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Healthy Living with Bipolar Disorder

The effects of the South-African cultural ethos on living with Bipolar Disorder

I am honoured to have been asked by the IBFP to write about our culture and its impact on the treatment of Bipolar Disorder in South-Africa. South Africa is often called the 'Rainbow Nation' as it embraces a multitude of diverse cultures. It is also a country with an enormous disparity of wealth, grinding poverty for most and many other social and economic challenges. This impacts greatly on how Bipolar Disorder is perceived and treated within the society.

After introducing myself, I will provide an overview of the South African context to afford a deeper understanding of what affects the South Africa cultural dynamic. Afterwards I will propose recommendations for workable solutions for the South African situation. In order to deepen the understanding of the South African cultural ethos, I will present examples of first person accounts written by patients, clients and colleagues from numerous cultural backgrounds that include differences in terms of race, religion, sexual orientation and financial status.

The Author

I have written this from my personal perspective. I am a white, middle-aged, middle-class, educated, married mother raised in the Christian faith. In my personal journey, I have faced the dragon of Bipolar Disorder head-on and finally befriended it. I have moved from being a victim to a hero of my own life. When my dad died by suicide in my early 20s, I dealt with it by staying emotionally numb. Ten years later, after the birth of my second child, I experienced post-natal depression combined with bipolar mania. I was diagnosed with BPD1 (Bipolar Disorder I) and was hospitalised three times for mania from 1997 to 2003, during which time I decided not to be a statistic and to take full responsibility for my life and behaviour. It was a traumatic, long and hard journey towards healing with a holistic approach using many varied modalities to nurture and support myself. I now believe I am managing my life, living productively and feeling fulfilled.

My experiences have motivated me to work towards reducing the stigma and mystery surrounding Bipolar Disorder (manic depression). I have been working in the field of complementary medicine for 22 years with a special interest in mental health and have been co-ordinating a bipolar support group for five years, giving me the opportunity to interact with many people and their families who are experiencing imbalance in their lives. In parallel, my work with mental health awareness workshops and presentations has



International Bipolar Foundation

exposed me to other professionals in this field, as I facilitate interactive workshops to encourage difficult conversations concerning depression, mania, self-harming and suicide, where people from all aspects of mental health listen to one another's views. I don't believe that there are any definitive answers that are universally effective but I do believe that interactive conversations create a way forward for each individual.

The South African Context

It is estimated that 50 million people live in South Africa. Historically, Colonialism and Apartheid determined that South-Africa had four racial categories by which people were classified. Using these same race indicators as a means by which people continue to self-identify according to race, the 2010 midyear estimated figures for these categories were: Black African at 79.4%, White at 9.2%, Coloured (mixed race) at 8.8%, and Indian or Asian at 2.6%. By far the major part of the population classified itself as African or black, but it is not culturally or linguistically homogeneous. Major ethnic groups include the Zulu, Xhosa, Basotho (South Sotho), Bapedi (North Sotho), Venda, Tswana, Tsonga, Swazi and Ndebele, all of which speak different Bantu languages.

Neither the white nor the mixed-race and Asian populations are ethnically homogeneous, descending from many diverse origins: Dutch, Flemish, Portuguese, Norwegian, German, Greek, French Huguenot, English, Polish, Irish, Italian, Scottish, Indonesian, Indian, Chinese, Javanese and Welsh. Culturally and linguistically, they are mostly divided into the Afrikaners, who speak Afrikaans, and English-speaking groups.

Added to South Africa's melting pot of immigrants over the last few centuries are the many recent asylum seekers and refugees that arrive daily from all corners of the African continent bringing with them their own unique cultures, belief systems and languages.

We must consider that South-Africa has not long (1994) emerged from the dark, repressive regime of Apartheid which left a terrible legacy of extreme poverty, unemployment, health crises and poor education in the largest sector of the population. The continuing disparity of wealth and socio-economic status impacts further with high rates of HIV/AIDS that has decimated families and left a country with many orphans and child-headed households. Together with high levels of crime and gender based violence, many argue that our nation remains deeply traumatized.

Evidence is emerging from low- and middle-income countries to indicate that mental ill health is strongly associated with poverty and social deprivation. Living in poverty, low socio-economic status, exposure to stressful life events like crime and violence, inadequate housing, unemployment and social conflict, are all linked to mental ill health. Poverty is also associated with exclusion, isolation, feelings of disempowerment, helplessness and hopelessness, which can lead to chronic insecurity and social mistrust, affecting people's



International Bipolar Foundation

mental well-being. This increases the risk of people being vulnerable to mental illness and being disabled by this condition.

On 18 July, Mandela Day, we were encouraged to pledge 67 minutes to the service of someone less fortunate than ourselves. The local newspaper was full of ideas for volunteers to join initiatives for children's projects and homes, schools, sport, the elderly, abused women, the environment and animals. If you search you'll find one or two examples where one can offer to support mental health initiatives, but not many. This demonstrates that mental health is low down on people's awareness and priorities, and this includes the Government.

South-Africa faces many challenges in promoting the mental health of the nation. These are compounded by the existing inequalities, but we also have to take cognizance of the multitude of cultures, beliefs and practices of our people. South Africa has a Constitution grounded in Human Rights and has ratified the United Nations Convention on the Rights of Persons with Disabilities. These documents obligate our Government to ensure that the dignity of persons living with mental illness is respected through promoting and protecting their rights. However, mental health remains a low priority, although legislatively a powerful framework exists that should ensure adequate treatment and support for our citizens.

Jonathan Burns, a leading South African psychiatrist, says that South Africa has "nailed its colours to the mast through enacting legislation and signing international treaties aimed at upholding and ensuring the human rights of people with mental disability. Despite this, the nation continues to fall far short of meeting the needs of its citizens affected by mental illness. The mental health gap is considerable in South Africa, despite a progressive regime that has championed the rights of other disadvantaged groups in society. Real life factors such as poverty, illiteracy, income inequality, homelessness, war and displacement, discrimination based on ethnicity, race, and gender, population explosion, social exclusion, stigma, and abuse all impact the mentally ill individual's ability to access services and realise full personhood within their communities. A rights-based approach to mental disability means domesticating such treaties as the CRPD (Constitutional Rights of Persons with Disabilities)." Burns goes on to say: "By all accounts, the South-African Government is not carrying out its obligations and responsibilities as a signatory to the CRPD. As is the case in many low- and middle-income countries, health and social services for the mentally disabled remain grossly inadequate, under-developed and under-funded."

The reality for most South Africans is that there is inadequate support or treatment available.

"Far too often, critically suicidal patients have to wait for hours to be admitted and often they are turned away due to lack of space", says Director of the South African Depression



International Bipolar Foundation

and Anxiety Group (SADAG) Zane Wilson. "Frequently, mentally ill patients will be admitted to general wards if there is no separate psychiatric inpatient unit. This increases stigma and decreases the quality of care for these patients."

Stigma aggravates and compounds the lived reality of people who seek treatment. In society, people with psychosocial disability are often looked upon with indifference or fear and so are isolated and feel alone, without direction. This presents a significant problem when one considers that researchers at the Department of Psychiatry and Mental Health at the University of Cape Town (UCT) found that as many as 16.5% of South Africans suffered from common mental disorders such as depression and anxiety. Even more concerning perhaps is that 17% of children and adolescents suffer from mental disorders. Research has concluded that mental illness ranked third in their contribution to the burden of disease, after HIV and AIDS and other infectious diseases.

Mental health services and human resources are limited in South Africa, with 0.28 psychiatrists, 0.45 other medical doctors, 10.08 nurses, 0.32 psychologists, 0.4 social workers, and 0.13 occupational therapists per 100,000 people in the country. There are 41 psychiatric inpatient units in general hospitals in the country with a total of 2.8 beds per 100,000 people. For South-Africa's approximately 50 million population, there are only 23 State psychiatric hospitals, providing 18 beds per 100,000 people - only 1% of these beds are reserved for children and adolescents - and the number of mental hospital beds has decreased by 7.7% in the last five years. (Lund 2008)

Dr Crick Lund, Chief Research Officer of the Mental Health and Poverty Project (MHaPP), says that, in addition, their research found the distribution of human resources between urban and rural areas to be disproportionate. Statistics for many rural areas show there are no psychiatrists, limited nurses, and critically low numbers of social workers, even though 1.5% of the rural population was treated for a mental illness in 2005. "Diagnosis, treatment and support for people with a mental illness is difficult enough to find in urban areas," says Johannesburg-based psychiatrist Dr Thabo Rangaka. "In rural settings, where people don't have the information or the funds, this can be virtually impossible."

Intersecting the very real problems of accessing health care services for people with mental illness, is the existence of different cultural interpretations and beliefs of what constitutes a mental illness or what the appropriate response should be. Dr Leana Uys and Dr Lyn Middleton in their book "Mental Health Nursing - A South African Perspective" say that some cases are seen as a result of spells that have been cast, possession of spirits or trance states when communication with ancestors or a call to be a sangoma (traditional healer) occurs (Uys 2010).

A culture as diverse as ours raises the benefits and problems of different thinking where contradictions co-exist. For example, some thinking in the African culture is that "mad"



International Bipolar Foundation

people hold the thinking of the future and they should be honoured. Within the Nguni culture (mainly Xhosa and Zulu), it is believed that people who are mentally unstable could be possessed by good spirits and so they are taken care of by the community who provide food, clothing and shelter. Other thinking that sees mental ill health as 'possession' rejects or ostracises the individuals and there are even incidences of stoning them to death or accusing them of witchcraft. Language also shapes the way illness is expressed where the vocabulary of some languages restricts the expression of certain emotions.

Dr Lund and the Mental Health and Poverty Project (MHaPP) study team believe that it is not only the government's responsibility to address mental health – there also needs to be greater awareness in the wider society about mental health issues. “We need to challenge the old stereotypes about mental health, stereotypes that say that people with psychosis are bewitched or possessed by demons; that people who are depressed are lazy,” says Dr Lund. It is vitally important that rural communities be educated about mental illness and community caregivers and nurses be trained in psychiatric care so that all South Africans with a mental illness can have access to diagnosis, treatment, and support.

Recommendations

As we've seen, South-Africa has one of the most diverse populations in the world, so the question of treatment differences with regard to culture is an interesting but complex one. However, there are certain similarities between differing cultures because, after all, what binds us together is our essential humanity. All of us, as humans, need, at the most basic level, food, shelter and clothing – and in addition we need work, a sense of purpose and of belonging, affirmation and self-expression.

In my practice as a complementary therapist, I spend a lot of time encouraging patients to take care of these basic human needs. I find that with a firm foundation, some of the chaos can settle to provide a more stable base from which to work.

This method of establishing a firm foundation assists everyone, whatever their situation, background or culture, so it's a good and simple universal start. It also allows the patient to feel as if they are addressing their health rather than focusing on being ill.

So, regardless of culture or diagnosis, when I am counselling or working with patients, I always start by asking about eating, drinking water, sleeping and exercise. All of this I learned and adapted from my own journey of learning to live well with bipolar disorder. I teach what I know to be true, helpful, healing and appropriate and I try to lead and guide by example.



International Bipolar Foundation

Sometimes I question whether I can be of assistance to someone with a different cultural background. In a way, I accept that there are aspects I will never understand because the circumstances of our lives are so different. However, because of the cultural diversity in South Africa we have always been exposed to people who are different. This was not assisted by apartheid which created artificial segregation. In spite of this, we have always seen and interacted with others different from ourselves, more so since independence and equal rights came into our constitution.

It is abundantly clear that, with the best will in the world (and some impressive legislation to boot), we in South-Africa are not making significant headway in the treatment of bipolar disorder in terms of the population at large. To my mind, this calls for a different approach: fresh thinking and new initiatives. In my own world, I have found that gathering people together (sufferers, carers, doctors, healers and family members) and opening up a dialogue, or facilitated conversation, can yield impressive results. I believe we should put our efforts, energy and funding into projects with high returns such as:

- Support groups (Intentional Peer Support)
- Group Therapy
- Awareness workshops – interactive facilitated conversations
- Community building – it is the community that “holds” its members
- Care of the Carers
- Educational DVDs and CDs
- Toll free helplines

SUPPORT GROUPS (INTENTIONAL PEER SUPPORT)

A support group provides a place of stability and security, a place in which you can feel respected, nurtured and cared for, and above all it provides a “listening place”. It is a place of non-judgment for sharing and equality which removes isolation by creating a common identity.

They are low cost and completely relevant because they take on the flavour and the culture of the people who are present. In the support group that I launched five years ago, the Bipolar Bears, we have about 40 members who benefit from the supportive, non-judgmental, non-prescriptive space to find their own path to healing. We engage in creative, positive, fun and life-affirming activities which lift the mood at the beginning of a meeting,



International Bipolar Foundation

before we share and listen to each other's stories. Participants say they feel understood and less alone and leave with practical ideas for management as well as a helpful shift in perspective.

Activity based support groups like art, dance, walking or interest groups afford the participants the opportunity of support while enjoying healthy activities when they don't have to feel as if they are "ill". The group chosen and the degree of assistance required is determined by how stable one feels.

GROUP THERAPY

In South-Africa where there are large numbers of people who live below the poverty line, we need low cost, highly effective and sustainable intervention.

The power of the group dynamic often enables people to process issues more deeply and then go on to greater heights in a carefully designed safe space with sustainable outcomes. I feel that group work is not given enough credibility by the medical profession, having seen and felt, first-hand, its astonishing impact.

AWARENESS WORKSHOPS – INTERACTIVE FACILITATED CONVERSATIONS

Education, by means of awareness workshops, presentation and discussions, is badly needed in:

- Schools
- Hospital and medical institutions
- The corporate world
- Community – any groups (religious, sports, outreach programmes)

There are some private initiatives which provide these sorely needed opportunities for growth and awareness-building. I am a firm believer in the idea that it is better to do something and to be proactive, rather than to sit back in apathy owing to the daunting size of the problem.

Awareness workshops are more effective with mixed audiences and when they use an interactive, conversational style. The aim is to build a sense of community while discussing the difficult topic of mental health. The mixed audience allows people to understand other points of view and so creates a real picture of the issues faced by someone else. The



International Bipolar Foundation

facilitator asks some pertinent questions allowing the audience to learn from one another. At schools, the mixed audience includes high school students, teachers and parents. In hospitals, we include doctors, nurses, support staff, patients and their families. The mixed audience makes facilitation a challenge but the rewards are immense and participants leave relieved, having undergone a shift in their thinking which brings hope.

This method is simple, low cost and effective and helps people feel less alone.

COMMUNITY BUILDING – IT IS THE COMMUNITY THAT “HOLDS” ITS MEMBERS

Nowadays there are many techniques for building community or team building. These can be used for any group and directly or indirectly can improve mental health by increasing empathy, compassion, emotional intelligence and the connectedness of the group. This is a preventative approach.

CARE OF THE CARERS

Staff motivation and morale are often a problem in highly stressed jobs like caring for patients with psychosocial disabilities, especially when pay is low and conditions are not ideal. Workshops with medical staff called “Care of the Carers” effectively deal with stress management and offer constructive techniques for self-help. They feel more appreciated and staff illness and absenteeism are often reduced.

EDUCATIONAL DVDS AND CDS

In a community where there are large numbers of poor and lowly educated people, DVDs and CDs enable them to access information in a cost-effective manner. To spread helpful ideas to those who can't afford private help, I made a DVD called “On the Edge - Living Well with Bipolar” which has been well received by mixed audiences because of its practical, simple and low cost ideas for managing bipolar and general health.



International Bipolar Foundation

In an effort to present a spectrum of views on this subject, from people who actually live with the condition here in South-Africa, I approached a culturally diverse group of people, all of whom are living with Bipolar Disorder (myself included) and asked them to describe the ways in which their culture has helped or supported them on this journey and the ways in which it might have hindered their progress. The following is a summary of their responses:

PERSONAL RESPONSE 1: Suzanne Leighton

I am a white, middle-aged, middle-class, educated, married woman of Christian background.

I think that many of my experience and observations are not unique to South-Africa but rather to being middle class and educated.

An aspect of my culture that helped me was the supportive nature of people in my community. I am truly grateful to have been dealing with this at a time when disclosure and honesty were socially acceptable. The previous generation's habit of "keeping skeletons in the cupboard" meant we never adequately dealt with my father's suicide and the suppressed emotions took their toll.

The recognition of the power and the existence of support groups has been a wonderful resource where I was able to experience how my story and path helped others and how the group cared and supported me when I needed it. From a professional point of view, the support group was where I learned the most about bipolar for my work.

I found a general understanding about medical conditions and easy access to information helpful.

I like the availability of many paths and options for treatment and that a holistic approach is more accepted nowadays. This suited my belief system and I appreciated having enough money to follow the treatment plan of my choice. Having a family that supported me through the bad times enabled me to concentrate on getting better, with the assurance that they were "holding the fort".

My upbringing, at home and school, instilled a discipline and classical education that introduced me to many avenues of thinking that have stood me in good stead. It also afforded me a creative youth where art, drama and literature were considered important and provided a foundation from which to explore art as healing.

Although religion wasn't a focus in my family, the religious instruction I received at school provided a moral grounding. I have since developed my own spiritual practice and believe that this has provided me with a means of accessing the important part of me that is greater



International Bipolar Foundation

than my physical self. This discipline and established spiritual practice has enabled me to strengthen my core and remain centred and grounded in times of turmoil.

It is comforting to know that the constitution exists and provides a safety net by demanding equal rights for people with psychosocial disorders, even though I didn't need to use this personally.

While there is stigma in my culture, there are no superstitions about mental illness.

Aspects in my culture that hindered me were our drive to strive for perfection and a conservative society that imposes rules regarding acceptable behaviour, making it difficult to be different. Anne-Marie Robb, a mental health activist, calls this "cultural insistence on control of the mind." There are still remnants of bourgeois or 'stiff-upper-lipped' British thinking about not speaking about difficult, embarrassing and private things. They are still evident here in South-Africa, but luckily not so much in the healing and health community of which I am a part.

Another hindrance was the public's "blind" faith in the medical profession even when what they do or propose doesn't work. My family was in favour of the accepted medical treatment and I felt alone and unsupported in my choice of a holistic approach. I did not want to accept the diagnosis of an "incurable and potentially fatal condition" but had to find my own way, as my belief in finding a means of management without medication was rejected by most. Even though I was determined, it was lonely, new ground and so, hard work.

I noticed I was held back by other people's fear (and my own I suppose) and that they didn't want me to try something different, although it was what I wanted and I did it responsibly with guidance.

Later I noticed that some people had a dismissive attitude to the work I've done. For example, I have been told that, if I am now managing my life un-medicated then I must have been wrongly diagnosed or that I will definitely relapse. Maybe these unsupportive comments and generalisations are because it is broadly held to be true or because of their worry of potential relapse. Their fear and disbelief prevents them from acknowledging what I have achieved. Without even showing interest, they dismiss me as wrong or taking irresponsible risks.

In general there is a low awareness and understanding about bipolar and how to support someone. People don't know what to do, how to behave or what to say, so they prefer to avoid the issue. There is also fear and the hope that they don't ever have to experience it. Stigma, denial, avoidance and silence make things worse.



International Bipolar Foundation

It is not generally accepted that a mental illness is actually a family dynamic and so there is often a denial of others' roles in the dynamic of the unhealthy family. Some believe that the diagnosed person is the only problem and don't look at the role of everyone in the group. There isn't enough focus on support and a management plan for the rest of the family.

Differences of opinion and everyone wanting to be right are issues that are difficult to manage and can lead to disputes. Often I feel that doctors and family members don't listen to the patient and take his/her chosen route seriously.

In our times of instant gratification there seem to be three players who hold a structure in place even though it may not be working. They are: the "lazy" public who want a pill to cure the situation, the pharmaceutical companies who promise cure with medication and doctors who like to think they know the answers. It seems to me that often everyone is trying their best but they can't see the flaws of the solution they believe in.

It takes a lot of courage to step out of this entrenched thinking but I did it and my life management seems to be working well. I will, however, continue to be vigilant and take care of my overall health with diligence.

PERSONAL EXPERIENCE 2

I am a black, young, middle class, educated, lesbian single woman of Christian and Xhosa African background.

I have found that being maverick has awarded me the opportunity to thrive and stay alive. Christianity has been interpreted and used as a tool to oppress and discredit my sexuality by my society. The Xhosa aspect of who I am has been used to socialize an individual that adheres to patriarchy and traditions and cultures that have no ethical basis in our contemporary times.

However, my education was my saving grace. The ability to critically analyse what I had been taught to be 'truth' has allowed me to sift through the allegories to find my own truth that would allow me to live with my illness, sexuality, religious beliefs and know that they can all co-exist in a spectrum of absolute joy.

The Xhosa culture taught me that bipolar disorder was craziness, an abnormality, a label to attach so that I had an excuse for my behaviour; something to hold onto so that I would not be accountable for my actions. Their solution involved herbal remedies that were founded on the basis that someone had caused this 'craziness and abnormality' thus causing my 'madness' for choosing to be with women instead of men.



International Bipolar Foundation

Today, I can say that Christianity has taught me that my illness was something that God has given me to help me learn the valuable lessons of life. In retrospect, the raging mania and the debilitating depression have revealed many valuable and humbling lessons and I am grateful to God.

My Xhosa culture contributes very little to who I am as it is difficult to practise a culture if one's society cannot see or be involved in a more progressive and ethical way. Many have argued whether cultures can transform and still subscribe to their origins without compromising their basis. I think that it is possible for them to be progressive; my challenge is to create awareness so that my people can embody the transformation to allow others to disclose their illness without the fear of being the 'crazy' and 'abnormal' one in the family. I do not know how to achieve this goal yet, but being aware is the first step. I live with the hope that it will reveal itself in the end.

There were many obstacles in my journey through bipolar disorder.

It was particularly difficult because I found that my family did not talk about these things. They believe that one needs to hide things because this is the way to do things. So it was no surprise that my choice to see a psychiatrist after I was admitted to hospital after my first suicide attempt was not supported. I knew that this choice would isolate me from my family but I had faith in God that I could survive.

The other difficulty I encountered was letting go of many friends with whom I grew up who did not contribute to the person I was trying to be. This caused further isolation but I chose to join support groups instead, like "The Bi-Polar Bears", and this group gave me my first life-line in a very long, lonely time.

PERSONAL EXPERIENCE 3

I am a white gay man in my early thirties, with a university background in the arts.

Although I am a state patient and should get my medication from the state, in practice this has not worked out because they are unable to dispense a particular medication I need. Counselling options were limited to a 15 minute check-up by a student when I went once a month to get my medication. In my case, I had the white middle class privilege of a father with a medical aid who could pay for a private psychiatrist and the high cost of the medication. I don't know where those who cannot afford it go in our society when they are desperate to discuss serious mental health issues. As a freelance artist, I have not been able to afford medical aid, and when my father dies I don't know what I'll do.



International Bipolar Foundation

One would expect that privilege and education would be helpful, but my white middle-class parents, and even I, were surprisingly ignorant when confronted with the signs of bipolar disorder. Both blamed the other genetic family line and accused each other of being bipolar. My father thought it had something to do with my being gay and having too many female hormones. He thought this made me over-emotional and prone to psychosis. Months later, after finally getting around to reading the books my mother gave him, he began to understand.

PERSONAL EXPERIENCE 4

I am of mixed Sotho and Indian heritage, and am a postgraduate student. I am a single male and an atheist from a multi-religious background, but culturally I identify myself as Muslim.

I have no specific homogenous cultural heritage. My family, including extended family, is from vastly different backgrounds with roots in Africa, Asia and Europe. I think that this in itself creates an open-mindedness that is accepting of the reality of mental illness, specifically Bipolar Disorder.

My immediate family are, with no exaggeration, completely understanding of my condition. They are responsive to my requirements and are in tune with the vagaries of the condition.

I feel that initially, my immediate family expected there to be a complete “cure” for my condition. I don’t think that this was a cultural artefact, but rather a mild form of denial.

With my extended family, not having any interaction specifically on this topic I cannot speak authoritatively, I get the impression that those with a traditional upbringing would not acknowledge the existence of mental illnesses at all, or only the extreme conditions (for example, schizophrenia). I suspect that they would view any of the symptoms of Bipolar Disorder as character flaws.

With regard to Islam itself, I don’t think that the religion or its tenets provide direct hindrance or assistance in living with the Disorder, except for the fact there is an element of predestination (Takdir) inherent in the belief. I think that this leads to one resigning oneself to the fact that this burden is by the will of God, perhaps preventing seeking treatment, but this is only conjecture and I haven’t experienced this myself.



International Bipolar Foundation

PERSONAL EXPERIENCE 5

I am a Coloured (mixed ancestry) woman and mother, wife, daughter and occupational therapist working in mental health care at a psychiatric hospital. I am also of Muslim faith. Most Muslim people in Cape Town are termed Coloured.

Behaviour that I observe as helpful for patients in my care is that Coloured patients mostly feel supported when they receive visits and telephone calls from family and friends while in hospital. The helpfulness of this care and concern applies to everyone. It does seem that Muslim patients receive more visits from family and friends than non-Muslims do. This may be a generalization but reasons for this may be prompted firstly by an emphasis in Islam on the importance of caring for the ill and aged and secondly by a belief that if an ill person prays for one, the prayer may be more significant as the person is closer to God. Most of our patients are economically very deprived and feel supported by receiving financial support from family in order to purchase necessities.

Acceptance of, and openness about, their illnesses within communities counteracts stigma and it is helpful for families receive help themselves in the form of a support group or family counselling which provide education and support.

Aspects which hinder patients in my care are a lack of resources within state psychiatric hospitals, insufficient rehabilitation and discharge plans and insufficient resources within communities to support those people discharged from hospital. These result in a high turnover of patients called “revolving door patients.”

On a societal level there is a lack of government established programmes which tackle the stigma of mental illness in a meaningful manner. There should be a drive to educate the public about mental illness and other related issues. Family engagement in counselling does not happen enough and is often started too late for any reconciliation.

Substance abuse in the Western Cape has reached epidemic proportions yet is not addressed by the state with sufficient seriousness. This enormous problem would also exacerbate existing stressors related to the bipolar symptoms.

There is a lack of support in communities themselves i.e. a lack of social capital. This creates a sense of having no hope to cope with everything which is disturbing including mental illness. In the townships (ghettos) some people never leave those streets. Inaccessibility of clinics particularly in rural areas and rude clinic staff are often reported.

In impoverished communities there is a serious lack of engaging in meaningful activity. There is the absence of sport and activity clubs, groups etc. This could be due to issues particularly of crime but also of neglect by the state. High schools also have abandoned certain subjects like woodwork, physical education, art etc.



International Bipolar Foundation

General unemployment and dire socio economic conditions are also negative factors. This also affects attendance at clinics due to the unaffordable public transport and the inaccessibility of clinics, particularly in rural areas. Rudeness in clinic staff is often reported.

Poverty also hinders chances of being healthy in other aspects of one's life, for example by adopting a healthier lifestyle by eating more healthily. Smoking of cigarettes and excessive intake of alcohol are very widespread, especially in poorer areas.

Ever-increasing inequity and materialism and poor housing, sanitation, etc. all hinder recovery.

PERSONAL EXPERIENCE 6

I am a caring; thoughtful and detailed person who does not really subscribe to the thinking of gender, race and other physical forms of describing myself, as I believe I had to go through a personal journey which has lead to looking at myself as a "spiritual being."

However, I am 42 year old, black, Xhosa speaking woman living in Free State Province with my 10 year old son. I am emerging "soul" who is learning from every person how to become a better person and trying to live in the "NOW."

I was diagnosed bipolar in 1995 after I had an episode of "having dreams" from my grandmother.

In managing my bipolar, I use the internet for information, I spend time doing activities to get to know myself rather than labelling myself as ill, I go to a support group and I take complementary medical supplements which enhance my stability. I have used psychiatry, psychology and nursing, at state and private institutions, depending on my finance, but I know that a comprehensive, integrated approach, where I take responsibility for my health, works for me. The "Psycho Rehabilitation Programme" at Cape Mental Health was particularly helpful because of the non-judgmental attitude of the counsellors and workers. I was also assisted by the Department of Health which provided me with medication when I needed it and dedicated doctors.

I have learned that it is important to emerge from the societal standards of my culture without being dogmatic but to refine my character to meet the environment I live in. My language, area and community set the tone, however, I now enjoy co-existing with all but not become subservient to anyone.

I come from an African family who have also tried to have a comprehensive approach in the illness by understanding my desire to follow my dreams as a guide and so pursue training to become a traditional healer – also called and Igqirha or Witchdoctor. I will have to work out the issues that arise because of differences between the traditional and western approaches, methods and philosophies.



International Bipolar Foundation

PERSONAL EXPERIENCE 7

Anne-Marie Robb is a mental health activist and advocate. She says: “Most importantly, psychiatric discourse can be shown to be patriarchal and needs to be challenged and deconstructed so that the possibility of social transformation takes place within a feminist ethic of care.

This has political and material implications as popular beliefs around diagnosis, institutionalisation, medication, and visits to psychiatrists; ‘strange behaviour’, inability to function in the work place, emotional instability and perceptions of being incapable of self-care or legal capacity have disempowered the Bipolar “patient.” This impacts on the vulnerability of those diagnosed and our human rights are at risk.

Change is possible but we must direct and drive it in the right direction. This is what activism is and we need to recognize that we, the marginalised, need to immerse ourselves in living the struggle and not leave it to others.

I no longer feel as shamed by my diagnosis and feel empowered by my knowledge to speak out against our subjection to the disciplinary ethos of psychiatry, a masculinist endeavour, and to search for alternatives to accommodate my life that is haunted by descriptions in a hospital file as “psychotic”, “major depression” and “manic” or simply just referred to as Bipolar 1. We have a right to full personhood and with this comes the responsibility of self-care and exploring the best means for ourselves to navigate our journey through life respectful of others.” (Anne-Marie Robb, 2009)

Concluding remarks

In spite of the political freedoms and human rights advances, there has been a growing trend of economic inequality, poverty and unemployment, which has marked the social, economic and political landscape in South Africa. Clinical, social and economic interventions can positively benefit the mental health of South Africa’s communities, yet mental health is not given the priority it deserves in our society.

Dr Lund points out that it costs our economy more to ignore the burden of mental disorders than to provide appropriate resources.

The lack of community-based mental health services also puts additional pressure on already stretched primary health services and hospital beds. Zane Wilson of SADAG observes that there is a significant “gap between the wonderful legislation... and what we find when it comes to implementation, the resourcing, the providing and the infrastructure for people to access services.”



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Mental illness not only leads to increased health expenditure, reduced productivity, and social exclusion, it also increases poverty which in turn heightens the risk of violence, malnutrition, obstetric risks and increases the prevalence of mental illness while worsening their treatment outcomes.

“South Africa has a wonderful National Mental Health Care Act but it is often a hindrance to getting people the appropriate help”, says psychiatrist, Dr Rangaka. “Service providers often don’t know how the act works or what is expected of them, and services simply do not exist. This seriously affects the quality of patient care and response to crisis.” Dr Lund agrees: “We need a clear national mental health policy that is endorsed by a range of stakeholders in a truly consultative process. We need provincial Department of Health buy-in from all provinces, as well as multi-sectoral involvement, including Departments of Education, Social Development, Housing, the Police, Correctional Services, Labour and Justice.”

South Africa is a melting pot of cultures that we call the rainbow nation. We have huge problems, but underlying them we have a culture of “ubuntu” which refers to the importance of community. We have reached a high level of need and desperation in the state of mental health and it becomes increasingly important to find low cost, effective and sustainable ways forward to offer hope. While the situation is dire, I am comforted by the fact that there are methods that satisfy these criteria and that I and others are urgently involved in making a difference.

In South-Africa issues that need consideration are differences in communication (verbal and non-verbal), time perception (social time versus clock time), space perception, social organisation, ability to control one’s environment and biological variation which includes dietary preferences. (Uys 2010)

Cultural influences and impacts are bound to be very diverse and have many different outcomes. Managing Bipolar Disorder may be similar wherever one lives in terms of the personal challenges and issues it raises – but it will be significantly different in cultures that are, literally, worlds apart. Having said that, I feel that mental illness (or ‘imbalance’ or ‘disease’, or whatever one chooses to term it) is NO respecter of boundaries, geography, language or indeed culture.



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