10 Madness in Zanzibar: An Exploration of Lived Experience

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It is clear that the outcome for schizophrenia is better in developing than in industrialized countries (see Hopper this volume) yet attempts to account for this difference have been speculative and elaborated in "a virtual ethnographic vacuum" (Hopper 1992:95). It is also clear that family predictors of relapse—hostility, criticism, and emotional overinvolvement expressed by relatives toward the ill family member—have proved robust when tested cross-culturally (Jenkins and Karno 1992). Jenkins (1991) has urged attention to the cultural salience and meaning of these predictors of relapse. Ethnographic study of particular families in the developing world coping with psychotic illness in the household is recommended to explain how social and emotional factors might moderate prognosis (Corin 1990; Sartorius 1992; Lucas and Barrett 1995).

Hostility in familial interactions is identified when criticism is generalized or pervasive (for example, "he's a failure at everything he does") or rejection ("he can live on the streets for all I care"). Criticism is defined in terms of a negative affective response (usually anger) to rule violation observed in language content and paralinguistic features of speech (Vaughn and Leff 1976). It is necessary both to identify cultural rules and to appreciate the range of familial and community responses to rule violation in order to understand criticism and hostility. Emotional overinvolvement must be understood in terms of kin relations and notions of the self. Overinvolvement and altered self/other boundaries may be presented in a variety of culture-specific idioms, whereas appropriate involvement with kin may be judged only by local standards (Jenkins 1991). Social withdrawal is a strategy by which people with schizophrenia buffer emotionally intense social interaction (Brown, Birley, and Wing 1972; Corin 1990).

This study examines three families that included five people diagnosed with schizophrenia and develops an understanding of illness, course, and impact on the family emotional environment that is grounded in a knowledge of cultural norms and social processes, including political upheaval and ethnic conflict. It is drawn from a more extensive study conducted in...
Zanzibar, Tanzania (McGruder 1999) that sought to develop an ethnographically grounded approach to the study of schizophrenia. The study examines culture-specific notions of self and the spaces between self and significant others and takes into account cultural ideas about agency, accountability, and the appropriate handling of emotion.

Methods and Participants

Zanzibar is a semiautonomous island state in the republic of Tanzania, where traditional medical practice is legal and various forms of it are used. Biomedical psychiatric care was introduced there by British colonial authorities with the building of the first lunatic asylum at the turn of the last century (McGruder 1999). In 1988, I was an occupational therapist at Zanzibar's Kidongo Chekundu Mental Hospital. During that year, I interviewed twenty-three patients diagnosed with schizophrenia about their uses of traditional medicine and their illness explanatory models (Kleinman 1980). In 1994, I interviewed and observed traditional healers identified by the mental hospital's community outreach nurse as those involved in care of the mentally ill. In 1996–97 I conducted the study I report on here.

Thirty-two patients were nominated for the study by hospital staff. All met both ICD-10 and DSM-IV diagnostic criteria for schizophrenia and were recently discharged or ready for discharge. On forms I prepared, staff members recorded their impressions of patients' functional levels and living situations. I calculated a rough measure of illness severity for each by dividing the summed inpatient lengths of stay by the time elapsed since diagnosis. From the thirty-two nominated, I selected seven patients to get a mix of both genders and a range of ages, functional levels, illness severities, lengths of psychiatric history, and family constellations. The three families I report on here were the first I selected and those with whom I spent the most time. Two university human subjects protection boards and the medical research committee of the Zanzibar Ministry of Health approved the study methods and informed consent procedures.

During the eleven-month period of the study I visited families at home twice each week on average and they visited me. Social norms in Muslim Zanzibar allowed me to spend more time with female family members than with males. I accompanied families on visits to kin in the countryside and in town, attended weddings and memorial services, cooked with the women, went on picnics, and celebrated the end of Ramadhan with them. I accompanied four of the five patients on their follow-up visits to the mental hospital. None were inpatients during the study. All
but one were taking medication through the outpatient department. My research assistant, Ahmed A. Salim, a local psychiatric nurse, and I conducted one taped interview with each family midway through the study year.

In addition to this prolonged engagement with the three identified families, I held two gender-segregated focus groups to discuss familial norms for expression of emotion, criticism, correction, and discipline. Some participants in the focus groups were mental hospital personnel; none were family members in my study. I talked with other community members about notions of self, madness, spirits, and Islam. Dr. A. I. Abdulwakil, a psychiatrist born in Zanzibar and educated in Tanzania, Germany, and Nigeria, has provided valuable consultation periodically during the decade I have spent learning about Zanzibar.

**Families, Self, and Emotion in the Swahili Culture of Zanzibar**

Marriage is nearly universal in Zanzibar and only 2.5 percent of Zanzibari women remain childless; the average desired number of children is 6.5 (Garssen 1988). Divorce is common. The values of modesty, concern for the rights of others, respect, shame, and privacy guide behavior in Swahili societies (Swartz 1991). Kin are portrayed in proverbs as more reliable and dependable than nonkin, but also potentially more irritating given their closeness. Offspring who contravene parental desires and lose their parents’ blessing risk the loss of heaven. Child rearing is shared across the extended family.

Ninety-eight percent of Zanzibar residents are Muslims, and of those, 90 percent are Sunni Shafi’ites (Garssen and Haji 1989). Islamic ideology shapes daily rhythms and lifecycle marker events, informs moral choices, and provides succor for dealing with illness and adversity. Local Islamic scholars accept Al-Bukhari’s collection of hadith as the body of writing that documents the acts of the Prophet Mohammed and thereby provides a guide to living. These hadith include accounts of healing by the Prophet, of his dealing with witchcraft, and advice about the finn. The Qur’an and hadith convey that Allah will not put upon humans more than they can bear, that suffering expiates sin, that one must bend to Allah’s will, and that a heavenly reward awaits those who embrace with gratitude the tribulations that Allah sends them. They also endorse the idea that spirits are active in the everyday experience of humans.

Spirits are widely held to be a cause of madness. In 72 percent of cases of psychosis identified in an epidemiological survey in Zanzibar, families
used both hospital and traditional forms of treatment (Bondestam, Garssen, and Abdulwakil 1990). Traditional treatment includes botanical remedies, therapeutic uses of the Qur'an, and spirit ritual.

The self in Swahili culture, while individuated, remains permeable to the presence of other beings. Spirits are more powerful than humans and can bring illness, bad luck, infertility, and other problems. Anger and violent feelings provoked in human interactions may be deflected into and expressed in interactions between humans and spirits (Caplan 1992). The spirits’ willingness to act impulsively and unashamedly on desire marks them as “other.” The spirits, whose ethnicity may be Arab, European, Malagasy, Ethiopian, or of a variety of mainland tribes, are troublesome like foreigners who intrude but do not greet (Giles 1995). Spirits may also be Swahili. But even Swahili spirits are autonomous, rude, selfish, and not given to controlling or concealing their emotions, unlike their (idealized) human counterparts who strive to live up to high standards of courteous behavior. Spirits may be sent purposely to harm, inherited from deceased ancestors, or attracted by one’s desirability.

Neither the body and the soul, nor the body and mind are opposed concepts or spaces. Rather mwili (body) and maumbi (God-created nature) encompass nafsi (individual essence or vitality), roho (soul), moyo (heart), and akili (mind, intelligence, or reason). Both humans and other animals have nafsi and roho, so the vitality and soul concepts here are different from those of Christianity. Nonhuman animals do not have akili. A psychiatric nurse friend compared nafsi to the id and both roho and moyo to the ego. Statements of emotional or bodily feeling and self may use nafsi, particularly when emphasizing an individual point of view, but more often use roho and moyo (Johnson 1939).

Moyo is heart, both anatomically and figuratively. Things that one keeps to oneself are hidden in the heart, a private internal space. One woman participant in this study was distressed when hearing male voices (hallucinations, we would say), because hearing the men meant that they could see “even into [her] heart,” a shameful experience. The heart may be broken, but this does not connote the degree of desolate unhappiness it does in English. It means something akin to disappointment. Hate (chuki), love (upendo), and happiness or joy (furaha) are felt in the roho or moyo, as are other emotions and sensations. Like many in the developing world, Swahili persons are said to construct individual identity in terms of social group membership (Swartz 1991; Middleton 1992). Yet my observations resonate with Kleinman’s (1980) assertion that developing world people can define themselves in ways that accord much importance to the social group and yet be ruggedly individualistic. Although much social intercourse and action is tied to group goals and wants, the individuated
self is recognized in a number of Kiswahili proverbs that remind us that:

_Akili ni nyewele, kila mtu ana zako._ Reason (intelect) is (like) hair, each person has her own.

_Kizuri kwahe, kibaya na nevenzahe._ (What is) good to her (may be) bad to her companion/friend.

_Penye wengu, pana mengi._ In a place having many people, there are many points of view.

The first of these proverbs is so common in ordinary talk that Kiswahili speakers truncate it: _Akili, nyewele_. Many verbs in Kiswahili make use of a reflexive particle and the ease of its incorporation even in borrowed verbs is more evidence of an individuated reflexive concept of self.

At focus group meetings I explained that some doctors believed getting better after mental illness is less likely if there are strong emotions expressed in the family. In order to appreciate whether families of patients were unusual in this regard, I needed help understanding how emotion was usually expressed in Zanzibar families. I asked participants to mention words for emotions that were part of family life, indicating that I assumed some conflict to be universal. In both men’s and women’s groups, love (upendo) and hatred (chuki, uchukivu) were mentioned first. The two groups’ lists also included anger (hasira), grief (msiba), sadness or sorrow (huzuni), and joy or happiness (furaha). Beyond these terms, women’s and men’s responses diverged.

Next I asked participants to tell which emotions generally ought to be hidden and which ones might be shown freely; which emotions can be suppressed or controlled and which are impossible to control. Concealment of certain emotions and thoughts is important in Swahili society (Swartz 1991; Yahya-Othman 1994). Men and women agreed on the importance of hiding chuki (hate). Hatred should be held in the heart and allowed to dissipate. Keeping a pleasant exterior and greeting the object of one’s hatred would gradually diminish hate – an example given by two women was of greeting one’s cowife despite hatred and jealousy (voivu). Enacting courtesy or kindness was said to produce a prosocial feeling, called mazoezi (accustomedness) (confer Swartz 1991).

Participants agreed that anger (hasira) should be controlled or hidden and proverbs attest to the importance of doing so.

_Hasira ni hasara._ Anger is loss.

_Hasira ya mkizi ni faida ya mwani._ The anger of the cuttlefish is the profit of the fisherman.

In explaining the first proverb, people told stories of loss of temper leading a parent to strike a son or daughter – their grown offspring in the
examples I heard – causing severe injury or death. The second proverb was explained in terms of the demonstration of anger leading to the loss of some desired result in interpersonal interaction such as social loss of face or destruction of friendship.

One woman offered the metaphor, “Anger is soda.” Being used to our hydraulic metaphors of suppressed emotion, I took this to mean that, if unreleased, anger might explode. “No,” she explained, “if you shake a soda and it bubbles up, you can only let it out a little at a time, not all at once. But better still you can also leave it be and it will calm down again.”

When asked what emotions could be shown freely, women told of the dangers of all strong emotion, even joy (furaha). In an animated and lengthy discussion several told stories, some taken from Indian film, in which expression of joy was followed by death or grief (msiba). Although men discussed the control of anger and hatred, they could not think of an example in which joy must be hidden or suppressed. When I shared some of the women’s stories of expressed joy turning to grief, the men scoffed. It seems that while women are thought less capable of controlling emotion, they themselves evince more wariness than men do of any strongly expressed emotion, even joy.

Both groups discussed self-control during grieving. It is considered a shameful thing for an adult to cry. An adage reinforces this: Miu msima hula ni aibu. Grief is an emotion one cannot manage alone. During matanga, the social gathering of kin and friends following a death, the bereaved is never alone so that grief may be communally managed. It is not a shame to cry alone or to admit that you cried alone. To cry quietly is expected. Too noisy a show of grief is seen as an impertinent questioning of Allah’s will.

Children are admonished not to cry. Boys are told jikaze (shore yourself up) and don’t be like a girl. Girls are told jikaze or you will not get a suitor. Adults also described teaching emotional self-control through the example of adult behavior. One woman who worked in a household with American children expressed distaste for how much crying they did. “Any child old enough to speak, to tell you what is wrong, should not be crying so much.”

On the topic of love (upendo) men and women differed again. Men said it is often necessary to hide love; women said that it is impossible to do so. I asked the women if it were (hypothetically) possible to hide love, would this be a good thing to try to do. They would not entertain the hypothetical but shouted me down saying, “You can’t! You can’t!” They reminded me of the wrap garment I was once given as a gift and the saying on it: Mapenzi ni kikohosi hayawezi kufichika: Love is (like) a cough,
it cannot be hidden. Several pantomimed trying to suppress a cough that burst forth anyway. Men and women agreed that it would be a rare thing to express love verbally, but men said more emphatically that this is a matter of *aibu* (shame).

The preferred interaction style in Zanzibar is not very outgoing and intrusive especially between adults. The valued social demeanor is one of calm reserve. The lack of what we call assertiveness is not a sign of low self-esteem. Rather it appears to be a hallmark of healthy self-respect. One who offers unsolicited opinions, advice, or correction to other adults who are not one's children is considered ill bred or uncouth. Inside families, criticism is indirect as a rule. Disapproval, especially between adults, should be expressed through an intermediary. Both men and women stated that always with elders, generally with age peers, and often with their own and other people's children (depending on the specifics of the situation), it is best to take a complaint to a third party in the family and ask him or her to intervene. When having a problem with an elder, one looks for someone even higher in age and esteem. This avoidance of direct confrontation or criticism is not at all a laissez-faire principle of noninterference. Rather, it is a way to bring pressure to bear without being direct or causing the other to suffer shame. Participants agreed that one's children are not free to do as they like until after they are married, and even then should heed parental advice. The valorization of elders' authority, of emotional reserve in interpersonal social space, and of indirectness in disapproval, establishes an important context for observations of emotion and involvement in the families of persons with schizophrenia.

Despite his command of English and my provision of explanations and examples (taken in part from Jenkins [1991]) Ahmed, my research assistant, had great difficulty helping me to translate "emotional overinvolvement." At first he suggested we use *kudekesea* (to spoil). It was not until he saw a negative example of overinvolvement in a family that he grew certain that *kudekesea* did not cover it. There was no easy translation. For the purposes of the focus group meetings, Ahmed settled on a long construction for overinvolvement that would be glossed: "If one family member and the ill person are like a whole world unto themselves, or for example, if the family member loves the ill person too much or alternatively doesn't give him or her sufficient freedom or time/space, or pries very intently into private matters pertaining to that person." Focus group members agreed that one may carefully watch a disturbed family member but should do so in unobtrusive ways so that the person does not feel "pried into."
The Household of Amina, Hemed, and Kimwana

Amina, the head of the household, was the wife of Hemed and mother of Kimwana, both diagnosed with schizophrenia. Hemed had spent 32 percent of his time as an inpatient since first diagnosed in 1961, all of that before 1979. With the exception of a brief period in 1991, Hemed had not taken psychotropic medicine since 1979. Kimwana was diagnosed at age twenty in 1983, but had never been an inpatient. She attended the outpatient clinic at the mental hospital and took neuroleptics most of the time. Amina divorced Hemed in 1970, but after he had a stroke and had no other relatives on the island, she took him back into their home to care for him.

During 1996–97 the household included (in addition to the three aforementioned): Amina's mother, two married daughters and their children, one unmarried daughter who was away at university most of the time, one unmarried son studying at Islamic teacher's college, Hemed's half brother who is deaf-mute, and Hemed's adopted sister and her children. Two infants were born to the household during the study year. Amina also had siblings in town and matrilineral kin in rural central Zanzibar. Kimwana visited them only rarely, when compelled to do so. Hemed did not leave the house.

The interactions and discourse I observed in this family support Jenkins' suggestion that cultural conceptions of the causes and meaning of mental illness can mediate the creation of social-moral status for ill family members that inhibits criticism and hostility (Jenkins 1991). When asked, Amina labeled family illnesses as tests from Allah. She accepted the problems in her family with graceful acquiescence to Allah's will as I shall illustrate. While Amina saw the ultimate cause for illnesses in the family as the Almighty, spirits were sometimes seen as more proximate causes. Hemed first became ill during his involvement in racially charged preindependence politics. According to Amina, he would go to political meetings and then come home upset and talking in ways she did not understand. He would speak, as if to someone else, on the whereabouts of political figures. He would threaten his children and beat his mother at times. I thought that the stresses of these meetings and the political nature of Hemed's work at the time contributed to the onset of his illness. Amina said, however, that they believed it was related to a spirit he inherited from his father.

When Kimwana first had an incident of disturbed behavior (going outside one Sunday night and pleading in a loud voice for forgiveness from her deceased maternal relatives and her coworkers) Amina and her mother assumed the problem to be spirit possession. Perhaps a spirit from
the maternal side of the family piqued at not having been duly recognized for protecting the child through her long years of schooling and into her government employment; perhaps a spirit sent by a jealous coworker via witchcraft; these were the older women's first ideas about the problem. When they could not get the spirit to say what it wanted, nor to calm down, they wondered if Kimwana might have cerebral malaria. They took her to the general hospital where she was admitted, eventually diagnosed with schizophrenia, and discharged on medication. For a time, Amina and her mother thought the white tablets were antimalarial pills. Eventually Amina learned that this was ugoniwa wa ahili (illness of reason), a term used at the mental hospital but not an indigenous concept in Kiswahili. Amina considered traditional treatment for Kimwana and did consult a traditional practitioner at one time. For both Kimwana and Hemed, the family had used primarily "hospital medicine" and Qur'an reading.

Kimwana concerned her mother and sisters most when she was reclusive, or refused food, or to bathe, or do her hair. She heard the voices of men who worked in front of their home repairing bicycles say cruel and critical things to her. She told me that those who tormented her were there every day. Some days she did not hear them, but they were always there.

During our 1988 interviews, Amina often deferred to Kimwana or sought her input in narrating the story of her illness. In Amina's telling, Kimwana's illness was related to her work outside the house but now she nearly always stayed home. Amina seemed to withhold judgment, however, on whether Kimwana should be working or going out. She consistently refrained from anything like criticism or hostility when speaking about her daughter, whether Kimwana was present or not. Her tone in narration was neutral and matter-of-fact, never angry, although at times adamant or excited. She calmly remarked that Kimwana felt that the "bicycle repair men concern themselves with her affairs." Her tone conveyed no scorn, just a lack of agreement with this perception. She reported that sometimes Kimwana complained about having to take the medicine and she would reply, "Yes, my daughter, just rest from swallowing those tablets if you like." Amina believed that being without the medicine for too long would bring a recurrence of problems but she did not force the issue. She could be direct with Hemed when she felt it necessary.

Hemed still responded to the voices of unseen others, but was no longer difficult to manage. "The strokes have broken his anger," said Amina, and with his anger gone, she no longer saw his illness in the way that led her to divorce him. Once when Ahmed went to interview the family in 1988, Hemed came in from his place on the porch to see who the visiting
stranger was. Amina told Hemed, “Say, these are matters for the doctor here. Don’t stay here. Go out. He wants the opportunity to talk with us alone. Don’t just say things.” Hemed left without argument. Amina was at that time rather dismissive and possibly hostile toward Hemed. Later, after his second stroke and subsequent greater disability, I observed only her kindness, concern, and patience with him. But a complex multigeneration household like this has other members to consider.

When I visited in 1994, Faki (a younger brother) mentioned to me that Kimwana’s maternal grandmother sometimes scolded her. During that time, Kimwana was often laughing to herself during prayers and during meals. “Grandmother becomes quite angry with her and tells her to stop,” Faki said. I asked how the rest of the family responded. He shrugged. “We are accustomed. We say nothing. We know she is ill, but grandmother is not used to it. She doesn’t think it is an illness.”

I once observed Grandmother scold Kimwana rather fiercely for a small mistake. I had been offered a second cup of coffee but had declined. It was too late; Kimwana was already pouring. “Why have you poured?” Grandmother demanded fiercely, “she doesn’t want it! Pour it back! Pour it back!” She went on for a bit scolding Kimwana. Ahmed, my research assistant, intervened by asking for the already poured cup. Later, he commented that he was surprised by the vehemence of the grandmother’s response. Her show of irritability was a bit outside the valued emotional reserve and certainly different from other family members’ manner with Kimwana.

When I met Bimkubwa, Kimwana’s younger sister, in 1994, one of the first things she said to me was that her father was also mad and that so many people in the house was a problem. Europeans have much smaller families in comparison, she asserted; “There are too many of us and this place is too noisy.” By 1996, Bimkubwa had married and seemed more calm, exuding a quiet strength and an aura of controlled determination. She was pregnant and had recently moved back home while her husband was studying overseas. She attempted to be direct with Kimwana but was not generally successful. For example, she told me that she would require Kimwana to come along when the other women came to visit me. When Kimwana said she could not, Bimkubwa did not argue with her but did not acquiesce to the situation with grace.

Sibling relationships are ones of hierarchical authority. One is generally bound to obey one’s senior brothers and sisters. But in 1996, Bimkubwa was an adult, having achieved adulthood through marriage. She had more education than most, worked and contributed to family finances, and came to be in charge of her older sister Kimwana’s treatment. She was more forceful than her mother about encouraging Kimwana to take the
hospital medication and did not accept Kimwana’s refusals as readily as Amina did. She took control of the storage and dispensing of medication after Kimwana threw all the tablets down the toilet once. Bimkubwa was the one who had intervened in 1991, when Hemed was disturbing the neighbors with his shouting, by going to the mental hospital and bringing him some haloperidol and benztropine.

I accompanied Kimwana on eight of her outpatient clinic visits, six of those with Bimkubwa along. Bimkubwa brought along the fluphenazine her brothers sent from England for Kimwana’s use. She complained to the doctor that Kimwana now did nothing to help at home where before she had been very helpful. In 1994, their brother, Faki, had expressed concern to me that Kimwana did too much. The psychiatrist inquired during one office visit if Kimwana had opportunities to socialize at home. Was the family isolated? Were there other young women? Did they invite her to sit with them? Bimkubwa replied, “We are thirteen of us there in a small house and we are together.” Bimkubwa listed herself and two other women as close to Kimwana’s age and said:

We do invite Kimwana (to socialize). Most times, she refuses, or if she comes, after a bit she gets up and goes her own way. The television is in the room where Kimwana sleeps and we all gather there to watch it. But even then she withdraws. She doesn’t like to watch and lies close to the wall, facing it.

September 1996 was a particularly difficult month for this family. On the first of September, Kimwana took an overdose of malaria medication. She was released from the general hospital after about twenty-four hours. Later she would tell me that she had wanted to die because her psychotropic medication made her feel so miserable. In mid-September, the flu or a bad cold went through the whole household, and Amina commented that they were too poor even to buy aspirin. Kimwana was asking not to be given her psychotropic medication and her mother was not forcing the issue.

By September 28, all had recovered from the virus and I spent a Saturday cooking with them. Kimwana was nowhere to be seen when I arrived. We began cooking and no one commented on her absence. Our cooking was interrupted by the arrival of some men from the extended family who brought additional things to cook. They pulled Amina aside to discuss the grandchildren’s school fees. There was much confusion with children coming and going in two shifts from Qur’an school. Some were sent to the market for the coconuts now needed to prepare the eggplant the men had provided. In all the confusion we allowed a huge vat of tea to spoil when the milk in it curdled. One of the grandsons and I asked Amina whether the tea might be saved by straining it. She was a bit sharp
with us, repeating, “It has curdled. It is spoiled.” Grandmother began to grate coconuts. She always insisted on grating the coconuts herself, despite her complaints about arthritic knees and ankles and the flexed posture one must assume for this task. Amina made a new pot of tea. Later while we had lunch we could hear Hemed across the hall shouting “Lies! Lies!” Kimwana had not joined us during this entire time, neither cooking nor eating. I asked Amina whether it was better to go see her and greet her or just leave her alone. Amina thought a minute and said to leave her alone.

Responsibility for feeding so many people when cooking plans change, and things do not go smoothly, made it a very difficult day for Amina. Her tone was sharp with two of her irritants, for a second or two. The economic pressures of having two younger male breadwinners away with no work and three disabled people in the household seemed to be mounting up. Amina became very sad in recounting her troubles. I thought for a moment that she was going to cry. She said that life is hard; then, “In Kiswahili we say, this is just a test. I am just waiting patiently [for relief, implied]. I am resigned.” The implication here was that such tests come from Allah.

Throughout this difficult day, when both Hemed and Kimwana were more disturbed than usual, there was still an air of permissiveness and tolerance. They were allowed to withdraw from face-to-face contact with others and Amina maintained their space by discouraging others from interfering with them. Later, Kimwana said this about her need to be alone:

I do like being on my own. I feel like calming myself, just silently. Just quiet and silent. Being with people I feel like I am just tangled with them. I know I am sick and I like to be on my own without getting harassment from people.

I also noted Amina’s use of the interrogative mbona in correcting the children on the difficult day described previously. Mbona is employed in statements more rhetorical than directly interrogatory, such as “Don’t you see that it is…” (Johnson 1939:269). This linguistic form is less direct than an accusatory statement starting with “you.” In Amina’s descriptions of Hemed’s accusations when he first went mad, she did not recount what he actually said to his elder female relative or to his son when he “abused” them, just that he began “You, you, you…” This is enough to differentiate his aggressive communication from her reserved style and speaks to the cultural valorization of indirectness. I noted this indirectness many times in intrafamilial communication and in messages directed at me, as when Amina encouraged me to fast without saying I should, or when Kimwana corrected my way of juicing lemons, by saying, “We generally do it like this.”
Despite a variety of interaction styles in this multigeneration household, Swahili cultural norms for communication and emotional expression and Islamic beliefs about the acceptance of adversity support a low-expressed emotion environment that appears to have benefited both Kimwana and Hemed. Sometimes their behavior tried their kin sorely, yet there was apparently very little criticism or hostility directed toward either of them. During the hottest months of the year, Kimwana slept beneath the only fan in the house. Hemed was afforded care when he became dependent and despite a legal Islamic divorce was taken back into the household. Moreover, while family members held different opinions about the nature of the illness and the appropriate treatment for it, there was little attempt to control Kimwana or Hemed or portray them as sources of problems for others. That is, there was little evidence of emotional overinvolvement.

The Household of Khadija and Yusuf

The next family I describe is like the first in several important ways: a two generation history of schizophrenia; a younger generation member who helps manage her sibling’s illness; spirit-related explanatory models accepted alongside that of “hospital medicine”; and a worldview, supported by Islamic faith, that expects and acquiesces to adversity, particularly in the older generation. The odd beliefs of the younger patient are not criticized. Disapproval was voiced rarely and in indirect and reserved ways. There are important differences between the families as well. The younger generation patient (Yusuf) had acted out aggressively during periods of psychosis, had been hospitalized frequently, and had different strategies available to him for social withdrawal. Each patient’s history and illness ideas are presented first, followed by examples of family interactions.

Of all of the people with a diagnosis of schizophrenia in my study, Khadija had the highest level of social functioning. Her oldest son, Yusuf, was more seriously ill. They lived in a small house in town, owned by the extended family, in order to be close to the hospital should an emergency arise. Khadija was the head of the household, cooked for nine or ten people daily, visited kin in rural areas to collect food and fuel, and sold handicrafts her sisters made. During the study period the household also included Khadija’s two youngest sons, her young half brother (a child), her granddaughter, three children of friends from rural areas who wanted their children schooled in town, and, for a short time, one of Khadija’s young grandsons. Ruweya, Khadija’s older divorced daughter, lived across town in a private apartment in a female friend’s home.
In 1957, soon after her marriage at age fourteen, Khadija’s first child was stillborn and she became restless and anxious. This problem was diagnosed as spirit related and successfully treated by a traditional healer. In 1958, she miscarried. Eventually she had two daughters and then Yusuf. In 1964, her first husband was killed during the Zanzibar revolution. She and the children were imprisoned briefly. In 1969, she married again. Shortly after the birth of her fourth child in 1970, her second husband left. Khadija became very restless and cried for three days. She ran from her home, was picked up by police, and taken to the mental hospital. This was her first hospitalization. Her parents recounted to nurses the similar illness Khadija had experienced after the stillborn child. Khadija was given the diagnosis “schizophrenia, postpartum psychosis.” In all, Khadija married three times and had three daughters and five sons. At least one more of these births, in 1972, initiated a period of restlessness and confusion for which she was treated on an outpatient basis. In addition to obstetrical events, her onset of symptoms often coincided with periods of hot weather and with the laborious rice harvest. Between 1970 and mid-1997, Khadija was admitted to the hospital for eleven brief stays, spending 3 percent of her time as an inpatient. She had attended the outpatient department with increasing regularity, obtaining medication every six to eight weeks and occasionally staying away for a few months.

Khadija could not recall the name of the disorder for which she received traditional treatment after her first child’s stillbirth or anything else about her treatment, except that it gave her relief. She described herself as recently having gotten better as a result of help from the hospital. She seemed reluctant to speak directly about her illness or other troubles in life. Like many elders who avoided discussions of difficult times past, she expressed satisfaction that she could not remember. “Praise Allah, I have been fortunate to forget that time.” We asked Khadija to tell us about the best and worst times of her life. She replied:

Troubles? I didn’t have many. I had my family, my relatives there, and we were many. And therefore once I got problems there is a place to rest and there is comfort. I didn’t have much difficulty in life.... There were, as I said, only those problems of politics [refers to her first husband’s murder during the revolution] but, in general there weren’t problems. I was nicely brought up by my parents. I was married; gave birth. No problems to grieve.

Khadija often evidenced an attitude of acquiescence to adversity. One day she and I were sitting in her kitchen as she prepared lunch. Khadija said that life is changes. First, you get pregnant, then you give birth, then you nurse the baby – all changes. Then you carry the child on your back.
and raise it – still more changes. She followed this with another example from women’s lives listing role changes from child to big sister, wife, mother, and then grandmother. “Life,” she repeated, “is all changes.”

Later we were talking about the revolution and she told me that a neighboring family lost two men, one in the June 1961 election riots, and another at the time of the revolution itself. “A shame,” I said. “No,” she corrected me, “it is just change again: happenings, events.” She said that all events are already written. If such things happened again it would also be because they are written; because Allah wills it.

During Yusuf’s first three admissions to the mental hospital he was given no medication. His provisional diagnosis at age twenty-five was acute confusional state secondary to marijuana abuse. On his fourth admission, seven months after his first discharge, he began receiving chlorpromazine and his problem was viewed as psychosis, later specified as schizophrenia. Between 1988 and 1997, Yusuf was admitted to the hospital twenty-nine times, spending 34 percent of his time as an inpatient.

When asked about the best and worst times of his life, Yusuf replied, “I enjoyed life before I got this fīnī.” Yusuf said he had at least one fīnī (Jinn) and several angels that used his body. He could hear them but not see their faces. Sometimes they spoke through his mouth and this was a miracle. He felt like he was together with many other beings, Jinn and Angels who talked and whose presence he could feel. He once threw himself from a building and broke his leg during an episode in which “Many voices came out; different ones were coming out from my mouth.” A voice commanded him to jump. Some of the voices “do still command me to do bad deeds but I no longer follow them. I know they are enemies.”

Although he had frequently run away from it, Yusuf had also occasionally brought himself to the mental hospital. He was well liked there and did not mind going to the ward to nap after his outpatient occupational therapy group. Despite his potential identification with the institution or the people he found there, he resisted the label of madman or a mentally ill person. He externalized this opinion to others – an aunt he lived with once, nameless others who made this comment as he passed. He experienced his difference as a miracle, although at times a troublesome one. Although some of the beings who inhabited him were enemies and he must “forget what they say,” others were helpful in reminding him to say his prayers and in keeping him slim.

Yusuf’s discourse was often centered on issues related to Islam; some of it orthodox, some of it unusual. He desired a deeper immersion in
Islam. He was skilled at reciting Qur’an and had worked as an assistant to a Qur’anic healer. Yusuf had been treated with a variety of traditional treatments – botanical, spirit related, and Qur’anic – and his opinion of traditional treatment was positive. Yusuf, his mother, sister, and maternal great aunt agreed that he often improved with traditional treatment. Once Yusuf had taken hospital-issued medicines and the herbal preparations of a local healer together, until the man directed him to quit taking the hospital tablets. Yusuf complied and enjoyed a period of three months in which “his condition was very good, he calmed down so much” according to his sister. But that was followed by an abrupt and severe attack of psychosis, and Yusuf quit traditional treatment. He took fluphenazine injections at the time of the study, paid for by his sister. She was a believer in Islam, traditional botanicals, and biotechnology.

Khadija accepted spiritual explanations of illness but also saw to it that Yusuf took his injections. Yusuf’s hospital file describes a time when he struck Khadija and other times when he reported to hospital staff that he felt as though he wanted to strike or kill someone. He was generally courteous and mild mannered, however. Khadija would voice concern to Ahmed or others at the hospital if she saw that Yusuf was “talking all alone” or “laughing just with himself.” She directed him to attend the outpatient clinic if he did not initiate this, but did not make other demands of him. On learning that Ahmed and I were returning a young male patient to his father, Khadija advised us: “The father should be helped to understand that the young man must rest, that he can’t take much heat, and that his soul (roho) should not be made too sharp” – an idiomatic way of saying he should not be angered or irritated. She spoke of her own rural extended family of rice, clove, and coconut cultivators as affording her the opportunity to rest as needed because they were many. Extended family size and financial networking seemed integral to removing the pressure for productivity from ill individuals. Yusuf’s symptoms and hospitalization periods were markedly reduced in the year following Ruweya’s return to Zanzibar from England when she undertook economic support of her mother and brother.

One day Khadija, Ruweya, Yusuf, and my assistant Ahmed came to our house for lunch. Khadija brought up the topic of how much Yusuf smoked and slept. She gently contradicted Yusuf’s claim of smoking ten a day, saying that his consumption was going up and up and was more like twenty. She said, “He does forget how much he smokes,” and reiterated that he just smokes and sleeps, all in a matter-of-fact tone while avoiding direct eye contact with him.

On another occasion during a conversation that was more formal, an audiotaped interview, Ruweya showed mild irritation with Yusuf’s talk of
miracles and wonders. He was telling about the time he and his sister had been in India and Oman. He got excited, speaking rapidly and said:

It was sunny and I thought, “I’m in Paradise” and there was a place that was so cold and I thought it was Heaven. Then I went to India and I was shown hell fire and heaven, alternately for six months and so then I thought it was not a place to stay. Then I returned to Zanzibar. The weather is fine here and I decided to stay.

Ruweya frowned and commented quietly that she did not like it when he spoke nonsense. Yusuf was voluble during this interview and much of what he said was metaphorical and hard to understand. Both Khadija and her paternal aunt Raya were present and neither reacted to this statement about heaven and hell or other fantastic things Yusuf said. Later, Ruweya told me that she thought Yusuf was trying to tell, in talking about heaven and hell, about the time they went from sea level heat to the cold of very high elevations in India.

Ruweya despaired of Yusuf’s ever getting better. She worried about his future, and perhaps having to take care of him. She was instrumental in getting him involved in an outpatient group at the hospital, and washing his own clothes again, but she accomplished this by going through an intermediary at the hospital. Although Ruweya remarked that it is difficult when a young man, apparently fit, could not work, she did accept it. She felt much affection for her younger brother, and struggled to maintain her patience when he verbalized fantastic ideas.

Yusuf walked about a lot and his roaming was solitary. No one in the family tried to restrict his movement. While his family’s respect for his preference for being alone is similar to that of Kimwana’s family, the gendered advantage that Yusuf had was obvious. As a male he could move about without violation of gendered social norms. While Kimwana’s family allowed her to seek solitude inside the house, they became anxious when, during a period of restlessness, she wanted to go outside. They locked the doors. Generally, Kimwana saw herself as unable to go out and only did so once each month to keep her appointment at the mental hospital. Thus, they had cause for alarm. Part of their concern had to do with Kimwana’s status as an unmarried female. Yusuf’s maleness afforded him an additional strategy for withdrawal from social contact. Despite this gender difference, both families discussed thus far present a picture of a culture in which adversity is expected and embracing it without complaint is sanctified, and where indirectness, reserve, and tolerance in human interactions are highly valued. The last family I describe presents a picture, not of cultural variation so much as, of the distance between cultural ideals and lived human behavior.
Shazrin's Extended Family

The al-Mitende family is part of an Omani Arab clan that has practiced cousin marriage for several generations. The household I studied included the identified patient, forty-three-year-old Shazrin, and five other adults. Shazrin is in the care of her half brother, Abdulridha, who had the same mother. Their shared mother and Abdulridha’s father were double cousins. Moreover, Abdulridha’s father was Shazrin’s second cousin. Abdulridha is married to Ruhaida, who was raised in the home of other extended family relatives. They have a developmentally disabled daughter, Azlina. Rohaizat is Abdulridha’s other half sister, but via his father. She is married to their cousin, Amour. Amour and Rohaizat have ten children in the household, including one daughter who is also developmentally disabled. Rukia is the oldest adult in the household. She is Rohaizat’s and Abdulridha’s paternal aunt by blood. She is Amour’s mother. She is Shazrin’s and Abdulridha’s mother’s cousin.

Shazrin’s problems began when she was just thirteen years old on the night of the new moon at the end of Ramadan. While applying henna with other female relatives, she saw a black cat enter and walk across the room, then disappear. The next day after visiting kin and feasting she felt unwell, complained of being hot, and of feeling as if she were going mad. She lay down to rest. Her mother told her to take off her new dress and her bracelets first and tried to help her to do so, but Shazrin began screaming. Her behavior was similarly disturbed over the next few days. Because of her report of seeing a black cat, she was thought to be suffering spirit possession via witchcraft. She was treated with traditional medicine by several practitioners with little or no improvement for the better part of a year. Then the family’s neighbor and friend, a young medical doctor recently appointed to the mental hospital, persuaded them to take her there. The next time Shazrin became disturbed and hard to control, the police were called to take her to the mental hospital. She was admitted on an urgency order, a frightened child on a ward of grown women. She was diagnosed as a case of childhood schizophrenia by a visiting American psychiatric consultant. She remembered him as "very fierce." At age fourteen, according to letters in her medical record, Shazrin was already considered "chronic."

Since that time, she had divided her time between the mental hospital and the household of her half brother, Abdulridha, and that of her mother’s sister, Asha. During most of the period of my study, Shazrin ate and slept at the home of her half brother. One wing of the home included the sitting room and bedrooms of Rohaizat and Amour’s family. Abdulridha, Ruhaida, and their daughter, Azlina, had a bedroom and a
sitting room upstairs in the other wing. Shazrin slept in their sitting room. Downstairs was the living space of Rukia, their aunt. There were some common rooms where the two wings met and a shared kitchen building in the courtyard below.

Shazrin had continued with traditional treatment intermittently throughout her thirty-year psychiatric history. She had been taken for a wide variety of treatments up and down the Swahili coast. Her half brother continued with a scalp treatment based on Arabic humoral medicine “to cool Shazrin’s mind,” using the recipe of a cousin who was a healer. Abdulridha disavowed all earlier traditional treatment and consistently aligned his views with hospital medicine in our discussions. Shazrin had spent approximately 19 percent of her time as an inpatient at the mental hospital since she was first diagnosed, and was admitted there fifty-six times. She was also briefly admitted to psychiatric units at two mainland hospitals. From 1988 until 1993, the family relied most heavily on the mental hospital for Shazrin’s care. She resided there about one-third of the time. After a dysentery outbreak on the female ward in 1993, Abdulridha took Shazrin out of the hospital and vowed never to send her back again. He collected medicines through outpatient services at the hospital for both Shazrin and his daughter. Sometimes they attended these appointments.

Bodily discomforts, painful menstruation, and insomnia had been prominent symptoms throughout Shazrin’s history. In the past she was talkative, sometimes hostile and aggressive. Her problematic symptoms during the period of the study were crying, not sleeping, and daytime inactivity. She occasionally kept the household awake by crying loudly most of the night. She had taken a variety of medicines over her thirty-year history of treatment, including up to fifty milligrams of fluphenazine every two weeks (a very large dose). In 1978, she had a course of electroconvulsive therapy. During the period of this study her medication was changed from haloperidol to thioridazine. Her psychiatrist hoped this more “activating” dopamine blocker would alleviate Shazrin’s crying. Abdulridha had been complaining about Shazrin’s crying to me for five months before he brought it to her psychiatrist’s attention. Inspired by a radio program on depression from the Voice of America, Abdulridha came to see that there “is a medicine for this crying.” He frequently admonished Shazrin not to cry with the adage that it is shameful for adults to do so.

Shazrin had often run away from home and had asked to be admitted to the mental hospital or had demanded that the family bring her there. Other times the family initiated admission. Hospital staff noted a difference between her behavior on the ward and that described at home. She often settled very quickly, even before medication was administered.
Sometimes the family refused to take Shazrin home when doctors recommended discharge. One doctor asked the social worker to explain to the family that Shazrin’s problems were an illness for which she should not be punished. The narrative that follows was elicited by a diplomatically worded question about the doctor’s suspicions that Shazrin’s problems were exacerbated by familial relationships and that she was sent to the hospital as punishment. As Shazrin sat beside him looking fretful and distressed, Abdulridha narrated a series of incidents: one in which Shazrin attempted to beat her mother and in which he intervened, one in which Shazrin ran from home while others were preparing to break the fast during Ramadan and went on her own to the mental hospital, and one in which Shazrin toppled a large clothing cabinet inside a small room, effectively trapping their mother there. Although her brother believed Shazrin had longer periods of remission of symptoms in those days, she was “worse” when ill because she was young and strong. He said:

My control [of her] helped a bit, because she stopped some of those things, like [when] she used to strike people. She had energy because she was young. She is a coward now; her energy is lost. I have the ability to hold (stop, stabilize) her the way I want.

The male nurse who nominated Shazrin for inclusion in the study considered Abdulridha an exemplary caretaker. From our very first meeting (for informed consent) I noted Abdulridha’s dramatic account of self-sacrifice to undertake the care of his sister. I also thought it odd that he was so aware of her menstrual cycle and could recount for me in this first meeting and on many subsequent visits exactly when she began and ceased to bleed. This information was shared enthusiastically and sometimes in public spaces, which struck me as strange in this culture where privacy and concealment are valorized. I worked to set aside my inferences about the nature of Abdulridha’s involvement with Shazrin, even as observations accumulated, because hospital workers, including my research assistant Ahmed, saw Abdulridha as nothing other than a good brother. Eventually I learned that Abdulridha knew the length of Shazrin’s menses because he washed the blood from her clothing. I found it incongruous that he would wash menstrual blood from her clothing when he proudly asserted that he had cured her incontinence by making her wash the soil from her own sheets and garments. Ahmed also found it most unusual, but it did not shake his impression that Abdulridha was a good and concerned caretaker.

It was many months later, after a tape-recorded interview with the family, that Ahmed’s opinion changed. On the evening of the interview, Shazrin was unable to answer most of the questions directed to her and
she became visibly uncomfortable with the situation. After a few attempts we gave up questioning her and concentrated just on the portions of the interview directed to other family members. After about an hour, Shazrin rose from her chair to go get some water. Abdulridha demanded to know where she was going and then chuckled at her, telling us that she was not actually in her usual state of mind. Ruaida counselled us to try our questions with Shazrin at another time, speaking with her alone. While Shazrin was out of the room, I tried to persuade Abdulridha that our questions, even those directed to him, might be making her uncomfortable and that she need not be present for the rest of them. He disagreed, denied it was a problem for her to sit through this recounting of her illness history, and accused Shazrin of blaming others for her problems. He raised his voice to summon her back to the sitting room. When she returned I tried to reassure her that we did not wish to upset her. Abdulridha and Ruaida began to tease her, saying that they would send her back to America with me. They laughed at her. She neither made eye contact with anyone nor responded to any of this. Abdulridha said, “She is not here at all now; she has been covered completely. . . . This indeed is the problem. I told you that you would see it.” She sat silent as we proceeded a bit longer with the interview. Then she rose again and left the room. Abdulridha shouted for her to leave the door open. Ruaida and Rohazlat began to laugh. Again Ahmed and I tried to persuade Abdulridha to release Shazrin from this interview. Again he refused, saying that she just wanted to lie down and that she could wait. He called her. She returned. He insisted that she stay. “Wait a while. You just don’t want to listen,” he said to her in a harsh and accusing tone. He prompted us to proceed. Although we ceased directing questions to Shazrin, he occasionally teased her with them. We hurried through the remaining questions and left.

On the way home, I restrained myself from telling Ahmed what I thought of these interactions because I wanted to hear his opinion before giving mine. He said he felt bad to be part of this tormenting of Shazrin and said we must only try to interview her alone on a day when she seemed better, perhaps at my house. In written notes Ahmed observed that Shazrin was turned into a laughingstock, and Abdulridha made matters worse when he forced her to speak. Ahmed concluded that in spite of being brother and sister, their relationship was more that of slave and master, with Shazrin extremely fearful before Abdulridha and his markedly critical and ridiculing tone of voice.

Jenkins has written about cultural dimensions of “emotional overinvolvement” as the “loss of family orientation” as the caretaker “adopts a nearly exclusive dyadic orientation with the patient” (Jenkins 1991:407). Abdulridha remained unmarried for five years between his divorce and
his marriage to Ruhaida, odd given the resources at his disposal to secure another bride. When he returned from work, Abdulridha was in Shazrin’s company. He directed her morning and evening hygiene and grooming. He was rarely in the company of his brother-in-law/cousin Amour, despite their residing in the same house. He did not sit at the mosque or the coffee seller’s corner, like other men his age in the neighborhood. Jenkins also noted reports by overinvolved relatives that focus on the caretaker’s extraordinary suffering because of the identified patient’s illness. Abdulridha seemed to take Shazrin’s crying as a personal affront:

I tell her, ‘I do everything for you. You should stop all those behaviors in order to give me some encouragement but if you misbehave you will discourage me/break my heart.’ She would say, ‘I am not crying’ but all the same she keeps on.

After I had been with the family for six months, others inside and outside it began to share their opinions that Abdulridha’s behavior toward Shazrin was not good for her or was contributing to her problems. “He tries to control her too much,” one said, “He pushes her.” “It is shameful the way he takes care of her bathing and her menstruation, with all those women in the house who could do that,” said another. In addition to this intrusive overinvolvement and criticism from Abdulridha, Shazrin was the object of criticism and ridicule from some other family members. Although Abdulridha had vowed never to return Shazrin to the mental hospital, I heard Ruhaida threaten her with permanent placement there more than once. Eventually, I no longer tried to put off my inference that this was a family marked by negative expressed emotion and overinvolvement. I grew uncomfortable around them and began to dread my visits there. I felt like I was colluding in the process of troubling Shazrin somehow, although I maintained a supportive stance toward her. On a couple of occasions, Abdulridha tried to recruit me to join in disapproving of Shazrin’s behavior. I resisted but he often twisted whatever I said and used it to get at her.

During an exercise in which the family was participating in preparing a kinship diagram, I saw how overinvolvement produced the very symptom that Abdulridha said troubled him most: Shazrin’s loud crying. When we finished mapping Abdulridha’s “dynasty,” we turned our attention briefly to Shazrin’s father’s side. (Recall that Abdulridha had a different father.) Shazrin helped by naming her father’s three wives. Abdulridha filled in some other details until it became clear that the old man had married his own grandchild. I recorded it without comment. Shazrin looked tense.

When I returned for the next visit, I began with my usual list of questions for clarification and ended by confirming that Shazrin’s father’s
second wife was indeed his granddaughter. During all this Shazrin became progressively more restless on the floor, flipping over from side to side to prone, jiggling her legs, and rubbing her face in an odd repetitive way. Abdulridha and Ruaida noticed this and ascribed it to her medicine no longer working. Abdulridha imperiously summoned Rukia (their aunt) from downstairs to help us with the older generations of the genealogy he could not do. Although she was busy cooking and did not want to participate, Abdulridha commanded her to stay. As the tension mounted, Shazrin stood up abruptly and walked from the room. Abdulridha commanded her to come back and sit down. She did but was physically even more restless. Abdulridha continued his questioning of Rukia and would not be dissuaded. Shazrin stood to leave again and Abdulridha ordered her to sit again. As she approached the door and said that she was leaving to go to her aunt’s place, Abdulridha caught her arm and ordered her to stay. As she turned back she burst into very loud crying and screaming. Abdulridha called to me over the din, “You will now see everything of her illness, how it is.” He called to Shazrin raising his voice to break through her loud screams, “Today you are showing your doctor your shame.” “Let her go,” I urged Abdulridha, practically begging, for this emotional display was powerful and difficult to watch. “I must control her here,” he said. “I am afraid to let her go.” “What do you think she will do?” I queried. “I do not know but I must control her here. She can’t go out.” I learned later he gave her a cold shower to “calm” her that night.

I left dumbfounded that Abdulridha and Ruaida could casually discuss this emotional display as a symptom of Shazrin’s illness and not admit to a connection between Abdulridha’s control of her and this frustrated outburst, or between the shame at exposure of her grandfather’s incest and her restlessness. Her crying did serve the instrumental purpose for Shazrin of carving out some space around her. Within minutes, her crying had cleared the small sitting room of more than half the adults assembled there. Several months earlier I had heard about another incident of Shazrin “crying the whole night” from Ruaida as I sat with both women. Ruaida said Shazrin cried because she was angry, but Shazrin hotly denied anger. I cannot say whether Abdulridha’s self-confessed need to control Shazrin bodily can be justified by her past behavior. I feel certain that without Abdulridha’s controlling overinvolvement and the harsh scolding, threats, and ridicule Shazrin experienced, she would have been a higher functioning person and less miserable. I saw glimpses of this person when Abdulridha was not around, when Shazrin visited my home with other women, and when she made small jokes to me when we were alone.
Conclusion

This chapter shows two contrasting emotional styles in families of patients with schizophrenia in Zanzibar. In the families of Hemed and Kimwana, and Khadija and Yusuf, indirectness in conflict resolution was valued and tolerance for the individual (even idiosyncratic) nature of family members was apparent. In this emotional style, notions of appropriate familial concern are entwined with the belief that all adversity is sent from Allah for a purpose one cannot know, and that preternatural spirits are active in producing deranged behavior. Recent research in the United States has shown that family members’ beliefs about a patient’s ability to control him or herself and perceptions of an internal locus of control for themselves support higher levels of negative expressed emotion (Hooley 1998; Lopez, Nelson, Snyder, and Mintz 1999). Norwegian researchers found guilt in family members to be a correlate, and perhaps a determinant, of high levels of criticism, hostility, and emotional overinvolvement (Bentson et al. 1998). In Zanzibar, it would appear that acquiescence to the external control of the Almighty undercuts guilt, exonerates patient and family, and sustains tolerance and acceptance of the patient. Swahili cultural notions of personhood, and the valuing of reticence and indirectness, also participate in this protective environment, which seems to mitigate against emotional overinvolvement even in large, close families living in comparatively small spaces.

The second style is evident in the case of Shazrin and Abdulridha. In this family, the idea that Shazrin’s problems were sent by Allah was brought up only once, obliquely, when Ruhaida explained to her older generation male that I was with them to learn about their tests or trials. Shazrin and her patriline were often identified as the source of the problem. Blame swirled around her. Although this, too, is a religious Muslim family, whose ancestors built several mosques in Zanzibar, the notion of embracing adversity was not prominent. Perhaps it is their class status (for they are persons of the former ruling class now in reduced circumstances since the revolution) that energized Abdulridha’s embrace of Western medical explanations for his sister’s crying. It certainly seemed his allegiance to biological explanations obtained from psychiatrists and the Voice of America legitimated his interference with Shazrin in his own mind and allowed him to see himself as part of the “modern” world. He had given up his life, he said, to care for this medically marked and deficient person. Ruhaida looked from her own retarded daughter, to that of her sister-in-law, to Shazrin and sighed, “We have three like this we must care for in this house.”
Finally, these cases support the argument that elements of “expressed emotion,” particularly criticism and emotional overinvolvement, can be identified across cultural settings (Jenkins and Karrow 1992). Indeed, it was after we observed the first incident in which Shazrin was ridiculed that Ahmed translated the concept of emotional overinvolvement in terms of the ill family member being interfered with and “pried into” too much, of having insufficient freedom, and of being part of a dyad that is like “a whole world” unto itself. That my method was ethnographic description rather than the standardized Camberwell Family Interview typically used in expressed emotion research made it possible to capture the contextual and interactive nuances that rendered these factors consequential for family members in a particular culturally inflected way. More studies in this vein can go further in answering Jenkins’ (1991) call for a comparative understanding of “expressed emotion” that is grounded in an understanding of cultural definitions of self, agency, autonomy, and accountability.

NOTES

1 All names used are pseudonyms chosen by the families themselves. Kimwana chose her name, which means “small daughter,” and gave her younger sister the name “Bimkubwa,” which could be translated “Miss Boss Lady.” I have known this family since 1988. Kimwana participated in another study with me at that time.

2 In describing Amina’s care of her ill family members I do not mean to depict her as a long-suffering martyr. She talked of troubles rarely, and some of that only at my researching behest.

3 I continued to follow these families after the study year described previously. In 2000, one of Yusuf’s younger half brothers joined the household and began to voice criticism of Yusuf. As Yusuf’s symptoms increased, Ruweya used the newly formed family support group at the mental hospital to indirectly intervene with her half brother and persuade him to moderate his approach to Yusuf. This points up the limitations of one-time snapshots of family factors and illness profiles taken from one key informant that have been typical in expressed emotion research and World Health Organization schizophrenia outcome studies, respectively. An ethnographic approach allows consideration of changes in large and complex families over time.

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