NIH Public Access

Author Manuscript

Soc Sci Med. Author manuscript; available in PMC 2009 December 30.

Published in final edited form as:
Soc Sci Med. 2006 August ; 63(4): 979–990. doi:10.1016/j.socscimed.2006.03.003.

Challenges to HIV prevention in psychiatric settings: Perceptions of South African mental health care providers

Pamela Y. Collins
Columbia University, New York, NY, USA

Pamela Y. Collins: pyc1@columbia.edu

Abstract

Mental health services in South Africa increasingly feel the brunt of the AIDS epidemic. Despite the high prevalence of infection in the psychiatric setting, HIV risk reduction interventions targeting South Africans with psychiatric illness remain few and far between. The attitudes of mental health care providers about sexual relations and HIV among people with mental illness continue to influence the extent to which these issues are addressed in care settings. This study examines these attitudes through the use of a semi-structured interview administered to 46 mental health care providers in four provinces of South Africa. I found that personal, contextual and political factors in the clinic and the hospital create barriers to integrating prevention activities. In particular, providers face at least three challenges to intervening in the epidemic among their patients: their own views of psychiatric illness, the transitions occurring in the mental health care system, and shifting social attitudes toward sexuality. Barriers operate at the individual level, the institutional level, and the societal level. At the individual level providers' perceptions of psychiatric symptoms shape their outlook on intervention with psychiatric patients. At the institutional level disruptive transitions in service delivery relegate HIV services to lesser importance. At the societal level, personal beliefs about sexuality and mental illness have remained slow to change despite major political changes. Minimizing barriers to implementing HIV prevention services requires institutional and health care policies that ensure adequate resources for treating people with mental illness and for staff development and support.

Keywords

Mental health care providers; HIV prevention; South Africa; Barriers

Introduction

The AIDS epidemic in South Africa has grown exponentially over the last 10 years. Studies estimate that 5.3 million adults are infected with the virus (Department of Health, 2003). Although medical care for people with AIDS largely remains the responsibility of primary care services, mental health services increasingly feel the brunt of the epidemic. In fact, both HIV infection among people with psychiatric disorders and psychiatric illness among people with HIV infection underscore the critical role that mental health care providers will play in integrating HIV prevention and care activities into mental health care settings. The high prevalence of HIV infection among people admitted to psychiatric wards suggests that people with serious mental illness do not escape risk. Recent preliminary studies reported prevalence rates of 9% in one state psychiatric hospital and 29% on the acute psychiatric admission ward at a large tertiary care hospital (Singh, Nair, & Vasant, 2002; Zingela, Esterhuizen, Kruger, &

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Webber, 2002). A report estimating the impact of the AIDS epidemic on mental health services in Gauteng Province forecasts a sharp increase in demand for psychiatric hospital beds as prevalence rates climb and HIV disease progresses (Struthers, 2002).

HIV risk among people with mental illness

Despite the alarming prevalence of infection in the psychiatric setting, HIV risk reduction interventions targeting South Africans with psychiatric illness remain few and far between, even though the vulnerability of people with severe mental illness (SMI) (e.g., schizophrenia, bipolar disorder, major depression) to HIV infection (even in environments of relatively low HIV prevalence) has been well-established through studies in North America and Europe (Kalichman, Kelly, Johnson, & Bulto, 1994; McKinnon, Cournos, Sugden, & Guido, 1996; Otto-Salaj, Heckman, Stevenson, & Kelly, 1998; Rosenberg et al., 2001). These studies have shown that people with SMI are often impoverished and that many live in geographic areas with high HIV prevalence where their sexual partners are more likely to be HIV-positive. Substance use, inconsistent condom use, exchange of sex for money or other goods, and sex with multiple partners have also been associated with increased risk for HIV infection among people with SMI. Specific psychiatric symptoms are associated with increased risk (McKinnon et al., 1996), and cognitive impairment may further contribute to risk by limiting the ability to acquire and apply social skills (Green, 1996).

Awareness of these issues energized the development of interventions to help change attitudes and reduce sexual risk behavior (Carey et al., 2004; Collins, Geller, Miller, Toro, & Susser, 2001; Susser et al., 1998). Successful interventions in North America help people with SMI acquire skills to use and negotiate condom use. These interventions use repetition and role-playing to help participants learn and adhere to prevention messages. To my knowledge, no studies describing such interventions in South African mental health care settings have been published.

The South African mental health system and HIV

In 1910 at the establishment of the Union of South Africa, eight mental institutions provided care for 3624 patients. That number has since grown to 24 public psychiatric hospitals that deliver acute and chronic care for approximately 14,000 patients (Emsley, 2001). Historically, public mental health services in South Africa were characterized by reliance on hospital-based care, racial inequities in service provision, and underdeveloped community services. In 1994, reforms leading to more comprehensive care (including community health services, mental health promotion and prevention of mental illness) for all South Africans began in earnest.

A comprehensive mental health policy was developed in 1995 that promoted a broader view of mental health services, but the uneven distribution of hospitals, clinics, and funding across provinces limited the extent of the service reforms, as have inadequate numbers of mental health care providers (Robertson, et al., 1997): in 2001, South Africa had 429 registered psychiatrists for a population of 44 million (Emsley, 2001), and nurses outnumber all other mental health providers (Freeman & Pillay, 1997).

Traditionally, public mental health services have been oriented to people with psychotic disorders, developmental disabilities, and epilepsy (Emsley, 2001). Psychopharmacology remains the predominant form of treatment in the public sector. Access to newer, atypical antipsychotic drugs varies by province and available resources. Psychiatric hospitals remain the point of entry into care in many cases.

The crisis generated by the AIDS epidemic led South Africa's mental health system to make AIDS prevention an integral part of its agenda (Freeman, 2000). However, AIDS cannot be

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

prevented without frank discussion of sexuality. Old policies, specifically the Mental Health Act of 1973, provided limited guidance for addressing sexual issues in psychiatric settings by using language that discouraged the development of guidelines for sexual behavior in institutions; it made sexual relations with a woman a punishable offense, and male sexuality was ignored.

The Mental Health Act has been revised and updated. Significantly, the revised act recognizes that sexuality is a part of the lives of people in the mental health care system (including those in institutions) and grants people in institutions the right to consensual intimate relationships. Of particular relevance to the AIDS epidemic, institutions are now permitted to endorse open access to condoms; however, a frank discussion of sexual activity in many institutional settings has not become reality.

Mental health care provider attitudes and HIV-related services

The attitudes of mental care health providers (MHCPs) to sexual relations and HIV among people with SMI continue to influence the extent to which these issues are addressed in care settings (Collins, 2001; Herman, Kaplan, Satriano, Cournos, & McKinnon, 1994; Wright & Martin, 2003). North American studies suggest that lack of knowledge, stigmatizing ideas and institutional barriers have limited providers' readiness to respond to HIV prevention needs in mental health settings (Herman et al., 1994; Satriano, Rothschild, Steiner, & Oldham, 1999; Walkup, Satriano, Hansell, & Olfson, 1998). Providers' age, sex, sexual orientation, and clinical experience working with HIV have been linked to their comfort in addressing HIV in some mental health care settings (Wright & Martin, 2003).

In inpatient settings MHCPs struggle with ethical and moral questions about permitting sexual activity between people under their care. Is the patient truly able to consent? Is the public space of the hospital an appropriate arena for sexual activity (Mossman, Perlin, & Dorfman, 1997)? How will families react if they discover a hospitalized relative has been sexually active? If sexual activity occurs in the hospital is the clinical staff responsible for ensuring protection from HIV infection (Thom, 2003)? These questions are usually neglected by mainstream HIV educators and medical care providers, and consequently the caretakers for men and women with psychiatric illness bear the burden of decision. In fact, access to HIV prevention strategies and care for people with SMI often depends on these mental health providers.

Two studies have examined MHCP perceptions of HIV and sexuality in psychiatric settings in South Africa (Collins, 2001; Moors, 2000). Collins (2001) reported on providers' perceptions of HIV risk among women with SMI and their responses to sexuality and reproductive health needs. Despite perceptions of HIV risk and vulnerability, in some settings providers prioritized pregnancy prevention via administration of hormonal contraception over concerns about HIV infection. Most providers viewed family planning as a critical component of the care of women with SMI: appropriate family planning protected vulnerable women from post-partum psychiatric illness, protected children from inadequate care, and, according to some, prevented the "transmission" of mental illness.

Moors (2000) examined policies and practices around HIV prevention at six psychiatric hospitals in the Western Cape. She assessed measures used to contain HIV infection these institutions through interviews and group discussions with 152 nurses. The results showed that many nurses did not adhere to universal precautions and that condoms were not widely available in the facilities. Nurses were often inadequately educated on HIV transmission and lacked guidance on how to address patient sexuality in the institution. Even when staff were aware that the patients were sexually active, there was no great attempt made to provide HIV education or condoms. For example, 33–35% of respondents believed that the majority of patients in facilities for people with developmental disorders were sexually active; however,

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

these facilities offered the least HIV-related education of all the institutions that were surveyed. Moors concluded that measures to contain HIV infection at the facilities were insufficient. She highlighted the need for support services for staff so that they might express their questions and anxieties about HIV/AIDS.

Both studies underscore the need to understand the complex forces that influence provision of HIV and related services in South African mental health care settings. This paper examines those issues that challenge MHCPs' ability to intervene in the epidemic among their patients: their own views of psychiatric illness, the transitions occurring in the mental health care system, and shifting social attitudes toward sexuality.

Research methods

The author collected data from 46 semi-structured individual interviews with mental health care providers in four provinces of South Africa over a 3-month period. Due to the exploratory nature of the study, a qualitative methodology was used. Participants were recruited at clinical facilities through snowball sampling. MHCPs were usually notified of the study at their clinical staff meetings. At these meetings, providers or administrators recommended other facilities, and these sites were then contacted via telephone and visited.

The selected research sites represented the range of South African mental health care settings. Thus, included in the sample of sites were: one residential facility; three state hospitals; one private, long-term care institution; two primary care clinics; two general hospital psychiatric wards; one mental health non-governmental organization (NGO); and one private psychiatric practice. The participants were men and women who provided clinical, rehabilitation or administrative services; verbal consent for participation in the study was acquired. Ethics approval for the study was obtained from the New York State Psychiatric Institute (USA) and the University of the Witwatersrand (South Africa). All interviews were conducted in English. Participants received no reimbursement for participation.

Data collection and analysis

A semi-structured interview was administered to 46 MHCPs in the work place. Interviews lasted from 30 to 90 minutes. The interviews covered the following broad categories: patients' vulnerability to HIV infection; the impact of mental illness on sexuality; barriers to effective HIV prevention; reproductive health; the family's response to sexuality in the individual with mental illness; perceptions of patients' attitudes toward sexuality; culture and sexuality; and special considerations for developing HIV prevention programs in South Africa (Collins, 2001). All interviews were transcribed.

The goal of the analysis was to identify and characterize the barriers to providing HIV prevention interventions. The data analysis employed open and selective coding (Charmaz, 2002). All interviews were read several times and subjected to an open coding procedure. The interview schedule asked participants directly, "What might be some of the barriers to effective HIV prevention in this population?" Codes were first developed from responses to this question and subsequently for the remainder of the responses on the basis of five interviews. All interviews were then coded using the list of open codes generated. Additional codes were developed as needed. A selective coding procedure, in which related codes were grouped, generated a smaller number of themes. Three themes emerged that appeared to encompass most providers' perceptions of barriers to prevention: Psychiatric symptoms as barriers to safety and prevention; Transitions in the health care system; and Talking about sex: Transitions in South African society.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Results

Research sites

State hospitals—These hospitals provided acute care, rehabilitation, and chronic, custodial care for people with serious mental illness. Providers estimated that Black patients composed 60–70% of the institutions' populations. While patients with schizophrenia and other psychotic disorders predominated in institutional settings, people with affective disorders (major depression, bipolar disorder) were also represented. An admission to an acute ward typically lasted 19–30 days. Longer stays ranged from 6 weeks to 3 months. Patients discharged from hospitals were typically referred to community health clinics for monthly or more frequent follow-up. Almost 40% of patients at one state hospital were "chronic", with stays of several years. Sex between patients occurred on the wards in some state hospitals, and the sprawling, park-like grounds also offered secluded places for sexual encounters.

Private chronic care facility—This institution was one of several private, psychiatric facilities that had contracts with the government to provide chronic care. Patients at this facility were admitted for 6 months to 1 year, and repeat admissions were common. Those without family were admitted indefinitely. The patient population consisted primarily of people with psychotic disorders and adults or children with developmental disorders. Sex could occur on the wards, but nurses at this institution believed that most patients had lost sexual interest due to hormonal contraceptives administered at the facility. A nurse commented, "Maybe they will play together and the male patient will grab her. She will run back to us and tell."

Residential facility—This private residential facility offered long-term housing, group therapies, and medication administration for 16–17 residents with mental illness in an urban area. Providers described patients with chronic, psychotic illness—primarily schizophrenia and bipolar disorders. Providers acknowledged that relationships between patients were "casual, or giving their bodies because they've run out of cigarettes."

Mental health NGO—This outpatient facility hosted a day program, therapeutic groups, and rehabilitation services for men and women with mental illness. The patient population included men and women with schizophrenia, bipolar disorder, depression, and milder mental illness. The majority of patients were men, and Black; most patients lived with their families. White patients tended to be among the more severely ill. Attendance at the program varied, with some patients reporting daily and others coming every few months. Providers guessed that half of the patients were involved in sexual relationships. One commented, "We often have to do programs on sexual harassment. If a new lady comes in she's targeted."

Primary care clinic—Two psychiatric nurses worked in this primary care clinic that provided mental health services (administration of psychiatric medications) on specified days of the week. The clinic served a large urban catchment area that included a number of poor Afrikaans and "Colored"[1] communities and a small number of Black patients from other communities. The nurses knew little about most patients' sexual lives, but asserted that some patients "changed partners" and that due to "social constraints—they may sell themselves."

General hospital psychiatric ward—This 30-bed inpatient unit provided 10 alcohol rehabilitation and detoxification beds, 5 beds for homeless patients, and 5–6 beds for female patients. The length of stay averaged 2 weeks, after which time patients in need of further care were transferred to a state hospital. The patient population included people with SMI

[1]The term 'colored' refers to South Africans of mixed race and was one of the four designated racial categories under the apartheid government: Black, White, Colored and Asian. The term remains in use today in South Africa.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

(schizophrenia, bipolar disorder, major depression), often complicated by marijuana use. Nurses worried primarily about sex that occurred on the wards at night and reported that men and women were not adequately separated.

The providers

The 46 providers who participated in the semi-structured interviews ranged in age from 25 to 61 years (mean = 41). Of these, 35 were women. The study sample included 22 nurses, nine psychologists, seven social workers, four rehabilitation workers, two psychiatrists, and two general practitioners. Of the 22 nurses, 18 were professional nurses, and 14 had received specialty training in psychiatry. The remaining four were staff nurses. On average, providers reported 8.8 years of clinical experience (range: 0.5–24). The majority of the participants were Black, and though interviews were conducted in English, the first languages of the participants included Xhosa ($N = 4$), Afrikaans ($N = 7$), Tswana ($N = 4$), Venda ($N = 4$), Shangaan ($N = 2$), Spanish ($N = 1$), Tonga ($N = 1$), Tsonga ($N = 2$), and Zulu ($N = 1$). Thirteen providers were native English speakers. Most providers worked in residential or inpatient hospital settings (27 of 46) where they formed part of a multidisciplinary team that included social workers, nurses, sometimes psychologists, and—rarely—psychiatrists. Many participants also rotated through the outpatient services of their institutions.

The vast majority of providers interviewed believed that mental health care providers (31 out of 46) should be responsible for providing HIV prevention strategies. Many believed such programs should work in concert with government-sponsored or community programs. A social worker suggested that institutions such as her own residential facility should educate patients. “In hospitals, nurses and social workers would run them, but widespread public education should happen—more posters, TV talks. Everybody—doctors, general practitioners —should be involved. The Federation for Mental Health should push it forward.” Ultimately, several providers suggested, people with mental illness should be trained to conduct HIV prevention activities and educate each other.

Psychiatric symptoms as barrier to safety and prevention

Providers most frequently identified psychiatric symptoms as the critical barrier to HIV prevention among people with mental illness. The presence of these symptoms limited patients’ abilities to understand information about HIV. A nurse explained:

> The concept of AIDS is not well understood even by healthy individuals. There’s a lot of misinformation. If a person now gets mentally ill, the table is upside down. The person had misconceptions before mental illness. It gets worse. He will attach delusions to the whole concept, which makes it worse. They do pass their ideas to each other, so it spreads.

Misconceptions, according to providers, included the belief that AIDS was not a serious illness or that HIV did not exist.

At the hospital sites, patients in the inpatient wards were acutely ill and unable to understand and act on prevention messages. A nurse working on the psychiatric ward of a general hospital explained:

> They don’t understand what you’re talking about because they’re mentally ill. When a person is better, the mental illness has been controlled; sometimes they ask questions about where does this [AIDS] come from.

A psychiatrist echoed these concerns:

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

> Outside—there are programs in the primary care clinic. In my ward I have a problem. When they get here they have lost insight. They're in the fourth dimension….One can't use physical barriers and knowledge as a weapon against infection.

In many instances nurses provided condoms or pamphlets to individuals suspected of being sexually active, known to have HIV or another sexually transmitted disease, or who had been involved in an incident of sexual abuse. They were reluctant to give condoms to patients whom they perceived to be too ill to make proper use of them. One nurse explained, "We had a box of condoms, but now they are finished. Only those two patients used them. You don't know who to give the condoms to. Some will suck on it or put it in the wrong place." Providers sometimes referred to chronically ill patients with particular despair. A nurse at a psychiatric hospital explained:

> Mild schizophrenics do understand. Moderate—maybe 50% understand, but severe ones, there's nothing you can do. They know nothing. They are retarded. The world has collapsed for them. Those are in the wards [with] repeated attacks of mental illness.

Patients who were treated in outpatient settings were still unlikely to receive HIV-related information according to one nurse:

> I think it's rare because of their condition. Many people tend to think these programs aren't meant for mentally ill individuals, so they spend most of their time educating mentally healthy patients. Even at the clinics I know they're neglecting mentally ill patients.

Despite their emphasis of the severity of symptoms and the difficulty of conveying the right message to people with SMI, some providers were aware that skills building and repetition were necessary for working with this population. One nurse noted, "They are tired when you take a long time. They want to do a piece, then another day [another] piece of information." Similarly, an employee at a residential facility described the complexity of providing adequate HIV prevention information to patients. She observed that barriers included "lack of concentration and absorbing information." She noted that she

> would have to do it frequently for little bits of time. You would need visual aids, puppets, videos, acting—repetition, not just auditory. I think one would actually be quite graphic: actually show them how a condom is put on.

Clinical experience had taught these two providers how interventions might be conducted, but their lack of exposure to models using such approaches to HIV prevention and patients' symptoms left them stymied as to how to go about it.

The providers' views of psychiatric symptoms and of the people experiencing them provided more subtle barriers. A primary care doctor noted, "I think people are prejudiced against psychiatric patients. They say, 'What's the use of telling them about this? They won't listen. They won't understand.'" Other responses confirmed these prejudices, which usually merged the patient and the illness. A psychiatric nurse at one state hospital explained that one barrier to prevention was "the patients themselves". Others observed:

> "They know about it, but they don't care…"

> "They are supplied with condoms, but they don't use it, they just misuse it…"

These comments illustrate the distance between some providers and patients. Whether providers are demoralized by frustration or de-motivated by stigma, their comments suggest that they occasionally lack the empathy needed to take on the challenges of HIV prevention.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Other providers noted that people using mental health services had to manage both their symptoms as well as the reactions of community members and family to their symptoms. Outpatient providers observed that active psychiatric symptoms left patients vulnerable to rejection by their communities. Caseworkers spoke of patients jilted by boyfriends or spouses once the mental illness was discovered. Some relationships survived only because of the disability grant that patients received and then contributed to the family finances. These painful experiences contributed to HIV risk in the eyes of some providers. A nurse on general hospital's psychiatric ward commented, "…usually when they label you that for life …nobody will come near you. That's why these women strip and follow these guys. Nobody will ever come to you."

On the other hand, a community's negative reaction to psychiatric symptoms sometimes had a positive value with respect to HIV risk. A small number of providers suspected that people who experienced rejection actually were less likely to contract HIV. One nurse explained:

> What I have realized is because of the rejection by the community, that thing somehow saves them from most of the things [like HIV]. When you get mentally ill in the community they don't accept you as readily. There's stigma or rejection. They think maybe you are bewitched. Your closest friend rejects you and then in that process you're facing the rejection—you're protected by your family. You have no boyfriend and everybody's afraid. I think that's why a lower number of psychiatric patients have HIV.

Transitions in the health care system

In addition to the barriers presented by psychiatric symptoms, many providers experienced a sense of disorganization as they adapted to reforms in the health system after the 1994 elections. One nurse said of her province:

> The government hasn't paid the doctor for seeing public patients, so now they flatly refuse to see our public patients. With the whole transformation, some things are haphazard. We try to stick to things that worked in the past. You must do things to satisfy the department and the clients. You must be flexible all the time. Once things are more settled and have more directions, it will go better.

In addition, there were not enough staff to carry out educational programs in hospitals and clinics. The demands of patient care overwhelmed and stretched their resources, leading providers to question whether HIV should really be a priority. Efforts at HIV education came after the more urgent tasks of managing psychiatric symptoms, discharge planning, meeting with families to educate and support them, and assisting patients in attaining disability grants. These concerns required full-time attention. "We're all so busy trying to keep them in balance and trying to solve relationship problems in the family," commented one nurse.

Staff shortages were not the only concern; providers also complained of a general neglect of psychiatric services by some hospital administrations. Because of this, some providers felt vulnerable and feared for their own safety. A male nurse at a state psychiatric hospital noted that HIV risk was also high for staff:

> Because some of the patients—acutely psychotic ones—when they come they're breaking windows. Sometimes you end up touching the blood. The structure of the hospital has to be taken into consideration. You've got glass there, but nothing to protect the patient from the glass. If he breaks the glass he can spread whatever he has."

At another site, the broken windows of the psychiatric ward left gaping holes and jagged edges through which the wind passed freely into patients' wards. There were insufficient funds to purchase new syringes, and inadequate supplies of medication. Staff reported that syringes

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

were re-used to give injections of psychotropic medications. At two sites, providers talked about the need for physical barriers; they attributed sexual liaisons between patients (and consequent HIV risk) to the poor condition of the wards. A nurse explained: “It would be better if we could get a place for female psychiatric patients under lock and key and a place for male psychiatric patients—especially during the night. Also, we have a shortage of staff to monitor their movements.” At a general hospital in another province, one provider complained:

> We don’t know the HIV status of our patients. We had a boy who reported he was sodomized by a patient. That patient later developed a high fever and was HIV positive. Last week I saw they were spending funds on a staff kitchen, and I think that’s not a priority. We need separate places for women, men, and children. Also psychiatry was very much neglected. So, a lot of things happen. There have been some reports that some male staff abuse patients.”

Some providers believed that integration of mental health services into primary care would ease resource and time constraints. A move toward integration, said one psychiatrist, would allow staff to take on responsibilities like HIV prevention:

> Lately we have decentralized services. We used to go out to neighborhoods and set up under a tree. Now we have taken all the meds to primary care clinics. We consider giving out tablets a non-professional duty, so now when the psychiatric staffs come, they can teach and run groups and empower the patients. That would be the way to teach the patients, through the psychiatric staff. Then we could train the patients to teach patients.

Others feared that if patients were sent to primary care settings, they would be neglected. One provider commented that general health workers feared psychiatric patients and that “[they] still see the category [psychiatric patients] as not their responsibility, but the responsibility of psychiatric nurses.”

One staff member believed that the mental health system must be better organized before HIV prevention programs could be put in place.

> I think the community psychiatry program needs to get off the ground first…you need to get people well. I’m not saying one must come before the other. We get condoms. They are available. My only concern about South Africa is that we need to get some decent psychiatric care on the ground. I know the primary care movement is strong, but as usual, the psychiatric patients are being pushed aside. You show me one general hospital that will admit psychiatric patients.

Talking about sex: transitions in society

Social transitions accompanied changes in the health system. The providers emphasized that South Africans typically held conservative attitudes toward sex and that secrecy about sexuality was normative. But there was growing recognition that old values were changing. A 52-year-old female nurse explained:

> [In] our culture, we don’t even use the name sex. It’s very private. We can’t talk about sex…If you’re married, you must go and sleep in a private house with your husband. In the morning, it’s as if they know what you’ve done. You become very shy. The word sex is offensive….”

Referring to South African youth she continued, “These days they don’t care! They want to have a child before they get married. When I was married I was too shy to tell my mother I was pregnant. Now they don’t care. It is their right to have sex! They have rights—boys and girls!”

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Where Sex is Open: Changing Institutional Values

Changing sexual values were also reflected in the mental health system with the revision of the Mental Health Act of 1973. The new values presented a special challenge for providers of psychiatric care, whose patients, according to one nurse, were already "more sexually active than normal people". She explained, "We are now treating patients under these conditions—where sex is open." A social worker at a residential facility commented, "The way we were all brought up impacts on us. The past. South Africa was quite conservative. That needs to be addressed to take away the stigma. I strongly believe sexuality with the mentally ill has been neglected."

One challenge for providers was the perceived danger of sex for people with mental illness. A psychiatrist spoke about sexual activity at his hospital: "At night they sleep separately, but the patients' rights charter says they have the right to associate with the opposite sex. We don't know about [consensual sex], but we hear about the assaults." Another provider described the dangers for patients in her institution and her community:

> Even in the ward situation we have a problem. I've actually asked the workshop to make a new screen again. They say they will build a new ward, but up to now it's not existing. When manic patients come onto the ward and they're hypersexual—there [are] problems. I can imagine in the community it's even a bigger problem. Family structures are not as they used to be. There's a lot of promiscuity. There's a transition from old cultural values to new ones that's caused a loosening of family relationships.

In inpatient settings providers struggled to control the environment and to control patients' behavior, sometimes resorting to hormonal interventions to "reduce libido."

In outpatient settings, where providers were less responsible for patients' safety, openness about sex brought positive developments in some interactions with their patients. A psychiatrist observed that his male patients sometimes initiated conversations with him about the sexual side-effects of their medications. Occasionally, wives accompanied men who openly discussed their sexual problems with the provider. He explained:

> Some patients are liberated enough to bring their wives to tell the doctor. When you do that it means that you and your wife are one and very open. The male is supposed to cautiously and secretly discuss sexuality with males. Lately, I have older men coming to me to discuss their [sexual] problems with me.

Another psychiatrist in an outpatient setting described his bewilderment with such conversations and by his patients' eagerness to talk about sex. "It's a new area for me. In the past few months I've been confronted with it…I'm learning. Let me just add, both [patients] are youngish and I was surprised at how eager they were to [discuss sex]. I'm the one who has to go through the learning curve."

Learning to talk about sex: communication and its barriers

Under the new Mental Health Act providers would have to respond to the AIDS epidemic by talking about sex and HIV risk. But even though the majority of providers said they were comfortable talking about sex with patients, some felt ill-equipped to initiate these conversations. One provider at a residential facility described her difficulties discussing condom use: "We hand them out fairly easily. They get them for nothing. You get a few who ask because they're active outside _____. They don't ask for condoms for sex inside ____. One doesn't exactly know how to tell a resident not to sleep around—that AIDS is a problem." Those who did initiate conversations generally did so when clinical circumstances obligated them to. A male nurse commented, "I came across a psychiatric patient in the clinic having a

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

sexually transmitted disease. I know they do involve themselves in sexual relationships. I had to counsel that patient in how to use a condom. I was forced to educate that patient."

Other dynamics—like cultural acceptability and ethnicity--made these discussions difficult. Providers strongly agreed that ethnic affiliation influenced their ideas about sexuality among their patients. Many struggled when talking about sex with patients of different ethnicities. When providers anticipated their patients' responses to conversations about sex or HIV, they felt even less inclined to discuss these issues with members of different ethnic groups. An Indian nurse described racial tensions in her clinic:

> We work with an Afrikaans community. It's an adjustment for them to have us here. You know the thoughts are still very ancient. It's something people have grown up with. I have a lady who refuses to come to clinic because she doesn't want to see the "coolie" doctor. I hope she doesn't mind the "coolie" nurse.

The cultural distance she experienced, as well as her beliefs about the quality of her patients' relationships, influenced her decisions to speak to them about sex or HIV. In general, she opted not to initiate these conversations. She was acutely aware of how the patients might respond if she were to distribute condoms: "They would think, 'What is this one thinking about?'" She believed that the clinic attendees were ashamed to take condoms from the clinic and that a discussion of these issues would strain her relationship with them.

Similarly, White providers sometimes felt self-conscious about their safe sex messages. They feared that some patients might interpret information about condom use as an extension of the previous apartheid government's alleged desire to limit the Black population. One white provider spoke of her anxieties about discussing sex with Black patients:

> I think [there is] suspicion in the sense that some of the Black patients who are less educated think, now this white doctor is trying to tell me to stop sleeping around. Suspicion in terms of, 'should I buy what they're telling me?' They might think you're trying to impose your culture on them.

Black providers often described the differences in attitudes toward sex among different African ethnic groups. A Black nurse reported, "According to Shangaan culture, they won't talk much about sex. They don't feel comfortable. Vocabulary is restricted. They don't use these words." In reference to sex in the psychiatric setting, this meant, according to another Black nurse, "They don't think about that." She explained that the women advised each other in the hospital, "'no, you must wait for your husband.' They know very well not to do anything if the husband's not there."

The vast majority of providers perceived that for Black patients, discussing sexual topics was "taboo", "stigmatizing", and appropriate only under certain conditions. These perceptions sometimes prevented providers from openly discussing sexual activity that occurred in hospital settings. A Black male nurse spoke of the sexual activity in his institution, "There are a few patients having affairs with female patients. We provide them with condoms. We don't formalize it. It is our culture. We feel uncomfortable saying, 'come, here are condoms.'"

Avoiding taboo discussions was reinforced, paradoxically, by a sense that "cultural" ideas were immutable, even though cultural values were clearly shifting. A Colored psychiatric nurse commented about her experiences trying to provide HIV education, "If it's a cultural thing there's not much you can do about it. Especially with Black men where they believe they must have more than one wife. They say that's culturally acceptable for them." A white male psychologist voiced his frustration with this belief: "I think the idea of culture is used to invoke a lot of oppressive practices. For example—similar debates in the gay community—it's not a

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

part of my culture to wear a condom if I'm an African man…That's one area—the way culture gets used in terms of sexual politics."

A few providers suggested that people of the same ethnic group should conduct HIV prevention interventions. In addition to removing language barriers, they felt that the ability of the patient to understand and absorb the message depended upon the ethnicity of the person delivering it. Some felt this was particularly true for psychiatric patients, who, accustomed to discrimination and rejection, needed intervention by providers they could trust.

Discussion

The data presented here represent the particular experiences of a small number of MHCPs and may not be representative of most South African providers; nevertheless, their words are instructive. The providers in this study face challenges in providing mental health care during a time of political and social transition in South Africa in which structural changes have preceded changes in attitude and behavior for MHCPs. As the prevalence of HIV infection grows, aspects of patient care, especially sexuality, that could have been ignored in the past are now critical. Yet the immediacy of acute psychiatric illness among patients, the daily hassles in the work place, racially charged interactions, and stigma compete with the AIDS crisis for attention.

Due to competing concerns in care settings, few sites addressed the need for ongoing prevention activities. Barriers operated at the individual level, the institutional level, and the societal level. At the individual level providers' perceptions of psychiatric symptoms shape their outlook on intervention with psychiatric patients. Providers work in a system in which the sickest people are the ones who gain access to care. In the public system, providers must also address the social needs of impoverished patients. But, providers did develop sheltered workshops and other psychosocial rehabilitation activities with chronic patients into which HIV prevention interventions could have been incorporated. Failure to do this may be related to the fact that sexual activity, in certain treatment settings, is often interpreted as an expression of psychiatric illness. Providers may opt to focus on treating the psychiatric illness or reducing sexual desire medically, rather than addressing HIV risk.

At the institutional level, other barriers arise. The mental health system is in transition as efforts to move to community care and integration of mental health services into primary care proceed. In this study, many providers perceived these changes as disruptive. But, as previous South African studies note, many of these changes are meant to free up mental health care professionals so that they can provide HIV/AIDS-related services (Freeman, 2000; Swartz & MacGregor, 2002). North American researchers have reported that in clinical settings where MHCPs feel overwhelmed with responsibilities or view HIV as a secondary concern, HIV-related activities often depend on the initiative of a few motivated individuals (Wright & Martin, 2003). This occurred at some of the study sites. In this period of transition, South African mental health care institutions, of all kinds, run the risk of allowing these motivated individuals to in fact become the providers of HIV care and prevention programs – on their own initiative rather than through a system wide protocol.

At the societal level, major political changes have occurred. Transitions in the mental health system occurred in the context of larger post-apartheid societal shifts in ideas about sexuality and gender equality. Calvinist values that emphasized male authority, "'pure' New Testament principles, rigid austerity, and strictness in conduct and morals" gave way to the ascendance of women to political power and to legislation of equal rights regardless of sex and irrespective of sexual orientation (DuPisani, 2001). Even so, personal beliefs about sexuality have remained slow to change. Under these circumstances, talking about HIV prevention is a challenge.

Cultural ideals about sexless purity contrast sharply with patient behavior during episodes of acute illness observed by providers (Collins, 2001). Racial stereotypes of sexuality, as well as fears of offending patients whose ethnicity differs from that of the provider, shape the possibilities for HIV intervention and influence the level of provider motivation to address these issues.

There may be other explanations for the limited attention given to HIV/AIDS at the study sites. Unlike those working in settings with low HIV prevalence, South African providers also live at great risk of HIV infection. Talking to patients forces providers to confront the possibility of their own infection. Among the few providers who spoke about the personal consequences of the AIDS epidemic, most acknowledged fears of being diagnosed with HIV and of the accompanying stigma.

Responding to HIV prevention needs in psychiatric care settings

Despite the barriers, providers did make efforts. They arranged sex education talks in some settings, distributed condoms, and, perhaps most encouraging of all, they identified themselves as the responsible parties for providing HIV prevention interventions. The question now becomes, how can providers meet these challenges given the reality of limited resources for mental health services and the great demand for clinical care?

Some efforts are currently underway. Implementation of the Mental Health Act of 2002 will enable providers to openly confront the need for sexuality and HIV-related policies in care and treatment settings. Since the time of this study, the Directorate of Mental Health has established a task force on HIV/AIDS that has developed guidelines for the management of HIV/AIDS in psychiatric institutions. The guidelines provide a resource for addressing issues around HIV testing, confidentiality, and management of HIV disease in psychiatric settings. MHCPs in specific provinces have taken this work further (Thom, 2003). Finally, training projects where MHCPs receive the tools to provide prevention interventions (basic information about HIV/AIDS, HIV care and treatment, confidentiality, developing sexual policies, talking about sex, supporting staff members affected by HIV/AIDS, and integrating HIV prevention into the daily routine) have been piloted in some institutional settings (Collins et al., in press). Such interventions, developed in collaboration with MHCPs, will equip providers to negotiate the particular challenges they face in their facilities.

Acknowledgments

This study was supported by a grant from the Fogarty International Center AIDS International Training Research Program and NIMH K01 MH01691. I would like to acknowledge Arthur Kleinman, Mickey Pearlman, and Hella von Unger for their helpful feedback and thoughtful contributions to the topics discussed in this paper. I am extremely grateful to the Center for Health Policy at the University of the Witwatersrand, Johannesburg, for providing a departmental base during the study; Clifford Allwood and Melvyn Freeman for facilitating access to providers in multiple settings in South Africa; Carel Mouton for his generous assistance; and the many South African mental health care professionals who candidly shared their thoughts on this complicated subject.

References

Carey MP, Carey KB, Maisto SA, Gordon CM, Schroder KEE, Vanable PA. Reducing HIV-risk behavior among adults receiving outpatient psychiatric treatment: Results from a randomized controlled trial. Journal of Consulting and Clinical Psychology 2004;72(2):252–268. [PubMed: 15065959]

Charmaz, K. Qualitative interviewing and grounded theory analysis. In: Gubrium, JF.; Holstein, JA., editors. Handbook of interview research: Context and method. Thousand Oaks: Sage; 2002.

Collins PY, Mestry K, Wainberg M, Nzama T, Lindegger G. Daring to talk about sex: Training South African mental health providers in the era of AIDS. Psychiatric Services. (in press).

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Collins PY. Dual taboos: Sexuality and women with severe mental illness in South Africa—Perceptions of mental health care providers. AIDS and Behavior 2001;5(2):151–161.

Collins PY, Geller PA, Miller S, Toro P, Susser ES. Ourselves, our bodies, our realities: An HIV prevention intervention for women with severe mental illness. Journal of Urban Health 2001;78(1): 162–175. [PubMed: 11368195]

Department of Health. *National HIV and syphilis antenatal sero-prevalence survey in South Africa*, 2002: Pretoria, Health Systems Research, Research Coordinator and Epidemiology. 2003

DuPisani, K. Puritanism transformed: Afrikaner masculinities in the apartheid and post-apartheid period. In: Morrell, R., editor. Changing men in Southern Africa. Pietermaritzburg: University of Natal Press; 2001. p. 157-175.

Emsley R. Focus on psychiatry in South Africa. British Journal of Psychiatry 2001;178:382–386. [PubMed: 11282826]

Freeman M. Using all opportunities for improving mental health—Examples from South Africa. Bulletin of the World Health Organization 2000;78(4):508–510. [PubMed: 10885175]

Freeman, M.; Pillay, Y. Mental health policy—Plans and funding. In: Foster, MFD.; Pillay, Y., editors. Mental health policy issues for South Africa. Pinelands: Medical Association of South Africa Multimedia Publications; 1997. p. 32-54.

Green MF. What are the functional consequences of neurocognitive deficits in schizophrenia? American Journal of Psychiatry 1996;153:321–330. [PubMed: 8610818]

Herman R, Kaplan M, Satriano J, Cournos F, McKinnon K. HIV prevention with persons with serious mental illness: Staff training and institutional attitudes. Psychosocial Rehabilitation Journal 1994;17 (4):97–104.

Kalichman SC, Kelly JA, Johnson JR, Bulto M. Factors associated with risk for HIV infection among chronically mentally ill adults. American Journal of Psychiatry 1994;151:221–227. [PubMed: 8296893]

McKinnon K, Cournos F, Sugden R, Guido JR. The relative contribution of psychiatric symptoms and AIDS knowledge to HIV risk behaviors among people with severe mental illness. Journal of Clinical Psychiatry 1996;57:506–513. [PubMed: 8968298]

Moors, E. An assessment of measures to contain HIV/AIDS within mental health facilities in the Western Cape: Management Training Scheme. England: National Health Service; 2000.

Mossman D, Perlin ML, Dorfman DA. Sex on the wards: Conundra for clinicians. Journal of the American Academy of Psychiatry and the Law 1997;25(4):441–460. [PubMed: 9460033]

Otto-Salaj LL, Heckman TG, Stevenson LY, Kelly JA. Patterns, predictors, and gender differences in HIV risk among severely mentally ill men and women. Community Mental Health Journal 1998;34 (2):175–190. [PubMed: 9620162]

Robertson, B.; Zwi, R.; Ensink, K.; Malcolm, C.; Milligan, P.; Moutinho, D., et al. Psychiatric service provision. In: Foster, MFD.; Pillay, Y., editors. Mental health policy issues for South Africa. Pinelands: Medical Association of South Africa Multimedia Publications; 1997. p. 69-93.

Rosenberg SD, Trumbetta SL, Mueser KT, Goodman LA, Osher FC, Vidaver RM, et al. Determinants of risk behavior for human immunodeficiency virus/acquired immunodeficiency syndrome in people with severe mental illness. Comprehensive Psychiatry 2001;42(4):263–271. [PubMed: 11458300]

Satriano J, Rothschild RR, Steiner J, Oldham JM. HIV service provision and training needs in outpatient mental health settings. Psychiatric Quarterly 1999;70(1):63–74. [PubMed: 9924733]

Singh, D.; Nair, M.; Vasant, U. New onset psychosis in HIV positive patients. South African Society of Psychiatrists, 12th National Psychiatry Congress; Cape Town, South Africa. 2002.

Struthers, H. The likely impact of HIV/AIDS on service provision for people with severe mental illness. Gauteng Province Department of Health; South Africa: 2002.

Susser E, Valencia E, Berkman A, Sohler N, Conover S, Torres J, et al. Human immunodeficiency virus sexual risk reduction in homeless men with mental illness. Archives of General Psychiatry 1998;55 (3):266–272. [PubMed: 9510221]

Swartz L, MacGregor H. Integrating services, marginalizing patients: Psychiatric patients and primary health care in South Africa. Transcultural Psychiatry 2002;39(2):155–172.

Thom R. HIV/AIDS and mental illness: Ethical and medico-legal issues for psychiatric services. South African Psychiatry Review 2003;6(3):18–21.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Walkup J, Satriano J, Hansell S, Olfson M. Practices related to HIV risk assessment in general hospital psychiatric units in New York State. Psychiatric Services 1998;49(4):529–530. [PubMed: 9550247]

Wright ER, Martin TN. The social organization of HIV/AIDS care in treatment programmes for adults with serious mental illness. AIDS Care 2003;15(6):763–773. [PubMed: 14617498]

Zingela, Z.; Esterhuizen, F.; Kruger, C.; Webber, LM. Prevalence of HIV infection in a group of adult psychiatric inpatients in two wards in Weskoppies Hospital. South African Society of Psychiatrists, 12th National Psychiatry Congress; Cape Town, South Africa. 2002.