving as examples. Simultaneously, they manifest the behavioral ideals of society by persevering in their especially difficult life path; their patience, their courage is like that of the canonized saints. We see here the ambivalence with which misfortune is regarded in the culture area. Our case study of "Mme. Lorca," presented in the second section of the paper, is illustrative.

Visible saints may be viewed as models of and for life and social action in the Mediterranean culture area. We may further see them as living embodiments of dynamic cultural psychological conflicts. For in the Mediterranean area, as we shall see, much ambivalence is related to aggression, the family, power and responsibility, and misfortune. Indeed, Gilmore (1982), in his important article clarifying the nature and basis of the Mediterranean culture area, suggests that ambivalence, which he calls "structural dualism," is one of the central and characteristic features of the cultural area. In the next section, we discuss the tradition of the saints from which developed the contemporary visible saints.

The Early Saints

The early saints always lived lives of "passion," i.e., suffering. The saints generally suffered martyrdom. But often before their demise, they also suffered some form of torture or imprisonment visited upon them by external forces such as Roman emperors, traitorous relatives, pestilence and the like. The early saints rarely died in the comfort of their own beds at ripe old ages. A few examples of the various sorts of saints will suffice to demonstrate some of their characteristics.

Saint Sebastian

Saint Sebastian was a captain in the Praetorian guard of the Roman Empire, but was discovered to be a Christian. For this "crime" he was sentenced to death. He was tied to a tree and shot with numerous arrows. His passion was extreme but he survived his many wounds and returned to the Governor's palace to denounce the persecution of Christians. Upon seeing that Sebastian had survived the arrows, the Governor had him clubbed to death and thrown into a ravine to conceal his body so as to prevent veneration of his remains. Sebastian appeared the following night to (Saint) Lucide to inform her of the location of his remains so as to have them recovered and properly buried (Antony-Schmitt 1977; Coulson 1958). A popular figure, he is depicted in numerous hagiographic accounts as well as religious iconography, especially that of the Middle Ages. In Alsace he served for a time as the patron saint of quilters (because of the arrows which were the symbol of quilters) (Antony-Schmitt 1977).

Saint Thérèse of Lisieux

Saint Thérèse died less than a century ago (1897) and has become one of the most popular of all saints. Thérèse Martin (her family name is that of one of France's most popular saints) led an uneventful life, joining the convent at an early age as did most of her sisters. She wrote her life story, The Story of a Soul, in 1895. It became immensely popular after her death from tuberculosis, a disease that was for some time seen romantically in France and other Mediterranean areas (see Sontag 1979). She suffered greatly with this illness, wasting away before her death, at the tender age of 26, which assured her popularity. Significantly we find that Saint Thérèse manifested, "a neurotic condition against which she had to fight all her life long ... she was subject to black moods, to days of depression without any cause ..." (Coulson 1958:713). Saint Odile

Some elements of an Alsatian saint, Saint Odile, are of sufficient interest to consider her in detail. She is the last example we will include. Saint Odile represents a type of saint that became increasingly important in the history of Christianity as various oppressors of the faith disappeared. Saint Odile's antagonist is life itself, rather than Roman rulers, other non-believing persecutors or illness. The patron saint of Alsace, Saint Odile did not suffer martyrdom though she suffered in other ways.

Alsace itself is the Easternmost province of France (see Gaines n.d., 1985b). Saint Odile is revered there and her nunnery, still standing in the Vosges Mountains of Western Alsace, has been a place of pilgrimage for about 1,000 years. Odile is one of those saints who has not been formally canonized by the Church. However, she appears on all religious calendars and her saint's day is duly recognized throughout France.

As is true for many saints, her life has served as a model for living in this part of the Mediterranean culture area. She is a key symbol (Ortner 1974) which summarizes many important themes including an unjust fate, suffering, perseverance, good and good fortune, dedication to God, purity, piety and the like. (We note here that one third of the 1,400,000 Alsatians are Protestants. These Alsatians do not believe the legend of Odile nor do they place any stock in her or her relic's healing abilities [see Gaines n.d., 1985b]).

Saint Odile was taken from her natal royal household soon after her birth circa AD 800. Her removal was so hasty, in fact, that she was not administered the holy sacrament of baptism. Her removal from her home was occasioned by her congenital blindness. Because of this handicap, her father, a provincial nobleman, felt she would be useless in the formation of political alliances through marriage. For this reason, he planned to do away with the sightless child.
Fortunately, Odile was spirited away from her father by her brother. (In some accounts, she is saved by her governess.) For some years Odile lived anonymously in exile. When a young adult, Odile was returned to her family by her brother who had prevailed upon Odile’s father to accept her into the royal home. Her father felt remorse. It was clear that Odile had led a simple, virtuous life away from home. Her father then accepted Odile and set about redressing the earlier omission of baptism. When Odile received baptism, she miraculously gained sight. Odile asked her father if she could dedicate her life to God in thanks for the receipt of this wonderful gift. He consented and built a nunnery for her. In time, Odile became abbess of the nunnery. There she lived out her life in quiet dedication to God and the unfortunate (Gaines n.d.).

Elements of St. Odile’s life are illustrative of Mediterranean notions of suffering. For example, she was born blind and, to make matters worse, forced to leave her natal home and live in exile. All this occurred through no fault of her own. She was but an innocent victim of circumstance. For years she lived a precarious existence, for to live away from one’s family is to live among enemies as this is how non-kin are viewed in the culture area (see Campbell 1964; Lee 1954; Peristiany 1966).

We also see that upon gaining her sight, Odile chose to dedicate her life to God, rather than attempting to seek a worldly life which had been denied her by the trick of fate. Demonstrating great virtue, she selflessly gave herself to God in thanks for his gift of sight; she seems not to have fretted, nor have her followers, over the possibility of divine causes for her initial blindness. The story shows the arbitrary nature of misfortune; the good and the bad happen through no fault of one’s own.

The Past: Saintly Forms of Suffering
Suffering can be experienced in many ways. Its elaboration in thought and action among Mediterranean peoples must be seen as a central aspect of this culture area’s daily discourse. In this section we will consider the relation of the saints to suffering and apotheosis to the role of saint.

The saints, after whom people of the Mediterranean have patterned their own notions of personal suffering, did not all suffer similar fates. Saint Odile in fact is somewhat unusual for her time, though she is a kind of saint that became more common in Mediterranean Europe. Originally, those revered as saints were martyred in some fashion. In later times, however, individuals who had not been martyred came to receive the appellation. Formal canonization requires that the Church recognize the life of an individual as sacred and have suitable proof of their martyrdom for the faith. The Church may then place the person’s name upon the Church “canon,” or list, thereby canonizing him or her.

Individuals who were canonized but who were not martyred are properly called “confessor” (e.g., William the Confessor), by which is meant that the individual, while not martyred, had borne witness to Christ by virtue of his/her confession of the faith during an exemplary life of endurance, perseverance, suffering and virtue.

Changes in the perception of suffering and bearing of witness to Christ arose after the Grant of Toleration in AD 313 issued by Emperor Constantine. The Grant meant the end of persecution of Christians by the Roman emperors. The trials and temptations placed before the Christians tested them and demonstrated (i.e., “confessed”) their faith. The loss of this longstanding source of persecution, which served clearly as a standard against which early Christians could define and measure themselves, seems to have led to a reformation of the nature of Christian life and changed the path to sainthood and cynosure status. Early Christian teachers, such as Saint Basil and Saint John Chrysostom, began to emphasize that the ordinary Christian life, “when lived consistently in a spirit of loving self-offering to God” (Attwater 1965:8) could in itself be a kind of martyrdom equivalent to that of the formally canonized saints.

By the fourth century AD, the honor of sainthood was extended even to ascetics and later to bishops and great teachers, people who had not suffered the ultimate passion, death, for the faith. These practices expanded the role and presence of saints in Mediterranean Europe and seem to have led to the large numbers of formally and informally recognized saints. But as well, there are countless uncanonized saints, known only to their neighbors or God alone’ (Attwater 1965). It is these neighborhood saints, which the senior author (ADG) calls “visible saints” who, along with the dead in heaven, are honored every year on All Saints’ Day (November 1) in Latin Europe.

The essential element of the life of a saint is not perfection, but a kind of heroism. As Kemp (1948) put it, the ‘total giving of the self to God or Christ in an heroic way,’ is holiness itself. For martyrs, the nature of their deaths shows this selfless giving in and for the faith. For others, including our visible saints, a life of passion and the ability to endure a life of privation and suffering, both of which are believed to be granted by the grace of divinity, is central. Their suffering recalls that of Christ and symbolically stands for it. As Saint Paul said, “I live: yet not I, but Christ liveth in me.”

The point is that in the Mediterranean, there is ambivalence about misfortune: while it is greatly feared, it also represents the potential apotheosis to sainthood. We may also see in the well-known expectations of tragedy and misfortune articulated by people of the Mediterranean (Campbell 1964; Bailey 1971; Peristiany 1966) what may be a certain level of wish-fulfillment. The exaggerated concern over potential disaster thus may be in part a desire for it. As well, the very attention paid to visible saints, and to the misfortune of others in general...
in the Mediterranean tradition, is suggestive of the ambivalence with which misfortune is regarded. This relates to the patterning of masochistic tendencies in the tradition.

*Moral Masochism and Sainthood*

Another element, masochism, appears in stories of the saints whether they are canonized (St. Sebastian), traditional (St. Odile) or lay (Mme. Lorca, our visible saint). Here we can but briefly sketch the nature of masochism in the Mediterranean culture area.

While it is known that masochism represents the “turning against the ego” of the sadistic drive, we wish to point out that our reference is to a particular sort of masochism, namely, moral masochism. Generally, individuals tend to avoid any pain, but in the masochistic individual pain gives pleasure and is to be striven for (Fenichel 1971:358). But the pain cannot be too great, lest it overwhelm the pleasurable sensations.

As we will see from our discussion of visible saints, masochists derive pleasure from exhibiting their misery. Related to this is the ascetic who mortifies the flesh to express in a distorted form his blocked sexuality and thereby derive masochistic pleasure. Taking pride in one’s suffering is thus related to masochistic pleasure (Fenichel 1971:363–365).

But note that, as Freud suggested (1950), paraphilias (APA’s [1980] new terminology) such as masochism appear with both passive and active aims. Thus, the saint inflicts him- or herself on others as he or she pridefully displays his or her forms of suffering. For this reason, visible saints are often unpopular with their closest kin, especially their spouses. The case of Mme. Lorca, presented below, evidences this domestic enmity. Moral masochism appears culturally standardized in the Mediterranean. Therefore, we would argue it is a form *distinct* from that found in another cultural context where the culture has not patterned masochism into this form.

Punishment by fate or God, in terms of failure, illness and the like, “may be seen as the expression of being the father’s sexual object transformed into the idea of being beaten by the father and then by God (the Father) or destiny” (Fenichel 1971:364). The sad life, the burden of the saint, has its compensations in this as well as in the fact that such divine suffering, such passion, is indicative of divine involvement with the person. Such concern on the part of divinity anoints the individual and gives him or her special powers within their families and communities. Moral masochism, then, may be seen as an avenue to the attainment of power within the domestic and wider social community (DeVos 1984).

Life in the Mediterranean is conceived of as a trail of tears, a succession of misfortunes and suffering. But life so conceived can have its compensations. One such in the Mediterranean worldview is the role of visible saint. For a life of misfortune, under which one continues to bear up, is the means of the apotheosis to the role of visible saint and its store of secondary gains and power. Misfortune and suffering are inexorably linked with saintliness and goodness constituting a central structure of ambivalence in this culture area. It is in the visible saint that these cultural themes are united and given visible, tangible form. We return to these points below.

*Daily Discourse and the Rhetoric of Complaint*

Among Mediterranean groups research has demonstrated the exaggeration (from the researchers’ point of view) of illness symptoms and complaints (Zborowski 1978; Zola 1966) and the decidedly familial and community referents in psychopathological delusions (Parsons 1976). We wish to point up an aspect of social interaction in Mediterranean cultures which bears witness to the worldview of life as suffering and suffering as ennobling. This feature of Mediterranean interaction has been called the “rhetoric of complaint” (Gaines 1982a, b).

The rhetoric of complaint is a form of discourse through which one presents oneself to the external world in social interaction. As Blumer (1966) and Schutz (1968) have noted, social interaction generates social reality by means of the exchange of meanings brought to and taken from interactional encounters. In the Mediterranean, one seeks to minimize the perceived risk of falling prey to supernatural and natural forces, the latter including the envy and jealousy of others, by presenting oneself as unfortunate, battered by the winds of fate and scarcely able to continue the struggle for life. The micropolitics of social life in the Mediterranean governed by gossip (Bailey 1971) demand that individuals conceal good fortune and demonstrate their social worthiness by a rhetoric indicative of a lack of success or good fortune. One verbalizes a social life of problems or mundane developments which try one’s patience. This presentation of self seeks not to tempt others or make the self fall victim to the envy of others. One does not talk of glowing possibilities, plans and goals, and how well things are going; one complains (Gaines 1982a).

The rhetoric of complaint may be seen as a means of validating the self in social interaction and simultaneously obtaining narcissistic and masochistic gratification through interaction with others. It is a cultural strategy for showing one’s worth and significance (saintliness) in a world in which assurances of intent are constantly needed (see Campbell 1964; Gaines 1982a, b; Lee 1959). This rhetoric, as we shall see, is central to an understanding of the strikingly positive results of the diagnostic instrument administered to Mme. Lorca.
The Saints in Everyday Life

In this section, we will point out briefly the ubiquity of the saints in the lives of the people of the Mediterranean. We do this to demonstrate the familiarity of people of this culture area with the lives of the saints, a familiarity that makes the saints such potent, exemplary figures.

A most common aspect of the European tradition of the saints, encountered daily by its inhabitants, is the custom in which places and shrines are named for the saints. Many population centers are named for saints (e.g., San Marino, San Francisco, Santa Lucia, Santa Barbara, St. Michel, etc.). In fact, in France alone there are some 4,000 cities, towns, and villages named after St. Martin. The places where saints were martyred is locally known (e.g., Montmartre) and some commemoration is often made by the local population.

Another level of familiarity of the laity with the saints is through the Christian naming tradition. In this system individuals are given one or more names of saints (e.g., Jean-Paul, Marie-Thérèse, Jeanne-Dominique, etc.) as given names. In France, and other Latin countries, individuals celebrate their respective saint’s days which are noted on secular as well as religious calendars. Until recently, French parents had to select names for their children from a government-approved list composed entirely of saints’ names.

Places of worship are especially numerous in European lands contiguous with the Mediterranean (physically or culturally) and serve as repositories of iconography and hagiography. In places of worship one finds ample evidence of the lives of saints in icons and symbolic artistic representations as well as in the relics, exhibited actual body parts (a foot bone, knuckle, a heart) of a saint or saints, reposing in a reliquary of precious metals and jewels.

To these exposures should be added the system of education in Latin lands, both lay and religious, which employs the lives of the saints as part of the instruction concerning the founding of the nation and Church, respectively (it should be remembered that saints were often responsible for bringing Catholicism to the people of particular areas as well as such things as alphabets [e.g., St. Cyril]). Thus, for both lay and Church instruction, saints play a significant role. Saints may also be used in secular and religious institutions as a means of moral instruction, as models to emulate.

Finally, we should mention that there is a wide range of rituals associated with various saints, aside from the usual personal celebrations of saint’s days. Various fêtes are commemorations of saintly successes, trials and fates. Thus, a complex social life of rituals acquaints members of Latin and Islamic communities with the lives of the saints. And, an association of suffering and saintship is made (Crapanzano 1973).

As is well known, the visual character of the Mediterranean tradition, as opposed to the word-oriented tradition of the Northern European Protestant culture area, means a very different approach to learning. In the Mediterranean area, the young are early exposed to stories and depictions of dismemberment, violation and mutilation associated with the lives of saints, which are everywhere present (not to mention the martyrdom of Christ himself). Such stories and scenes, it would seem appropriate to suggest, must have a tremendous impact upon early psychological development.

During psychological development the instillation of fears that the horrors associated with the saints may occur in one’s own life may be important, for such things even happened to saints who did not deserve such fates. One may fear a world that would visit such treatment upon such sacred souls as the saints. The saints are further seen as the unfortunate victims of arbitrary, external forces, for informants never think saints were motivated by self-destructive impulses. One also learns in this tradition that those who suffer are those who are remembered, venerated and adored; they are the semi-divine.

Through naming traditions, the religious life, art, and education, saints manifest themselves as objects of intense interest and as focal points of attention in the Mediterranean culture area (and its daughter cultures in the New World). The saints are clearly social foci in the Latin and Islamic Mediterranean (Rabinow 1977; Eickelman 1976). Saints embody and focus cultural ambivalence regarding aggression and veneration, love and hate, fame and misfortune, serving as guides and models of and for (see Geertz 1973) social life in the Mediterranean. Saints are also repositories of power (see Attwater 1965; Coulsen 1958; Crapanzano 1973; Gelner 1963).

II. MADAME LORCA: A VISIBLE SAINT

Madame Lorca

Madame “Lorca,” the name is a pseudonym, was encountered while conducting an investigation of depressive experience among women residents of a nationally subsidized housing project located in the suburbs of Paris. Our informants were largely spouses of ouvriers (blue collar workers) or ouvrières themselves, employed on car assembly lines, in construction, in utility plants or machine shops. Our pool of informants reflected the ethnic plurality of the project. They included nineteen French, nine Spanish, two Portuguese, and two Algerian women.

A number of methods were used to examine depressive experience among our informants. These included the Zung Self-Rating Depression Scale (SDS) (Zung 1965), the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DMS III) (American Psychiatric Association 1980)
and the Research Diagnostic Criteria (RDC) (Spitzer et al., 1978). As checks on instrument validity and reliability, we relied most heavily on ethnographic fieldwork through participant observation elsewhere in the culture area and within Mme. Lorca’s environment, as well as clinical presentation and the analyses of natural discourse about depressive experiences.

The case study of Madame Lorca was selected for detailed analysis for several reasons. She was among those subjects with very elevated scores on the SDS. She and another woman (“Madame LeGuille”) also reported a much higher number of symptoms than other informants. Significantly, Mmes. Lorca and LeGuille were mentioned by peers more frequently than any others in the community in their discourses about stress, sadness and suffering.

In the eyes of their peers, they were often “sad” and “anxious.” Their state was seen as non-pathological and “natural,” as an unremarkable consequence of their ‘difficult lives’ filled with troubles. The difficulties included familial and personal illnesses, loss of family members, chronic financial problems, recalcitrant husbands, “disobedient” and “troublesome” children. However, these two women had “held strong” and were consistently lauded by their peers for their “perseverance” and “patience.” And, they were frequently referred to as “saints.” The cynosure, we recall, is not the model person, not the most successful, or otherwise desirable to become (from an outsider’s viewpoint), not even the most emulated person in the society, but simply one who receives the most massive and continuous attention in society.

We see here in the social classifiatory and evaluative scheme of our informants the very coincidence of misfortune/suffering and saintly status discussed earlier. We note that while the people of the housing project represented distinct ethnicities for the time being, for they can all become French ethnics (see Gaines n.d.), they clearly shared a common cultural framework by which they evaluated and interpreted their own and others’ experiences. Due to constraints on the length of this paper, we consider in detail but one case of a visible saint, that of Mme. Lorca.

*History of Present Illness*

Mme. Lorca, 37 years of age (in 1981), was born and raised in a small town in Catalonia, Spain. She moved with her husband and children to France eleven years earlier. They have lived in their present apartment in the suburbs of Paris for the past ten years. She and her husband have been married for sixteen years. Her husband, forty years of age, works in an automobile factory not far from the apartment. The couple have seven children, six of whom are attending the local public schools. The oldest child, Maria, is fifteen. She sometimes stays home from school to assist her mother when mother is ill, as her role in the home is that of assistant mother befitting her age and sex in this cultural context. The youngest child, just four years of age, is not yet in school.

During the five months in which we had continuous contact with Mme. Lorca, she experienced an episode of illness lasting approximately one month. Her chief complaints during this period were, “Je suis malade et déprimée” (“I’m sick and depressed.”) She felt “used up.” Mme. Lorca reported having these feelings for the last several years, with periodic amplification of symptoms similar to those described here. Here symptoms included insomnia, sleep continuity disturbance, increased appetite with concomitant weight gain (some five kilograms) in a two week period, decreased libido and persistent nausea (“nausée, mal au coeur”). She related an inability to concentrate on usual daily activities (i.e., taking care of the “baby,” house cleaning and the elaborate social ritual, shopping).

During this episode she described her mood as “burdened,” “sad,” and “soulless” (“vide”). She related that she felt “empty” and hopeless and reported an increase in frequency of crying spells. At baseline, Mme. Lorca reported crying only occasionally, most often when she “thought about (her) dead children.” (The reference to ‘dead children’ relates to several miscarriages Mme. Lorca had suffered. These will be discussed further below.) She also complained of anergia, punctuated only by short spells of fifteen minutes or less duration during which she experienced tachycardia, an increase in perspiration, dizziness and a sense of “overwhelming weakness.”

Mme. Lorca stated that her last bout of sickness occurred exactly eight months ago. “I remember the date, because it happened just after a big battle with my husband.” The symptom constellation of that episode was very similar to that of the index episode described here, although at that time she also suffered from dyspepsia, “burning throat” and diarrhea. Maria, her oldest daughter, took a week off from school to care for the youngest of the Lorca children. During this illness, Mme. Lorca received much attention from her friends. As she is a devout woman, during the period she was confined to bed her parish priest brought communion to her.

During her previous episode, her friends pressed her to see a physician. This she did, and the physician “prescribed an antibiotic.” When asked to show the medicine, Mme. Lorca produced a bottle of antacid. The “antibiotic” was “prescribed” for her gastrointestinal difficulties and she was referred to a psychologist at the dispensaire d’hygiène mentale located in the housing project in which Mme. Lorca and her family lived. When asked if she followed the physician’s suggestion and referral, Mme. Lorca dismissed the query with a wave and a grunt, indicating a sense of contempt. She seems not to have sought psychiatric or psychological assistance.
Although she stated that this episode was as incapacitating as her last one, at no time during the index episode did Mme. Lorca consider seeking professional help, nor did her daughter stay home from school to assist her in childcare and other domestic activities. Mme. Lorca did not miss Mass nor did she miss her other highly significant daily ritual, shopping for groceries.

Mme. Lorca has been plagued by these symptoms and their amplification for about eleven years, with quiescent periods of reduced discomfort. She could offer no personal theories or Explanatory Models (see Kleinman 1980) of her illness episodes or for factors which might contribute to the dampening or amplification of her symptoms. However, she did associate her first episode with a number of stressors. These stressors included her family's move from Spain to France and two subsequent miscarriages. Both miscarriages occurred in the eighth month of pregnancy. She had her first miscarriage in Spain which also occurred in the third trimester.

The move was particularly traumatic for Mme. Lorca for, as she says, her family had been living in her natal village and was in regular contact with her parents and siblings. In addition to losing the interaction with her family of origin, Mme. Lorca also moved to a country whose language, while related to her native tongue, was unknown to her. Her second miscarriage occurred less than a month after her relocation to France. We note also that her two most recent illness episodes were immediately preceded by instances of marital discord.

**Mental Status Observations**

During the second week of the index episode, Mme. Lorca completed a Zung SDS. During that session, she was alert and oriented as to person, place and time. Although she described herself as "déprimée" and "triste" (sad), her mood and affect seemed to show a full range of modulation, perhaps even lability, and were only slightly more dysphoric than in the "baseline" state. Speech rate and pattern were within normal limits and she exhibited some tearfulness when discussing particular topics.

Our informant denied any suicidal or homicidal ideation but confessed to recurrent nightmares in which some significant other, usually her husband, dies. We here note the wish-fulfillment nature of such dreams and, given the difficulty for Mme. Lorca and the children without him, their masochistic flavor. Mme. Lorca also spoke frequently of the loss of three nearly full-term babies. All of these were named and christened before burial. Our informant denied any visual hallucinations, Schneiderian symptoms, or delusions of reference. Mme. Lorca, however, did report hearing the voice of God in dreams, and believed that her three miscarriages were a direct result of "divine will." Most of her discourse about "fate" or God had a slightly persecutory tone, e.g., she employed such phrases as, "when God took my babies . . . ."

Her recent and remote memory and ability to interpret abstractions were within normal limits. Mme. Lorca exhibited poor attention span and increased distractibility during her illness, but maintained her remarkable facility for remembering what all of her significant others, including her neighbors, were doing and saying. Her general fund of knowledge may be said to have been limited, but, as Mme. Lorca put it herself, "What difference (does it make) who is prime minister, as long as the rents are controlled and we don't have war?" In terms of implicative habits, Mme. Lorca did not smoke and drank wine only infrequently.

Finally, she could produce, and was only to happy to do so, detailed phenomenological accounts of her symptoms. This would be expected given the key mode of self presentation noted above, the rhetoric of complaint, but not if she suffered from clinical depression. Also characteristically, Mme. Lorca's insight into the nature of her problems would be described as limited.

**Formal Psychiatric Assessments**

**The Zung SDS**

The Zung SDS is used internationally to answer the clinical or research question, "How depressed is this person?" As is evident in Table 1 below, the results of the administration of the SDS to Mme. Lorca seemed to indicate that she was very depressed. In fact, her SDS index was 79, a score which one expects to be indicative of "severe clinical depression." To affirm or reject this diagnosis and to rule out other possible diagnosis, other diagnostic instruments were administered to Mme. Lorca.

**DSM III and the RDC**

In terms of the criteria contained in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM III) (APA 1980), Mme. Lorca meets the criteria for "Major Depressive Disorder, Recurrent." And, if we employ the Research and Diagnostic Criteria (Spitzer et al., 1976), we would, based upon reported and observed symptoms, diagnose her as "endogenously depressed."

For the APA (1980), the diagnostic criteria include a dysphoric mood or loss of interest in all or almost all usual activities as criteria for depression. The mood is characterized by the (American) sufferer as "depressed," "sad," "blue," "hopeless" or "irritable." Notable here is the affective component which is a prominent and relatively persistent, but not necessarily dominant, symptom. In addition to the mood disturbance, as least four of the following symptoms are to be present (to receive a diagnosis under the new criteria) in the individual for a period of at least two weeks:
### TABLE 1  
Informant’s responses on zung self-rating depression scale

<table>
<thead>
<tr>
<th>Question</th>
<th>Response*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel down-hearted, blue and sad</td>
<td>Some of the time</td>
</tr>
<tr>
<td>2. Morning is when I feel the best</td>
<td>Some of the time</td>
</tr>
<tr>
<td>3. I have crying spells or feel like it</td>
<td>Some of the time</td>
</tr>
<tr>
<td>4. I have trouble sleeping thru the night</td>
<td>Most of the time</td>
</tr>
<tr>
<td>5. I eat as much as I used to</td>
<td>None or little of the time</td>
</tr>
<tr>
<td>6. I enjoy looking at, talking to and being with attractive men/women</td>
<td>None or little of the time</td>
</tr>
<tr>
<td>7. I noticed that I am losing weight</td>
<td>None or little of the time</td>
</tr>
<tr>
<td>8. I have trouble with constipation</td>
<td>Most of the time</td>
</tr>
<tr>
<td>9. My heart beats faster than usual</td>
<td>Most/all of the time</td>
</tr>
<tr>
<td>10. I get tired for no reason</td>
<td>Some of the time</td>
</tr>
<tr>
<td>11. My mind is as clear as it used to be</td>
<td>Some of the time</td>
</tr>
<tr>
<td>12. I find it easy to do the things I used to</td>
<td>Some of the time</td>
</tr>
<tr>
<td>13. I am restless and can’t keep still</td>
<td>Some of the time</td>
</tr>
<tr>
<td>14. I feel hopeful about the future</td>
<td>Some of the time</td>
</tr>
<tr>
<td>15. I am more irritable than usual</td>
<td>Some of the time</td>
</tr>
<tr>
<td>16. I find it easy to make decisions</td>
<td>Some of the time</td>
</tr>
<tr>
<td>17. I feel that I am useful and needed</td>
<td>Some of the time</td>
</tr>
<tr>
<td>18. My life is pretty full</td>
<td>Some of the time</td>
</tr>
<tr>
<td>19. I feel that others would be better off</td>
<td>Some of the time</td>
</tr>
<tr>
<td>20. I still enjoy the things I used to</td>
<td>None or a little of the time</td>
</tr>
</tbody>
</table>

SDS Raw Score: 63. SDS Index: 79—"Severe Depression".

* Informants were obligated to respond using the multiple choice format (see Zung 1965).

1. Poor appetite or significant weight loss (when not dieting) or increased appetite or significant weight gain.
2. Insomnia or hypersomnia.
3. Psychomotor agitation (pacing, pulling or rubbing of hair, skin or other objects; an inability to sit still) or retardation (seen in slowed speech, increased pauses before answering, markedly decreased speech or slowed body movements).
4. Loss of interest/pleasure in usual activities, or decrease in sexual drive.
5. Loss of energy, fatigue.
6. Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt.
7. Complaints or evidence of diminished ability to think or concentrate, such as slowed thinking or indecisiveness.

These APA diagnostic criteria in the United States for a “Major Depressive Disorder” closely approximate the RDC criteria as well. However, the utility, even the validity of these diagnostic criteria in other cultures, even some in the “West,” is problematic. Important here is the cultural specificity of the criteria and their role in the process of diagnosis (Devereux 1964; Farmer 1980; Gaines 1979). We may consider other psychosocial aspects of the subject before affirming the diagnosis indicated by the three instruments.

**Family and Medical Histories**

Mme. Lorca’s non-psychiatric medical history contained some significant elements including a complete hysterectomy more than four years prior to the index episode, not long after the birth of her youngest child. The reasons for the surgery were not clear, i.e., Mme. Lorca could not relate a coherent account of the reasons for the surgery. She did report some genitourinary irregularities and several “very difficult pregnancies.” Her body weight, although some twenty five kilograms above ‘ideal’ weight, did not pose a problem. She did not regard herself as having a weight problem or as being obese.

Mme. Lorca was the third of eight children, seven of whom were living at the time of the research. An older brother died as an infant. Concerning his demise, she could only state that the death was a result of “sickness.” To her knowledge, no member of her family had been treated for psychiatric disorders, although she referred to “crazy spells” which afflicted her father and which were precipitated by heavy drinking. Two of her brothers were also described as having drinking problems. She said that her mother was “often sad.” An uncle, her father’s brother, committed suicide when Mme. Lorca was very young, for reasons “unknown” to her.

As indicated above, our informant proved to be a rather inaccurate life historian. Other research has suggested that such would be a problem for medical history taking for Mediterranean culture area patients because of the rhetoric of complaint and a particular style of self presentation (see Gaines 1982a). Specifics from her childhood were reported with confidence, only to be subsequently contradicted with equal confidence. These inconsistencies seemed to appear most frequently with reference to her parents. In speaking of her father, most evident were slips of the tongue, abandoned directions of discourse, pauses, sighs, persistent inability to recall certain past events, and marked variations in the tempo and volume of her voice as well as its quality.

As an example, she described her father as “kind,” but later detailed scenes in which he physically abused her, her siblings and her mother. Her relationship with her father was referred to as “close,” but she subsequently confessed to persistent feelings of rejection and of being ignored by him because of her physical appearance. Her older sister and a younger one were “more pretty and slender” than she, and therefore, in her logic, received the lion’s share of
his attention. (We can but note here the profound significance of beauty in Mediterranean cultures; another cynosure to investigate.)

Mme. Lorca tried to portray her parents’ marriage in a positive way, but the tenor of the relationship as reported contained considerable Sturm und Drang. She referred to her mother as a “saint,” and said that she was always prepared to intercede with her husband on her children’s behalf and, importantly, that she was “tolerant” of her husband’s excesses, highlighting a positive view of the endurance of suffering seen also in fundamentalist Christianity (see Gaines 1982c, 1985a). Her mother was, of course, depicted as a devout Catholic.

Relationships with her siblings were recalled with fondness. Mme. Lorca was especially attached to two of her younger sisters. They were, it seems, very dependent upon our informant. Like Mme. Lorca, they married and remained in the town in which they were born and raised. She reported that the nature of their relationship changed very little following their respective marriages. A chief topic of their daily conversations, males, merely shifted from talk about father and boys to talk about husbands.

Family Dynamics

Perhaps the most salient fact about Mme. Lorca’s relations with her children and her husband was their striking resemblance to those she described for her family of origin. Distinctly patriarchal, the family of our visible saint recalls its classical Roman counterpart. Indeed, many aspects of the modern Mediterranean family may be rooted in the Roman paterfamilias (La Barre 1946). Like that ancient institution, most of the men rule with a certain tyrannical flair and feel it appropriate to physically chastise their children and spouses. Mme. Lorca, for example, did not find this unusual, having witnessed similar behavior in her own family. And, wives and children were know to occasionally strike back actively or passively.

Interactions between Monsieur Lorca and his three sons were conflictual. As M. Lorca was frequently absent from the home, it often seemed as if their interactions were limited to verbal and corporal punishment. He was somewhat “easier” on his daughters, with the exception of Marie, the oldest, whom he regarded with some suspicion; she was approaching “that age” when her actions might dishonor the family.

To Mme. Lorca fell the chief responsibility for childrearing, an aspect of the marked division of labor by sex in the family. All domestic chores were relegated to the females. Mme. Lorca was considerably less strict with the children than was her husband. As a result, her children regarded her as an ally and mediator between them and their father. This is the typical dynamic noted in France by Mead long ago and more recently (Gaines n.d.) as well as in other areas of the Mediterranean (e.g., Peristiany 1966).

Rapport between M. and Mme. Lorca was poor. During interactions which were observed, M. Lorca had little to say to his wife for, when he was home, she came in a distant second to the television. He manifested little compunction about mildly berating his wife in the company of others. It is significant that M. Lorca was noticeably more kind and attentive to his wife during the first three weeks of the index episode described herein. His patience seemed to wane, however, toward the end of the sickness episode. Despite internal tempestuousness, there was considerable in-group loyalty in informants’ families and in those seen in other research in the culture area (Campbell 1964; Gaines n.d.; Wolf 1969; Wylie 1957).

Social Functioning

Our informant had nine years of formal education. She described herself as an “average” student who was well liked by her peers. In observing Mme. Lorca in her element, one noted immediately that she remains a popular person. Her friends are exclusively women, as befits a saint and one concerned with the politics of reputation in Mediterranean lands (Bailey 1971). Although many, but not all, of her friends are Iberian expatriates, Mme. Lorca and her friends converse in French when they congregate around her as she stands, propped against a shopping cart, in the front of the co-operative store. These diurnal sessions were segregated by sex, as men rarely shop.

It was not difficult to ascertain their principal topics of discourse. These included the social activities and the health or, more often, ill health of various members of the community and financial difficulties, which seemed as chronic as most illnesses seemed to be. Important within the domain of social activities of others were the transgressions of husbands, the promiscuity of “kids these days,” and out of favor women; these topics were not, of course, mutually exclusive, and appear equally important in other regions of the culture area (Bailey 1971).

The topic of conversation receiving most of the attention of Mme. Lorca was that of health and illness. The other topics were nearly overshadowed by the tireless verbal dissection of the tumors, infections, surgical procedures, known and rumored causes of death, illness or misfortune of people in the community as well as public and entertainment figures.

Mme. Lorca’s coterie was perhaps most engrossed, within the domain of health and illness, with disorders, malfunctions, both real and fantasized, of the reproductive tract. These included problem pregnancies, menstrual problems and so forth. Our visible saint was widely held to be an authority in her world in the fields of ethno-obstetrics and gynecology. Significant in this regard was the public knowledge of her three miscarriages and the termination of her own procreational career.
In her role of advisor, ethno-obstetrician and confessor, some of the power and magical qualities of saints in other parts of the culture area were imputed to her. Other aspects of daily discourse in the domain of health and illness worthy of note included the considerable attention paid to horrible, natural disasters, industrial accidents, automobile accidents and calamities of any other sort. The same predilection for dwelling on the macabre is amply evident in the media of France and other Mediterranean countries.

The membership of Mme. Lorca’s coterie fluctuated between eight and ten women. The other women brought their problems to Mme. Lorca whose own difficulties surpassed those of her confidantes. She possessed knowledge and experience and steadfastness superior to others which set her apart from the mundane, and from others; her hardships were indicative of divine involvement. Despite the great social prestige her position brought, Mme. Lorca, employing the rhetoric of complaint, on more than one occasion complained that her role as Mother-confessor-advisor was “stressful and unrewarding.” She bemoaned the lack of such a figure in whom she could confide and who could respond to her needs. Yet it was clear that the other members of the coterie were exquisitely aware of every problem that Mme. Lorca had experienced or was experiencing. A latter-day Saint Sebastian, she frequently exhibited her own wounds to others.

To further advance our comprehension of Mme. Lorca’s illness, we need to examine the problematic nature of the clinical construction of depression.

III. ASSESSING DYSPHORIC AFFECTS ACROSS CULTURES

Terminology

Aware of the arbitrariness of labels, and their cultural basis and significance, we must address the thorny question of terminology. “Depression” has been used alternately in the psychiatric literature to refer to a mood, a symptom, and a syndrome (Marsella 1979). Though few of us have not experienced something akin to a mood of depression, feeling “down,” “blue” or “in the dumps,” clinical depression is uncommon and is a serious condition with a high rate of mortality.

Although much confusion results simply from arbitrary and colloquial usage of the term, it is clear that depression, if a unitary phenomenon, is one of the most widely varying of all mental disorders. Indeed, some investigators have questioned the validity of its discreteness and its universality (Marsella 1979). Below we will further investigate the nature of dysphoric affect and its patterning and apply these considerations to our visible saint.

Epidemiology of Depressive Experience

Treatment of depressive disorders poses serious financial difficulties in both the public and private sectors of the health care systems of the United States, throughout the Mediterranean culture area and beyond. The American Psychiatric Association has recently asserted that 8 to 11 percent of the males and 18 to 23 percent of the females in the adult populations of the United States have at some time experienced a major depressive episode in their lives (Boyd and Weissman 1981). It is currently thought that women in industrialized nations are twice as likely to suffer depressive episodes than are men (Weissman and Klerman 1977). Such sex differences in the epidemiology of depression continue to puzzle researchers. For our research, an important question must be posed: Is Mme. Lorca an example of a research diagnosis of “depression” that would be tallied in an epidemiological survey of affective disorders in France?

Brown and Harris (1978) in a study of the “social origins of depression” among women suggest the following as factors which increase vulnerability: working-class background; lack of employment outside of the home; pessimistic personality styles; and the absence of a confiding relationship with the spouse. The real or imagined loss of loved ones has long been implicated by psychoanalysis which distinguishes between grief and enduring, unresolved depressive responses (Kupfer and Frank 1981:32–35). Weidman (1969) has also suggested that migrant status might predispose persons to increased depressive and paranoid symptomatology. And hysterectomy has been implicated (Martin et al., 1980) as a risk factor. The risk factors noted here read like the vitae of Mme. Lorca and her peers.

The Biology of Depression

The study of depressive experience has been the subject of considerable inquiry and debate (Beck 1980). The interest of the medical profession has a long history. Hippocrates attributed ‘melancholia’ to an imbalance of bodily humors. Now, over 2,300 years later, some clinicians suggest that depression is attributable to imbalances in the brain’s biogenic amine neurotransmitters. Some data have pointed to measurable abnormalities in a number of biological variables among some patients exhibiting clinical depression. These abnormalities include imbalances in the levels of several neurotransmitters and metabolites as well as marked changes in neuroendocrine function and sleep patterns. But a glaring difficulty remains for those advocating biological etiological theories; most patients diagnosed as suffering from depressive episodes do not exhibit these abnormalities.
As noted in DSM III, in American psychiatric circles the affective component is a prominent and relatively persistent symptom. But, as noted above, at least four other symptoms must be present for at least two weeks to derive a diagnosis of depression. Research oriented clinicians have suggested that the APA criteria are far too broad, and have posited the existence of subtypes of depressive disorder to account for manifest differences in symptom constellations, course and biological parameters.

The best known of such subdivisions is probably the contrastive dichotomy of “endogenous” versus “exogenous” (or “reactive”) depression (Beck 1982; Kupfer and Frank 1981). The former is seen as stemming from some biological abnormality and is marked by somatic symptomatology while the latter is seen as a reaction to stress or loss and characterized as having a smaller somatic component and more affective fluctuations (Beck 1982; Kupfer and Frank 1981). It is believed that the forms of depression have different clinical courses and require different therapeutic modalities. Endogenous depression is said to be less amenable to psychotherapy but responsive to electroconvulsive therapy.

It has been suggested that proposed laboratory tests (e.g., the dexamethasone suppression test or the thyrotropin-releasing hormone stimulation test) discriminate between endogenous and reactive depression. However, the initial enthusiasm for these putatively “specific” laboratory tests was unwarranted. We are brought full circle and return to the gold standard, that of clinical presentation. Can it be assumed that patients presenting with a preponderance of more somatic or vegetative symptoms, such as our visible saints, share an underlying biological defect? If so, should we also assume that this defect is somehow responsible for their status as saints and not a learned and culturally patterned means of perceiving precipitated experience, articulating it, exhibiting it and, in general, coping with it? Given ethnographic knowledge and experience, we suggest that the answer to both questions is “No”. This and other research indicates that differences are not biological but reflections of, for example, “psychological-existential” versus “somatic-vegetative” (Marsella 1979) psychocultural mechanisms which frame the experience of dysphoric affect (Kleinman 1980).

One problem for researchers has been the conscious or unconscious utilization of a narrow biomedical model (see Kleinman 1980; Gaines and Hahn 1982; Hahn and Gaines 1985; Mishler et al., 1981) or some simple cause-effect models of depression so abundant in psychoanalysis or psychology (e.g., the “learned helplessness” model). Also implicated is the Cartesian mind/body dualism (see Eisenberg 1977; Capra 1983) which actually antidates Descartes (La Barre 1970).

Depressive conditions appear culturally specific and symptom constellations, even in the same culture, have been shown to vary with age (Blazer and Williams 1980), sex (Marsella 1979; Farmer 1982), educational and socioeconomic levels (Kleinman 1980), developmental experiences (Mechanic 1980), linguistic styles (Leff 1981) and many other variables. The degree of westernization has also been implicated in symptomatology (Kleinman 1980; Marsella 1979). The unity of the phenomena under investigation thus becomes highly problematic.

The Cultural Patterning of Dysphoric Affect

China
A few investigators have been more holistic in their research, eschewing biological reductionism. Kleinman (1977, 1980) has advanced what is undoubtedly the most comprehensive of extant models. He has shown how perception, labeling and valuation of dysphoric affect vary across cultures. Drawing on his work in America, Taiwan (1980) and the People’s Republic of China (1982). Kleinman has detailed “coping strategies” employed to manage stigmatized affect. In Chinese culture, many strong affects are disvalued.

Among his Taiwanese subjects, for example, the cognition of negatively valued affect was most often countered with: 1) suppression or minimization of the intensity and sequels of the troubling emotion; 2) somatization of depressive experience and the amplification of physical complaints as illness; 3) undifferentiation of disvalued affects by lumping them together under vague labels; 4) externalization of attention following the initial cognition of distressing affect; 5) displacement of concern from the actual emotion to the concrete situation that precipitated or sustains it.

North America
These psychocultural mechanisms stand in stark contrast to those most often seen in middle-class, college-educated Anglo-Americans among whom the recognition and expression of strong or dysphoric affect is positively valued in nonpublic places in suitable forms. As a result there is an abundance of labels to describe such affects (i.e., differentiation) and more skill in communicating such experiences. Other important American coping strategies include psychologization in the place of somatization, overemphasis and an internal focus of the individual on states of consciousness and affect (Kleinman 1980; Marsella 1979).

The Mediterranean
Our Mediterranean informants dealt with dysphoric affects in ways which differed markedly from the means seen most frequently in Chinese and North American cultures. In looking at the coping mechanism which were employed by Mme. Lorca, the second visible saint of the community and the other women
in the sample, it is important to note the elaboration of tales of misfortune; from infancy onward, the recounting and analysis of misfortune play a large role in many lives throughout the Mediterranean culture area (also see Toussignant 1984). This preoccupation is unrelated to particularly distressed life situations. This tendency to dwell upon and elaborate misfortune is so marked that psychiatric texts in France are obliged to consider “artificiality” at length. The rhetoric of complaint is thus a widespread means of coping with dysphoric affect, and exhibiting one’s trials to others.

Though a widely used and respected diagnostic instrument indicates the presence of recurrent clinical depression in our visible saint, we feel the diagnosis to be exceedingly problematic. We would suggest that Mme. Lorca is not a “classic case” of depressive pathology at all. Instead, we see in her a cultural role which mimics an American notion of depression but which is fashioned from several significant cultural themes long associated with her culture area.

Affect, Coping Mechanisms and Sainthood

Strong and negative affects are strictly disvalued in Chinese culture. In contrast we see the sanctioning of such emotions in the Lorca family in particular and in the community at large in general. Although members of the community claim different Mediterranean origins, there is a common evaluative framework that is learned, shared and employed. The wide use of this framework suggests of a common culture shared by community members of different ethnicities (e.g., French, Spanish, Algerian) (see Arensberg 1963; Davis 1977; Gaines n.d., 1982a, 1985b; Gilmore 1982; Peristiani 1966; Pitt-Rivers 1963).

Sadness and Anger

While there is clearly positive sanctioning for the expression of negative affects in family and community, there are a number of stipulations regarding their expression. These stipulations reflect the culture’s ubiquitous gender distinctions. Mme. Lorca was free to publically express unresolved forms of grief and sadness. She was often briefly tearful when discussing distressing events or circumstances. Yet she was never labeled by her peers as ‘weepy,’ ‘complaining,’ or ‘whiny’ (or ‘chronic complainer’). ‘Hyperochondriacal’ as she most certainly would have been in North American or Northern European Protestant contexts. On the contrary, she was described as “brave,” “courageous,” and was admired, for she “held strong” in the face of great adversity. In a word, she was a “saint.” Thus the rhetoric of complaint (for men or women) is not demeaning; it is ennobling.

Mme. Lorca had less latitude a propos another strong affect-anger. Most of her anger was directed at her husband (recall her dreams), but was expressed in muted or oblique ways, such as complete silence or sulking in his presence. On a number of occasions, she was observed to express her anger directly, by yelling at M. Lorca. The children present were altogether unruffled by her expressions. Occasionally she was testy with them. Her expressions of anger, however, were insignificant in comparison with the outbursts of her spouse. The pattern was reversed in the case of M. Lorca; anger was rarely inappropriate for him to express, while sadness was less easily or extensively expressed. He did not visibly share his wife’s unresolved grief for the miscarried babies; he appeared disinterested when the subject arose in conversation.

Somatization

As among Chinese patients, these women of the Mediterranean manifested abundant somatic complaints, which we see clearly in the literature (e.g., Etcherelli 1967; Rochefort 1961) and the ethnography of the area (Herzlich 1973; Wylie 1957). These and other studies (see Sonntag 1979) of Mediterranean peoples also show conditions that would appear to be depression. Such conditions are not treated as pathological. We see in Mme. Lorca, and the other women in our sample, similar patterns—elevated SDS scores which can be attributed to sleep disturbances, increased heart rate, fatigue, weight fluctuations, constipations, thoughts of death and suicide, lack of interest in usual activities, etc. Yet their many somatic complaints were not accompanied by severe depressive mood. Significantly, none of the individuals with high scores or other results indicative of depression were unable to function. From a formal psychiatric perspective, their ability to interact with significant others and to fulfill basic needs should have been significantly compromised. That this was not the case calls into question the validity, in this setting, of both the diagnostic instruments and the nosology used.

Mme. Lorca and her peers would readily admit to being “sad” or even feeling “helpless,” but further discussion of the psychological components seemed forced and artificial. She would be described by U.S. psychiatrists, as would her peers, as “not psychologically minded” (and hence not a candidate for psychotherapy). Mme. Lorca exhibited a reluctance to explicitly link depressive experiences to stressors. She admitted that her last two illness episodes were immediately preceded by extreme marital discord. And there was agreement among her friends that her illness episodes were “normal” given her “difficult life.” But never did she or her friends suggest that her illness or symptoms were triggered by domestic strife.

Religion

Another means of coping with the culturally constructed interpretations of experiences productive of dysphoric affect in its chronic or episodic form
are increased religious observances. During “difficult times,” our informants reported that they prayed more frequently; the Catholics increased their recourse to the sacraments of confession and communion as well as seeking the counsel of the parish priest. While such coping may result in what Devereux (1980b) termed “remission without insight,” Mme. Lorca and her peers’ coping mechanisms have adaptive value within the cultural context. We can observe here that in marked contrast to the harmony and suppression of strong emotions seen in the Chinese family, conflict is a characteristic component of the family dynamics of our informants.

The Chronic Sick Role
The chronic sick role and concomitant suffering are positively sanctioned by Mme. Lorca’s family and peers. The canonized and uncannonized saints of history have acted as exemplary models for them. While mental illness in brief or prolonged bouts is not approved in this area, numerous somatic complaints are acceptable sequelae to a life of ‘difficulty’, as Herzlich also found in her study of beliefs about illness in France (1973). Illness episodes engender the concern and attention of significant others. Illness may in fact be seen as “liberating” and positive as it focuses attention on one; “when one is well, no one cares, life goes on as usual” (Herzlich 1973). Illness, then, focuses attention of the all important family upon the sick.

There are many reflections of familial patterns in our visible saint’s personal brand of Catholicism. Like several of her peers, she expressed a vague fear of a stern patriarchal God who meted out punishment and tested her (e.g., “taking” her children). The saints, Mary, and Jesus, however, could intercede in a pinch, as does she for her children and as did her mother before her. She usually attended Mass twice a week, and reported praying on a daily basis, to “Jesus and the Saints and the Virgin.” (When asked if she prayed to God, our informant seemed confused, and replied that she did not.) Praying consisted largely of recitation by rote of simple prayers she had learned as a child, and of direct requests for health or the resolution of family and financial problems.

As elsewhere in the Mediterranean, sickness is seen as a result of external forces, fate, life and or society (see Herzlich 1973), not personal actions or relations. The ill are held to require the indulgence of others and a dependent role. Interestingly, for several informants, Jesus, the saints and, less surprisingly, Mary, collectively embodied the characteristics considered maternal in many areas of the Mediterranean culture area. The concept of Jesus as mother is wide-spread and of considerable antiquity (see Bynum 1983).

CONCLUSIONS: TRISTE TOUT LE TEMPS; THE CULTURAL PATTERNING OF DYSPHORIA

In a subsequent ethnolexicographic research project in Strasbourg and Paris, we initiated the compilation of a lexicon (see Boehm 1980 for the rationale and methodology) of terms referring to dysphoric affect in France. This work demonstrated the existence of a condition of long-term or permanently unresolved grief or sadness over a loss, just as we see in Mme. Lorca with reference to her children “taken by God.” Such states were seen by informants in France as influencing daily action, thought and mood, though among middle-class Americans such things as stillbirths and miscarriages “are regarded by some as ‘nonevents’ or ‘nondeaths’ of often unnamed ‘nonpersons’” (Osterweis et al., 1984).

In France this response to trauma or loss, is labeled, “triste tout le temps” or “fatigué tout le temps.” These states are well-known to informants; they appear to them as quite reasonable, occur fairly widely in the experience of people questioned (who were mostly middle-class) and are seen as appropriate and ‘natural’ responses to loss or misfortune. The condition could be described as a ‘chronic reactive depression.’ However, such an entity is not to be found in American psychiatric nosologies. And, the existence of the triste tout le temps syndrome suggested to American psychiatric professionals questioned by the senior author (ADG) that ‘problems must have existed with the premorbid personality.’

However, the condition is well-known in France and elsewhere in the Mediterranean culture area and is simply tolerated or is treated by rest at home for periods of weeks or months (or even years). Severe cases may be placed in National Rest Homes (sanitaria) where they may stay for years (government supported) with no diagnosis other than “tired” or “sad all the time.” The condition appears in the popular literature without comment (e.g., Etcherelli 1967) as well as in films (e.g., Truffaut’s, “The Woman Next Door”). We may thus recognize that Mme. Lorca is actually using a culturally patterned and well-known means of expressing dysphoric affect in a chronic picture which evidences periodic amplification and dampening of symptoms. Her ‘performance’ is well understood by her culture-mates who also can empathize with her. Her condition, then, is a patterned syndrome particular to this cultural area. The condition, coupled with the tendency to somatize conflicts or traumas and the form of self presentation (the rhetoric of complaint), combine to produce a presentation which mimics severe clinical depression on clinical psychiatric instruments. But our use of ethnographic knowledge, including interactional patterns and history, allows us to understand Mme. Lorca and her role of visible saint and to thereby disconfirm the findings of the clinical instruments.

It is certain that the distribution of visible saints is skewed in the direction
of women. More women are visible saints because they are expected to passively accept externally imposed suffering (often, ultimately, by a stern God-Father-Husband). Suffering is a woman's lot, 'especially since she has already sinned; she has been born a woman.' Indeed, many popular notions of women's roles are formulated in religious doctrines of the area; social dynamics are thus reinforced by religious beliefs, which may have their origins in family-based sentiments (La Barre 1970).

It may be said that saints are losing their primacy as social cynosures in some parts of the Mediterranean culture area. Suffering is less and less fashionable in the universities and middle-to-upper classes of Paris, for example. We note that the "psychoanalytic revolution" which occurred in France in the late sixties and early seventies was not felt profoundly in all of urban France. As Turkle (1978) expertly shows, the analytic interests of the French Freudians were not insight, "but listening" (écouter), bearing witness to a patient's existential position. Insight therapies have not "caught on" in the culture area. A psychologist at the dispensaire near the housing project where our informants live stated that French women seem to have an aversion to "talk therapy," as did Mme. Lorca, and that in addition, Iberian and North African women were notorious for declining or failing to keep appointments (something for which the French are also known). The males of these ethnic groups were said to be even worse though the care is paid for by the State.

SUMMARY

The model of the visible saint presented here is predicated upon our understanding of an intricate complex of interrelated beliefs and experiences not just about the family and religion, but about the self, interpersonal interactions, sex roles, the nature of life as suffering, as a grim, 'thankless struggle that one cannot quite win' (Cornelsen 1971), about body images, social evaluation and prestige, styles of self presentation and self description, folk etnography, and the nature of 'health' and 'illness.'

In this paper, we have considered a culturally constituted social cynosure in which a wide variety of cultural themes and values are united and exemplified. The cynosure serves as a model of and for social action in the communities in which it is found. Our focus on a key social cynosure has allowed us to explore a host of cultural themes, values and a worldview embodied by this cynosure of the Mediterranean culture area and through which they are expressed. Our multidisciplinary approach combined anthropology, psychiatry and history. The approach allowed an understanding of Mme. Lorca, and by extension other visible saints, in a manner sufficiently full to pay tribute to this central role of the cultural tradition.

The analysis demonstrates that the visible saint is not different from other culture members, but rather manifests simply more significant elements of the tradition than do others. The role patterns dysphoric affect into a syndrome distinct from that of clinical depression but which may be confused with it when assessment strategies include only psychodiagnostic instruments. The findings suggest caution in psychiatric epidemiological research is warranted despite the much heralded innovations represented by the development of instruments such as the Zung, RDC, Diagnostic Interview Schedule (DIS), and Present State Examination (PSE) (see Weissman and Klerman 1978).

The bounty of significant semantic elements which the saints embody gives them a prominent and focal position in their cultural context and the adoration and respect of their peers, for they show the way to live nobly in a life path believed to be, from birth to death, but a bridge of sighs.

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NOTES

1. The term "visible saint" has also been used to refer to the Puritan idea of living as an example for the world (see Morgan 1975).

2. This article has a secondary aim with respect to European ethnography. That is, the paper firmly locates France within the Mediterranean culture area. Heretofore, France has sometimes been excluded from groupings of Mediterranean cultures (Ptikin 1963) and sometimes (properly) included (e.g., Pitt-Rivers 1963).

3. The visible saint also appears in Catholic-influenced Caribbean and Latin American societies, such as Haiti and Brazil in which West African cultural elements are also found.

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