UNDERSTANDING THE SEXUAL RISK BEHAVIOURS OF PEOPLE LIVING WITH DIFFERENT MENTAL ILLNESSES AND THEIR VULNERABILITY TO HIV INFECTION

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Declaration

Except for references specifically indicated in the text, and such help as has been acknowledged, this thesis is wholly my own work and has not been submitted to any other university, technikon, or college for degree purposes.
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Dedications

This work is dedicated to all the people who are living with mental illnesses and those who are advocating for their rights.
Abstract

This study was primarily carried out in order to assess the sexual risk behaviours of people living with mental illnesses as well as their vulnerability to HIV infection. It sets out the basic realities of the interaction between mental illness and HIV/AIDS and its impact on individuals and communities. This study explores the implications for health policy and practice, and suggests how to provide better support and assistance in the empowerment of people living with mental illness as far as HIV and AIDS is concerned, including community support. It was also the aim of this study to look into the factors that expose this group of people to HIV infection as well as to understand the link between HIV/AIDS and mental illness. It also tested the inclusion of people with mental disabilities in HIV and AIDS prevention and education programmes.

The research was conducted on the basis of a qualitative research design. A semi-structured interview schedule was used in broad based interviews to gather information from caregivers or guardians of people with mental disabilities as well as the professionals in the mental health sector. The results of the research revealed that people who are living with mental illnesses are a vulnerable group as regards HIV infection. It also conveys that this group of people presents with sexual risk behaviours, which increase their vulnerability to HIV and AIDS. In addition, there are many barriers against the inclusion of this group of people in HIV and AIDS prevention and education programmes and, as a result, they are often excluded from participating in such programmes. Importantly, the findings of this study acknowledge that there is a two-fold relationship between mental illness and HIV/AIDS. It indicates that mental illnesses are still regarded as mysterious in the community and there is much stigma and discrimination towards the mentally ill, increasing their vulnerability to HIV infection.
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CHAPTER ONE

1. Introduction

1.1 Background of the Study

As in many parts of the world, there has in South Africa been an increase in the number of people suffering from mental illnesses. According to Lund, Tomlinson, De Silva, Fekadu, Shidhaye, Jordans and Patel (2012), one in six South Africans is likely to experience a common mental disorder. This indicates that the burden of mental illness in South Africa is extensive especially considering that there is a relationship between physical and mental health and more so with respect to HIV and AIDS. Studies by Freeman, Patel, Collins and Bertolote (2005) and Stiffman, Doré, Earls and Cunningham (1992) reveal that people suffering from mental illnesses are at high risk of HIV infection due to risky sexual behaviours as well as the mental illness itself. This is a call for concern taking into account that the number of people suffering from mental illnesses is increasing as stated earlier. Studies by Grassi, Biancosino, Righi, Finotti, and Peron (2001), Chuang and Atkinson (1996), and Checkley, Thompson, Crofts, Mijch, and Judd (1996) reveal that people with severe mental illnesses have a higher prevalence of HIV infection compared with the general population. These studies indicate that there is an increasing need to understand and highlight the role of mental disorders in the acquisition of HIV. South Africa is reflected in Gray, Vawda and Jack (2013) as a country in Africa with a large number of people who are infected by HIV. In light of this, there is a need to explore the link between mental illness and HIV/AIDS in order to address and prevent the spread of HIV among people with mental illnesses.

Severe mental illnesses embrace a variety of conditions. These include schizophrenia and personality disorders, which represent only a small component of the spectrum of mental illnesses. Conditions such as bipolar disorder have been shown to result in high-risk behaviour if not treated. According to Goodwin and Jamison (2007), bipolar disorder tends to worsen if not treated, causing the affected person to suffer more frequent and more severe episodes of the illness. During these episodes of the illness, the affected
individual may engage in sexual risk behaviours or drug injection, which may then place him/her at risk of contracting HIV. Mead, Bevilacqua, and Key (2012) concur that the pattern of manic symptoms associated with bipolar disorder including euphoria, hyper-sexuality, impulsivity and poor judgement often result in risky sexual behaviours.

People who suffer from severe mental illnesses have substantially compromised social and occupational functioning according to Mead et al. (2012). Generally, they are often discriminated against, marginalized and have limited access to appropriate resources as well as services such as HIV and AIDS prevention programmes. The needs of people with mental illnesses are often overlooked. This is not a challenge faced by people with mental illnesses only, but the whole population of people living with disabilities. Yousafzi and Edwards (2004) argue that individuals with disabilities have frequently not been included in HIV prevention and AIDS outreach efforts as it is assumed that they are sexually inactive and thus are not at risk of HIV infection. People living with mental illnesses are vulnerable to HIV infection hence HIV and AIDS care and treatment programmes will never be effective in the community at large if these people are not identified as a vulnerable group. Therefore, this study explored how mentally ill persons are exposed to the HIV virus as well as the risk factors and behaviours that make them vulnerable to the infection. This study thus aims at informing the relevant stakeholders to include this group of people in policy formulation as well as in the rendering of HIV and AIDS related services or programmes.

1.2 Research Problem, Goals and Objectives

Moosa and Jeenah (2013) note that the prevalence of HIV infection is higher among individuals with mental illness than in the general population. With this high incidence of HIV among people with mental illnesses, there is reason to believe that this group of people is indeed vulnerable to HIV infection. Therefore, this study focused on describing the sexual risk behaviours of people living with mental illnesses as well as the factors that make them vulnerable. People living with mental illnesses are at high
risk of contracting HIV infection. According to Jonsson, Furin, Jeenah, Moosa, Sivepersad, Kalafatis, and Schoeman (2013), it is estimated that in South Africa 26.5% of patients with mental illness also have HIV. Several studies such as that by Stiffman et al. (1992) reveal that HIV and AIDS have been reported to be more prevalent among this group of people, with the reason being that people living with mental illnesses have poor judgment and are often impulsive. Hence they are vulnerable to abuse and manipulation and consequently are vulnerable to HIV infection as well. They also present with risky behaviours, which expose them to HIV infection. In essence, this study explored the question “what are the sexual risk behaviours of people living with different types of mental illnesses and how do these behaviours expose them to HIV infection?” The study sought to describe the risky behaviours that lead people with different types of mental illnesses to become more vulnerable to HIV infection so as to explain the reason why HIV is particularly more prevalent among this group of people.

1.2.1 Goals

The goal of the study was to provide a description of the sexual risk behaviours as they present themselves within different types of mental illnesses and how this contributes to this group of people being vulnerable to HIV infection. This study emphasizes the notion of different types of mental illnesses because the symptoms of mental illnesses differ and therefore the risky sexual behaviours of this group of people will differ according to their type of mental conditions. The second goal of this study was to inform and invite HIV and AIDS intervention and prevention strategies to address the specific needs of people living with mental illnesses through contributing to the existing literature. It is evident from the previous studies that there are few or no HIV and AIDS intervention programmes for many mentally ill persons.
1.2.2 Objectives

The objectives of this study were to discover the vulnerability of people living with mental illness to HIV infection, through uncovering various forms of sexual risk behaviours among them. People living with mental illnesses are a vulnerable group by virtue of their disability. However, they also present with risky behaviours and thus this study describes how these behaviours increase the vulnerability of this group of people to HIV infection.

Another objective of this study was to explore the particular needs of people living with mental illnesses in as much as HIV and AIDS are concerned. Often, people living with mental illnesses have not been included in the HIV and AIDS prevention and education programmes available. According to Meade and Sikkema (2005), this is because this group of people is assumed to be asexual and, as such, not needing any HIV and AIDS related information since they do not understand the real world. This study however explored the needs of people living with mental illnesses with the aim of raising the awareness of stakeholders, policy makers as well as family members so that they can include them in matters concerning them. Moreover, it was one of the objectives of the study to uncover the role of mental illness in the acquisition of HIV. Mental illness has a major role in the acquisition of HIV and the study describes the ways in which mental illnesses contribute to placing sufferers at risk of contracting HIV and assesses the ways in which different types of mental illnesses impact the social lives of people who are living with the illnesses.

1.3 Theoretical Framework

Social Work is interdisciplinary in nature; it focuses on vulnerable populations as the profession’s core clients and it is concerned about empowering people. Thus, the disability theory is used which focuses on the strengths rather than the disability of the affected individual. Gitterman (2014) states that social workers in practice today deal
with profoundly vulnerable populations, overwhelmed by oppressive lives, and circumstances and events they are powerless to control.

Vulnerability is a complex concept with a variety of definitions arising from different disciplines such as climate, poverty, health problems including HIV and AIDS and other related problems. Brooks (2003) describes the concept of vulnerability as a strong analytical tool which is used to describe conditions of proneness to harm, helplessness, and marginality. In this study, vulnerability encompasses the social, economic and physical factors which could increase the susceptibility of an individual or group of persons with mental illnesses to HIV infection. People living with mental illness have been identified in previous studies such as that by Starace, Ammassari and Trotta (2002) and Mead et al. (2012) as a vulnerable group. This study thus seeks to highlight the risky sexual behaviours, which expose this group of people to HIV infection. Gitterman (2014) states that social workers seek to promote the responsiveness of organisations, communities and other social institutions to individuals’ needs and social problems. Therefore assessing vulnerability can be used by stakeholders for guiding actions to enhance well-being through reducing risk factors among those groups which are found to be vulnerable. By so doing, if the vulnerability of people living with mental illnesses could be assessed, preventative measures would take place so as to reduce their proneness through tackling the risk factors.

According to Mechanic and Tanner (2007), vulnerability refers to the point at which a person or group of people are most likely to be exposed to the risk of being attacked or harmed, either physically or emotionally. Vulnerability is, therefore, not easily assessable though it may be easy to recognize personally the feelings of vulnerability and to comprehend the outcome of vulnerability amongst people in a similar condition. According to Pelling (2003) and Gunjefo (2007), vulnerable people and places are often excluded from decision-making and from access to power and resources. This is in agreement with Moosa and Jeenah (2013) who state that people living with mental illnesses are often excluded from matters that concern them and they lack access to basic resources such as health care and education.
In order to reduce the HIV and AIDS epidemic among people living with mental illnesses, there is a need to reduce their vulnerability. This would require prediction and alleviation programmes as well as encouraging the active participation of people living with mental illnesses in those programmes. According to Gunjefo (2007), there is a need for building capacity to withstand and cope with HIV and AIDS through educational programmes that are directed at the mentally ill. This would help to address in HIV and AIDS related programmes the issue of the exclusion of people who are living with mental illness. According to Gitterman (2014), social workers working with vulnerable groups need to provide a counterforce to vulnerability and risk by encouraging protective forces that help people become more resilient in dealing with life's challenges. Therefore, tackling the root causes of vulnerability such as poverty, poor governance, discrimination, inequality and inadequate access to resources would ensure that this group is less at risk. Weiser, Wolfe and Bangsberg (2004) add that reduction of risk among this vulnerable group may be an essential step to ensure that people living with mental illness are less vulnerable to HIV infection.

People living with mental illnesses are believed to be a vulnerable group to HIV infection partly as a result of their environmental circumstances which increase their vulnerability.

Mental health conditions play a pivotal role in increasing the vulnerability of people to the HIV and AIDS epidemic. Yousafzi and Edwards (2004) note that people suffering from mental disorders often have impaired judgment, reduced fear of consequences, and increased vulnerability to outside influences. As a result, their sexuality is different to that of the whole population because they do not have the balance between the ego and the super ego as Checkley et al. (1996) indicate. The balance between the id, ego and the super ego allows people to act in a way that is socially acceptable, but people with mental illnesses lack this ability since their super ego, ego and id are believed to be in states of intra-psychic conflict. Checkley et al. further state that an imbalance between the ego and the super ego is due to the fact
that mental illnesses often result in poor interpersonal relationships, poor judgement, impulsiveness and dependency on drugs or alcohol or on both drugs and alcohol.

In these conditions, people with mental health problems have a tendency towards naivety which exposes them to an increased risk of abuse and exploitation. This can lead to very high rates of unprotected sex with multiple partners and casual sex with other high-risk groups such as drug abusers and people living with HIV. This therefore indicates that lack of a personal perception of risk may pose a major challenge for HIV/AIDS prevention programmes among people with mental illnesses. As a result, people with untreated mental disorders may be at risk of engaging in behaviours that further the spread of AIDS. Chuang and Atkinson (1996) note that there is increasing evidence that those with serious mental illnesses are at higher risk of HIV infection than the general public. While existing studies have proven that people suffering from mental illness are vulnerable to HIV infection, this study contributes to this subject matter by describing factors that make the mentally ill more vulnerable through exploring their vulnerability in relation to different types of mental illnesses.

1.4 Significance of the Study

This study sets out important facts on the interaction between mental illness and HIV/AIDS and its impact on individuals and communities in the Buffalo City region of East London. It is intended as a call to action through raising awareness of the importance of addressing HIV and AIDS issues in mental health, as well as the risky sexual behaviours of people living with mental illnesses especially as related to HIV/AIDS and to advocate for increased emphasis on mental health issues in all areas of HIV prevention, treatment and care. This is important since the topic has not been covered extensively in research. Herman, Stein, Seedat, Heeringa, Moomal and Williams (2009), for example, present a study on the link between HIV/AIDS and mental illness in South Africa. The study focuses on the prevalence of mental disorders among
people who are infected with HIV. Their study however does not account for the role played by mental illness in acquiring HIV infection. A study by Meyer, Smit, Le Roux, Parker, Stein and Seedat (2008) has proved however that people who are suffering from severe chronic mental illnesses are more at risk of HIV infection than other communities are. The study by Meyer et al. generalizes its findings to the whole group of people living with mental illnesses, thereby overlooking the relationship between types of mental illnesses and the vulnerability amongst this group of people. There is a possibility that the vulnerability and the sexual risk behaviours of people living with mental illnesses vary according to the type of mental illness. The researcher hopes to stimulate discussion around this concept.

In addition, Herman et al. (2009) suggest that mental illnesses that are of an emotional nature such as stress and depression are commonly diagnosed amongst people who are infected by HIV. This is because HIV diagnosis aggravates high stress levels as people tend to think about the stigma associated with HIV and AIDS and a positive status is still regarded as a death sentence. This stress plays a huge role in the development of mental illnesses among this group of people. This indicates that mental illnesses are increasingly becoming common within communities and little is known by the community about the different types of mental illnesses. On the other hand, people who suffer from severe mental illnesses such as schizophrenia are more vulnerable to HIV infection due to their mental disability, as indicated by Meyer et al. (2008). This is, according to McKinnon, Cournos and Herman (2002), mainly because people who suffer from mental illnesses often engage in risky sexual behaviours that then expose them to HIV infection due to their impulsiveness. This shows that mental illness is closely linked to HIV and AIDS, thus this study seeks to understand the risky sexual behaviours that expose the mental health users to HIV infection.

This study seeks accordingly to raise awareness on the prevention needs of people with mental illness and to invite HIV and AIDS care and treatment programmes
to be attentive to this group of people. It also examines the extent to which the vulnerability of people with mental health problems contributes to their susceptibility to HIV infection. According to the Murray and Lopez (2002), 60 percent of African nations have no national mental health policy, and many have no programmes or legislation. This study could raise awareness among the health organizations with regard to the rendering of primary health care services to people who are living with mental illness as well as to finding ways to curb the risk behaviours for HIV and AIDS. Often, programmes that are implemented to address and to prevent HIV are generalized to the whole population, thus not taking into consideration minority groups such as people living with mental illnesses who might not be able to benefit from those particular programmes because their psychological functioning is altered. However, this vulnerable population might benefit from programmes which are directly implemented towards helping them specifically to understand HIV and AIDS. Therefore, the development of a mental health policy may have to accommodate the issue of HIV as it affects this group of people to a large extent.

This research study could provide information on the link between high HIV infection and mental illness particularly, on vulnerability and the risky behaviours of people living with mental illness, which may expose them to HIV infection. Further, this study would also be a review on how HIV and mental illness have a cause-and-effect relationship and thus invite service providers to find alternative ways of dealing with this comorbidity. This study would be beneficial to the Department of Health and Department of Social Development. It will raise their awareness on the psychosocial problems of people living with mental illnesses so that they can train mental health social workers to work specifically with this group of people. Furthermore, this study would be beneficial to the drafting and revising of the new mental health policy as this study will look into the gap between mental health and primary health care.

The South African Federation for Mental Health in 2010 launched awareness campaigns on integrating mental health into primary health care. The South African
Federation for Mental Health is the umbrella body for seventeen mental health societies and numerous member organisations throughout South Africa. These societies are accountable to this federation in so far as the standard of service delivery is concerned. They however organised this campaign as an attempt to reduce stigma and discrimination and to include mental health into primary health care. However, this attempt was viewed by the Department of Health as costly because it would involve the training of health care professionals so that they would be able to work with both mental and physical health care problems. However, such reasoning tends to pose barriers to care for people with mental illnesses and they usually end up not being included in wellness programmes that might reduce the spread and the prevalence of HIV infection. This study seeks to attract the attention of policy-makers, those who are responsible for planning and managing health and social care services, organizations or professionals working in health and social care and organizations representing people living with mental illnesses as well as the mental health service users. This invites them to work together in addressing the needs of people living with mental illnesses as well as to reduce the spread of HIV among the mentally ill.

1.5 Limitations

In this study, some old sources have been used to provide the reader with more data on the topic. There is some information which is found in old literature which gave the researcher more ground to look into this study as it raised some issues which are relevant to this study but which have not been covered extensively by other recent studies.

1.6 Chapter Outline

Chapter 1 consists of the background of the study as well as indicating what the study is about and why the researcher decided on this particular study. In includes an overview of the link between mental health and HIV/AIDS.
Chapter 2, the literature review, explores the theoretical literature that helps understand risky sexual behaviour and vulnerability of people living with mental illness. Empirical studies related to the topic are also reviewed.

Chapter 3 covers the research methodology. The researcher conducted this study based on a qualitative research method and this chapter justifies the reasons for using this method and also describes all the sampling methods as well as methods of data analysis which were used to ensure that the researcher obtained adequate information for this study to be valid and reliable.

Chapter 4 presents the analysis of the collected data. The responses are categorized analysed and presented thematically to highlight critical aspects of the research process and the topic.

Chapter 5 concludes the dissertation and highlights recommendations in respect of the study. Based on the information analysed, the researcher declares her conclusion and then proposes solutions and programmes to assist in dealing with the sexually risky behaviours and the vulnerability of people living with mental illnesses.
CHAPTER TWO

2. Literature Review

2.1 Introduction

People suffering from mental illnesses face multiple social stressors that may contribute directly or indirectly to their engaging in sexually risky behaviours. Literature reveals that HIV and AIDS are more prevalent among the mentally ill as compared to the general community. This chapter explores risk factors as well as the risky sexual behaviours that contribute to the vulnerability of people living with mental conditions in contracting HIV. It is essential to understand mental illnesses before one can explore the behaviour patterns of people living with mental illnesses. The researcher will thus briefly describe some common mental health conditions to give the reader an insight into this discussion. As will be seen, people living with mental illnesses may have much in common as relates to their diagnosis and symptoms. However, they still need to be treated as individuals because mental health conditions differ and affect patients’ or clients’ lives differently.

Herman et al. (2009) propose that there is a need for a better understanding of the role of mental illness in the acquisition and course of HIV infection. Husbands, Cattaneo, Makoroka, Pires, Watchorn and Whitbread (2012) and Checkely et al. (1996) agree, noting that people with severe mental illnesses present with higher levels of HIV prevalence than the general public. The need to understand the causes of HIV and AIDS prevalence among people living with mental illnesses has not yet been fully addressed. Most studies have focused mainly on the psychological effects that surface when individuals discover their HIV positive status. This study however examines the sexually risky behaviours of people living with mental illnesses and their vulnerability to HIV infection, with the aim of understanding the prevalence of HIV infection among this group of people. This will therefore inform the social work profession about the needs of this group of people so that they can find ways to empower them since social workers seek to enhance the capacity of people to address their own needs.
2.2 Mental Illness

The American Psychiatric Association (2013: 20) defines a mental disorder as “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning”. Mental illness is a multifaceted concept, but it is generally acknowledged as real and involving disturbances of thought, experience, and emotion. According to Gould (2010), mental illnesses are psychological problems that are reflected in behaviour associated with distress or disability and are often not considered as part of the normal psychological development of a person. It seems difficult to define mental illness and different authors define it by describing the common symptoms produced by different mental health conditions. Mental illnesses are generally defined based on a combination of an individual’s feelings, thoughts, actions and perceptions. Gould also states that mental illnesses cause functional impairment in people, making it more difficult for them to sustain interpersonal relationships and to carry out their day-to-day activities. Some mental illnesses are believed to be severe to the extent that they may lead to self-destructive behaviour and in some instances cause the sufferer to commit suicide.

People who suffer from severe mental illness are usually dependent on their caregivers because they are unable to lead an independent life. According to Bhugra (2007), individuals with a severe mental illness have typically been mentally ill for many years and are unable to fulfil roles in society normally expected of individuals of their age and intellectual ability; thus, they are most likely to receive family care giving. Mental illness is also closely associated with drug and alcohol abuse and homelessness as indicated by Bhugra. These social factors can seriously harm an individual in the sense that they make it more difficult to seek help as well as to get treatment. Some mental illnesses can be treated and some can be managed just like any other physical illnesses and the affected individual may be able to lead a normal life. However, Social Work goes beyond the medical model's focus on individual diagnosis to identify and address social inequities and structural issues, according to Allen (2014). Social
workers therefore demonstrate a greater capacity to look beyond the illness and treatment issues, to consider the broader social and political issues in mental health.

People suffering from mental illnesses are considered a vulnerable group in society, as they are unable to protect themselves or to perceive risk factors around them. Mental illness does not only put its sufferers at risk of contracting HIV but it also leads to poor adherence to HIV treatment, thus leading the virus to be resistant to medication. Studies by Sacks, Dermatis, Looser-Ott, and Perry (1992) and Checkley et al. (1996) found that there is consistently strong evidence from high-income countries that adherence to highly active antiretroviral therapy is lowered by depression, cognitive impairment, and alcohol use and substance use disorders. This shows that if mental illnesses are not treated they can lower or reduce adherence to HIV treatment. This is also a risk factor as the infected person can easily infect other people. As indicated in these two studies, mental illness plays a major role in the acquisition as well as treatment of HIV and AIDS. There is therefore a need to understand the role played by mental illness in the acquisition of HIV and in this research the behaviours and factors that place this group of people at risk of contracting HIV are examined. The link between HIV/AIDS and mental illness is discussed in detail later in this chapter.

Classification and Categories of Mental Illnesses

People living with mental illnesses share similar characteristics. Sacks et al. (1992) explain that the most common characteristic is the fact that their mind and thinking are affected by the illness. However, because of diverse symptoms mental health conditions are classified differently. This means that mentally ill people do not present with the same symptoms or behaviours but they differ according to the different kinds of illnesses. In addition, their behaviour is determined by whether they are on medication or not. People who are consistent on their medication may live a normal life while those who do not may present with serious symptoms. On the other hand, with intellectual disability, the illness is permanent since it cannot be treated.
The Diagnostic and Statistical Manual of Mental Disorders (DSM 5) is an improved version of a diagnostic manual by the American Psychiatry Association (2013) after the DSM IV which was used for many years, emphasising the five axes. The DSM 5 is currently the commonly used tool to guide clinicians and researchers on the diagnosis and classification of mental illnesses. The use of a DSM 5 is very important to elicit reliable diagnoses, which are essential for guiding treatment recommendations for those who are affected. The DSM 5, unlike the DSM IV, has moved to a non-axial coding style where it now describes different mental illnesses in detail and provides their codes under section II.

Some of the mental illnesses common in South Africa are discussed below, according to Gould (2010), to give an insight into the symptoms of these illnesses. This section will also highlight the extent to which these mental illnesses can affect an individual as well as explain how they are linked to HIV infection.

2.2.1 Psychoses

Gould (2010) states that psychoses are characterised as more severe mental disorders where there is an inability on the part of the affected person to distinguish between external reality and phenomena that are mentally produced as a result of the mental disorder. He adds that a psychotic experience is one whereby an individual is unable to differentiate between external reality and internal mental phenomena such as delusions, hallucinations or false beliefs.

Schizophrenia is one example of psychosis. According to Bhugra (2007), it is diagnosed when an individual reports the experience of auditory hallucinations, delusions of thought control, delusions of passivity, or a delusional perception of special connotations of external events. It is mainly characterized by distorted thoughts and perceptions, nonconforming communication, inappropriate emotion, abnormal motor
behaviour and social withdrawal. Schizophrenia is classified by the DSM 5 under the Schizophrenia spectrum and other psychotic disorders, which include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. According to the American Psychiatric Association (2013), these disorders are defined by abnormalities reflecting delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behaviour and negative symptoms.

Regier, Farmer and Rae (1990) state that drug induced psychosis is also a common mental health condition especially among the youth due to the rise of unemployment, school dropouts as well as peer pressure and the increasing availability of drugs in schools and communities. This category of mental illness is regarded by Barry (2002) as the most severe mental illness because people who are suffering from psychosis tend to respond to the voices or hallucinatory visions, thereby becoming a danger to society as well as to themselves. This is however due to the fact that they cannot distinguish between the real external environment and the hallucinatory visions or auditory voices.

2.2.2 Personality and Mood Disorders

The American Psychiatric Association (2013: 645) defines a personality disorder as “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment”. A personality disorder is a set of traits that combine to negatively affect one's life. They have a wide range of causes and some are easier to treat than others. Gould (2010) describes personality disorders as longstanding, maladaptive, and inflexible ways of relating to others, and asserts that the behaviours or symptoms characteristic of them usually begin in childhood or early adulthood and continue into adulthood. People suffering from personality disorders have great difficulty in dealing with other people. This is so because they always think that their behaviour patterns are
normal hence they tend to be rigid and are unable to respond to the changes and demands of life.

Barry (2002) states that personality theorists believe that the usual cause of mental illness is the result of two factors, genetic physiological inheritance and the effect of the family environment on the child during infancy and childhood. This indicates that these disorders can be genetic or they can be a result of parenting styles as well as the family patterns of the affected individual. For example, where children grow up in circumstances where there is domestic violence, this can affect the way they act with their peers and also be a foundation of later mental illness. Even so, people react differently to different situations, thus some may develop disorders and some may not. According to Barry, personality disorders can be highly disabling since the affected individual has a narrow view of the world and thus fails to cope within a dynamic society.

Mood disorders are primarily characterised by a disturbance of the mood. Depression is one of the common mood disorders. The affected person becomes withdrawn and loses interest in his/her daily activities, thus experiencing impairment in his/her social as well as occupational life. An individual suffering from depression experiences depressed moods, feels worthless and in most instances becomes suicidal. McKinnon et al. (2002) add that a depressed person has a persistent absence of positive affect in response to events, and this negative affect will recur daily. This type of mental illness is also common among people who are infected with HIV due to the inability to cope with or accept their new status as well as the fear of being judged and being discriminated against. Bipolar and manic disorders are also classified under this category since they are characterised by severe mood swings.
2.2.3 Anxiety and Post-traumatic Stress Disorders

According to the American Psychiatric Association (2013), anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioural disturbances. Anxiety disorders are classified under section II of the DSM 5. Anxiety is a mental state which can affect most people. It is defined in the DSM 5 as an anticipation of future threat, which is more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviours. For example, in anticipation of a challenging situation most people may feel anxious. Such anxiety can be triggered when one is waiting for test results, taking an examination or giving a public performance or speech. According to Gould (2010), anxiety can be problematic when it is experienced as devastating, and the avoidance of situations that provoke it starts to severely compromise the range of daily activities such as work or leisure that the person usually undertakes. The psychological effects of anxiety may include the feelings of fear and may be behavioural. Phobias and panic disorders can also be classified under the anxiety disorders. They emanate when an individual develops a persistent and irrational fear in relation to a certain object, activity or situation that leads to experiences of high levels of anticipatory anxiety resulting in avoiding what is feared.

Post-traumatic stress disorder is characterized by the re-living of a traumatic event, symptoms of increased arousal, avoidance of things that will remind the affected person of the original traumatic event, and diminished interest in daily activities. Post-traumatic stress disorder can result from any event that is of a highly threatening or potentially disastrous nature such as abuse and accidents. Studies such as that by McKinnon et al. (2002) revealed that the onset of the symptoms of a post-traumatic stress disorder might take place months or years after the actual traumatic event. According to Volavka, Convit, Czobor, Douyon, O'Donnell and Ventura (1991), individuals who experience severe trauma, including sexual abuse or domestic violence, may experience delayed, severe stress reactions. These reactions may thus seem inexplicable unless their connection to the earlier trauma is understood.
2.2.4 Intellectual Disorders (Intellectual Development Disorders)

The DSM 5 classifies Intellectual Disability under the neurodevelopmental disorders. According to the American Psychiatric Association (2013), intellectual disability (intellectual developmental disorder) is characterized by deficits in general mental abilities, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience. Kapp (1991: 29) indicates that mental disability is defined by four criteria, namely the intelligence and the developmental, medical and social criteria. He defines mental disability as “deficiency and a state of incomplete mental development of such a kind and degree that the individual is incapable of adapting to a normal environment and inability to maintain existence independently of supervision, control or external support”. Intellectual disability is measured using the IQ test that determines whether an individual is mildly, moderately, severely or profoundly disabled. Kapp states that intellectual disability is often inherited or may be caused by poor living conditions of the affected individual’s family.

It is reported that mental illness and intellectual disability co-occur. Hayes (2009) states that people with intellectual disabilities appear more vulnerable to stress or anxiety and that their use of less effective coping skills contributes to mental illness as well as challenging behaviour. Therefore, for the purposes of this study, intellectual disability and mental illness are not going to be treated separately since they both constitute mental health conditions. Table 2.1 in the appendix gives the old and the modern IQ classification of people with intellectual disability. The old model was very discriminating and labelling because of the names that it gave to people with intellectual disabilities. They were called idiots and morons, imbeciles and the dull. These names are very strong and they can be destructive to the affected individual. These names also reflect the community or society’s attitudes towards people living with mental illnesses.
Kapp (1991) goes on to explain the three groups with which mental retardation is grouped for educational purposes. Group I (IQ 50-70/79), the educable mentally handicapped, do not cope in a regular normal school but can acquire the reading and writing skills of a primary and senior school but these skills can be acquired only at a very slow pace. The educable mentally handicapped can live independently as well as cope with work related instructions. This group is relatively independent and they can cope very well in society and can live independently. This also means that this group can be hardly noticed by others hence they may not be affected by the stigma and discrimination that is faced by others who are living with mental illnesses.

Group II (IQ 25-50): the severely mentally handicapped can master basic self-care and communication skills and domestic and vocational skills so that they can live in a protective environment. This enables them to perform simple routine work under supervision. They are also referred to as ‘in-educable but trainable’. This therefore means that this group of people may face difficulties with HIV and AIDS educational programmes as they may not be able to comprehend the information conveyed in the media as well as booklets. Group III (IQ 0-25): the profound mentally handicapped, are excluded from education and are usually cared for in rehabilitation institutions or at home. They can hardly perform any activities and therefore need close supervision, being highly dependent on the caregivers. This group of people may be identified as the one that is at high risk of being sexually abused as they are always dependent on someone else and they have been reported to be unable to report incidents of such abuse to the caregivers as well as the police. Therefore, this group may be considered to be at high risk of HIV infection.

The mental illnesses that have been discussed above show that people who are living with mental illnesses are susceptible to a range of risks due to their level of functioning being impaired. With the common mental illnesses discussed above, one can clearly see the reason why this group of people is considered to be vulnerable to HIV and AIDS.
2.2.5 Disorders Attributed to HIV in the brain

People who are infected with HIV are reported to develop mental illnesses during the late stages of AIDS. Acuff, Archambeault, Greenberg, Hoeltzel, McDaniel, Meyer and Wagner (1999) classify these disorders into three categories, namely HIV associated dementia, minor motor cognitive disorder and delirium and HIV-Associated Dementia (HAD): These authors state that HIV Associated Dementia is generally characterised by abnormalities in the cognitive and motor abilities that significantly impair one’s ability to function effectively. This normally occurs in the later stages of HIV infection, thus it is believed to be an indication for the progression to AIDS.

Acuff et al. (1999) propose that people who develop minor motor-cognitive disorder tend to suffer from mild diminution in their motor or cognitive functioning, as well as mild impairment in their memory. These changes may not be easily noticed by others since they have a minor impact on them. Acuff et al. define delirium as a neuropsychiatric disorder characterized by reduced consciousness or awareness of one’s environment, the reduced ability to sustain attention, illusions as well as memory and perceptual problems. This kind of mental disorder is reported to be the most common neuropsychiatric condition especially amongst hospitalized HIV positive people who are severely ill.

2.3 Theories of Mental Illness

According to Bhugra (2007), the development or onset of mental illness can be a result of diverse social, biological and psychological problems. Several theories of mental illness have been developed focusing on each of the above-mentioned factors related to the evolution of mental illnesses such as a biological or genetic basis, social problems such as poverty and psychological problems including stress. According to Allen (2014), social work utilises theories of human behaviour and social systems to intervene at the points where people interact with their environments. The following
section provides an overview of psychological theories in defining mental illness, also emphasising social work theories.

2.3.1 Biological Theory

According to the biological theory, mental illnesses are a product of faulty biophysical processes in the brain of the affected individual. Carson, Butcher and Coleman (1998) state that the biological perspective believes that mental illnesses are a medical disease of the central nervous system that is either inherited or caused by brain pathology. According to biological theorists, mental illness is biological and neurophysiological. They believe that a human is an organism that consists of natural functions which are designed by nature and thus mental illness is the breakdown of such functions. Wakefield (2006) explains that a mental disorder is a detrimental mental dysfunction, whereby a mental dysfunction is a failure of the capacity of some mental mechanism to perform a function for which it was biologically designed.

This theory explains that mental illnesses stem from the ill functioning of some parts of the brain which were naturally designed to perform a certain function within the nervous system of a human being. According to biological theories of mental illness, a number of factors influence the behaviour of an organism. Sarason and Sarason (1999) assert that mental illness is caused by genetics, neurotransmitter-related chemical imbalances, stress-related factors, nutritional factors and many others. Genetics means that mental disorders can be inherited within the family. For example, it is possible for a child to inherit the mental illness from his/her parents or grandparents because the child might be born with those genes that place him/her at high risk of developing a mental disorder.

According to the biological theory, mental illnesses are determined by physical and organic processes as well as brain functioning. Maguire (2002) states that the neurobiologists believe that mental disorders are the result of faulty patho-physical
processes and neurochemistry. This is in agreement with Carson et al. (1998) who state that genetic abnormalities are a result of irregularities in the structure or number of an individual’s chromosomes. Further, the nervous system is considered to be the master control centre because most of the functions accomplished by the body are controlled in the nervous system. It is also the centre for sensations, emotions and thoughts. Sarason and Sarason (1999) state that there is abundant evidence that various behavioural deficits result from defects in the central nervous system.

In clarifying the process of the development of mental health conditions, the biological theory explains that mental illnesses are caused by different types of brain abnormalities such as the loss of nerve cells and excess or deficit in the chemical transmission between neurons. The biological perspective implies that many types of abnormal behaviour are due largely to factors beyond a person’s control; primarily the types of brain and body people are born with and the environment in which they live, will affect their mental health. The way in which we behave is therefore dependent on the relationships of different processes within the mind. Maguire (2002) asserts that the biological theory views deviant behaviour as a psychiatric disorder or a disease. This explains why people living with mental illnesses present with risky sexual behaviours which then place them at risk of HIV infection.

2.3.2 Psychodynamic Theory

Sigmund Freud is the founder of psychoanalysis and the psychodynamic approach to psychology. He also pioneered the personality theory where he believed that the human mind is composed of three elements: the id, the ego, and the superego. Freud’s psychoanalytic theory has influences in Social Work. According to Walsh (2013), the psychodynamic theory is still useful in Social Work since it assumes a broad view of the impact of social realities on clients’ lives, fully embraces the strengths perspective and helps oppressed persons develop a stronger sense of identity. The psychodynamic theory believes that abnormal behaviour is not only caused by
biological factors but rather psychosocial factors. This theory is concerned with how internal processes such as needs, drives and emotions motivate human behaviour. Freud believed that an individual's behaviour is a result of the interaction between these three subsystems, the Id, ego and the superego. He viewed the interplay between these subsystems as crucial in determining one's behaviour. He believed that each person has biological drives from their id.

These need to be satisfied but this is prevented by the superego, which is the moral part of the psyche. The superego uses anxiety and guilt to prevent humans from acting on the id's impulses. However, between the id and the superego is the ego, which tries to find ways of satisfying the id in a way that the superego will accept and that is in line with reality. According to Carson et al. (1998), if the three subsystems id, ego and super ego happen to strive for different goals, inner conflicts or intra-psychic conflicts arise and if these conflicts are unresolved they lead to mental disorders. According to Freud, individuals may become overwhelmed by internal or external demands or both, hence they frequently use ego defence mechanisms to avoid becoming overwhelmed by those internal and external demands.

This school of thought emphasises the influence of the unconscious mind on human behaviour. Sigmund Freud emphasised the unconscious part of the mind that he believed to be the place where hurtful memories and other painful experiences are kept repressed. According to Freud's psychoanalytic theory, the conscious mind includes everything that is inside of our awareness. This is the aspect of our mental processing which we can think and talk about in a rational way. Whereas the unconscious part is those things that the conscious mind wants to keep hidden from awareness or repressed because they are usually unpleasant. However, Freud still believed that the unconscious mind could have an influence on our behaviour even if we are unaware of these feelings, thoughts, urges and emotions. According to Bienenfeld (2006), Freud believed that if these issues are unaddressed, they lead to abnormal behaviour.
The psychodynamic theory was discussed by James and Gilliland (2003), who built on the earlier work of Freud. They state that Freud regarded human psychological states as an energy system in which blockages in the flow of thoughts would result in disease or illness. They indicate that he also described these blockages as the mental or emotional loss of balance where he emphasised the repression and suppression of one’s thoughts. Freud’s concept of repression explains that some people for example tend to avoid talking about their bad experiences. As a result, they may lose control of their feelings and then suffer from depression or other mental disorders such as post-traumatic stress disorder. Freud, as cited by Bienenfeld (2006), further introduced the notion that the manner in which one thinks and feels affects one’s view of the world. His work essentially demonstrated that extreme inner conflicts could become a source of mental illness. He further asserted that behaviour is the product of underlying conflicts of which people often have little awareness. Freud’s theory of psychoanalysis is informed by two major assumptions, namely that much of mental life is unconscious and that past experiences, especially in early childhood, shape how a person feels and behaves throughout life. Therefore, early childhood experiences are central in the modelling of an individual’s emotions and thus central to problems of living throughout life.

Figure 2.1 in the appendix explains Freud’s Model of the mind. He believed that the greater the unconscious conflict, the greater the person’s vulnerability to stress. This is because not all the unconscious mental contents are dealt with appropriately; they have been brushed away without being solved completely. Hence, when they re-surface, they become overwhelming, causing the person more stress. Furthermore, a disorder that occurs in childhood is caused by a combination of early traumatic experiences that trigger the emotions and unresolved conflicts associated with the early events. According to Borden (2009), theorists like Erikson and Adler broadened the psychoanalytic theory by emphasizing the role of distorted interpersonal relationships in maladaptive behaviour. According to Bienenfeld (2006), Erikson’s theory is more social than biological even though it does not overlook anatomy and other physiological
factors in personality development. Nevertheless, as people advance through different life stages, social influences become increasingly more powerful. Their main focus is on the social environment as the source of explanations for maladaptive behaviours thus deemphasizing the biological theory. This theory is relevant to Social Work since it explains the development of some mental illnesses, thereby making it easier for the social worker to go through the helping process with a person living with mental illness. Furthermore, it makes it easier to understand the behaviours of people living with mental illnesses, thus highlighting the factors that can potentially place them at risk of contracting HIV.

2.3.3 TheBehavioural Theory

The behavioural theory suggests that behaviour is learnt and modified through stimuli and reinforcement and for that reason people learn from their experiences. People's behaviour can be reinforced positively or negatively therefore this shapes who they become in life. According to Holland (1999), the behavioural theory believes that problem behaviour is maintained by positive or negative reinforcement. This explains that when behaviour is positively reinforced, it is more likely to continue and when it is negatively reinforced, it will most probably end. Carson et al. (1998) note as well that the behavioural theory suggests that behaviours are fashioned through various forms of learning, including modelling, classical conditioning, and operant conditioning. In this regard, a behaviourist may propose that in operant conditioning, depression is caused by a lack of positive reinforcement. Thus, for example a person whose spouse has passed away may present with symptoms of depression because of the general lack of interest in behaviours that were once pleasurable (or reinforced). This loss of interest in this case will be due to the fact that the spouse with whom the person used to engage with is no longer present or the person could be avoiding things that would be a reminder of the late spouse.
The behavioural theory suggests that human behaviour is learned as individuals interact with their environment. According to Holland (1999), principles of the behavioural theory support the view that particular behaviours may be shaped and learned, and acquire functional relationships with environmental or social events that may be interpreted by others as form of communication. The behaviourists believe that behaviour is learnt through reinforcement and modelling. They believe that if behaviour is reinforced positively, there are greater chances of it being repeated. Thus, behaviour can be reinforced through the response of others in the environment and its occurrence affected by different setting events and environmental factors. An example according to Carson et al. (1998) is that of a person who performs in public, when he/ she is cheered up, he/she is mostly likely to continue with his/her performance because of the positive response that he/she gets from the audience.

According to Carson et al. (1998), mental illness or maladaptive behaviour is believed to be a result of a failure to learn adaptive behaviours. According to the behavioural perspective, abnormal behaviour is not conceptualised as a mental illness but rather the result of a naturally occurring process, whereby specific behaviours are inadvertently shaped over time. The behaviouristic perspective also believes that some maladaptive behaviour develops as a result of learning ineffective or maladaptive responses. An example as explained in Carson et al. is that of a person who acts inappropriately in a public place and makes people laugh. Those people who laugh will reinforce his/her behaviour thus he/she will continue even if the behaviour is not societally approved.

This theory is further considered an example of the social model theory of disability. Bienenfeld (2006) indicates that the social model of disability believes that disability is a problem of society with barriers being created by the social environment. These barriers can be physical or attitudinal. In this model, it is argued that society creates disabling barriers through reinforcement and punishment for certain behaviours.
In the case of people who are living with mental illness, the society has created disabling barriers in the sense that they have discriminated against this group of people and stigmatize them. Therefore, people living with mental illnesses are not only faced with the problem of suffering from a mental health condition but with being rejected by the community and by family members as well.

Furthermore, their illnesses as well as behaviours are not understood by the community hence the community needs to be educated about mental illness and its link to HIV so that they can be more supportive towards people living with mental illnesses. The focus of this model is full integration of the disabled individual into society. According to Bienenfeld (2006), people who are suffering from mental illnesses are usually excluded and isolated within the community and therefore this model would play a major role in tackling stigma and discrimination against the mentally disabled. Stigma and discrimination are believed to be a contributing factor to the risky sexual behaviours of people living with mental illnesses as they tend to try to please everyone since they are not well accepted within their communities. Stigma and discrimination have also been associated with lack of access to HIV care programmes by people living with mental illnesses. This thus increases their vulnerability to HIV infection and re-infection.

2.3.4 The Labelling Theory

Labelling theory is a sociological theory that was developed by a number of different sociologists and researchers with regard to exploring various aspects of human behaviour and particularly with regard to how a person’s behaviour is viewed by others as compared to social norms and societal expectations. The focus of the labelling theory is mainly on the special roles provided by society for nonconforming or deviant behaviour. A social role is defined by Singh, Berkman and Bresnahan (2009), as a set of expectations we have about behaviour. Social roles are necessary for the organization and functioning of any society or group. According to the labelling theory,
mental illnesses do not exist, as they are a complete social construct that is lacking objective reality. Scheff (1974) asserts that mental illness is not a disease but a social role thus identifying and labelling an individual mentally ill casts him or her into a new social role. He affirms that the labelling of someone as mentally ill results from a particular form of nonconformity, the violation of residual rules in society which cause people to believe that one has a mental illness. Labelling theory believes that there are rules that define what is real, and if you violate these understandings you have lost touch with reality and are psychotic. People labelled as mentally ill assume the behaviours of the mental patient as portrayed through the mass media; these are however viewed as violations of various rules in society rather than as signs of an underlying illness.

According to Bienenfeld (2006), the sociologist T. J. Scheff who wrote the book “Being Mentally Ill” in 1966 founded the labelling theory of mental illness. He challenged the common beliefs about mental illness and proposed a sociological model of mental illness in contrast with the traditionally accepted medical model of mental illness. Bienenfeld further postulates that people learn cultural stereotypes through jokes, cartoons and the media. Once these stereotypes have been learnt, they are internalized and then affect one’s self-concept. When an individual becomes mentally ill, these internalized ideas become relevant as they begin to dominate one’s self-concept. According to Sarason and Sarason (1999), labelling occurs when people are categorized on some basis, whether that basis is relevant and fair or not. With the labelling theory, the stigma of being labelled mentally ill actually causes one to become mentally ill due to self-fulfilling prophecy. One realizes what others expect of him/her as a person suffering from mental illness and then acts out those roles according to the society’s expectations. Thus he becomes mentally ill. In explaining mental illness, the labelling theory believes that people tend to internalize things that are said about them; consequently they act or behave according to those labels. According to Scheff (1974), this theory is concerned with how self-identity and behaviour of individuals may be determined or influenced by the terms used to describe or classify them. For example if
people say one is crazy the person may then act in this role and fulfil those statements that are used by others to describe him or her.

Bienenfeld (2006) confirms that the labelling theory is associated with the concepts of self-fulfilling prophecy and stereotyping. This study explains that if people are labelled in the community they tend to act in the way that the society expects of them. Kroska and Harkness (2006: 332) argue that low self-esteem, low self-efficacy, and feelings of inactivity contribute to or are themselves mental health problems. This therefore indicates that when an individual is labelled he or she can develop low self-esteem, thus they suggest that this low self-esteem can lead to mental illness. They further state that the modified labelling theory believes that labelling also exacerbates existing mental illness. Essentially, according to Bienenfeld, labels can be destructive because they draw attention to one aspect of the person, while ignoring other aspects that make him or her unique. Labelling a person can cause permanent damage to that person, and this damage can come in the form of discrimination by others and feelings of self-doubt and inadequacy on the part of the affected individual. This may also inhibit people from seeking help because when people feel stigmatised, they may be reluctant to seek help because they do not want to be labelled as mentally ill. Thus, they become more vulnerable to HIV infection since they will be living with an untreated mental illness. This is due to the fact that those who live with an untreated mental illness tend to get involved in drug use and they often become homeless thereby being at high risk of sexual abuse and HIV infection.

2.3.5 The Biopsychosocial Theory

Social work theories primarily conform to the biopsychosocial approach because it takes into consideration social and environmental stressors, which have been found to be central in the onset of mental illnesses. These theories emphasise the social environment as the context for individual well-being. The biopsychosocial model of mental illness utilises all the theories that have been discussed earlier and merges them
into one model. This theory encompasses the psychological, biological as well as the socially related factors that cause mental illness and is considered the most relevant to intervention in the context of social work interventions. The biopsychosocial model is believed to be the work of George Engel who emphasized this model in the 1980s. According to Ghaemi (2011), the biopsychosocial model gained much recognition in the field of Social Work where it was commended for enhancing collaboration between psychiatric social workers and clinical psychologists. The biopsychosocial model gives clearer explanations for the causes of mental illnesses and it helps the affected individuals to access all the help they need. It does not focus only on one dimension but rather it focuses on a range of possible factors that can affect an individual through taking into consideration the social and environmental factors. Goodwin and Jamison (2007) state that the biopsychosocial model has been the underlying principle of clinical practice within social work rehabilitation services for many years. This model is also increasingly utilised in social work as it encompasses the environmental, social as well as the biological aspects of an individual’s life.

In explaining this approach, Perring (2010: 56) asserts that there is no single factor that is said to be the sole cause of mental illness, and instead it is caused by disorders which result from a complex set of forces that act upon each individual. Mental illness can emanate from a spectrum of factors ranging from stress and trauma related factors, neurotransmitter related chemical imbalances, alcohol and substance abuse, genetics, socio-cultural factors as well as the nutritional factors. Rangan and Sekar (2006) state that the biological, social and psychological factors often overlap. Thus, the biopsychosocial theory believes that mental illnesses are caused by the combination of these three factors, for example, biological causes that relate to chemical imbalances in the brain, psychological causes that include severe shock or trauma and social causes like poverty and discrimination. Ghaemi (2011) notes that neuroplasticity research, which describes how neurons within the brain reproduce and grow new connections across the life span, verify the biopsychosocial theory. This study explains how the environment interacts with the nervous system to cause mental
disorders or abnormalities in the brain. Therefore, it is in agreement with the biopsychosocial model in that mental illnesses are caused by the social, biological and psychological factors.

2.4 The Strengths Perspective and the Systems Theory

Nicholas et al. (2010) state that the systems theory and the strengths perspectives in social work offer frameworks for understanding and analysing the interrelationship between the individual and the social problems. In this study, the systems theory and the strengths perspective are the main social work theories that were used to understand the interrelationship between people living with mental illnesses and their sexual risk behaviours that pose as a risk factor for HIV infection. Authors like Perring (2010) and Checkley et al. (1996) argue that people with mental illnesses are an oppressed group so innovative approaches are needed to address the lack of power, control, stigma, and poverty. People living with mental illnesses are often not consulted or included in making decisions that directly affect them. Social work practice has therefore adopted theories to help the social service professionals in working with individuals with mental health conditions and in particular, the strengths perspective and the systems model, which are the basis of social work practice.

2.4.1 The strengths perspective

The strengths perspective is central to social work. It was originally founded in mental health services and focuses on the capacities and potentialities of the clients (Saleebey, 1996). Saleebey states that the main focus of the strengths perspective is on enabling individuals and communities to articulate and work towards their hopes for the future, rather than seeking to cure the problems of the past or even the present. Nicholas et al. (2010) state that the strengths perspective highlights the importance of strengths disputing dominant medical, deficits-based approaches which emphasise pathology and illness. The strengths perspective therefore views clients in terms of their strengths to help them build on their capacities. Therefore, it examines the survival
skills, abilities, knowledge, resources and desires that can be used to help meet client goals, according to Saleebey.

The strengths perspective assumes that human beings have the capacity for growth and change, knowledge about their situation, and resilience from past experiences. The major focus of the strengths approach is collaboration and partnership between social workers and clients. It also empowers the mental health professionals to help clients gain insight into their innate strengths, increasing resilience and improving their well-being, according to Nicholas et al. (2010). According to Healy (2005), the strengths perspective focuses on the individual’s strengths and capacities instead of concentrating on personal pathology. She asserts that it recognises that the person is not the problem but has a problem, which he or she can play a big role in resolving. Thus, the strengths perspective is empowering in that it helps clients to be aware of their strengths that they can work on in order to overcome the situation they are experiencing at a particular time. The strengths perspective focuses on the exploration of future possibilities through recognising and building on the clients’ capacity to help themselves and their communities.

The strengths perspective assumes that all people have strengths, capacities and resources. Nicholas et al. (2010) state that the strengths perspective views the clients as experts in their situations and it regards social and environmental barriers as targets for change. Clients therefore are seen as having the ability to determine what is best for them and whether the social service professionals could help them in identifying and working on their strengths so that they will have the ability to bring solutions to their problems. This view is in contrast to societal perceptions where people living with mental health conditions are not considered as having any strengths but are often reduced to being seen as incapable of directing their own lives. Consequently, people living with mental illnesses have lost faith in their capacities as well as strengths. Chuang and Atkinson (1996) state that people who suffer from mental illnesses are
submissive and can be easily manipulated by others. This study indicates that people with mental illnesses lack confidence in their abilities since the community has labelled them and made them to believe that they are incapable.

When using the strengths perspective, the social worker assumes that clients, in this case people living with mental illnesses, have multiple strengths. Healy (2005) suggests that, with the strengths perspective, the social worker tries to assess the strengths of the client and emphasizes these strengths in the helping relationship so as to empower the client through making him/her realise his/her strengths. Strengths and resilience are seen by Saleebey (2005) as a product of facing and overcoming adverse life events and traumatic situations, and can be used as a resource for actual problem solving. Thus, an individual who was suffering from schizophrenia who was once seen as a victim may be viewed as a survivor of schizophrenia who managed to develop exceptional capacities for survival.

The strengths perspective thus restores people’s esteem through highlighting and redirecting their focus towards building their strengths. Rangan and Sekar (2006) state that psychiatry ascribes and uses the disease model in treating mental health problems and mental illnesses. The strengths perspective however attempts to understand clients in terms of their strengths through systematically examining survival skills, abilities, knowledge and resources. According to Saleebey (2005), the strengths perspective influences both the well-being and the coping of people with mental illness as well as their quality of life. This perspective has the underlying assumptions that human beings have the capacity for growth and change, knowledge about one’s situation and resilience. Therefore, people living with mental illnesses have the power and ability to solve their own problems with the social worker facilitating this process with helping them to realise their strengths.
2.4.2 The Systems Theory

The systems theory is another theory that has direct relevance to social work. The systems theory emphasizes reciprocal relationships between the elements that constitute a whole. Thus, its emphasis is on the relationships among individuals, groups, organizations, or communities and mutually influencing factors in the environment. The systems theory focuses on the interrelationships of elements in nature. It believes that, the balance between the individual and the social system, and the efforts to avoid disorder are essential for growth. According to Barry (2002), the systems theory emphasizes the role of other systems in contributing to individual and community wellbeing. It believes that when one part of the system is not functioning well, it affects the whole system.

The systems theory, according to Ackoff (1981), believes that no single part can function on its own, meaning that a person is linked to many resources and people around him/her and on whom the person keeps on relying for his/her needs. Muguire (2002) states that the systems theory operates in a person-in-environment (PIE) or from an ecological perspective. This model takes into consideration the effect of one’s environment on his or her life and thus it believes that a person cannot be separated from his or her social, economic or physical environment. Therefore, an individual, family or community is a system and if one subsystem is not functional, it affects the whole system. In the context of people living with mental illnesses, these subsystems may seriously contribute to their vulnerability to HIV. Therefore, it is essential to look into the environment of people living with mental illnesses to understand their sexual behaviours as well as their needs.

Ackoff (1981: 15-16) defines the systems theory as a set of two or more interrelated elements with the following properties: Each element has an effect on the functioning of the whole, each element is affected by at least one other element in the system, and all possible subgroups of elements also have the first two properties. The
systems theory therefore focuses attention as well as on the complex interrelationships among its constituent parts. Barry (2002; 43) likewise defines a system as “a collection of working parts, that when combined, make up a more complex working object or abstract entity” and a subsystem as “a concrete or abstract, essential part of a larger system [that] relates in specific ways with all parts of the larger entity”. The systems theory believes that without the subsystem, the system can never function. Examples of subsystems include; family, community and environmental resources that form a system, with which an individual would have difficulty in coping if they were to be absent.

Healy (2005) supports the idea that the systems theory provides ways of understanding clients’ problems and issues and indicates that the ecosystems perspective retains the notion of wholeness. The author, Healy, states that the ecosystems perspective recognises that the parts of the system can never be entirely separated from each other. Therefore, problems arise due to a poor fit between a person’s environment and his or her needs, capacities and aspirations. In the context of mental health, people living with mental illnesses cannot live satisfactorily unless they are linked with the necessary resources. This might be the main reason why people living with mental health conditions may not cope well within the community because there is a poor fit between the environment and their individual needs. According to Rodgers (2009), this group of people is often stigmatised and faces discrimination, and as a result they live in isolation within the community so that there are limited systems in their lives because the other systems do not play any role in their lives.

The primary mission of social work is to enhance human wellbeing and to help meet the basic human needs of all people, as well as to empower people, who are vulnerable, oppressed and living in poverty. The systems theory therefore may help professionals to understand their clients holistically. According to Barrera (2008), with the systems theory, professionals use concepts of micro (individual), mezzo (family),
and macro (community) level interaction to assess how illness affects the individual and other interrelated systems. Change and adaptation to the mental illness may affect all within the system: the individual, their family, the community and surrounding environment. The systems theory enables the professionals to not only help the affected individual, but to engage with the whole system so that the whole system can be empowered in dealing with a particular problem. In this regard, this study seeks to understand the risky sexual behaviours of people living with mental illnesses and to devise ways to prevent the spread of HIV among them. By so doing the community can also get educated about mental illnesses so that they can learn to accept those who are affected, thereby reducing stigma and discrimination.

Barry (2002) contends that there is no human being who exists in complete isolation from others. She adds that personality is formed as a result of interactions with immediate family and later in life with teachers, peers and others. This study as well as other studies such as that by Sacks et al. (1992) and Checkley et al. (1996) therefore will help the service providers and the government to understand the needs of people who are suffering from mental health conditions through highlighting those parts of the system that are not operational. It is evident that people who suffer from mental illnesses are excluded from most of the HIV and AIDS related programmes, thus the findings of these studies indicate the gap between mental health and HIV/AIDS.

2.5 Mental Illness and HIV/AIDS

Douaihy, Jou, Gorske and Salloum (2003) assert that for people living with HIV infection who are consistent with their medication, their antiviral regimens often precipitate or worsen psychiatric symptoms, thereby inhibiting positive health outcomes, since antiretroviral are believed to be the primary cause of some mental illnesses. Mental illness is linked with HIV and AIDS, as a causal factor and as a consequence, this means that mental illnesses may be a result of AIDS infection and they may also expose one to HIV infection. According to Baingana, Thomas, and Comblain (2005),
about three-quarters of people with HIV and AIDS will have at least one psychiatric disorder in their lifetime. Mental illnesses may cause the sufferers to experience severely distorted thinking or cognitive impairment. These disorders may in turn pose many challenges in HIV treatment by increasing the likelihood of the client engaging in high-risk behaviours and other maladaptive health behaviours such as substance abuse and treatment non-adherence. Acuff et al. (1999) concur, highlighting that people with serious mental illnesses are likely to experience a severely impaired quality of life as well as shortened HIV-related survival due to limited access to health care. Henceforth, mental health treatment and support for people living with HIV and AIDS is a key issue to both improving their quality of life and preventing the further spread of the HIV infection among people living with mental illnesses. Mental illness increases vulnerability of its sufferers to HIV infection. According to Byrne, Petrak and Salvage (2006), mental health problems, drug and alcohol misuse, and learning difficulties can influence behaviour in ways that lead to greater risk of HIV infection. Therefore mental health treatment and support for people living with HIV and AIDS is a key to both improving their quality of life and preventing the further spread of the infection. Social work, however, brings a distinctive social perspective to mental health. Allen (2014) states that social work recognises the social antecedents and determinants of mental distress throughout the life course that are often missed with purely medical illness approaches. This means that social work promotes social change, problem solving in human relationships and the empowerment of people to enhance their well-being.

Many persons with HIV are believed to experience psychiatric problems, such as anxiety and depression, and some develop psychotic symptoms, usually in late stages of HIV infection. Consequently, it may be unclear as to whether the mental illness has occurred as secondary to HIV infection or has developed independently. Sullivan, Koegel, Kanouse, Cournos, McKinnon, Young and Bean (1999) postulate that in most cases of co-occurring serious mental illness and HIV, the mental illness preceded the HIV infection. However, the mental health providers may not take into account people living with mental illnesses since they are believed to be asexual. Sullivan et al. concur
that health providers are more frequently seeing patients whose serious mental illness appears to have begun after they contracted HIV infection. This is because the HIV treatment and prevention programmes have been successful in most areas. HIV and AIDS have received much recognition and as a result people living with HIV have managed to access the necessary health care services due to the awareness campaigns that took place. This therefore has also exposed those who have developed the mental health conditions as a consequence of the HIV infection to obtain mental health care since they are already exposed to the health care services. Thus, the mental illness that they develop due to HIV infection has managed to gain attention from the health providers, unlike what happens with those who develop their mental illness independently from HIV infection.

There is enough evidence from previous studies such as those by Herrman, Saxena and Moodie (2005), Sacks et al. (1992) and Checkley et al. (1996) that indicate a relationship between mental illness and HIV/AIDS. Mental illness is believed to be placing its sufferers at risk of contracting HIV as well as interfering with their treatment. Further, HIV and AIDS are believed to be a direct cause of serious mental illness across the world. According to Herrman et al., there is a high seroprevalence of HIV infection in people with serious chronic mental illness as compared to the general community. A South African based study by Meyer et al. (2008) found that there is a high prevalence of mental disorders among HIV infected individuals in South Africa. This study explored the emotional impact an HIV positive diagnosis has on individuals and is consistent with what Perring (2010) refers to as the psychological/ interpersonal theory of mental illness that focuses on the psychological effects of significant events and how this can lead to mental illnesses.

According to a report by Van Larberghe, Evans, Rasanathan, and Mechbal (2008), the prevalence of HIV and AIDS in mentally ill inpatients and outpatients has been reported to be between 5% and 23% compared with a range of 0,3% to 0,4% in
the general population in the United States of America. HIV infection has become more prevalent among people living with mental illnesses. Van Larberghe et al. state that some studies have reported that the behavioural risk factors for spreading HIV among people with severe mental illnesses is between 30% and 60%. According to Singh et al. (2009), adults with serious mental illnesses in South Africa have a 2 - 36 times higher seroprevalence of HIV than the general population which is 3-6. HIV-infected people on the other hand have a higher prevalence of serious mental illnesses. Acuff et al. (1999) contend that the course of HIV infection may embrace medical complications that create changes in one’s mental status. These conditions are believed to model the common psychiatric conditions, such as depression, mania, anxiety, and psychosis.

The studies mentioned above indicate that there is a twofold relationship between HIV and mental illness in that HIV infection can lead to mental illness due to the stress and anxiety brought about by a positive diagnosis of HIV. This is confirmed by Van Larberghe et al. (2008) who state that people with HIV/AIDS often suffer from depression, anxiety and substance abuse as they face the difficulty of living with a chronic life threatening illness and the fear of rejection and stigmatisation. Developing AIDS or simply being HIV-positive has a major impact on an individual’s mental health. Hence, being diagnosed with HIV can have profound effects on the mental wellbeing of an individual through the associated stigma and discrimination, as well as through the progression of the disease itself. Byrne et al. (2006) state that all chronic, life-threatening conditions bring particular stressors such as long-term discomfort, physical deterioration, physical and financial dependence and the prospect of premature death.

Studies by Gottesman and Groome (1997) indicate that some antiretroviral treatments are the foundation of some mental illnesses such as depression and anxiety disorders among people who are HIV positive. The ARV treatment and other kinds of therapy are associated with side effects on the central nervous system, which may cause hallucinations and psychosis. Van Larberghe et al. (2008) add that HIV infection
has direct effects on the nervous central system causing neuropsychiatric complications such as encephalopathy, depression, mania and many other conditions. In addition, the impact of social issues such as discrimination, social denial, stigma, isolation, and lack of disclosure mean that HIV and AIDS have an intense psychological and social impact on the infected individual. On the other hand, people living with mental illnesses are at high risk of HIV infection. These studies indicate that HIV/AIDS and mental illnesses are strongly interlinked and therefore it is important to address the needs of people living with mental illness as far as HIV and AIDS are concerned so that HIV and AIDS prevention and education programmes can be improved to address their needs.

2.6 Mental Illness and Sexual Risk Behaviour

Risk behaviours are a concern in mental illnesses. Checkley et al. (1996) state that the individual risk behaviours of people suffering from mental illnesses may be impacted by cognitive deficits, vulnerability to coercion by others, and a desperate need for money since they are usually living in poverty. Checkley et al. (1996) and Sullivan et al. (1999) agree that poor judgment, impulsivity, high levels of sexual activity and poor negotiation skills make mentally ill people vulnerable to sexual exploitation. This is in contrast with views raised by Yousafzi and Edwards (2004) about the perceived sexual inactiveness of people with disabilities. Although sexual behaviour has been viewed as a factor in the lives of people living with mental illness, the structure and policies of the mental health service providers are often based on the premise that sexuality is not a significant issue for the mentally ill. According to Goldfinger, Sesser, Roche and Berkman (2001), the main behavioural modes of transmission and contraction of HIV and AIDS involve sexual behaviours and drug use practices among people living with mental illness. Sexual risk behaviours amongst the mentally ill include the following:

2.6.1 Hyper-sexuality

Gottesman and Groome (1997) indicate that people living with mental illness are at high risk of contracting HIV because they are believed to be sexually inactive while in
actual fact they are sexually active and they get involved with multiple partners. As such, people living with mental illnesses may present with promiscuous sexual behaviours and this shows that this group of people is not asexual as is often perceived. This high degree of focus on sex is called hyper-sexuality and people who suffer from mental illnesses who are sexually active are often believed to be hypersexual although this may vary according to different types of mental illnesses. Adams, McClellan, Douglass, McCurry and Storck (1995) state that the findings of their study on the sexually inappropriate behaviours of children and adolescents revealed that amongst the hypersexual group, those with histories of sexually inappropriate behaviours had a higher proportion of females and had a much higher rate of being sexually abused, physical abused and neglected, as well as displaying behavioural disorders.

There seems to be a link between bipolar disorder and hyper-sexuality or risky sexual behaviour as well. According to Singh et al. (2009), it is reported that women who are suffering from bipolar disorder tend to be hypersexual during the episodes of their illness and those who are suffering from general mental illnesses become hypersexual when their illness remains untreated. It has been revealed that many people in the middle of manic episodes have a very high level of sexual energy and they use that energy in different ways. A person who is bipolar may engage in risky and impulsive sexual intercourse or hyper-sexuality during episodes of mania. This indicates that bipolar disorder may be a cause of lost inhibition and increased libido among its sufferers, thereby exposing them to the HIV infection during these manic episodes.

Hyper-sexuality among people living with mental illness may be a result of not getting exposure as well as not getting educated about sex or the physical development of a human being since they are perceived to be sexually inactive, according to Kelly (2011). Some studies such as that by Herrman et al. (2005) indicate that the treatment of mental illnesses also plays a role in sexual stimulation among patients and thus they may become hypersexual.
2.6.2 Homosexuality

Homosexuality on its own has been closely linked to mental illness since it was previously classified under mental illnesses. Hickey (2011) states that homosexuality was classified by the American Psychiatric Association as a mental illness which needed to be treated. However, in 1974 homosexuality was no longer listed in the Diagnostic and Statistical Manual of Mental Disorders. Protests from gay people who felt that homosexuality was not supposed to be classified as a mental illness influenced this outcome. This indicates how homosexuality is related to mental illness. Nonetheless, some people still believe that homosexuality is a mental illness, yet the current research and clinical literature such as reported by Bailey (1999) and Gonsiorek (1991) demonstrate that same-sex sexual and romantic attractions, feelings, and behaviours are normal and positive variations of human sexuality.

Homosexuality is one of the sexually risky behaviours that have been noticed among people with mental illness. Mental illness sufferers usually engage in homosexual behaviours especially among male patients. Yousafzi and Edwards (2004) state that, among gay men who are living with mental illnesses, the combination of high sexual arousal and impotence often results in their being receptive partners in anal intercourse. The sexual needs of people living with mental illnesses have often been ignored, thus they are reported to have been sharing rooms in the mental institutions which expose them to homosexuality, as they do not have the opportunity to indulge in heterosexual relationships. People living with mental illness are also discriminated against within their communities and therefore their chances of getting partners of the opposite sex are very limited, so that they resort to homosexuality.

In a study conducted in Australia, Thompson, Checkley, Hocking, Crofts, Mijch and Judd (1997) observed that the behaviours most associated with HIV infection are male-male sex and intravenous drug use. Homosexuality is however believed to be common among people living with mental illnesses. This therefore indicates that people
living with mental illnesses have higher chances of contracting HIV infection since they become involved in same-sex relationships that are known to be a risk factor for HIV infection. Often, even with such homosexual relationships the use of condoms might be neglected by this group of people as they are not able to anticipate the consequences of their actions. They might also have intercourse in public places where condoms are most likely unavailable. This indicates the extent of HIV risk among people living with mental illnesses.

2.6.3 Trading with Sex and Engaging in Unprotected Sex with Multiple Partners

Mamabolo, Magagula, Krüger, and Fletcher (2012) assert that people living with mental illness have a history of trading with sex for small sums of money or for other goods such as drugs as well as shelter. Calitz (2011) adds that people also tend to manipulate those with mental illnesses because they know that they cannot comprehend things. Due to their poor judgment, it is difficult for them to distinguish between love and manipulation. According to Kelly (2011), disabled people in South Africa, which include the mentally ill, are more likely to be economically disadvantaged, uneducated, unemployed, and live in poorer quality housing than the general community. Living in poverty plays a huge part in increasing someone’s risk of HIV infection. People living with mental illnesses tend to be submissive because they have been taught by society that they are inferior so poverty worsens their social status. Thus, they tend to rely on other people for help.

People living with mental illnesses are faced with many challenges that directly expose them to HIV infection and even worsen their living conditions. Poverty and lack of employment opportunities are a challenge that faces many women who are living with mental illnesses, which also contributes to the increased risk of exposure to the HIV virus among them. According to Calitz (2011), sex can thus be seen by some women as the only way to secure income and other kinds of payment such as food, lodgings or clothes. Kelly (2011) concurs that, for some, sex can be seen as the only way to secure...
income, either through transactional sex for payment in any kind such as food, lodgings or clothes, as well as drugs.

Loneliness and social rejection increase the vulnerability of persons with disability to HIV infection. This was seen to contribute greatly to infection and re-infection despite the fact that the person may have knowledge of HIV and AIDS in the study by Singh et al. (2009). According to Kelly (2011), persons with disabilities may keep multiple partners as a result of social rejection because they also want to be accepted and appreciated within the communities. Because of the social rejection and discrimination, people living with mental illness are likely to have multiple partners because they might be afraid of losing them and cling on to them. Mamabolo et al. (2012) concluded that one of the prominent HIV risk behaviours among people who are living with mental illnesses is multiple sexual partners, which factor is associated with diagnoses of substance-related disorders and cognitive disorders. This study indicated how these factors could be a cause and effect of one another. People living with mental illnesses are therefore at high risk of being infected with HIV and they need to be protected from such harm.

This group of people is also believed to be unable to maintain long-term relationships hence they tend to have multiple partners. Sullivan et al. (1999) argue that the tendency of having multiple partners among the people living with mental illnesses may be as a result of poverty and dire need for drugs so they may resort to having multiple partners for benefits. Herrman et al. (2005) add that this group of people engage in sexually risky behaviours which include high rates of sexual contact with multiple partners, injecting drug use, sexual contact with injecting drug users, sexual abuse (in which women are particularly vulnerable to HIV infection), unprotected sex between men and low use of condoms. The above-mentioned studies indicate a strong link between mental illness and high risk sexual behaviour, thus there is a need to provide HIV prevention programmes specifically for this group of people. Ickovics,
Hamburger, Vlahov, Schoenbaum, Schuman, Boland and Moore (2001) conclude that these issues emphasise the need for early diagnosis and treatment in order to reduce mental illness, substance use, and slow HIV disease progression and also decrease mortality.

2.7 Mental Illness and Vulnerability (factors influencing risk behaviours)

Walsh (2013) proposes that the ethos of social work is to protect human rights and to intervene to prevent or end discrimination and inequality and protect vulnerable people from harm. People with mental illness are vulnerable to HIV and AIDS as well as to abuse and other forms of social oppression. Gunjefo (2007), states that vulnerability encompasses the social, economic and physical factors that could increase the susceptibility of an individual or group of persons with mental disability to HIV infection. Zakour and Gillepse (2013) state that vulnerability includes the extent and severity of damage that is likely to occur to the functioning and well-being of people and social systems. People suffering from mental illnesses are vulnerable to HIV infection and they lack the ability to perceive themselves as a group that is at high risk of being infected. The vulnerability of people with mental illness to HIV indicates that this group of people is defenceless, exposed and at high risk of contracting HIV, meaning that they do not have the means to protect or prevent themselves from it. This vulnerability is also affected by the severity of the mental illness. Research further suggests that risk increases with disorder severity as shown by Chuang and Atkinson (1996) that people suffering from severe mental illness are at high risk of contracting HIV due to their risky behaviours and lack of awareness of their condition. This can thus be regarded as one of the main reasons why HIV and AIDS are prevalent among people with severe mental illnesses.

It is evident from the information above that people living with mental illnesses are vulnerable to HIV infection and they lack the ability to perceive themselves as a group that is at high risk of being infected. The vulnerability of people with mental illness
to HIV indicates that this group of people are defenceless, exposed and at high risk of contracting HIV, meaning that they do not have the means to protect or prevent themselves from it. This vulnerability is also affected by the severity of the mental illness. Research further suggests that risk for HIV infection increases with disorder severity as shown by Chuang and Atkinson (1996) who note that people suffering from severe mental illness are at high risk of contracting HIV due to their risky behaviours and lack of cognisance. This can thus be regarded as one of the main reasons why HIV and AIDS are prevalent among people with severe mental illnesses.

In this respect, Yousafzi and Edwards (2004) postulate that disabled people experience a double burden in relation to HIV and AIDS in the sense that they have increased risk of infection and reduced access to prevention and care services. The findings of the study by Yousafzi and Edwards showed that people with disabilities are vulnerable to HIV and AIDS because they are marginalised, discriminated, illiterate and relatively poor. People living with mental illness, just like people who have disabilities, are often vulnerable to contracting HIV as they are potentially at risk of sexual or physical abuse and manipulation.

In addition, mental illness on its own plays a great part in placing its sufferers at risk of HIV since they can be easily manipulated and they cannot view themselves as people who are at risk of contracting HIV infection. This group of people is further placed at risk by the factors in the environment and the community in which they live. Singh et al. (2009) contend that most of the people that are suffering from mental illness are living in urban neighbourhoods that have been heavily affected by the AIDS epidemic and therefore they are susceptible to contracting HIV. People living with mental illnesses are reported to have poor HIV and AIDS knowledge, cognitive deficits, affective instability, behavioural impulsivity, and high rates of HIV risk-behaviour, which all contribute to HIV acquisition.
Yousafzi and Edwards (2004) add that people living with mental illness are predominantly vulnerable to HIV infection because of the higher prevalence of a variety of factors, such as poverty, homelessness, high-risk sexual activities, drug abuse, sexual abuse, social marginalization and the effects of psychiatric treatment. Sullivan et al. (1999) in their study of people suffering from schizophrenia discussed some of these factors and concluded that people living with mental illnesses are at high risk of HIV infection due to some of the above-mentioned social and economic factors. They considered people who are suffering from schizophrenia specifically, rather than exploring other types of mental illnesses as well.

2.7.1 Psychiatric Medication and Mental Illness

Averett and Wang (2011) concur that some medication increases the sexual desires of people living with mental illness placing them at risk of contracting HIV because they end up losing the ability to control their sexual desires. Mental illness plays a big role in placing its sufferers at risk of being infected with HIV because it reduces their thinking capacity and for that reason they are easy targets of sexual assault and sexual exploitation due to their naivety and poor judgement. Volavka et al. (1991) state that the same psychiatric risk factors that increase transmission of HIV also interfere with the adherence to treatment with antiretroviral medication. They further discuss that mental illness does not only increase the risk of infection with HIV, but the presence of HIV and AIDS also increases the lifetime prevalence of psychiatric illness for the infected individual. Mental illness may therefore be considered as a vital factor for HIV infection as well as for non-adherence to the HIV treatment.

Several studies such as by Averett and Wang (2011) and Starace et al. (2002), document the impact of depression on risky behaviours such as unprotected sexual intercourse, multiple sex partners and trading sex for money and drugs. Mental health is though rarely a component of the design of HIV prevention and intervention programmes. According to Averett and Wang (2011), depression also severely affects
one's emotional resilience and self-esteem. It also leads to a sense of hopelessness and guilt. Depression therefore leads to high-risk behaviours including substance abuse, which effectively distract or numb an individual from symptoms, but also greatly increase the risk of acquiring HIV as well as other sexually transmitted infections. Risky sexual behaviours among persons living with mental illnesses have been suggested to stem from both psychiatric symptoms, for instance mania among people with bipolar and from the social consequences of the illness such as homelessness and substance use. This however suggests that people living with mental illnesses may indeed be at high risk of HIV infection since there are numerous factors which can easily contribute to their vulnerability.

According to Thompson et al. (1997), psychiatric disorders are a barrier to medical care and adherence to HIV medications. Moreover, depression, stress and trauma can lead to disease progression and increased mortality. This indicates that mental illnesses play a vital role in the treatment and management of the HIV infection. It is therefore imperative to facilitate mental health treatment in order to reduce depression and anxiety, improve adherence and HIV health outcomes and, in turn, reduce the likelihood of death from HIV and AIDS related causes.

2.7.2 Sexuality

According to Van Dyk (2001), people living with mental illnesses who engage in sexual behaviour encounter societal prejudice and parental anxiety because the society does not expect them to be sexually active. Goldfinger et al. (2001) indicates that sexual health in people with mental illness has either been ignored or treated as a problem and was historically solved by involuntary sterilization. It has been indicated that people living with mental illnesses present with risky sexual behaviours. According to Sullivan et al. (1999) this high-risk activity may in part originate from poor interpersonal functioning, especially as the onset of serious mental illness often interferes with their normal psychosocial development. Since people who are living with mental illness are
considered to be sexually inactive, they are often not included in HIV and AIDS prevention programmes. Studies that have been conducted in this field, however, have challenged this myth by concluding that people living with mental illness are in fact sexually active. Gottesman and Groome (1997) indicate that this group of people are sexually active and also engage in sexually risky behaviours which make them more vulnerable to contracting HIV. Mamabolo et al. (2012) add that patients with bipolar disorder were described as experiencing hyper-sexuality during the manic phase, while patients diagnosed with personality disorders appeared to be at higher risk of HIV infection than those only diagnosed with an Axis 1 disorder. The above studies therefore disprove the misconception which states that people who are suffering from mental illnesses are asexual and rather provide the facts on the sexually risky behaviours of this group of people.

Goldfinger et al. (2001) state that among institutionalised people who are living with mental illness, shared same-sex bedrooms are the norm, privacy is usually unavailable, and sexual contact is specifically prohibited or assumed to be non-existent. Consequently, many of these individuals meet their partners in public places, such as parks, bars, or on the streets. In such cases, sex is not pre-planned therefore they are prone to practise unsafe sex, thus placing themselves at higher risk of contracting HIV. The society generally believes that people living with mental illnesses are not affected by HIV and AIDS, and as a result, no efforts are made to ensure that this group of people receive education on sexuality, HIV and AIDS. People living with mental illnesses need information on values and morals and they have a right to learn about sexuality, intimacy and love. This will enable them to protect themselves against sexually transmitted diseases as well as empower them to consent to and make better decisions about sexual intercourse.

Sexuality education cannot be provided in isolation from family, religious and cultural values. The combination of all these sources of information may help people living with mental illnesses to build on their own moral values and increase self-esteem,
according to Jafta (2008). According to Jafta, scientific learning theory confirms that through the modelling theory and conditioning process, parents socialise children into attitudes towards sexuality but for people living with mental illnesses they learn that sexual discussions are inhibited since parents tend to model negative attitudes towards sexuality. Therefore, people living with mental illnesses grow up with the notion that sex is a bad component of one’s wellbeing. As a result of a lack of correct information on sexuality, they are likely to obtain wrong information from other sources and thus satisfy their curiosity and needs in a way that society does not approve.

2.7.3 HIV and AIDS Awareness and Lack of Education

People living with mental illnesses lack accurate information on HIV and AIDS as well as sex education. Their inability to comprehend the reality of the risk involved in their sexual behaviours poses an alarming risk factor for HIV infection. For this reason, mental health professionals who are tasked to render educational and prevention programmes have to be educated on how to deal with people who are suffering from mental illnesses. Some studies such as by Kelly (2011) and Herrman et al. (2005) revealed that people who are living with mental illness have little or no knowledge on the risk factors for HIV as well as the HIV and AIDS prevention programmes. This shows that previous programmes may not have benefited this group and thus they remain at risk. As a result, the prevalence of HIV and AIDS is high among them as compared to the community at large. This implies that persons with mental disability have been left out in accessing information, as it is not tailored to their level of understanding.

The sufferers of mental illness are more likely to be illiterate and uneducated. According to Kelly (2011), the South Africa’s Department of Education indicated that the vast majority of young disabled people are not enrolled in any form of formal education and that even those who are in school are often deliberately excluded from sex and HIV education programmes. In South Africa, there are special schools that
cater for persons with intellectual disabilities. This however does not guarantee that every person with a mental disability can have access to these kinds of schools. Special schools are few in number and they are often full. The caregivers of people living with mental illness might be unaware of these kinds of resources until it is too late for the particular child to be enrolled. Some mental illnesses are severe to the extent that the affected individual cannot cope with academic skills and with general life skills because he/she is unable to comprehend information. Kelly (2011) states that many parents are reluctant to relay vital sexual health messages to their mentally disabled children because it is socially taboo or they feel it is inappropriate and will encourage promiscuity. This indicates that people living with mental illnesses are really in need of HIV, AIDS and sexual health education since they have been unable to access such information both from school and from their care givers.

Due to this lack of education, people living with mental illness are unable to benefit from the HIV and AIDS programmes; hence there is a dire need to formulate programmes that are specifically directed to this group of people. Breen (2006) contends that the community as well as the primary care givers of people living with mental illness do not see the need to educate this group of persons about sex, as they believe that they are asexual and that they will remain immature and without any sexual needs. According to Ray, Pugh, Roberts and Beech (2008), people with mental health problems who live in more isolated rural areas and small communities with little service provision are likely to find it more difficult to develop and preserve supportive social contacts and networks. This is seen in South Africa as well where people who are living with mental illnesses seem to be staying in informal settlements as well as in the rural areas. Breen adds that this lack of social contacts indicates that this group of people is excluded from many programmes that may benefit them due to their isolation and lack of networks.
Children suffering from mental illness, because they are not sent to school, tend to be kept at home thus isolating them from other children and thereby exposing them to sexual abuse. This is due to the fact that there will be no adult supervision thus some people may use such opportunities to groom these children as well as to abuse them sexually. Other children gain life skills at school as well as sex education, but the mental health sufferers do not benefit from such skills, as they are most likely not attending school. Breen (2006) states that even the practitioners feel anxious about offering sex education to people who suffer from mental illness. The norm of not sending children with mental illness to school increases the risk of stigmatisation and discrimination by other children. This will in turn lead this group of people into seeking love and attention, thus placing them at risk of being sexually manipulated. Breen also states that most cases of rape against the mentally ill are never reported to the police because they are easily threatened or manipulated due to their inability to be judgemental.

Jafta (2008) states that HIV and AIDS education is about teaching people safe sex, abstinence and faithfulness. Therefore, people living with mental illnesses deserve to be educated about all options rather than being taught about abstinence only. Lawson (1997) mentions that the HIV and AIDS charter of 1995 declares that all persons have the right to proper education and full information about HIV and AIDS. This does not exclude people living with mental illnesses. Therefore it is essential to address the myths about sexuality of people living with mental illnesses in the society so that people can be aware of the sexual needs of this group of people. Therefore, they will be able to include them in the HIV and AIDS programmes as well as other programmes that may benefit them.

2.7.4 Substance Abuse and Homelessness

According to Stoff, Mitnick and Kalichman (2004), the interaction between mental health and substance abuse problems escalates both the level of risk and the severity of HIV infection and re-infection. This is however due to the fact that drug abuse impairs
the thinking capacity of the affected individual. The stigma that is attached to substance abuse and mental disorders often impedes early diagnosis and proper treatment for HIV and AIDS. Mental illness is often associated with substance abuse. Regier et al. (1990) state that substance misuse frequently occurs alongside mental health problems, including mood disorders such as anxiety and depression, and schizophrenia and bipolar disorder that induce psychosis. This indicates that mental illnesses are closely linked to drug and alcohol use or its abuse. In the research done by the National Institute on Drug Abuse, findings revealed that mental disorders can increase vulnerability to drug abuse and that drug abuse constitutes a risk factor for subsequent mental disorders.

People living with mental illnesses are believed to be at high risk of engaging in the use alcohol or other drugs to cope with their illness. According to Thompson et al. (1997), alcohol or other drugs may cause or aggravate psychiatric symptoms. This is because a person’s mental health, their moods, perceptions and behaviours can be negatively affected by their use of alcohol or other drugs. However, for people living with mental illnesses, whose moods and perceptions are already distorted, this can be more damaging to them as it might worsen their mental health condition and interfere with their psychiatric medication. Therefore, diagnosis and treatment of one disorder will likely reduce risk for the other, or at least improve its prognosis. Substance use might reduce perceptions of risk and subsequently increase the likelihood of sex with a risky partner or unprotected intercourse.

HIV AIDS and mental illnesses are both closely linked to drug and alcohol abuse. For people living with HIV, reactions to a positive HIV test, illness progression, or other stressful events can lead to increased alcohol and drug misuse. On the other hand, severe mental illness is often associated with drug and alcohol use. The use of drugs and alcohol, which is common among people living with mental illnesses, may further impair individuals' ability to respond safely in high-risk situations. Thus, it increases the
spread of HIV as well as the non-adherence to HIV treatment. Thompson et al. (1997) contend that it is essential to link people living with mental illnesses with substance misuse rehabilitation services to reduce the spread of HIV among this group of people. According to Westermeyer (1992), substance use disorders affect both the progression of HIV disease and the response to its treatment. Among people who have untreated drug dependence, rates of adherence to highly active antiretroviral therapy are low. Drug abuse also plays an important role in the acquisition of HIV among the mentally ill. Meade and Weiss (2007) state that consumption of drugs leads to improved sexual performance, enhanced sexual pleasure and can significantly affect actual sexual behaviour. This implies that substance abuse plays an important role in placing the mental health sufferers at risk of contracting HIV as well as contributing to poor adherence to HIV treatment.

Substance abuse is defined by Zastrow (2008) as the regular or excessive use of drugs or substances. Substance abuse can lead to addiction and dependency. Nicholas et al. (2010) contend that a person who gets addicted to drugs, develops a strong and overwhelming need to continue using drugs and will do anything to get them. This therefore suggests that people who are using drugs are also capable of exchanging sex for them, which then also places people living with mental illnesses at risk of HIV infection. Some of the people inject themselves and this can also expose one to HIV infection since their needles are not sterilised. Alcohol also plays a significant role in the spread of HIV. Westermeyer (1992) states that alcohol is generally regarded as decreasing a person's inhibitions, by so doing, leading to sexual risk taking in some populations. According to Westermeyer, this may be of even greater significance for people with mental illnesses, whose vulnerability to alcohol's effects can be particularly profound. The use of alcohol is known to be associated with an increased risk of unsafe sexual behaviour so alcohol consumption may significantly influence how HIV spreads in populations.
Understanding and responding appropriately to the combined effects of both mental illness and drugs and alcohol abuse can be difficult since there is a risk that a mental illness may be unrecognised when there is coexisting substance abuse. This is because sometimes the psychotic symptoms may be solely attributed to the effects of substance abuse, thereby overshadowing the underlying mental illness. According to Westermeyer (1992), the psychiatric care of homeless people tends to be compromised by instability and uncertainty thereby making it more critical for the treatment of HIV infection among people living with mental illness who are also homeless. According to Goldfinger et al. (2001), some treatments for HIV such as Zidovudine require regular compliance and careful monitoring, which is highly problematic with people who remain homeless. Some of the mental health patients tend to live in the streets due to poverty or untreated mental conditions. The fact that many people with serious mental illnesses alternate between housing and periods of homelessness may affect their sexual behaviours. Homelessness places them at risk of being sexually abused as well as at risk of trading sex to obtain other commodities such as food and drugs.

In an example of the United States, the National Coalition for the Homeless has contributed towards fighting homelessness. This coalition is a non-profit organization formed in 1982 in the New York City by a network of people including people who had experienced homelessness, activists and advocates, community and faith based service providers, and others committed to addressing homelessness and ensuring the needs and rights of the homeless are met and protected. According to this coalition, mental illnesses may prevent people from forming and maintaining stable relationships or cause people to misinterpret others’ guidance and react irrationally. The caregivers of people living with mental illness therefore tend to give up on being the force of keeping these persons from becoming homeless. As a result of these factors and the stresses of living with a mental disorder, people with mental illnesses are at risk of becoming homeless as compared to the general population. This consequently poses as a risk factor for HIV infection as they become prone to sexual abuse once they become homeless. This homelessness may also lead people living with mental illnesses to
engage in risky sexual behaviours such as having sexual intercourse with multiple partners as well as trading with sex as stated by Goldfinger et al. (2001).

2.7.5 Sexual Abuse and Rape

Checkley et al. (1996) as well as Sullivan et al. (1999) share the same view that poor judgment, impulsivity, high levels of sexual activity and poor negotiation skills make mentally disabled people vulnerable to sexual exploitation. People suffering from mental illness are viewed as easy targets of sexual abuse because they can be easily flattered and they lack the ability to tell if someone is genuine or flattering. Eastgate (2011) states that sexual abuse is extremely common in people with intellectual disability and that the reasons for this vulnerability to abuse include poor understanding of what is appropriate, difficulty in negotiating equal relationships, and difficulty reporting abuse. A person with an intellectual disability or mental illness may not feel they have the right to make their own decisions about sex, or may be manipulated into an abusive relationship with rewards or flattery. As a result, this group of people living with mental illnesses are at risk of contracting HIV since their victimisation can be continual.

Kelly (2011) states that, in South Africa, disabled people, including the mentally ill, are three times more likely to be victims of abuse than non-disabled people. People living with mental illness constitute potential victims of sexual abuse. For example, women living with mental illnesses are often stereotyped as virgins and thus targeted for the mythical practices such as the “virgin cleansing” practice as found by Gottesman and Groome (1997) and Simwaba (2005). Gottesman and Groome discuss this form of abuse that they state has existed for centuries. The practice is based on the misconception that people who have sexually transmitted diseases can be cured by transferring the infective organism through sexual intercourse with a virgin. Kelly argues that people living with mental illness in South Africa, depending on the severity of the disability are often placed at a disadvantage in sexual relationships.
and sexual abuse perpetrated on them often is not reported, as the victim sometimes does not communicate the injustice. According to Kelly, in South Africa an awareness and communication campaign was conducted to disprove the myth that young virgin girls can cure HIV and AIDS. This was developed as a measure of addressing the epidemic of sexual abuse among the mentally ill and the children. Generally, with reference to the above-mentioned studies, people living with mental illnesses are significantly vulnerable to sexual manipulation and abuse.

Mamabolo et al. (2012) state that one of the biggest problems regarding HIV risk behaviour in their study of risk behaviour for contracting HIV among adult psychiatric patients was the issue of people living with mental illnesses being forced into unwanted sexual intercourse. They further note that, in their study, female patients with a history of treatment for sexually transmitted disease and those with a diagnosis of personality disorder showed a significant association with being sexually abused. Carey, Carey and Kalichman (1997) concur that people living with mental illnesses are more likely to be victims of sexual coercion and intimate partner violence as well as having unstable partnerships and high-risk sexual networks. This indicated how vulnerable this group of people is to HIV as well as different forms of abuse.

2.7.6 Poverty

The poor economic and social conditions that reinforce rapidly increasing HIV infection rates also highlight increasing mental health problems. People living with mental illnesses are more likely to be living in poverty as compared to the community at large. Breen (2006) states that people with disabilities are more likely to be unemployed, have lower income and fewer assets as compared to the rest of the population both in developing and developed countries. People living with mental illness are more likely to be unemployed in South Africa. According to Patel and Kleinman (2003), poverty is likely to be associated with malnutrition, lack of access to clean water,
living in polluted environments, inadequate housing, frequent accidents and other risk factors associated with poor physical health.

Sfetcu, Pauna and Iordan (2011) propose that mental health is often both a cause and a consequence of poverty, compromised education, vulnerability, difficulty accessing housing, health care and employment, and lack of access to welfare, social security, and community public services. Poor people are more likely to have inadequate access to health and care and therefore people with mental illnesses who are also poor, may not receive the necessary health care. According to Saraceno and Barbui (1997), poverty has been assumed to be a risk factor for mental disorders in that it may lead to circumstances of increased life event stressors, scarce social resources and inadequate health care. There is an association between poverty and mental disorders. Mental and physical health problems lead to increased health care costs thereby worsening poverty. On the other hand, living in poverty may lead to the onset of mental illness. Patel and Kleinman (2003) indicate that poor people are more vulnerable to mental illnesses due to factors such as insecurity and hopelessness, rapid social change, and the risks of violence and physical ill health. This indicates that mental illness is closely linked to poverty.

The rights of people with disabilities have been advocated for and the Employment Equity Act No.55 of 1998 suggests that people with disabilities should be considered for employment according to Hayden (1999) but there is still a gap with regard to people living with mental illnesses. However people suffering from mental illnesses are often viewed by the community as people who belong to the institutions since they are regarded as violent and unable to lead a normal life. According to the National Mental Health Development Unit in the United Kingdom (NMHDU), which provides national support for implementing mental health policy, people with severe mental health problems have a lower rate of employment than any other disabled group but they are more likely than any other group with disabilities to want to have a job.
In South Africa, people living with mental illness are provided with the social grant depending on the severity of their illness. For those who do not qualify for the social grant, they are left without income and thus they live in poverty as they are most likely to be unemployed. The above-mentioned risk factors are interrelated; for example as a result of living in poverty, people who are suffering from mental illness may resort to exchanging sex for goods thus placing themselves at the risk of HIV. For most of the mentally ill who have the privilege of becoming employed, they are most likely to be underpaid due to their cognitive inability. This however explains why poverty is more prevalent among people with mental illness. Poverty does not only expose people living with mental illness to HIV infection but it also hinders them from accessing the health care facilities, thus exposing them to further infection as well as the development of other related illnesses and resistance to ARV treatment due to inconsistency in taking medication as pointed out by Kelly (2011).

2.7.7 Gender and Social Inequality

People living with mental illnesses are generally not treated equally or fairly within the communities. According to Kelly (2011), women face dual obstacles - both the stigma of suffering from a mental illness and being female. As a result, they are vulnerable to sexual abuse and dangerous relationships. Women often face double discrimination both as a female and as a person with a mental illness. Kelly further contends that many women are desperate for loving relationships to such an extent that they expose themselves to unprotected sex. This however indicates that people living with mental illnesses are exploited by other people who feel they are superior to them and they do not have the ability to stand up for themselves. Women living with mental health conditions are even worse in this regard, because they have greater chances of being exploited. According to Mamabolo et al. (2012), psychiatric patients, mainly females reported being victims of sexual abuse. Women are already considered as weak within the community but for those women who are living with mental health conditions, it is even worse because they get exploited due to their gender as well as the mental health condition (Breen, 2006; 35).
Lundberg, Johansson, Okello, Allebeck, and Thorson (2012) suggest that serious mental illness exacerbates sexual vulnerability in women, by contributing to casual sex, exploitative and non-monogamous sexual relationships, as well as sexual assault by non-partners. In men, serious mental illness caused sexual inactivity due to decreased sexual desire and difficulties forming intimate relationships. This study by Lundberg et al. highlights how serious mental illness and gender inequality can contribute to the shaping of sexually risky behaviours and sexual health risks, among persons living with mental illness. It revealed that women are at risk of sexual exploitation due to their powerlessness within the society and their vulnerability because of the mental illness. Men living with mental illnesses are undermined within the society, thereby making it difficult for them to form intimate heterosexual relationships. Mental illness however affects the social and emotional life of its sufferers.

People living with mental illnesses are perceived as unable to take care of themselves and communicate anything sensible. Kelly (2011) states that families and caregivers of people who are suffering from mental illnesses often have to make decisions on behalf of these people, and often do not consult with them, even when they are able to take decisions or contribute towards the decision-making process. People who are living with mental illnesses are wrongly perceived and judged by the community and are not considered as normal. These misconceptions are therefore the main source and cause of the general inequalities between men, women and people with disabilities. This means that these misconceptions lead to inequalities that are social rather than natural.

A number of studies such as that by Lundberg et al. (2012) and Kelly (2011) have identified the challenges that people with mental health problems face in sustaining and preserving social contacts and social networks. People living with mental illnesses are usually sent to the psychiatric hospitals or care centres by their caregivers or they are usually locked in the houses to spare their caregivers embarrassment within
the community. This however makes it very difficult for people living with mental illness to be fully integrated in the community. They may also experience being bullied by other people within the community. It is therefore important to implement programmes within the community which will empower people living with mental illnesses as well as encourage them to participate within their communities as mentioned by Breen (2006).

In a study by Lundberg et al. (2012) about women in Uganda, economic dependence on intimate partners has been suggested to contribute to Ugandan women’s low negotiating power in decision-making about sex. Economic dependence places some women in situations where sex has to be traded for resources, and where women have little control over when to have sex, and whether to use a condom, thereby increasing these women’s HIV risk. This illustrates the challenges to sexual health and rights among people living with mental illnesses, especially women. Some of these challenges could potentially increase the women’s risk of HIV infection. Therefore, poor provision of mental health services may not only increase risky sexual behaviours, but also complicate HIV prevention among this group of people. A human rights approach is therefore needed for effective HIV prevention among people living with mental illnesses as with other marginalised groups at high risk of HIV infection.

2.7.8 Stigma and Discrimination

According to Heather (2005), stigma perpetuates a cycle of impoverishment and disability and is a barrier to full citizenship for people with mental illnesses as well as those who are closest to them. They may also hinder service delivery to the people who are suffering from mental illness, as they are believed to be violent and unable to understand concepts. Stolzman (1994) concurs that stigma and discrimination deter social integration, interfere with the performance of social roles, diminish the quality of life and prevent timely access to treatment, creating a vicious cycle of social disadvantage and disability for people who are living with mental illnesses. Embarrassment associated with accessing mental health services hinders people who
may be presenting with symptoms of mental illness from getting the help that they need, due to fear of being stigmatised.

According to the National Mental Health Development Unit (NMHDU) almost nine out of 10 people (87%) with mental health problems have been affected by stigma and discrimination and more than two-thirds of people with mental health problems (71%) say they have stopped doing things they wanted to do because of stigma and the fear of stigma and discrimination. This study indicates that stigma and discrimination affect people who are living with mental illnesses in all aspects of their lives and can destroy them. It also states that people with severe mental health problems have a lower rate of employment than any other disabled group. Schulze and Angermeyer (2003) add that people living with psychiatric stigma and its consequences often experience it as an aspect of suffering that is more overwhelming, life-limiting and long lasting than the illness itself. According to Kelly (2011), in South Africa, there is a wall of stigma, ignorance and misunderstanding, which prevents people with disabilities from protecting themselves against HIV infection and accessing the health services. Women living with mental illness are faced with the double stigma of being female and disabled and are highly vulnerable to sexual assault and dangerous relationships.

Weiss, Ramakrishna and Somma (2006; 282) suggest that stigma poses a barrier for public health efforts aimed at minimizing the onset of mental illnesses, as well as with prevention efforts directed at promoting early treatment. Furthermore, the community’s attitudes toward mental illness can also influence how policymakers allocate public resources to mental health services resulting in poor quality of medical care administered to people with mental illnesses. Kelly (2011) states that stigma results in many disabled women being looked down upon which undermines their self-esteem. According to Marais and Wilson (2002), the double stigma associated with HIV, AIDS and mental health problems has a negative impact on prevention and care efforts. It creates a context in which people are reluctant to come forward for testing, and has
strong psychological consequences for those who are HIV-positive; increasing social isolation and depression. The abovementioned studies indicate that stigma and discrimination towards the sexuality and sexual rights of people with disabilities still threaten universal access to HIV prevention, treatment and care programmes and services. Torrey (2011) concurs that stigma is the heaviest burden borne by mentally ill persons because it affects opportunities for housing, employment, socialization and relationships.

It has been established that viewing mentally ill persons as dangerous leads to stigmatization in some instances as they have been associated with violent behaviour. Torrey (2011) further contends that stigma against mentally ill persons is non-specific and based primarily on a lack of knowledge; for example, they are believed to have been punished by God for sins and they are also perceived as violent. People who have these co-existing problems face multiple types of stigma relating to their HIV status, mental illness and substance abuse, and may have difficulties accessing and adhering to HIV treatment and care. Therefore, people’s perceptions and fears about people living with mental illnesses need to be addressed to reduce stigma and discrimination among this group of people as well as improve their health conditions and social lives.

2.8 Mental Illness and HIV: Interventions, Prevention and Service Delivery

The needs of people living with mental illnesses have often been overlooked and they have not been fully considered in the HIV and AIDS awareness and prevention programmes. Some people believe that people suffering from mental illness are sexually inactive due to their mental disability. The epidemiological data on HIV and AIDS among people with serious mental illnesses indicates that this population is particularly at risk for HIV transmission and contraction, according to Batki and Selwyn (2008). This raises a great need to understand the sexual behaviours of this group of people to address their needs as well as to accommodate them in the HIV and AIDS awareness and prevention programmes.
Of further concern are the views of Murray and Lopez (2002) that 60% of African nations have no national mental health policy and many have no programmes or legislation protecting these groups in society. South Africa does have the necessary policy guidelines and the literature referred to above does allude to a link between HIV infection and mental disabilities. However, in 2010 the South African Federation of Mental Health Societies launched awareness campaigns on integrating mental health into primary health care in an attempt to reduce stigma and discrimination and to include mental health in physical health care. The Department of Health yet viewed it as costly as it would involve the training of health care professionals to work with both mental and physical health care problems. Such reasoning poses a barrier to the care of people with mental illnesses resulting in their exclusion from wellness programmes.

Intervention strategies can be effective if they can be viewed through a better understanding of how sexually risk behaviour presents itself amongst the various mental health conditions. It is however possible that since different types of mental illnesses have different symptoms, the vulnerability of people living with mental illness also vary according to the type of mental illness. Therefore generalizing all mental illnesses into one conclusion still leaves the needs of this group of people unaddressed, as they are still not fully understood. For this reason, there is an immense need to understand the mental illnesses themselves before even addressing the needs of people suffering from mental illnesses.

The HIV and AIDS needs of people living with mental illnesses are often neglected. Studies that have been conducted in this field are more focused on generalizing their findings to all persons that are living with mental illness rather than addressing different mental illnesses. Gottesman and Groome (1997) conducted their study with the focus on people who are suffering from schizophrenia and thus their findings are specifically for this group of people. People living with mental illnesses experience different problems so their situations need to be addressed considering the
type and severity of the mental illness. HIV and AIDS prevention and treatment programmes fail to address adequately mental health issues. On the other hand, mental health programmes often ignore HIV education and prevention. HIV and AIDS health care workers often lack training to identify or discuss the symptoms of deteriorating mental health with clients. Mental health care workers may neglect to see HIV status as a possible trigger for significant mental health conditions such as depression. Mental health care professionals have also been reported to be neglecting HIV and AIDS education among their patients. This therefore indicates that HIV prevention programmes are not yet effective among people living with mental illnesses.

2.9 Conclusion

Through understanding the environment and the sexual behaviours of people who are suffering from mental illnesses, it is possible to begin to understand some of the main factors such as poverty, drugs and alcohol as well as psychiatric medication that create their vulnerability to HIV infection. Meyer et al. (2008) state that people with mental illness are a vulnerable population, and HIV prevention and treatment programmes must be scaled up to address their needs. Inclusion of mental health into primary health care will ensure that people living with mental illnesses are well understood. They will be able to obtain the health care they need once their behaviours and their illnesses are understood. People living with mental illnesses lack the ability to advocate for their rights as well as basic needs. Community members view them as people who just deserve to be institutionalized, they do not see them as people who have rights and who deserve to be treated equally with dignity and respect. There is a need to understand people who are living with mental illness so that they can be included in the planning and implementation of HIV and AIDS prevention and educational programmes.
CHAPTER THREE

3. Research Design and Methodology

3.1 Introduction

The purpose of this chapter is to elaborate on the research design as well as the various data collection instruments and procedures utilized in this study. This research study adopted a qualitative research design, which was found to be the most suitable method of addressing the topic. De Vos, Strydom, Fouché and Delport (2005; 35) define research methodology as the total plan for conducting the whole research study. This implies that a research method encompasses all the sampling, data collection and data analysis methods used in a particular study. This chapter will describe the different methods used in this study to uncover all the tools utilised to elicit the best results for this study.

3.2 Research Design and Methodology

A research design according to Babbie (2010) is an outline for conducting a study which guides the researchers and helps them to obtain the intended results. In so doing, it increases the chances of obtaining information that could be associated with the real situation. There are two types of research designs, the quantitative and the qualitative research designs. According to Babbie, qualitative research is effective in studying subtle fine distinctions such as attitudes and behaviours since it allows for an in-depth understanding of data. The researcher chose the qualitative research method for this study since it enabled the researcher to obtain in-depth information on the behaviours of people living with mental illnesses. In the study, the researcher chose to utilize the qualitative research design because it is non-numerical and thus it allows the researcher to present the findings in a descriptive manner.
3.2.1 Qualitative Research Method

Qualitative research is defined by Creswell (2003) as a type of scientific method of enquiry, which seeks to explore and to understand phenomena. It answers questions by producing findings that were not determined in advance and are applicable beyond the immediate boundaries of the study. Yegidis and Weinbach (1998) postulate that qualitative research has an ability to provide complex written descriptions of how people experience a given research issue. It provides information about the “human” side of an issue. With reference to this study, it provides the opinions and views of the mental health professionals as well as the family members of people living with mental illnesses. Royse (2008) proposes that in qualitative studies, researchers seek to understand the life experiences of selected individuals especially those who may not be visible or well known to the society. Therefore, qualitative researchers may seek to describe the social worlds of such people according to Royse. With reference to this study, people have little or no knowledge about the challenges faced by people living with mental illness as concerns HIV and AIDS, because people assume that this group of people is not at risk of contracting HIV. A qualitative research method was therefore used in this study to enable the researcher to describe the sexually risky behaviours of this group of people so as to understand how vulnerable they are to HIV infection. A qualitative research design allowed the researcher to explore and describe the sexually risky behaviours of people living with mental health conditions. The descriptive nature of the qualitative research method will also make it easy for other stakeholders to make use of these research findings for future programmes and policies.

Qualitative research makes it easier for other people to understand the research findings of a study since they are descriptive and narrative in nature. Qualitative research according to Patton (2002) uses a naturalistic approach that seeks to understand phenomena in context-specific settings such as true world settings where the researcher does not attempt to influence the phenomenon of interest. This research design is exploratory in nature so it was deemed appropriate for this study. In the context of this study, this research method made it possible to obtain relevant
information regarding the sexual behaviours of people living with mental illnesses. Furthermore, the findings of this study are presented in a descriptive and narrative manner, giving the reader full insight into this field of study.

3.3 Sampling Methods

According to Bailey (1999), sampling methods can be classified into those that yield probability samples and those that yield non-probability samples. Non-probability sampling is described by Yegidis and Weinbach (1998) as a sampling method where some elements of the population have no chance of selection or where the probability of selection cannot be accurately determined. With this sampling method, the chances of selection from the research population are not equal, depending on the researcher. This study utilised a non-probability sampling method since it was targeting a certain population made up specifically of the people who have knowledge and experience of living or working with people who have mental illnesses. Neuman (2011) and Yegidis and Weinbach share the same opinion that non-probability sampling is a sampling method where some elements of the population have no chance of selection, or where the probability of selection cannot be accurately determined. This sampling method involves the selection of elements based on assumptions regarding the population of interest, which form the criteria for selection. With non-probability sampling, the chances of selection are not equal depending on the researcher. In this study, the researcher preferred the non-probability sampling method because of the sensitivity of the study topic as well as the limited number of people who have enough knowledge in the field of mental health.

3.3.1 Population

Polit and Hungler (1999) define a population as a totality of all subjects that conform to a set of specifications, comprising the entire group of persons that is of interest to the researcher and to whom the research results can be generalised. A population is also referred to as the universe according to Cargan (2007); he defines it
as a set or pool of elements from which a sample is to be selected. In this case the population comprised people who are working in mental health institutions and mental health organizations as well as the caregivers or guardians/parents of people who are living with mental illnesses. Generally, these are the people who have the responsibility of looking into the day-to-day life activities of the mentally ill. The population also included people who have worked with mentally disabled people and those who have direct interaction with them since they are experts in this field due to their work experience.

3.3.2 Sample

Royse (2008) states that trends or tendencies within a large population can be discovered from a small number of individuals; therefore, it is essential to do sampling when conducting a research study. A sample according to Lobiondo-Wood and Haber (1998) is a portion or subset of the research population selected to participate in a study, representing the research population. Cargan (2007) states that sampling is a process of choosing a part of the population that will be studied by the researcher as representative of the larger population. Although mental health services are limited, it would have been impossible to access the whole population hence the researcher selected a sample which was a manageable number of people from whom she could assess the findings representing the whole population of people living with mental illnesses.

In research, sampling refers to the use of a subset of a population to represent the whole population that is being studied. According to Rubin and Babbie (1997;75), a sample is a special subset of a population observed for purposes of making inferences about the nature of the population itself in order to ensure representation in terms of the character of the population under study. There are two categories of sampling, the non-probability and the probability sampling method. Denscombe (2010) states that in probability sampling each element of the population has an equal chance of being
included in the study while in non-probability sampling the elements do not have an equal chance of being included in the sample. Therefore, with probability sampling, all the elements have an equal chance to be selected and to make up the sample that will be studied. In this study, the researcher used the non-probability sampling method.

3.3.2.1 Purposive sampling

Purposive sampling is a non-probability sampling method in which cases are selected on the basis that they fulfil certain characteristics or in some instances to obtain maximum disparity. Babbie (2010) states that sometimes it is appropriate for the researcher to select the sample on the basis of his or her own knowledge of the population, its elements and the nature of the research aims. Therefore, he observes that in purposive sampling, the sample is selected from the population based on the researcher’s own judgement and the purpose of the study. The researcher chooses the sample based on whom they think would be appropriate for the study. According to Cargan (2007), this sampling method is used primarily when there are a limited number of people that have expertise in the area being researched. Babbie postulates that the participants are selected so that they can decisively inform an understanding of the research problem in a particular study where the researcher is purposefully seeking typical or divergent data.

This sampling method was appropriate for this study since the researcher wanted to focus only on people who have knowledge in the field of mental health and the population of mental health professionals is too small to warrant random sampling thus purposive sampling was utilised. The study aimed at gaining in-depth insight into the sexually risky behaviours of people living with mental illnesses so that this information could not be provided by just anyone, and the researcher had to focus only on people who have knowledge and expertise in this field. It was thus necessary to select the sample purposively so as to focus on people who are directly involved or affected by this topic. The sample was composed of elements that contained the most
characteristic, representative and typical attributes of the population that best served the purpose of this study.

Royse (2008) proposes that, in purposive sampling, participants need to have certain characteristics in common in order to be selected for an interview. In this study, participants had to be caregivers of people living with mental illnesses and mental health practitioners. This meant that the participants had to be experienced in working in the field of mental health or in caring for those living with mental illnesses. This attribute is essential for this study as it seeks to describe the sexually risky behaviours of people living with mental illnesses. The focus was not only on those who provide care to those living with mental illnesses but was also given to the professional in the field of mental health so as to understand these behaviours and their link to HIV from people who have knowledge and experience in working in this field.

The purposive sampling method believes that the participants are experts in the field that is being studied and thus focuses on the particular people who are known to possess information that is relevant to the study. Purposive sampling is defined by Denzin and Lincoln (2005) as a sampling method whereby the researcher selects the participants according to the needs of the study so that its focus is on those participants who are fully informed about the topic being studied. According to Bailey (1999), a purposive sampling method ensures reliability and competence of the participants since the participants are chosen based on their knowledge of the topic being studied. Purposive sampling methods target only those participants who have knowledge of the subject that is being studied. Thus, the researcher had to design her sample mainly focusing on the people who were able to provide her with information relating to mental health as well as HIV and AIDS. De Vos et al. (2005) agree with the fact that in purposive sampling, a researcher purposely seeks typical and divergent data through designing a sample that is composed of elements which contain the most characteristic or representative features of the study.
Purposive sampling seeks out certain individuals known to be available. The researcher thus chose to utilize practitioners from Cecelia Makiwane psychiatry department and others from Rehab in Southernwood to ensure that the people who were interviewed were relevant to this study. In the East London area, Cecelia Makiwane Hospital is the only public hospital that provides psychiatric services. The researcher therefore chose to interview the multi-disciplinary team of the psychiatric department to get the information relevant to this study. A total sample of 22 participants were selected and interviewed for this study which comprised five professionals from Cecelia Makiwane and another five from REHAB. The researcher also included two psychiatrists who were chosen based on their availability and willingness to participate in this study. This broadened the findings of this study as they also brought in their views from a different perspective. An additional sample of 10 people was drawn from the family members of mentally disabled people at the two institutions using a snowball sampling method which entails that one participant will refer the researcher to other people who possess the same qualities. Snowball sampling is defined by Denzin and Lincoln (2005) as a technique for gathering research subjects through the identification of an initial subject who is then used to provide the researcher with names of other potential subjects. In this case the practitioners referred the researcher to their known clients and the researcher relied on the staff at the two institutions to direct her to family members of patients who would be able to provide valuable information in relation to the topic. This additional sample allowed for different views on the perceived vulnerability as reflected in this study as well as the sexually risky behaviours of people living with mental illness. This sample comprised adults aged between 38 and 56 years. The majority were Xhosa speaking. A total number of 22 participants were interviewed for this study including two psychologists, four social workers, two senior mental health nurses, two psychiatrists and ten family members of the affected individuals.

Interviews were conducted with the participants and they did not entail a determination of people’s HIV status, since it has already been revealed in previous studies that HIV is prevalent among people living with mental illness. This study
therefore focused on the behaviours peculiar to mentally disabled people, which make them more vulnerable to HIV infection. Because this study focused on a specific field of mental health, the purposive sampling method was the most appropriate as it ensured that the researcher did not gather irrelevant information or waste time in interviewing people who were irrelevant and who had little or no knowledge about this core information of the study.

3.4 Data Collection

After identifying the participants, a researcher has to decide on the method that will be used to collect the data needed from that particular group. According to Creswell (2003), in data collection the researcher must not interfere with the flow of daily events and the study has to depend on the sensitivity of the participants. There are several methods that can be used. Tape recording in this case is the best method of data collection since it allows much fuller records than notes taken during the interview.

Data collection tools

3.4.1Semi-structured Interview Schedule

A semi-structured interview schedule is a data collection tool that uses open-ended questions to guide the researcher during the interview. According to De Vos, Strydom, Fouché and Delport (2011), the semi-structured interview schedule gives a detailed picture of a participant’s beliefs, perceptions, or accounts of a particular topic. It also allows flexibility since the researcher is able to follow up on interesting avenues that emerge during the interview and the participant is able to give a fuller picture on the topic being studied. Babbie (2010) states that in semi-structured interviews, the researcher remains under the guidance of the questionnaire but is also able to probe further on topics of interest in the study. The participants are also regarded as experts on the subject and therefore should be allowed maximum opportunity to tell their story because they may also introduce issues that the researcher would have not thought of.
De Vos et al. state that semi-structured interviews are especially suitable when the researcher is interested in complexity or process or when an issue is controversial or personal.

According to Rubin and Babbie (2011), researchers use standardised open-ended interviews to ensure that all interviews are conducted in a consistent, thorough manner, with a minimum of interviewer effects and biases. A semi-structured interview schedule was used as tool for data gathering. This type of data gathering ensured that the researcher accessed a significant amount of information from the participants and it also allowed for observation of non-verbal communication by the researcher. The responses were recorded for data analysis using a tape recorder that ensured that all the information was captured for data analysis. This type of data capturing allowed the interviewer to obtain comprehensive information and the participants felt more comfortable as it was done face to face. The interview schedule utilised two sets of questions, one for the people working in the mental health field and the other for the caregivers of the clients living with mental illnesses.

3.5 Data Analysis

To analyse the data, the researcher utilised a qualitative data analysis method which made it easier for the behaviours of people living with mental illnesses to be understood and interpreted well. According to Babbie (2010: 43), qualitative data analysis is the non-numerical examination and interpretation of observations for the purpose of discovering the underlying meanings and patterns of relationships. Qualitative data collection was the most suitable method to use in this study since the researcher intended to describe the sexually risky behaviours of people who are suffering from mental health conditions. De Vos et al. (2011) concur that analysing data implies that there is some kind of transformation in that particular data. In qualitative research, the researcher collects and processes data through analytic procedures that make it clear, insightful, trustworthy and understandable. According to De Vos et al,
qualitative data analysis is believed to be a process of inductive reasoning, thinking and theorising which is far removed from structured mechanical and technical procedures to draw inferences from the empirical data of social life.

Royse (2008) describes qualitative data analysis as a data analysis method that entails coding data into constructs and looking for themes or patterns that can describe the phenomenon. The data were therefore coded using open coding to ensure that the findings of the study were appropriately analysed since the study looked into different types and categories of mental illnesses. Babbie (2010) states that coding is an interpretive technique that both organizes the data and provides a means to introduce the interpretations of the information into certain quantitative formats. Coding is also defined by Neuman (2011) as an interpretive technique that both organizes the data and provides a means to introduce the interpretations of the data into certain quantitative methods.

Coding requires the analyst to read the data and demarcate segments within it. Each segment is then labelled with a code, usually a word or short phrase that suggests how the associated data segments inform the research objectives. Managing data is the first step in data analysis; it is thus referred to as the intensive data analysis phase. This phase includes reducing data, generating categories and coding the data. According to Babbie (2010), coding is taking a segment of the text and labelling it according to a meaningful category as determined by the researcher. The researcher used coding to classify the data according to the elements of the study. Edge coding was used, where the researcher coded the responses on the margin line of the writing pad to make the data analysis process easier.
3.6 Ethical Considerations

3.6.1 Informed consent

According to Fortune, Reid and Miller (2013), in any research, researchers are required to ensure that participants consent to becoming involved in the research or consent to their personal data being utilised. The researcher observed this ethic by requesting permission to conduct interviews from the head of the institutions that were involved. The participants were asked to sign a consent form to indicate their willingness to participate in the study. Fortune et al. propose that social workers need to be attentive to informed consent issues, particularly because many research participants are vulnerable and are victims of various forms of oppression, abuse and neglect.

3.6.2 Confidentiality and anonymity

According to Fortune et al. (2013), social workers have a long-standing commitment to client confidentiality and privacy. By consenting to participate in a research study, the participant would entrust the researcher with private information. Thus, the researcher has the obligation to disguise or hide the identities of participants in all documents resulting from the research study. The researcher must ensure that the participant understands his/her confidentiality rights and the researcher must inform the participants about who will have the right to access the information gathered from them. In this study, the researcher explained to the participants the purpose of the study and assured them that they would always remain anonymous and that the information gathered from them would be used only for the purposes of this research study. The participants were also given the opportunity to opt out if they felt uncomfortable in progressing with the interview. Walker and Myrick (2006) state that anonymity and informed consent have to be negotiated with the participants when conducting a qualitative research study. This is to ensure that the researcher does not cause any harm to the participants.
3.6.3 Avoiding Harm

The researcher also emphasized that she would not require any information on the HIV status of the clients as this is sensitive information that would not be necessary in this study as there is already enough literature that states that HIV and AIDS are more prevalent among people living with mental illness as compared with the general community.

3.7 Trustworthiness

Trustworthiness refers to the honesty of the data collected from or about the participants. According to Marshall and Rossman (2011), concerns with the trustworthiness or goodness of qualitative research drew upon the natural and experimental sciences. Qualitative research therefore borrowed from more quantitative approaches the criteria against which the soundness of a study has to be judged. Trustworthiness implies that the researcher has to clarify how the study design will likely ensure that the data and their interpretations will be strong and credible or valid. Macnee and McCabe (2008) define credibility as the confidence in the truth of the findings of a study. Validity, according to Babbie (2010), determines whether the research truly measures that which it was intended to measure or how truthful the research results are. Therefore, the researcher has to check constantly whether the findings are in accordance with the objectives of the study. With reference to the sexually risky behaviours of people living with mental illnesses, this study managed to explore and to describe the risky behaviours as well as the factors that place this group of people at risk of HIV infection. As revealed by this study, the vulnerability as well as risky behaviours of people living with mental illnesses can be reduced if the factors that are placing them at risk can be addressed. This process of checking the validity of the study is essential since it measures the quality of the study. Qualitative research is however believed to be achieving higher validity because, the data are closer to the research field and it takes into consideration the views and opinions of the research subjects.
3.8 Summary

In conducting a research project, the researcher may face challenges that may hinder the progress of the study or interfere with the findings. However, potential limitations that the researcher was anticipating were addressed through ensuring the validity and reliability of the findings of this study. The researcher thus believes that the research tools that were used in this study yielded effective results. The success of the study depends on the methods used by the researcher for data collection. The researcher is however confident that the research tools were relevant to this study and that the information that was gathered could be of great value in the field of mental health.
CHAPTER FOUR

4. Data Analysis and Presentation

4.1 Introduction

This chapter discusses the findings of the study and its results which are presented in relation to the two groups of participants. The first group consisted of caregivers and family members of people living with mental illness and the second group was made up of professionals who work in the field of mental health. These participants were chosen by a purposive sampling method; their expertise in this field ensured that the findings of this study respond to the research question. Quotations have been used in this chapter to illustrate themes that emerged during the interviews since the interviews were face-to-face.

The interviews covered the following broad categories: patients’ vulnerability to HIV infection, the impact of mental illness on sexuality and sexual risk behaviours of people living with mental illnesses. It also covered the family’s response to the sexuality of an individual with mental illness, the link between HIV/AIDS and mental illness, and special considerations for developing HIV prevention programmes for people living with mental illnesses in South Africa. These results were then analysed using qualitative data analysis, which entails that the researcher has to put the responses into different categories to allow the coding process. The researcher collected related information and thus the data are presented in this chapter according to those themes.

The questions that were presented to the participants were not limited to specific types of mental illnesses. They incorporated different types of mental illnesses including intellectual disability since it is classified under mental disorders in the DSM-5. This was to ensure that the researcher would obtain different views on the risk behaviours of this group of people, as well as identify which type of mental illness elicits high-risk sexual behaviour.

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4.2 Findings from Professionals within the Field of Mental Health

4.2.1 Is there a link between mental illness and HIV/AIDS?

The chart below illustrates that the majority of the participants believe that there is indeed a link between mental illness and HIV/AIDS.

![Figure 4.1 Relationship between Mental Illness and HIV](image)

The participants including psychiatrists, social workers and psychologists believed that HIV/AIDS and mental illness are closely linked. This corresponds to
findings by Himelhoch et al. (2007) who noted that mental illness is closely linked to HIV as a cause of HIV and as an effect of HIV infection. One participant spoke boldly saying:

*There is no doubt that HIV and mental illness are closely linked, because most of our clients either disclosed that they are HIV positive or they present with symptoms related to HIV.*

Even so, three of these twelve participants were more concerned about the effects of HIV and AIDS as a cause of mental health problems. The remaining nine participants saw causality in this relationship between mental illness and HIV/AIDS. They reported that many people who have been diagnosed with HIV often suffer from mental illnesses such as depression and anxiety due to the shock and stress of having to live with a life-threatening disease. On the other hand, there is HIV and AIDS prevalence among the mental health care users that is mainly due to the fact that this group of people is vulnerable to sexual abuse as well as to unprotected sexual intercourse. One of the participants went on to say;

*Our clients are usually caught having sexual intercourse in awkward places I think they utilise every opportunity they get to have sex because most of them are treated like children by their caregivers and never get the opportunity to get into intimate relationships. However, this kind of sexual intercourse usually is unprotected because it is not planned therefore it is easy for them to be infected with HIV.*

All the participants were in agreement that mental illness plays a major role in the acquisition of HIV among this group of people. According to these participants, people who have intellectual disabilities learn and copy most of their behaviour from other people. One of the senior nurses expressed the view that people with intellectual disability mimic normal people.

*This leads other people into assuming that people with intellectual disabilities understand and know what they are doing, when in actual fact they do not understand the consequences of their actions. This is a cause for concern especially where intimacy and relationships are*
concerned as they end up being sexually manipulated or abused and thus being prone to HIV infection’, she said.

Generally, people who have mental disabilities are understood to be unable to comprehend and to anticipate the consequences of their sexual behaviours. It was revealed during the interviews that people who are suffering from mental illnesses are vulnerable to HIV infection because they are easily manipulated to do things that can place them at risk. This agrees with findings by Yousafzi and Edwards (2004) who noted that people suffering from mental disorders often have increased vulnerability to outside influences and have impaired judgement. According to these participants, the mental health services in East London are still separate from the primary health care services. As a result, the participants did not manage to provide enough information on the role of the ARVs as the primary cause for some mental illnesses as they do not work directly with HIV and AIDS patients. Even so, they acknowledged the link between HIV/AIDS and mental illness and highlighted some effects of HIV and ARVs on the nervous system of the infected individual. Efavirenz (ARVs) was reported by these professionals to be one of the three drugs used as part of a standard first-line regimen in South Africa. Its side effects were reported to be bad dreams, mood and personality changes or confusion, which can sometimes be treated with an antipsychotic drug called chlorpromazine. However, it was reported that if the bad dreams persist, they might lead to insomnia (sleep disorder that falls under mental disorders).

Stavudine was also reported to aggravate side effects that sometimes affect the mental health of the infected person. Its side effects are usually associated with peripheral neuropathy (pain in the hands and feet). These side effects however are said to differ from person to person; some people never experience side effects while some do. HIV and AIDS are also believed to have a direct negative impact on the nervous system of the infected person. Acuff et al. (1999) add that HIV and AIDS may cause mental disorders during the late stages. Their findings are consistent with what was revealed in this study that HIV and its treatment are the cause of some mental illnesses.
One of the participants explained saying;

*People living with mental illnesses are in most instances dependant on their caregivers, thus it is not easy for them to cope with HIV infection. Therefore, it becomes more burden to their caregivers whenever they get diagnosed with HIV. Usually they will not have suspected that these patients may be infected with HIV. Hence, they may be diagnosed late with HIV and may struggle to cope with all medications, as their caregivers are usually old and illiterate.*

Findings of this study also revealed that people living with mental illnesses struggle to cope with HIV and AIDS because they are often dependent on their guardians. It was reported that, in most cases, these people live in poor conditions and are cared for by elderly people who have little knowledge of HIV. It is therefore difficult for this group of people to adhere to the HIV treatment as well as their psychiatric treatment. This is consistent with the findings by Sfetcu et al. (2011) who proposed that mental health problems are often associated with poverty, compromised education, vulnerability and difficulty accessing health care and employment services.

One of the participants explained saying,

*Due to poverty, most of the people living with mental illness tend to relapse because their medication runs out as they do not always have the money to fetch the medication from the clinic. For some, their support system is poor hence it is easy for them to relapse as there may be no one who takes the responsibility to care them. If a mental health service user relapses, it may possibly become difficult for him/her to take the ARVs because he/she might become homeless or be unstable to such an extent that he/she would miss the times for taking the ARVs. One way or the other, mental illness and HIV/AIDS are interlinked and are the cause and effect of each other.*
4.2.2 Do Your Patients Get Tested for HIV?

The table below indicates the statistics as to whether mental health patients are tested for HIV or not. Table 4.1 HIV testing statistics

<table>
<thead>
<tr>
<th>Patients not tested for HIV</th>
<th>Patients tested for HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>2</td>
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</table>

As shown in the table above, only two of the participants reported that their patients are tested for HIV. At one of these institutions, it was reported that patients are only tested when HIV and AIDS related symptoms are noticeable.

One of the participants said;

_We do not get our patients to be tested for HIV we just treat them for their mental health conditions and advise them to get tested if they open up to us about their love life. We also do not make it compulsory for them to disclose their status, only those who are willing to disclose can hence we cannot say we have accurate knowledge on their HIV statuses._

These participants also reported that most of their mental health service users who are living with HIV and AIDS are often referrals from the ARVs clinic. This means that there is a probability that their psychological problems developed following HIV infection. The participants stressed that mental illnesses in these people result from the side effects of the ARVs as well as from the stress of living with HIV/AIDS. They also reported that they are not aware of the HIV statuses of their clients since they do not always send them for HIV testing. It was further reported that the clients are tested for HIV in cases where they have reportedly been sexually abused or in cases where the patient presents with symptoms of HIV and AIDS. However, the rate of HIV and AIDS among patients at one of the institutions was reportedly very low but this might be due to lack of regular HIV testing.
It was further reported that most of the clients are unable to consent to voluntary HIV testing and counselling. Even though these professionals are well aware of their clients’ needs, they stated that it is illegal for them to conduct the HIV tests without the consent of the concerned patient. One of the social workers reported that their focus is on mental health hence they can only record the HIV status of a person who is willing to disclose his/her HIV status. This study indicates that the incidence of HIV and AIDS among this group of people is not properly documented since most of the patients are never tested and the status of some of them is never recorded by the relevant organisations. Conversely, this study highlighted that there is a prevalence of mental illnesses among people who are living with HIV and AIDS since the participants reported that they had a number of patient who were referred from the ARVs clinic for mental health services.

One participant reported that the mental health services are still lagging behind in East London; he reported that in other areas of South Africa, they have already taken into practice the integration of mental health services into primary care. He said:

*I am sure you are aware that there is a new system in the health department where the government is integrating mental health into primary health care. This means that they want to phase out the issue of treating mental health patients separately. It means that our patients will have to queue with people who are suffering from physical illnesses like headaches. Mental health service users need someone with patience who will listen to them as we do and support them. Is this going to be possible when this integration takes place? I doubt but we have to wait and see.*

During this interview, it came out that other people are against this policy since they are afraid that it might worsen the situation in the clinics. He explained that integration of mental health services into primary health care would ensure that the physical as well as psychological needs of the people are well addressed. He reported
that the current system only allows the patients to visit the psychiatry department separately for their treatment. However, it is time consuming and costly for the patients to go and join another queue to receive medication for other health conditions, for example the ARVs.

*Due to such long and repetitive procedures people living with mental illnesses and HIV/AIDS end up giving up because it is strenuous for them. Consequently, they relapse on their medications*, said one of the participants.

The participants reported that it was necessary to have their patients tested for HIV, especially considering that they are a vulnerable group and that HIV and AIDS are more prevalent among them. It came out that these professionals sometimes refer their clients for voluntary counselling and testing but not all clients honour these referrals because of the fear of discrimination and being judged.

4.2.3 Do you have HIV and AIDS prevention programmes for your clients? Are the clients aware of these programmes?

**Figure 4.2 HIV/AIDS Prevention programmes**

![HIV prevention and No HIV programme chart](chart.png)
Figure 4.2 above indicates the fraction of the participants who provide HIV prevention programmes to people who are living with mental illness.

Ten of the twelve participants reported that they provide HIV and AIDS prevention programmes to their service users. The remaining two participants from one institution reported that they also provide sexual education to their clients as a preventative measure. It was stated that people who have intellectual disability do not understand the physical development of their bodies and they do not know how to handle their sexual feelings. One participant went on to say,

*Even where menstruation is concerned they get totally lost, depending obviously on the IQ level of that individual for some it is a frustrating experience which they struggle to cope with.*

In this institution, they reported that their sexual education is always in line with HIV and AIDS education where they provide their patients with information on prevention as well as general information about HIV and AIDS. One of the participants explained saying,

*In most cases, patients do not always have an understanding of the information that is presented to them. This is a challenge that we face mostly among people with intellectual disabilities than those who are suffering from specific mental illnesses.*

This study revealed that, it was a difficult task to educate people living with intellectual disability as compared to those with general mental illnesses. This supports the findings by Kelly (2011) who contends that educators believe that people with intellectual disability are in-educable, thus the vast majority of them are not enrolled in any form of formal education and that even those who are in school are often deliberately excluded from sex and HIV education programmes.

The participants reported that the IQ level of some people who have intellectual disability is too low and therefore affects their ability to grasp and comprehend
information as well as to understand concepts. It was also reported that even though HIV and AIDS prevention programmes are available within institutions, it is difficult to address all the patients using one method because some have a very low IQ and they can hardly grasp anything. On the other hand, there are those who are highly functioning, who understand when taught or addressed about something. HIV and AIDS information and sex education are therefore provided for those patients who are said to be high functioning and who have the ability to understand concepts.

One of the participants said;

People out there do not understand the challenges that are facing us. Parents of most of our clients have given up on them and they just want institutions where they can dump their children as they become a hindrance in their lives due to their level of dependence on their caregivers.

People with intellectual disability range from those who are low functioning, moderate to high functioning. Those with low IQ, you cannot have an educational session with them at all they just have to be trained basic skills on self-care because they do not have the ability to grasp.

Therefore, those who have very low IQ (the low functioning) are left out since they do not benefit from these programmes. This therefore indicates a gap between mental health and HIV/AIDS because HIV and AIDS remain unaddressed among people living with mental illnesses.

At the other institution, it was reported that their clients benefit from one-on-one sessions that they have with the practitioners where they discuss everything that is of concern to that particular client including HIV and AIDS education. The participants reported that their patients understand them and they feel more comfortable around them.

We always take our time when we are dealing with our patients hence it is our duty to inform each and every patient about HIV and AIDS
prevention. This is to ensure that they are aware of such programmes out there, otherwise they may miss out on important and relevant material, explained one of the participants.

This however means that for those people who are not on medication, who do not consult with the practitioners, there is no specific HIV and AIDS programme. Considering their low level of functioning, it is impossible to assume that they benefit from the general programmes that are in place or from the media. These findings confirm what was found by Batki and Selwyn (2008) who raised the point that the epidemiological data on HIV and AIDS among people with serious mental illnesses show that this population is particularly at risk for HIV transmission and contraction and that the members lack the necessary information.

4.2.4 In what ways are people living with mental illness vulnerable to HIV and AIDS?

The participants acknowledged that HIV and AIDS are prevalent among people living with mental illnesses because they are a vulnerable group. This agreed with Yousafzi and Edwards (2004) who reported that people with mental disabilities are vulnerable to HIV and AIDS because they are marginalised, discriminated against, illiterate and relatively poor. The participants mentioned that these people are usually the easy targets for people in the community. They reported that people living with mental illness are often taken advantage of, for example; they can be convinced to exchange sex for a small token. Mental health professionals reported that people living with mental illnesses are vulnerable to HIV infection since they frequently experience sexual abuse as they are assumed to be hypersexual.

When looking at the incidence of sexual violence among persons with mental disability, it has to be taken into consideration that some of the cases never get to the attention of the caregiver. The caregiver in most cases gets to know some cases especially those cases that result in pregnancy or physical harm,
explained one of the participants.

People living with mental illness are reportedly at risk of sexual abuse because they are unable to make crucial decisions independently as presented by Kelly (2011). It was also shown during the interviews that most of the caregivers of people living with mental illnesses tend to lock them in the houses to protect them from strangers, since they are unable to make decisions independently. In addition, their parents are ashamed to walk with them due to the disability. Hence, this exposes them to sexual abuse as it will be easy for criminals to gain access while everyone else is not available at home. One of the participants explained saying:

In the African culture people trust their fellow community members hence people living in informal settlements have a tendency of leaving their children with the neighbours while they go to town or to work. However, you cannot guarantee the safety of your child while in someone else’s care.

This was also reported to be placing children with intellectual disabilities at risk because they might be sexually abused while in the care of their neighbours. People living with mental illnesses are viewed as the “silent” victims because they do not have the ability to defend themselves in courts of law whenever they become victims of rape and other forms of abuse. These findings also show that due to their mental condition and cognitive inabilities, people with mental illnesses lack the courage and ability to report such abuse to their caregivers. These findings are consistent with the literature as reported by Eastgate (2011) who states that sexual abuse is extremely common in people with intellectual disability and that the reasons for this vulnerability to abuse include poor understanding of what is appropriate, difficulty in negotiating equal relationships, and difficulty reporting abuse.

The participants also reported that people living with mental illnesses can be easily recruited into drugs.

Most of our clients relapse from their medication due to the intake of drugs. We are having a challenge of drug use among our patients and we are always educating them about this but most of the male patients are drug users.
This is believed to place them at risk since they might share needles and any other sharp objects capable of transmitting HIV. People living with mental illnesses are reported to be known for relapsing on their medication once they engage in drug and alcohol abuse; hence, their vulnerability becomes more apparent. In South Africa people who are living with mental illnesses receive social grants but some of the participants reported that this money does not always benefit those who have mental disabilities. They acknowledged that the money is misused by friends and relatives who abuse alcohol and drugs. They further stated that people living with mental illnesses also are recruited into these practices thereby exposing them to drugs and to sexual abuse during episodes of drunkenness. These findings are in line with those of Checkley et al. (1996) who state that the sexually risky behaviours of people suffering from mental illnesses may be impacted by vulnerability to coercion by others and a desperate need for money since they are usually living in poverty. This indicates that this group of people could be easily manipulated due to their cognitive deficits.

This study revealed that mental illnesses play a big role in exposing the sufferers to HIV infection because the patients cannot perceive the risks of their actions. People who are living with mental illnesses are viewed as a vulnerable group to HIV. It was reported that due to poverty it is very easy to lure these people into risky behaviour. Poverty was also reported to be playing a great part in placing people living with mental illnesses at risk for HIV infection.

Most patients live under conditions of inadequate basic commodities therefore people who can provide for these needs may easily turn into abusers. This means that they can use this as leverage for them to get what they want from these poor mental health service users, explained one of the participants.

It was revealed in this study that some of the patients end up not having the money to obtain their treatment from the nearest hospitals and they tend to relapse due to lack of medication. Furthermore, during these episodes, they usually engage in risky sexual behaviours and they may also become involved in drugs as well as practise
unsafe sex. These findings are in accord with those of Stoff et al. (2004) who suggest that the interaction between mental health and substance abuse problems escalate both the level of risk and the severity of HIV infection and re-infection. It was also shown in this study that most of the patients who adhere to their treatment are less vulnerable because they are controllable as they are often stable and living in a healthy environment, with people who can support them.

4.2.5 How do HIV and AIDS affect the lives of people living with mental illness?

It was revealed that people living with mental illness are also affected by HIV and AIDS like any other population groups and are at high risk of HIV infection due to their inability to consent for safe sex. They are also victims of sexual abuse and they are at high risk of HIV infection. The participants expressed their concern about how people living with mental illness can cope with HIV. They reported that often people living with mental illnesses relapse from their psychiatric medication and therefore they will also fail to adhere to the HIV treatment. One of the participants responded saying:

*We are faced with a problem of our patients who are in-and-out of the hospital because they fail to take their medication or are reluctant because the medication produces side effects which they cannot stand. How then are these people going to cope with ARVs treatment if they are already failing to cope with their usual psychiatric treatment?*

The participants reported that HIV is a burden on people living with mental illnesses and that they are concerned about them because it seems there is no easy way to prevent the spread of HIV among this group of people. The mental health professionals indicated further that people living with mental illness are faced with many risk factors within the community which make it difficult to protect them against HIV infection. They reported that those who are dependent on their caregivers, are often treated like children and they are not viewed as being at risk of HIV infection. As a result
they may become infected with HIV and never receive the necessary treatment as they are not expected to be victims of HIV infection. They reported that HIV infection among people living with mental illness may be a cause of death since they are not usually tested for HIV. Even so, if they are diagnosed with HIV, they may be unable to adhere to their treatment thereby causing the virus to be resistant. The participants reported that they have also failed on their part to have their patients tested for HIV because they were scared since one had to consent and so they only sent those patients who were presenting with symptoms of HIV infection to be tested. Also with the fear of being judgemental and fear of traumatising them by sending them for HIV tests the mental health care workers reported that they had been reluctant to send their patients for HIV tests.

One of the participants said:

*HIV is affecting everyone who is infected or affected by it. People develop depression and other stress related illnesses. I believe that it is worse for those who are already living with mental illnesses as it can overwhelm them thereby causing them to become hopeless as they will be having a double burden and double stigma within the community.*

The social workers reported that it would benefit people living with mental illness to receive HIV education but in most cases there is understaffing especially in the field of mental health, thus people living with mental illnesses never receive relevant information. It was also revealed that people living with mental illnesses have a double stigma once they are diagnosed as HIV positive. This is due to the fact that HIV is still associated with promiscuous sexual behaviour and thus people tend to view people living with mental illness as hypersexual. They reported that there is a need to formulate support groups for people living with mental illnesses where they can be given life skills and educational information about drugs, HIV and many other factors that concern them.
4.2.6 What are the sexual risk behaviours of people living with mental illnesses?

When the participants were asked this question, they reported that most of the people who are living with mental illnesses lack the ability to anticipate the consequences of their actions. Therefore, most of their behaviours are not intended to elicit sexual attention but rather to obtain love and acceptance. It was revealed that, especially among the intellectually disabled, the need for affection and hugging is usually misinterpreted by other people as they tend to assume that they need sex whereas they just need to hug and get affection from people because they are always side-lined within the community. The participants conveyed that some of these people are very asexual but due to rejection by their family members, they crave for affection which explains why their actions are usually misjudged.

*I wish people could just view these people as individuals not as “the intellectually disabled”, they are unique in their own way but people fail to understand them Here at the centre we try to give them love and attention and appreciate their efforts in everything they contribute to. This helps them to gain self-worthiness,*

said one of the participants.

It was further reported that people living with mental illnesses lack the ability to make informed decisions and they are easily manipulated while they lack the ability to negotiate for safe sex due to their naivety and submissiveness. They were also described as reckless in the sense that they can engage in sexual intercourse with different partners especially among women. It was reported that people who are living with mental illness are a vulnerable group to HIV due to the onset of the mental illness which robs them of their mental capacity thereby making them incapable of living independently and defending themselves against opportunists. This however is not always the case for people living with mental illnesses as it differs with the severity of the mental illness. The participants reported that some people living with mental illnesses do lead a normal life once they have the necessary life skills.
One participant related that:

For people who are suffering from mental illnesses, sex has been prohibited among them and they have been excluded from sexual education even within their families. This however makes them curious hence they would like to explore as a result they appear as if they are more sexually active.

Furthermore, it was uncovered that people who have intellectual disabilities might have experienced sexual abuse during childhood and that this may expose them to further sexual assault. It was also reported that even among other children who are not suffering from intellectual disability, victims of sexual abuse tend to become hypersexual or they are raped over and over. The findings of this study also revealed that people who are living with mental illnesses never receive sex education hence they do not know how to deal with their sexual desires. As a result, they tend to act in inappropriate ways to the extent of even having intercourse in public places.

People living with mental illnesses are usually caught having intercourse in awkward places where under normal circumstances one cannot consider them appropriate or conducive. This is also because they did not get the moral education and also they cannot make informed decisions, said one of the participants.

At one of the institutions studied, participants stated that they provide a room for couples to spend their time in so that they can teach them the right way to express their feelings so as to avoid inappropriate sexual behaviours.

People who are living with mental illnesses are reported to have a problem of easily gaining trust for other people as well as enjoying physical contact with them. Discrimination and stigma are reported to be the main causes of their craving for love and acceptance by others which explains why they like to hug. Ultimately, this is believed to place them at risk of being sexually abused because their need for physical
contact can be mistaken for sexual desire. People living with mental illnesses are also reported to have short-term relationships and are believed to be engaging in sexual activities with different partners. One of the participants explained as follows:

_The caregivers of women who are living with mental illnesses have a tendency of getting them sterilised or put them on contraception because this group of people often fall pregnant due to engaging in unprotected sex with multiple partners. This measure however only prevents pregnancy but it does not protect one from HIV infection._

This inability to consent to safe sexual intercourse is a huge sexual risk which can expose these people to HIV infection. This finding is in agreement with other studies such as that by Goldfinger et al. (2001), who revealed in their study that people living with mental illnesses have low self-esteem and do not have the ability to make informed decisions and thus they are unable to initiate safe sexual intercourse.

Commonly, men living with mental illnesses are assumed to have several girlfriends who are primarily attracted to their social grant money. They are believed to feel good about having multiple partners as it gives them a sense of dignity and acceptance within the community. The participants stated that people in the community have a tendency to make a joke of these people. For example, they call them girlfriend/boyfriend but some people who are living with mental illness cannot tell that it is a joke and they take it seriously and end up being manipulated and engaging in sexual activities with those particular individuals. Generally, it was reported that people living with mental illnesses tend to engage in sexual activities with multiple partners with whom they may not be in an intimate relationship.

According to the participants, people who are living with mental illness are generally ignorant; they do not know how to protect themselves against HIV and AIDS. They also do not have enough information on HIV and AIDS as well as the prevention
programmes. They are also reported to be suffering from low self-esteem which makes them feel inferior to other people; this ultimately makes them submissive in all situations. They also do not want to disappoint other people because of the fear of rejection, so they tend to please other people at their expense.

One of the participants said:

*People living with mental illnesses may become victims of abuse within the communities. People use them to go and buy drugs, to steal and to do many other dirty work. They are however in most cases willing to do the things they are asked to do because of emotional blackmail as well as a way of keeping the friendship.*

One of the participants reported that people who are living with mental illnesses often engage in alcohol and drug abuse. One of the participant explained this, saying:

*Regardless of the counselling and education they offer to this group about drug and alcohol abuse, they still continue to engage in these practices. These drugs and alcohol impedes the psychiatric treatment thereby causing them to relapse and that is when they get exposed to a lot of risky behaviours since they cannot think straight.*

Some men are reported to be sexually inactive while on medication and they tend to avoid their treatment as it takes away their manhood. By so doing, they become sexually active and mentally unstable thereby engaging in inappropriate sexual behaviours such as showing off their private parts as well as engaging in unprotected sexual intercourse.

It was reported that there are many instances where women who are living with mental illnesses have been reported to have been sexually abused during homelessness. The participants reported that it is very risky for someone to relapse as this can expose him/her to unpleasant circumstances such as staying under the bridges as well as sleeping at the street corners. Some people therefore take advantage of
them during this time as they are vulnerable and mentally unstable. This participant went on to say,

\[\text{It is therefore better for them to get institutionalised but unfortunately we do not have enough resources and even if we had enough resources our patients get exposed to drugs once they get back into their communities as they struggle to cope independently hence they relapse within a short period of time.}\]

4.2.7 Does medication play a role in the sexual behaviours of people living with mental illness?

The mental health practitioners reported that most of their male clients are sexually inactive due to the psychiatric medication. It was found that most of the male patients reported that they are greatly stressed at being asexual. Women are the ones who are reported to be more sexually active compared to the male patients. This is more common among women who are suffering from bipolar disorder. Poor adherence to their psychiatric medication is reported to increase their sexual desires and people who have untreated mental illnesses often engage in risky sexual behaviours. This indicates that HIV and AIDS prevalence can be reduced by treating the psychological problems of people who are living with mental illnesses. This study revealed that people who are living with mental illnesses become stabilised by their medication and they tend to lead a normal life when they are on treatment. This group of people tend to abuse drugs and alcohol whenever they relapse. This abuse of drugs also increases their vulnerability to HIV since it can lead them into engaging in sexually risky behaviours whilst they are under the influence of drugs or alcohol.

Even though the psychiatric medication is believed to decrease the sexual desires of some patients, it also helps to reduce the sexually risky behaviours among them. It also makes them stable and enables them to realise the consequences of their actions. The intellectually disabled are usually not on treatment unless if they are being treated for depression as a co-illness. People with intellectual disabilities are generally
believed to be unable to live independently. Due to their over-dependence on other people they end up being prone to abuse, thereby increasing their vulnerability to HIV and AIDS.

4.2.8 What are the community’s assumptions regarding the sexual behaviours of people living with mental illness?

One of the participants noted:

_The community assumes that people who are mentally disabled are hyper sexual, however this is not always the case. They just need to take out their sexual feelings but they do not know the appropriate ways of doing it thus they need sex education._

He further stated that this group of people is known for engaging in homosexuality, because they do not know how to deal with their sexual needs and they are often institutionalised. The interviewees reported that in institutions people living with mental illnesses are never given an opportunity to engage in heterosexual relationships therefore since they share dormitories with other men, they are left with no other option but to turn to homosexuality.

It was found during the interviews that people living with mental illnesses are usually perceived as violent so that people do not want to be associated with them. Under such misconceptions they are stigmatised and discriminated against. The participants reported that people who are living with mental illness are sometimes violent if they are not on treatment, and it is important for the caregivers to ensure that their affected family member is adhering to treatment. This will stabilise the patient, thereby reducing violent behaviour as well as other risky behaviours eventually making him/her more acceptable to the community. It also came out that some people who have an intellectual disability are said to be rarely violent unless they are provoked just like any other person.
This study revealed that some people think that people living with mental health conditions have a small brain. In the Xhosa community they call the intellectually disabled ‘uzincinci’ meaning their brain is small; those who suffer from mental illnesses are called ‘amageza’ meaning crazy.

*This kind of name calling on its own is degrading for the affected person. This shows that the community does not view these people as complete human beings thus they do not have respect for them and they feel superior to them*, said one of the participants.

People who have an intellectual disability are believed to be and are called children within their communities since their brain is believed to be small and thus they liken it to that of a child. People with an intellectual disability have been reported to have a low IQ score. The participants reported that this is an attribute that is not well understood by most of the community members so this group of people is assumed to be aware of the decisions they make. It was reported by the mental health professionals that this group of people experience normal physical development and that with some it may be not easy to tell that they have a mental health condition. This therefore hinders them from coping within the communities because people may have high expectations of them.

The community members also believe that people living with mental disabilities are hypersexual; this is because they have a tendency of having sexual intercourse in public places. One of the participants explained saying:

*People have different views and beliefs, but I have noticed that people living with mental illnesses are assumed to be hypersexual by most of the people. They think that people living with mental illness have a high libido that is why they are targets for sexual abuse.*

The participants reported that this is just an assumption but the reality is that people living with mental disabilities are lonely and that they are often kept indoors. One
participant reported that people living with an intellectual disability do not usually engage in any activities at home; their routine is always concerned with eating and watching TV throughout the day so their minds are not trained to do anything at all. As a result, this increases their level of dependency upon other people and reduces their sense of self-worth.

4.3 Findings from the guardians/family members

4.3.1 Which kind of mental Illness is your family member suffering from and how does it affect him/her?

Mental health conditions which were reported to be common by the family members or the guardians who were interviewed are schizophrenia, bipolar, drug induced psychosis and intellectual disability. One person was reported to be suffering from mental illness which had resulted from a head injury. Two participants reported that they did not know the name of the mental illness since the family members were reluctant to seek help due to denial; they believe that there is nothing wrong with them.

Figure 4.3 below illustrates the number of the affected family members of the participants as well as the different kinds of mental illnesses that they suffer from. As shown in Figure 4.3, the participants reported that their family member had one of the following illnesses: schizophrenia, intellectual disability, drug induced psychoses, bipolar, and mental illness due to head injury, while two patients’ diagnosis was unknown to the caregivers.

Figure 4.3 Types of Mental Illnesses and Number of People Affected
The guardians of people living with mental illnesses reported that they prefer their children to be institutionalised rather than to remain in the community. They reported that their affected family members can be easily influenced by others to commit criminal offences as well as to engage in drugs, so that remaining in the community is risky for them. These findings correspond with the findings of the previous researchers Yousafzi and Edwards (2004) who revealed that people living with mental illnesses have poor judgement and are impulsive. These attributes place them at risk of being easily influenced and taken advantage of by other community members.

The carers of people who have an intellectual disability were very concerned about the future of their children. In one case, the intellectually disabled person had two children from different fathers who were unknown to her family. The carer went on to say:
If you do not have a child who has a disability, it is very difficult to understand what we are going through. As caregivers, we have to protect our children living with mental illness from childhood to adulthood. Some of the people in the community are not considerate at all because they abuse these children emotionally, physically and sexually.

The caregiver reported that she is struggling with taking care of all these grandchildren since their biological mother is intellectually disabled and unfit to care for her children. It was revealed that people who are living with mental illnesses tend to move from one house to another visiting so-called “friends” and that sometimes they are asked to do mischievous things including stealing food and money from their parents’ houses. These participants reported that it is a big challenge to raise a child who has a mental disability, because he/she will always remain a “child” for the rest of his/her life and will never be employed but rather would remain dependent on the caregiver.

Figure 4.4 Gender Differences of People living with mental illnesses
4.3.2 Does the affected family member present with behaviours that might put him /her at risk of HIV infection?

Figure 4.4 presents the number of people living with mental illnesses as their caregivers revealed it. Two participants with family members who are suffering from schizophrenia reported that they had never experienced any sexual behaviour problems. They referred to the affected family members as “children” meaning; that they were not sexually active.

*I will not lie to you; my son is still a child. I do not think he has a clue in sexual matters. He is always around me all the time, if not he will be watching TV. He likes his TV a lot other boys used to tease him in the neighbourhood and I taught him to stay indoors so that he could stay out of trouble because it hurt me a lot when he came home reporting how other boys treat him.*

These participants reported that their family members were once institutionalised but they have found ways to cope with them and that they are currently stable and on medication. One participant reported that his son who was previously institutionalised is currently coping very well within the community and has a stable girlfriend. Another reported that her son was once arrested for rape but she did not know what was going on with him at that time. She reported that her son used to be violent and thus he was institutionalised after he was apprehended for rape. This caregiver reported that this institutionalisation helped her son greatly because he is now stable. Nonetheless, his mother still questions his relationship with his girlfriend, as she believes that the girlfriend is just enjoying the disability grant that her son is receiving. Generally, these findings indicate that most of the people who are suffering from mental illnesses may cope very well within societies if they are compliant with their psychiatric treatment.

On the other hand, most participants reported that they had their children sterilised and some put on birth control methods to prevent them from bearing children since they are sexually active. They reported that these people engage in sexual activities with multiple partners and that they are usually sexually abused.
Sterilisation seems to be the best option for them since they are unable to practice safe sex all the times, said one of the participants.

Perring (2010) and Himelhoch et al. (2007) also revealed that previously, people who had mental illnesses were sterilised so as to avoid passing the mental illness to their children. It was also revealed by other caregivers that this group of people usually engage in using drugs such as dagga. They reported that this is however against the nurses’ instructions and it worsens their condition as they end up not responding to their treatment. People living with mental illnesses are reported to be uncontrollable at times and to stay away from home. This is however a concern for the caregivers as they report that anything can happen to these people while they are away from home. One participant said:

I get very worried when my daughter doesn’t sleep at home because it is very dangerous out there. We always see in the news that people get raped and killed hence I don’t get sleep when I don’t know the whereabouts of my daughter.

One caregiver of an intellectually disabled person reported that she had always tried to protect her daughter and that she sleeps with her in the same room. However when her daughter is fetching water from the communal tap, she is approached by men and she was recently raped but the charges were dropped since the perpetrator reported that she is his girlfriend and her daughter failed to stand-up for herself. This indicates that people living with mental illnesses are unable to defend themselves in the court of laws and they can easily be considered as targets in the community. The caregivers reported that their children are at risk of HIV infection because they hardly understand when they are given information about sex and HIV and AIDS.
4.3.3 Would you say that sufferers of mental illness are vulnerable to HIV? How and Why?

All the participants reported that people who are living with mental illnesses are vulnerable to HIV infection. One participant said:

*I have been moving from place to place because wherever I stayed, people would target my daughter and rape her. As you can see, I am old now and the only option for me is to flee from the people who abuse my daughter so that we can be safe. Unfortunately, I have never found peace because people will call my daughter and tell her I am abusing her by keeping her in the yard so they take advantage of her.*

She reported that she opened many cases at the police station but she never received any progress reports from them. She also reported that once when she followed up on her case she was told that the case had been called off without her knowledge. Four participants reported that their female children are not safe in the community because they are being raped and justice is never done. They reported that some community members take advantage of these people since they are unable to protect themselves.

The participants also reported that they tend to avoid sex education, assuming that their children (affected family member) know nothing about sex. Shockingly they always discover that their children are sexually active without being able to guide them or teach them about the prevention methods. Three participants reported that their children are uncontrollable because they have peer pressure and listen to outsiders more than them as caregivers. The caregivers of the people living with mental illnesses reported that they find it difficult to provide sex education to their affected family members due to their inability to comprehend some information. Nonetheless, caregivers are very concerned about the rate of condom use among this group of people since they lack skills and accurate information.
The participants also reported that their children engage in sexual activities with anyone who proposes love to them. One participant reported that her son is always surrounded with many friends when he gets his social grant, saying:

_I am very worried about my son because he falls in love with some women that are known to be HIV positive in the community._

She further reported that these women even persuade her son to borrow money from the loan sharks so that he ends up without money for food and other basic needs and has his Identity book confiscated by the loan shark. These participants reported that it is a challenge to take care of a child who has a mental illness; and that they feel helpless in some instances since they cannot have full control of their children’s lives.

4.3.4 Have you ever been involved in any HIV and AIDS programmes that are implemented to benefit people who are living with mental illness?

Five participants reported that they were aware of the HIV support groups within their communities but they had never heard of any HIV programmes that were specifically meant for mentally disabled people. The participants reported that their affected family members are not accepted in the community; in fact, people usually make a joke of them so they prefer their children to stay indoors. Six participants reported that they were willing to have their family members tested for HIV and to receive sex education but they were scared that if they give them sex education they may get the wrong impression and become even more sexually active. These participants reported that people living with mental illnesses may have heard about HIV from their peers but they have the wrong information because they give them amusing responses when they try to educate them about HIV and AIDS. One participant reported that she had stopped talking about HIV and AIDS to her child because seemingly she is not yet sexually active and it seemed to be confusing her. It is evident that people living with mental illnesses lack accurate information about HIV and AIDS. These findings therefore tally with those of the previous researchers such as Kelly (2011), who found out that there are very few or no HIV prevention methods which target this group of people.
4.3.5 What do you suggest needs to be done to assist people who are living with mental illnesses as well as their guardians where HIV and AIDS are concerned?

The caregivers of the people living with mental illnesses feel that the government is not doing enough for this group of people because most of the people think that it is not necessary. They stated that people who are suffering from mental illnesses cope much better in institutions where they meet other people who are like them as well as trained caregivers who understand them without making uninformed judgements about them. They also feel that these kind of institutions are very few and that it is difficult for the sufferers to be admitted to such institutions.

One participant suggested, saying:

*It definitely will serve in the best interest of the people living with mental illnesses if the government could provide enough institutions for them because they are more vulnerable and at risk within the community. This also help them to master some skills that they are taught there hence relieving us from all the work that we do for them.*

Four participants reported that it is very difficult for them to send their children who are living with mental illness to the hospitals for medication because they are sometimes not cooperative and violent. They reported that they never receive any help especially when the affected person has relapsed or when he/she needs psychological assessment. One participant said,

*In most cases; we are the victims of violence when these people relapse because we cannot take them to the hospitals and at the same time we cannot get rid of them because they are our children.*

These interviewees therefore suggested that the government should help and be willing to assist them with involuntary admissions to the hospital. They believe that this will thus reduce the amount of homelessness which is a contributing factor to the vulnerability of the mentally ill people.
One participant reported that when her son relapses it becomes difficult for her to get him to continue with treatment because he uses drugs and becomes violent. When she calls the police for help, they tell her to call the ambulance because he did not commit a crime. She reported that when she called the ambulance, the ambulance came but she did not receive any help, rather she was told that her son was not sick and she was left in that situation; she was bitter. Participants reported that their children cope much better when they are institutionalized because they are not exposed to alcohol and drugs. They also reported that they do not experience discrimination and stigma in institutions because the people are all the same there and they receive their treatment regularly, unlike when they are in the community.

The participants also suggested that the government should assist them with the process of applying for social grants as well as special schools for the intellectually disabled. They reported that after a child has been found not coping in a mainstream school, it is difficult for them to place the affected child in a special school. One of the participants cried, saying:

*If only my daughter was diagnosed early and found a special school maybe she was going to be able to get certain skills for a living. As parents we do not have enough knowledge, I was always hoping that my child was going to improve at school until she got to grade five then the school called me in to ask me to send her to a special school.*

Therefore, people who have intellectual disabilities are often uneducated because their parents find it difficult to have them enrolled in special schools. Parents highlighted that they struggle to acquire the psychological assessments from the public hospitals due to a long waiting list. It was thus suggested that the government should help the communities even in the rural areas with special schools in order to reduce illiteracy among the mentally ill.

The caregivers of the people who have intellectual disabilities reported that they face challenges with regard to the application for the social grant because it takes time
and it requires the applicant to be assessed by the psychologist. They also suggest that the government should consider training and hiring more health workers in the psychiatry department. The shortage of psychologists and psychiatrists presents a barrier in helping this group of people as they need assessments for placements in appropriate schools so that they can access formal education. This therefore leads to high rates of unemployment and illiteracy among this group of people.

4.4 Conclusion

This study established that society assumes that persons with disabilities have no sexual feelings. The immediate contacts of those living with mental health conditions will for this reason not engage in sexual discussions or giving HIV and AIDS information. Loneliness and social rejection increase the vulnerability of people living with mental illnesses. This was seen to contribute even more to HIV infection despite the fact that some of these people may have knowledge of HIV and AIDS. The results of this study highlight that there is a lack of support from all stakeholders including government and the community where mental health is concerned. This lack of support from the community makes it difficult for the caregivers to care for their affected family members since they have to cope with the stress of taking care of a person who is disabled as well as coping with the pressure from the community. Vulnerability of the mentally ill to HIV infection and AIDS is generally high, especially considering the conditions that these people live in. The fact that they receive a grant from the government is a step forward but it has also become the reason why the community may have continuous sexual contact with them, to gain access to their social grant money.

Mental health professionals reported that children as well as adults with mental retardation and other forms of mental illness are more vulnerable to sexual abuse and exploitation within their communities. It was also revealed that these individuals are especially vulnerable because of their constant dependence on the caregivers, their
powerlessness within the society and their lack of education regarding sexuality and sexual abuse. People living with mental illnesses are often sexually stigmatised and perceived as asexual and presenting with uncontrollable libido which makes them targets for sexual abuse as they lack sufficient knowledge regarding sexual matters. The mental health conditions of people living with mental illnesses may also interfere with their ability to acquire and use information about HIV and AIDS. Therefore, this group of people has to be encouraged and taught to practise safe sex as well as how to protect themselves against sexual abuse.
CHAPTER FIVE

5. Conclusion and Recommendations

5.1 Introduction

The purpose of this study was to explore the relationship between mental illness and HIV/AIDS and to ask whether people who are living with mental illnesses present with risky sexual behaviours. This was also to find out if these risky sexual behaviours are a contributing factor to their vulnerability to HIV and AIDS since HIV is reported to be more prevalent among this group of people. The findings of this study do agree with those of previous studies; this study revealed that HIV/AIDS and mental illness are interlinked. People living with mental illnesses are at high risk of HIV infection as revealed in this study as well as in other previous studies.

5.2 Conclusion

Generally, the data indicate that people living with mental illnesses engage regularly in practices known to involve increased risk of HIV transmission. According to this study, people living with mental illnesses face multiple social problems that may directly or indirectly contribute to sexually risky behaviours; for example lack of knowledge, stigma and discrimination. It has been revealed in this study that people living with mental illnesses do not have access to HIV and AIDS information and that they lack sexual education. Hence, their sexual behaviours are viewed by society as abnormal because they do not know what is expected of them. Stigmatisation of people who are living with mental illnesses has strong psychological consequences for those who are HIV-positive as it increases social isolation and depression among them. Stigma associated with HIV, AIDS and mental health problems has a negative impact on prevention and care programmes. It also creates a framework in which people become hesitant to go for HIV testing.
Discrimination and stigma are destructive components in the lives of people living with mental illnesses. HIV and AIDS education and prevention programmes have not taken this group of people into consideration. They are therefore missing out on much information and the programmes which might save and prolong their lives because of the community’s attitude towards them. People who are living with mental illnesses are reported to be at high risk of HIV infection and HIV is believed to be more prevalent among them. This shows that there is a great need to accommodate people living with mental illnesses in the HIV and AIDS prevention programmes. Their social status in the community makes it difficult for them to access the help that they need because people are rigid and some are still stuck in their perception hence they do not view this group of people as vulnerable to HIV infection. Even though people who are living with mental illnesses are believed to be better off when institutionalised, this broadens the breach between them and the rest of the community. However, it makes it difficult for them to be integrated into the community and the community does not know and understand them in a better way.

This group of people is at risk of HIV infection not only because their mental condition affects their judgement but also because they may suffer from multiple diagnoses, such as substance abuse and personality disorders, which can lead to impulsive behaviour. Literature revealed that substance misuse frequently occurs alongside mental health problems, including mood disorders such as anxiety and depression, schizophrenia and bipolar disorder that induce psychosis. In this study, it has been revealed that people with schizophrenia tend to have low overall rates of sexual activity. However, people who are living with mental illnesses engage in risky sexual behaviours particularly if they are using drugs and when they relapse from their psychiatric medication. This highlights the role that multiple diagnoses play in placing this group of people at risk of contracting HIV and on engaging in high risk sexual behaviours. People who have co-existing problems face multiple facets of stigma such as relating to their HIV status, mental illness and substance abuse, and may have difficulties accessing and adhering to HIV treatment and care. It is therefore essential to
treat all the underlying conditions so that this group of people may be able to function fully.

People living with mental illnesses are often faced with triple stigmatization associated with having HIV, a mental illness and a substance use. This is due to the fact that they are prone to substance abuse as well as HIV and AIDS. HIV and AIDS may lead to some psychiatric problems while substance abuse may lead to risky sexual behaviours that may place them at high risk of HIV infection. It is therefore essential for mental health services to join forces with HIV programmes as well as drug rehabilitation programmes, as these three conditions are inseparable and they are the cause and effect of each other. This triple diagnosis may result in the extreme marginalization of the affected individuals. Hence, it further reduces their self-esteem, and often leads to non-adherence to treatment. Successful care of individuals with this triple diagnosis requires integrated treatment. This means that a holistic approach provided by an interdisciplinary team of social workers, medical providers, counsellors or therapists, and psychiatrists who share a coordinated treatment plan might be effective. Individuals with a triple diagnosis rarely receive adequate, flexible and integrated care since these conditions are treated separately in different health care sectors.

Notwithstanding the aetiology, people living with mental illnesses share certain characteristics that increase their risk of acquiring or transmitting HIV. Although a smaller portion of people living with mental illnesses is reported to be sexually active compared to the general population, those who are active engage in sexual behaviours that involve higher risk of HIV infection. Among people who are living with mental illnesses, the extent of the vulnerability to HIV infection or management is influenced by the nature and severity of their mental condition. Not all people who have a mental illness present with risky sexual behaviours. Some have been reported to be asexual and some have been reported to be leading a normal life. These findings are consistent with the literature where it has been noted that this group of people is
sexually active and that they engage in sexual risk behaviours that make them more vulnerable to contracting HIV especially those who are suffering from bipolar disorder. The findings of this study illustrate the importance of implementing programmes that will curb these risky behaviours and empower this group of people with life skills to support their wellbeing. It also defines prevention programmes that have to be directed at this vulnerable group in order to prevent the spread of HIV.

People living with mental illnesses are a vulnerable group to HIV infection as well as other sexually transmitted diseases. They are believed to be naïve and they present with risky sexual behaviours because they are often unaware of the consequences of their actions. This in turn leads other people into perceiving them to be hypersexual. It is the duty of the stakeholders as well as the government to raise the community’s awareness in connection with mental health. The community needs to be educated about mental illnesses to reduce stigma and discrimination against people living with mental illnesses within their communities.

People with serious mental illnesses are at increased risk of HIV infection. This may be because of vulnerability and lack of skills, illness-related behaviours and substance use. However, the results of this study suggest that mental health professionals lack awareness of the increased risks of HIV among this group of people. This is revealed in the fact that they do not routinely discuss sexual health issues with the patients unless if the patient presents with obvious symptoms of HIV. Mental health professionals have an important role to play in promoting sexual health in this population through educating them during their one-on-one check-up sessions. People who are living with mental illnesses can become stable if they adhere to their treatment, and, in this way, they are less likely to present with risk sexual behaviours. Therefore, it may also be primarily important for mental health professionals to monitor and maximize psychiatric treatment interventions. This would reduce the risk of infection during an acute psychiatric episode of high risk sexual behaviour or use of drugs, for example, optimizing treatment of bipolar disorder to prevent mania.
The findings of this study indicate that untreated psychiatric symptoms may possibly contribute to casual sexual encounters. The links between psychiatric symptoms and risky sexual behaviours was established in this study and have previously been described by other researchers. People living with mental illness who are also infected with HIV could thus hypothetically contribute to further transmission of HIV due to their risky sexual behaviours. This study and other previous studies further revealed that there is a strong link between mental illness, drug abuse and HIV/AIDS. Many people living with mental illnesses are reported to be prone to alcohol and substance abuse as their means and way of coping. This therefore further increases their vulnerability to HIV infection. This then is a cycle of illnesses in the sense that HIV also affects the nervous system of the infected individual. HIV prevention programmes therefore need to look into educating people about mental illness as well as substance abuse so that these programmes can be more effective and applicable to a large number of people.

Growing evidence on the vulnerability of people who are living with mental illnesses as well as their risk of HIV infection highlights the problems of programme exclusion among this group of people. It has been shown in the study that people living with mental illnesses require sexual health services as much as any other segment of the population, considering that they are more vulnerable to HIV infection and that they lack adequate information. This finding is consistent with the results of previous studies that revealed that HIV and AIDS education and their prevention programmes have not accommodated people who have mental disabilities. As a result, one of the researcher’s objectives is to highlight this grey area so that the prevention programmes can be scaled up to address the needs of people who are living with mental illnesses.

People living with mental illnesses also have limited access to the community resources, as a result; they are illiterate, living in poverty and discriminated against. In East London, for example, there are only three special schools that have been made
known to the researcher and these schools are reportedly full and with a long waiting list. This shows how people with mental illnesses are being neglected. Even so, the procedure to have a child enrolled at these schools demands money from the parent, which most parents cannot afford. Most of the people are also not aware of these kinds of resources hence they hardly benefit from them. Organisations that render services to the mentally ill are very limited. For example, in East London there is only one hospital that provides mental health care to the community, the Cecelia Makiwane Hospital. There is no mental institution identified in East London so for institutionalisation people have to be referred to the neighbouring towns such as Queenstown and Grahamstown. These findings are consistent with those of previous researchers who propose that mental health is often both a cause and a consequence of poverty, since people living with mental illnesses have compromised education, vulnerability, difficulty accessing housing, health care and employment, and lack access to community public services.

People who are living with mental illnesses are not only faced with a challenge of being mentally disabled and being a vulnerable group. They are also faced by a social inequality problem within the community caused by stigma and discrimination. These people need the support of both the government and the community at large since they are often faced with many social and environmental stressors. Their power and self-worthiness has been diminished by the labels that are stuck on them. These people have become defenceless and have accepted the way in which the community views them. As a result, they are overdependent on other people and lose their self-worth. This makes them submissive, placing them at high risk of being abused.

This study revealed a number of factors that contribute to the vulnerability of people who are living with mental illnesses. Most of these people are believed to be coming from poor backgrounds and they live under circumstances that increase their chances of getting infected with HIV. Some people who are living with mental illness tend to be homeless thereby being exposed to rape and drugs which may lead to HIV
infection. People who are living with mental illnesses are most likely to be illiterate making it is difficult for them to receive HIV and AIDS related messages. They are also faced with a challenge of sexual abuse and manipulation. Most of the people are not concerned about the wellbeing of the mentally ill and this makes them feel less human. This reduces their confidence and ability to face real life challenges and to be in total control of their lives.

Women and children are considered the most vulnerable groups of people within the communities, by virtue of their gender and social status. People who are living with mental illnesses are at higher risk because of the underlying mental illness. They must be regarded as the most vulnerable group and they need to be supported and protected within the communities. It is high time that people and organisations take initiatives to address the vulnerability of this powerless group of people. People still call them by names that devalue and dehumanise them. These kinds of names are somehow labelling. People living with mental illnesses tend to accept these names because they believe that it is what they are within the community. This however destroys all the capability of an individual as he/she is reduced to a worthless and hopeless individual who does not have a future and a purpose within the community.

5.3 Recommendations

HIV prevention and intervention programmes must broaden their scope to include a variety of other issues that directly affect the risks of HIV infection so as to ensure the effectiveness of such programmes. This would mean including people living with mental illnesses since it is evident that mental illnesses contribute to poor adherence to antiretroviral treatment for people who are both infected with HIV and living with mental illness. Furthermore, it has been proven that mental illnesses contribute to high-risk sexual behaviours. Hence, HIV and AIDS programmes need to take such factors into consideration in order for them to be effective across the whole population.
Increasing evidence on the vulnerability and high rates of HIV infection among people living with mental illnesses highlights the problems of programme exclusion. Current HIV and AIDS prevention and management strategies target other population groups, yet individuals with disabilities are more vulnerable and they live in circumstances that may expose them to HIV infection. People with mental illnesses are more likely to be unemployed, without a family support system and are more likely to become victims of exploitation, sexual coercion and violence. Hence, all HIV and AIDS initiatives should develop partnerships with mental health service providers and communities to create awareness about the epidemic, understand its implications for people with mental illnesses and provide inclusive HIV prevention programmes.

Mental health services need to team up closely with HIV and AIDS prevention programmes at all levels in order to facilitate conforming action involving other relevant community-based interventions in fighting this double burden of HIV/AIDS and mental illness. Several studies by Grassi et al. (2001) and Stiffman et al. (1992) have proven that there is a link between HIV/AIDS and mental illness, whereby mental illness is said to be a cause and an effect for HIV infection. Therefore, this integration of HIV and AIDS services into mental health care will provide health care workers with opportunities for identifying individuals at risk of HIV infection, introducing HIV prevention as well as detecting those who are infected and providing them with appropriate HIV treatment and care. Many people with serious mental illnesses are unable to individually obtain the medical care they need. Frequently, they depend on their psychiatrists or other mental health professionals to serve as their principal medical contact. It is therefore essential for the mental health care professionals to take into consideration the needs of their patients so that they can refer them to the resources they need.

Co-operation between HIV and mental health service providers should be strengthened to facilitate early intervention for people living with mental illness and HIV/AIDS. Research has revealed that mental illness is closely linked to HIV and AIDS.
It is however very essential that organisations and communities look into mental illness since it has been proven that it is more prevalent among HIV positive individuals. The mental health sector has to make people realise that mental illnesses are real and that they can affect anyone. It is high time that people accept mental illnesses as they have with other illnesses such as HIV, cancer and diabetes so that they can be able to face their challenges and support those who are affected. People are still in denial about mental illnesses and they still discriminate and stigmatise against the mentally ill. Mental health has to be integrated into primary health care to ensure comprehensive health care for everyone.

The government has to consider educating primary health care providers who treat HIV positive clients with mental illness about the simultaneous use of psychotropic and HIV medications; also encourage them to provide consultation when psychiatric symptoms interfere with HIV medical management. People living with HIV may be in denial or avoid being stigmatised for having a mental illness, hence it is necessary to educate them about the link between HIV/AIDS and mental illness. This will ensure that the symptoms of mental illness are treated, thereby eliminating other social factors related to living with mental illness such as poverty, homelessness and many others.

People living with mental illnesses have to be included in the HIV and AIDS intervention and prevention programmes to ensure that this group of people have access to the health services that they need. Introducing compulsory HIV testing and counselling that specifically targets individuals with mental illnesses in outpatient mental health clinics may be an important and innovative step. This will make sure that HIV testing is constantly conducted among this vulnerable population. It is evident that people living with mental health conditions are a vulnerable group hence their rights need to be advocated for and they need to be protected just like other vulnerable groups. The policies of mental health need to be made visible, available and known to the whole community. This will ensure that the whole community is aware of mental
health policies and there will be reduced stigma and stereotypes against this group of people. Massive education on mental health conditions has to be provided to the communities as well, to enable the community to become supportive rather than judgemental and discriminatory against this group of people. This can also highlight the strengths of the mentally ill and be empowering to them.

People living with mental illnesses have been taken for granted as indicated in the literature. Depending on the severity of the mental illness, people living with mental illnesses always need support but this does not mean that they cannot make decisions about their lives. They should be involved in decision making about their own lives. Historically, people living with mental illnesses had others making decisions on their behalf about what is good or bad for them. These decisions are however not always in their best interest but they are sometimes just convenient for the caregivers. Hence, it is essential to include these people in decision making so that they may feel that they are in control of their own lives.

People living with mental illnesses need sexual education so that they can learn what is socially acceptable as well as how they can negotiate for safe sexual intercourse. Approaches to preventing the spread of infection through education about sexual behaviours and intravenous drug use have to be integrated into both overall medical strategies and daily practice. This will therefore promote safe sex as well as reduce the sexual risk behaviours among this group of people. Literature revealed that specific counselling and education on condom usage can facilitate behaviour change. Henceforth, HIV and AIDS prevention and intervention strategies should incorporate specific provisions for the HIV education of people with mental illness. Most parents are reluctant to convey vital sexual health messages to their disabled children because it is socially taboo or they feel it is inappropriate and will encourage promiscuity. Therefore it is essential to educate these parents and empower them to be able to communicate
with their children who are living with mental illnesses so that they can also feel free to talk to their parents or care givers about the sexual issues affecting them.

Since it is evident from the literature that people who are living with mental illnesses are a vulnerable group to HIV infection, reducing the vulnerability factors might be a way of reducing the spread of HIV among this group of people. In order to reduce vulnerability of people who are living with mental illnesses to HIV infection, mental health stakeholders together with the government have to ensure that these people are treated for their mental health conditions. The treatment of mental health problems may bring various benefits for the affected individuals, their family and the community at large. These would include improved quality of life for people who are living with mental illnesses and their families and the community as a whole. In addition, these may also include improved health and effectiveness of HIV and AIDS treatment for those who are infected, a reduced rate of homelessness and provide more proficient use of health care services. Therefore, the significant role that mental health care could play in the prevention of HIV should not be ignored; the literature has proven that mental illness plays a significant role in the acquisition as well as spread of HIV.

Previous studies, such as the one by Meade and Sikkema (2005), revealed that mental disorders, including substance use disorders, are risk factors for HIV infection, and that the presence of HIV and AIDS increases the risk of development of mental disorders. HIV and AIDS prevention programmes need to address substance use as it plays a major role in spreading HIV infection as well as affecting the adherence to HIV treatment. Hence, effective treatment for substance use disorders, as well as preventive measures such as education for injecting drug users can reduce the spread of HIV among such groups and increase adherence to antiretroviral treatment for those who are infected.
People living with mental illness are often discriminated against and stigmatised. It is therefore the view of the researcher that this group of people may be easily taken advantage of because they would assume that if a person becomes intimate with them then that person is in love with them. This is because they also need to be loved and accepted in the community. Addressing stigma and discrimination in health care systems as well as the wider community may be an essential part of HIV prevention and mental health care. Stigma and discrimination impede mental health system improvement as well as mental health research. Therefore, stigma and discrimination associated with mental health problems and HIV need to be addressed at policy and practice levels, including public education and awareness campaigns.

The mental health sector has to encourage the local media to reduce stigma through avoiding sensationalism about mental illness and ensuring balance in broadcasting by promoting stories about recovery, accomplishment, and contributions by people with mental illnesses. It is also essential to educate the community about mental illnesses as well as the effects of labelling and name-calling. People have to know that labelling people with mental illnesses has some debilitating effects on the affected individual hence they have to refrain from labelling them by their illnesses. People living with mental illnesses as well as their family members have to be involved in all phases of programme developments, evaluation and implementation so that these programmes can address the most important aspects which are affecting their wellbeing within the communities.

Admissions into hospitals as well as other care centres have to be done for the best interests of the person concerned and their discharge should be carried out with appropriate levels of follow-up support. It is evident from this study that people living with mental illnesses tend to relapse once they are released back into their communities. Therefore there is a need for follow-up services and the patients have to be discharged once they are stabilised sufficiently. The community or social care
agencies have to address their needs effectively and monitor their progress closely so that they can provide them with the necessary support for them to be well integrated within their communities.

Increasing evidence on the vulnerability and high rates of HIV infection among people living with mental illnesses highlights the problems of programme exclusion. Current HIV and AIDS prevention and management strategies target other population groups, yet individuals with disabilities are more vulnerable and they live under circumstances that may expose them to HIV infection. People with mental illnesses are more likely to be unemployed, without a family support system and are more likely to become victims of exploitation, sexual coercion and violence. Preventative measures such as creating meaningful employment opportunities, and housing for people living with mental illnesses may better their living conditions as well as their quality of life. This would also ensure that this group of people is accessible in terms of rendering health care services to the communities.

The government has to expand training programmes for people living with mental illnesses to empower them with life skills so that they can obtain some skills which can enable them to find employment. Some people living with mental illness for example those who have mild intellectual disability can be able to obtain life skills and to live independently. This therefore would reduce the number of people living with mental illnesses who are living in poverty. It would also ensure that this group of people is kept occupied hence it might reduce the rate of drug and alcohol abuse among them. These life skills may also instil self-worthiness among this group of people, thereby improving their self-esteem and promoting independence.

The government has to consider implementing a policy that will enforce psychological assessment for every child at some point during early childhood to
determine whether the child has any special needs. For example, there has to be an obligation and a way to prove or record that the child has undergone such tests. This will ensure that parents are aware of the special needs of their children and it will help the children to receive the help they need such as appropriate schools and services at an early age. Most of the people realise that their children have disabilities when it is already too late for them to go to special schools, so most of the people who are living with mental health conditions are uneducated.

5.4 Summary

This study revealed that people living with mental illnesses are not asexual but are also a sexually active population. It highlighted what has been reported in the literature, that people living with mental illnesses are a vulnerable group and may easily be victimised by individuals who may expose them to HIV infection. In view of the findings of this study, people living with mental illnesses need to be protected, with women in particular, being protected from sexual abuse. HIV and AIDS awareness campaigns are conducted in the community at large. Most of the people are aware of HIV and AIDS through campaigns such as the World AIDS Day and the media. There is a need to evaluate current HIV and AIDS prevention programmes within mental health settings, if there are any, in order to make them more effective in reducing HIV infection and promote adherence to ARV treatment among this group of people.

It has been revealed in this study that women living with mental illnesses are at higher risk of being sexually abused or exploited. This therefore indicates that women living with mental illnesses are more vulnerable to HIV infection and this means that they need to be protected and to be supported as far as HIV education and prevention are concerned. People living with different types of mental illnesses experience different challenges with regard to their risky sexual behaviours. For instance, it has been revealed in this study as well as in previous studies that people suffering from bipolar disorder are more likely to present with risky sexual behaviours during the episodes of
their illness. This therefore calls for the HIV prevention programmes to take into consideration different types of mental illnesses so that these programmes can be applicable to the whole population of people living with mental illnesses.

HIV infection is believed to increase one’s risk of various psychiatric disorders and substance use disorders. It has been shown by the findings of this study as well as the previous studies that having a psychiatric disorder or substance abuse problem does not only affect adherence to antiretrovirals when occurring alone, but when they co-occur they lead to decreased adherence. There is a need to address this relationship between mental illness and HIV infection to devise a co-ordinated approach to the treatment of these life-threatening illnesses.
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Appendices

Table 2.1 Old vs. Modern Classification of Intellectual disability..

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<thead>
<tr>
<th>Old Classification</th>
<th>IQ</th>
<th>Modern Classification</th>
<th>IQ</th>
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<tbody>
<tr>
<td>Dull-normal</td>
<td>IQ 80-89</td>
<td>Mild mental retardation</td>
<td>IQ 50/55-70</td>
</tr>
<tr>
<td>Moron</td>
<td>IQ 50-79</td>
<td>Moderate mental retardation</td>
<td>IQ 35/40-50/55</td>
</tr>
<tr>
<td>Imbecile</td>
<td>IQ 25-49</td>
<td>Severe mental retardation</td>
<td>IQ 20/25-30/35</td>
</tr>
<tr>
<td>Idiot</td>
<td>IQ 0-24</td>
<td>Profound mental retardation</td>
<td>IQ below 20/25</td>
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Figure 2.1 Freud’s Model of the mind

The Mind

Conscious Mental Contents

Preconscious Contents (easily accessible)

Unconscious Mental Contents

Dynamically unconscious contents (difficult to make accessible)

Source: Sarason and Sarason, 1999:73
Semi-structured interview guide questions

Questions for family members

- Which kind of mental illness was your family member diagnosed with?
- How severe is this illness? What is your experience of your child/relative’s condition?
- Is the family member on treatment?
- Does s/he have knowledge or fully understand about HIV/AIDS as well as prevention measures?
- How did s/he get the information?
- Does the affected family member present with behaviours that might put him/her at risk of HIV infection?
- Would you say that sufferers of mental illness are vulnerable to HIV infection? How; Why?
- Have you been involved in any HIV programmes that are implemented to benefit people who are living with mental illness?
- What do you suggest to be done to assist families living with HIV positive people living with mental illness?
Questions for mental health professionals

- Is there a link between mental illness and HIV/AIDS?
- What role do the mental illnesses play in the acquisition of HIV/AIDS?
- How does HIV/AIDS affect the lives of people living with mental illness?
- Do your patients get tested for HIV/AIDS?
- How is the rate of HIV/AIDS among your patients?
- Do you have HIV/AIDS prevention programmes for your patients/clients?
  If yes, are your clients well informed of these programmes
- In what way are the people living with mental illness vulnerable to HIV/AIDS?
- What are the sexually risky behaviours of people living with mental illness?
- Does medication play a role in the sexual behaviour of people living with mental illnesses?
- In your experience in the field of mental health, what are the people’s assumptions regarding the sexual behaviours of people living with mental illness?
22 November, 2012

To whom it may concern

RESEARCH ETHICS CLEARANCE TO CONDUCT FIELDWORK TOWARDS MASTER’S DEGREE IN
THE FACULTY OF SOCIAL SCIENCES AND HUMANITIES

This is to confirm that the following postgraduate student has been ethically and academically
cleared by the Faculty of Social Sciences and Humanities, University of Fort Hare, to conduct
field and desk research towards the degree of Master of Social Sciences in Social Work:

Name of Student: Ms Deogracious Ndlovu
Student No.: 200508026
Research focus: Sexual risk behaviours of people living with mental illnesses within
the context of HIV/AIDS prevalence

The Faculty is satisfied with the student’s commitment and undertaking to abide by the
university’s ethical principles governing social science research.

We appreciate every support extended to her by outside agencies, individuals and institutions
to enable her successfully complete the study.

Thank you.

Very sincerely,

Professor Michael Somniso
Dean

Professor Wilson Akpan
Deputy Dean: Research and Internationalisation