adults heading across the square on their errands and the constant squawk of crows in the shade tree. In that cacophony of sounds reverberating and echoing off tin roofs and cement surfaces, the only discernable individual voices were those of the bicycle repairmen chatting among themselves or with their customers as they did their work.

Considering the additional commotion of the comings and goings of the members of the household, the noise must have been unrelenting. The many small children, though well behaved in the manner of most Zanzibari children, created a racket. Hemed, even though he could not walk or even bathe himself, could yell and often did for long stretches without ceasing. Several of the family members shared with McGruder their belief that the noise itself was exacerbating Kimwana's illness. Bimkubwa, the most Westernized of the siblings, told McGruder that Europeans have much smaller families and that their houses were much quieter. "There are too many of us and this place is too noisy," she said emphatically.

Kimwana often asserted that she felt better when she was alone. But given her auditory hallucinations and the general noisiness of her surroundings it was clear that she was talking not just about a desire for physical solitude but also for quiet. "I do like being on my own," she once told McGruder. "Being with people I feel like I am tangled with them. I feel like calming myself, just silently. Just quiet and silent." Unfortunately time alone was a scarce commodity in the packed household. And silence was all but unavailable.

The Emotional Temperature of the Household

It didn't take long for McGruder to sense that Amina's family displayed an amazing tolerance for the difficulties of having two severely mentally ill people (not to mention a deaf-mute) in their

household. It was a testament to the strength of this family unit that Hemed, even after the divorce for nonsupport and the years of violent psychotic episodes, was still taken care of by Amina and the family.

McGruder noted that the family took a remarkably relaxed stance toward Kimwana's illness in particular. When asked about Kimwana's symptoms, Amina gave matter-of-fact answers. When McGruder wanted to know what Amina thought of Kimwana's central delusion, all she could elicit was the simple declaration that her daughter felt that the "bicycle repairmen concern themselves with her affairs." Amina told McGruder that she did not share her daughter's belief, but there was no judgment or frustration attached to the delusions. To many questions Amina would only answer, "I am unable to know" or "I take it as one of God's mercies, one of God's wishes."

To try to give me a sense of the emotional tone in this house, McGruder recounted a day in late September after a particularly difficult few months for the household. Kimwana was recovering after taking an overdose of her medication, and a bad cold had sickened nearly everyone in the family. Amina had admitted to McGruder that they were too poor even to buy aspirin. Although each family member had mostly recovered from the illness, the family unit was still trying to regain its normal rhythm.

When McGruder arrived in midmorning she went right to work in the kitchen. She had found that participating in the daily chores was a much less intrusive way to observe the goings-on in the household than sitting in a corner with a notebook. Over the course of the morning she watched Amina prepare food for a dozen hungry mouths, negotiate the payment of school fees with a local official, send family members on a variety of errands, and deal with minor setbacks, including a large pot of ginger tea that had unexpectedly curdled. On top of this she did her best to keep the children (and

McGruder) from disturbing Hemed or Kimwana, both of whom were more upset that morning than usual.

In her notebook McGruder listed the stressors Amina dealt with that day. There were the relentless financial worries, three family members who needed constant care, over a dozen mouths to feed, and a small pack of children to be protected and cared for. McGruder crossed off one theory that might account for the differences in outcome of schizophrenia between developing and industrialized nations: the idea that life was simpler and less stressful for poor people living in more traditional cultures. McGruder suspects that this theory springs from a fantasy on the part of Westerners, who are soul-weary from lives of commuting, competing, and trying to find time for family. We want there to be a place in the world where our life might distill to a simple combination of satisfying work and close human interaction. In reality, a stress-free life was as elusive in Zanzibar as anywhere else in the world.

Despite the *zogozogo* and the hardships, however, Kimwana's behavior and her deficits were tolerated with remarkable equanimity. While Kimwana's activities and social interactions were often reported to McGruder as a gauge of her wellness, McGruder rarely witnessed Amina or anyone else in the family pressure Kimwana into displaying normal behaviors. During periods when Kimwana was feeling well, for instance, Amina would report that she had washed the dishes or swept the house. But Amina didn't assume a cause and an effect between productivity and wellness. This goes against some basic tenets of Western occupational therapy, which suggests that the path to mental health can be found in productivity and participation in group activity. Although the family viewed her participation in household chores as a sign of health, they didn't pressure her to perform chores with the assumption that they were curative. Indeed, when Kimwana was doing poorly, the family allowed and even encouraged her to withdraw from activity and to rest. Often, when she tried to help out during such times, her family cautioned her not to overextend herself.

For the most part, however, Kimwana was allowed to drift back and forth from illness to relative health without much monitoring or comment by the rest of the family. Periods of troubled behavior were not greeted with expressions of concern or alarm, and neither were times of wellness celebrated. As such, Kimwana felt little pressure to self-identify as someone with a permanent mental illness. This stood in contrast with the diagnosis of schizophrenia as McGruder knew it was used in the West. There the diagnosis carries the assumption of a chronic condition, one that often comes to define a person.

The prizing of rest over work and passive acceptance of abnormal behavior versus active encouragement or criticism were representative of an overall calm emotional tone in the household. Even on difficult days there was an air of tolerance when dealing with Hemed's and Kimwana's disturbed behavior. McGruder believed that this tone emanated not simply from the personalities in this particular family but from cultural cues in Zanzibar, and she took it as her mission to find the sources that created this emotionally even atmosphere.

Emotional Expression and Schizophrenia

The early research into the relationship between the emotional temperature within families and the long-term course of schizophrenia took place in England in the 1950s. Clinicians had anecdotally observed that some patients with schizophrenia released from hospital care came back within a short period of time, whereas other patients managed to stay out of inpatient care for longer periods. A team of researchers led by the psychiatrist George Brown

decided to try to figure out what factors might distinguish the two groups. They conducted lengthy open-ended interviews designed to encourage first-person stories from family members. There were no right or wrong answers; researchers attempted only to elicit rich descriptions of daily life with the mentally ill family member. After categorizing all the emotional reactions they could identify, they tracked the patients over time, noting their rates of relapse and general levels of functioning.

Initially they looked at the families of the patients who fared better, but they could find no behavior that had significant predictive value. Studying the families of the high-relapse patients, however, they did find factors that appeared to predict outcomes. Three emotional reactions from family members showed a relationship with the patients with higher relapse rates. Collectively referred to as "high expressed emotion" they were criticism, hostility, and emotional overinvolvement. In particular, high-relapse patients tended to live in an environment where at least one relative routinely criticized and attempted to control the patient's behavior.*

Criticism and hostility are relatively self-explanatory. "Emotional overinvolvement," however, is a term of art that requires a little explanation. It describes a range of behaviors that may include dramatic expressions of self-sacrifice, extreme devotion, overprotectiveness, or intrusiveness in the patient's life. One mother, for instance, was rated as emotionally overinvolved when she reported that she was so concerned with her son's condition that she had dropped all other interests from her life. Her sole activity, she reported, was to take care of him and protect him, "like a pearl or a diamond." This same mother said that she often became so distraught over her son's plight that she considered committing suicide by shooting herself, running out into traffic, and throwing herself down the family staircase.

Researchers have found a connection with high expressed emotion (EE) and poorer outcomes with some other mental illnesses, but nowhere is it as pronounced as with schizophrenia. Why is there such a strong connection? Researchers believe that the experience of being criticized or constantly observed and judged parallels the experience of the disease itself. It is not coincidence, in other words, that one of the central symptoms of schizophrenia is hearing demanding, critical, or disparaging voices. Social stress is a known trigger for psychotic episodes, and a number of studies testing diastolic blood pressure, skin conductance, and electrodermal reactivity all pointed to the connection between high-expressed-emotion relatives and increased feelings of stress in a patient. When confronted with relatives known for their high levels of expressed emotion, researchers could watch as dials measuring bodily stress rose in the patient.

This connection between high-expressed-emotion households and relapse rates proved true across cultures. Over the course of the 1970s and 1980s dozens of studies were conducted on populations in Denmark, Italy, Germany, Spain, France, North America (including both Anglos and Mexican Americans), China, Taiwan, India, North Africa, and Australia. In a paper that aggregated the data from a dozen studies, researchers noted that the relapse rates were *three to seven times greater* for patients from high-expressed-emotion families. The connection remained even when the sever-

*Expressed emotion researchers have been careful to point out that they were not tying emotional temperatures in families to the onset of schizophrenia. High emotion was not a cause of the disease, but rather appeared to be a factor that greatly influenced its course and outcome. While there is a significant difference between families with high emotional temperatures and those with low, this is not true in every case. Many high-expressed-emotion families care for schizophrenics with low incidence of relapse, and vice versa. It should also be noted that it is not only relatives who have been studied. Similar results have come from research into high and low emotionality expressed by caretakers in group homes and mental institutions.

ity of the initial symptoms and drug compliance were taken into account. In another paper that brought together the data from twenty-five studies, researchers found that the relapse rate was 50 percent for high-expressed-emotion families and 21 percent for low-expressed-emotion families.

God's Blessings

McGruder could sense that Amina's household had a low level of expressed emotion when it came to dealing with Hemed and Kimwana, but it took her quite a while to understand the cultural sources of that tone. She spent a good deal of her time trying to tease out the local religious beliefs that wove themselves around the ideas of madness in Zanzibar. Like 90 percent of Zanzibaris, Amina's family belonged to the Sunni Shafi'ites sect. This is an Islamic sect that believes in adhering faithfully to the teachings of the Koran and the stories collected by Al-Bukhari that recount the life of the Prophet Mohammed. It is from these stories, collectively called a hadith, that many Zanzibaris draw wisdom to manage the everyday challenges of life.

Both the Koran and Al-Bukhari's hadith recount ideas about suffering and hardship that McGruder could see had deeply informed the family's treatment of Kimwana and Hemed. Amina and other family members often repeated the belief that Allah would never put more burdens on a person than he or she could bear. "In our family we have this challenge but this is just life," Amina would tell McGruder when talking about Kimwana and Hemed. "Other people have other problems. Maybe their house has burned down. Everyone knows their own burden best."

McGruder came to understand that these were not just bromides. In the family's Muslim belief, managing hardships provided

a way to pay the debt of sinfulness. Illness or bad turns of fortune were seen as neither arbitrary nor a punishment. Rather, they believed that God's grace awaited those who not only endured suffering but were grateful for the opportunity to prove their ability to endure it. In this way Amina's remarkable ability to stay steady and resolute in the presence of sick and disabled family members was an expression of her religious belief.

McGruder had heard similar "God willed it" sentiments repeated among Christians in the United States, but the embrace of hardships in Zanzibar was qualitatively different. Although American Christians might believe that God had sent a challenge or a misfortune, they were also likely to believe that God had given them the strength not just to embrace the difficulty but to overcome it or learn a valuable lesson. In the cosmology of Western Christians, life's challenges provide opportunities to become stronger and to have a closer relationship with God. The burdens God sends to Christians in the Western world are incitements to self-improvement. The comforts that Amina found in her religious belief, by contrast, were not in an encouragement to overcome or learn from hardships. Rather, simply accepting her burdens was a continuous act of penance.

"Religion as I understood it as a child had more to do with what you believed than what you did during your day," McGruder told me. "Here in Zanzibar religion has much more to do with what you do. You can see it in how people live their lives, how they pray five times a day and fast during Ramadan." In McGruder's view, the steady care given to Kimwana and especially Hemed seemed to come out of the family's religious desire to prove worthy of the burden God had given them.

Sometimes it seemed that their acceptance of burdens bordered on the fatalistic. "Fatalism" is not a word McGruder would employ, given that its negative connotations violate the anthropologist's

credo to remain judgment-neutral. Still, McGruder found herself using such phrases as "acquiescence in the face of adversity" and "embracing difficulties as a natural part of life" almost as euphemisms. She remembers times when she tried not to let her jaw drop at the family's lack of upset. One such moment came when Kimwana took an overdose of her medication and ended up in the hospital. "There was no noisy woe-is-me talk or dramatic wringing of hands. They seemed to take it in stride like everything else," McGruder recalls. "When I asked what I could do, Amina told me that I could take a carton of milk to Kimwana in the hospital. So I took the milk." For McGruder, a fighter and problem solver by nature, it took some time to recognize the benefits of such acceptance of life's difficulties.

The Creatures in Our Heads

The other religious belief that was central to the family's conception of the illness was spirit possession. It would be easy for a Westerner to assume that belief in spirit possession would almost certainly increase the stigma for a mentally ill person. McGruder remembered the horror stories of spirit possession she learned as a child in the United States. Those beliefs were informed more by pop cultural representations (such as the movie *The Exorcist*) than by what she heard in church. Nevertheless her cultural understanding of these devil-focused narratives about spirit possession included dramatic suffering and ostracism for the person believed to be possessed. In the Christian context, possession is nearly always thought of as a profoundly disturbing experience, usually requiring dramatic and sometimes violent interventions. Given the choice between the biomedical understanding of schizophrenia and the spirit possession narrative, most Westerners assume the drier science-bound

explanation for the disease would certainly inflame less emotion and stigma. As McGruder came to understand the spirit possession beliefs of families like Amina's, however, she found them to be very different from Christian beliefs in the West. To begin with, spirit possession in Zanzibar was not an uncommon or necessarily an extreme experience. As Amina explained to McGruder, we all have "creatures in our heads."

The beliefs surrounding spirit possession in Zanzibar arose from the complex combination of traditional Swahili culture and Arabic beliefs about *jinns*. These spirits that often inhabit living individuals aren't uniformly good or bad but can cause problems if they are not dealt with in appropriate ways. A spirit handed down from one's ancestor is generally thought to have a protective effect for the person who carries it. Such an entity will cause difficulties only if it is ignored or not properly appeased. These spirits can have an ethnicity, gender, and religious affiliation of their own. A spirit might be picked up accidentally or through witchcraft. Sorcerers are said to raise and feed spirits, which they use to harm their enemies.

The main difference between the character of spirits and of humans, McGruder learned, is that spirits are often autonomous, rude, selfish, and not given to concealing their emotions. (In this way they are sometimes compared to tourists who intrude but do not greet.) When a spirit possesses someone, he or she often violates the social norms. A sister momentarily influenced by a spirit may strike a brother who is harassing or threatening her, for instance.

Because nearly everyone on the island believed in spirit possession and had a personal experience with it, the application of the belief to mental illness had the counterintuitive effect of lessening the stigma attached to the behavior of the mentally ill person. It made bizarre or disruptive behavior more understandable and forgivable. Like the sister who has a ready explanation for hitting her

brother, mentally ill persons and their family can evoke the narrative of spirit possession to explain unusual or antisocial behavior.

Belief in spirit possession also gives the family a sense of agency in that it allows for a variety of socially accepted interventions. "Spirits causing problems are not exorcised in the Christian sense of casting out demons," McGruder explains. "Rather they are coaxed with food and goods, feted with song, dance. They are placated, settled, reduced in malfeasance." It was common, for instance, to write phrases from the Koran on the inside edges of a teacup with saffron paste and then to dissolve the writing so that the ill person could literally imbibe the holy words. Similarly the Koran might be read over water before it was used for bathing. Pagan spirits would be driven away by such acts, and Muslim spirits would become subdued. Kimwana found such activities calming. She especially enjoyed it when family members read to her the short verses from the Koran that children learn to read and memorize early in school. "If someone reads and I listen, then my mind clears," Kimwana said. "It tells us to become compliant and wait patiently. I listen to the Koran and then I rest."

For McGruder the point was not that these practices were effective in combating the biological causes of schizophrenia. Rather, they were simple examples of how the spirit possession narratives kept the sick person within the social group. Importantly, the idea that spirits could come and go allowed the person with schizophrenia a cleaner bill of health when the illness went into remission. An ill individual enjoying a time of relative health could employ the spirit possession story to, at least temporarily, retake his or her responsibilities in the kinship group.

In all these ways the belief in spirit possession could decrease the sense of blame or shame carried by the family or the ill individual. The blessings and burdens of God and the mysteries of the spirit world were, after all, beyond the ability of the individual or family

to effectively control. As McGruder observed, "When humans do not assume they have rather complete control of their experience, they do not so deeply fear those who appear to have lost it."

In some ways the low expressed emotional atmosphere in the family stood in contrast to McGruder's work as a Western anthropologist trying diligently to understand it. At times she had to remind herself to turn off her analytical gaze, her desire to document and categorize the behavior she was there to witness.

She remembers one day when Kimwana invited her to sit with her on the steps of the family's interior courtyard. McGruder could tell from the liveliness in her eyes that Kimwana was more fully present than she had been recently. Kimwana sat, barefoot, with her back against the door frame, and talked of how enjoyable it was to feel the breeze. McGruder asked her what she had been doing prior to her arrival that day and Kimwana told her that she had been resting but not sleeping.

"When you rest, do you think a lot?" McGruder asked.

"Yes, I think so much," Kimwana admitted.

"What do you think about?"

"For example," Kimwana answered, "just now I was thinking if I would get better."

It was a promising opening. McGruder sensed that it would be a good time to ask her more questions about her disease experience. But then she found she could not bring herself to risk breaking the peacefulness of the moment. Making the ill individual aware that his or her behavior and cognition are being monitored and judged was, she knew, a sign of emotional overinvolvement. So as much as she wanted to question Kimwana more, McGruder turned the conversation back to the quality of the breeze and how cool it was to sit in the shade of the house, trying, as best she could, not to document the low emotional intensity of the household but instead to manifest it.