

Perceptions of Nurses at Ndola Teaching Hospital towards Sexual Health Needs of People with Mental Health Problems

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How to cite this paper: Chambatu, A., Chitundu-Mutambo, K. and Kwaleyela, C.N. (2023) Perceptions of Nurses at Ndola Teaching Hospital towards Sexual Health Needs of People with Mental Health Problems. *Open Journal of Psychiatry*, 13, 262-279.

<https://doi.org/10.4236/ojpsych.2023.134021>

Received: July 4, 2023

Accepted: September 17, 2023

Published: September 20, 2023

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Abstract

Sexual and reproductive health (SRH) is among the fundamental packages of health care, which all clients seeking health care should receive. However, it is unclear how healthcare providers, in particular, nurses perceive the issue of people with mental problems having sexual health needs. The aim of this study was to explore perceptions of nurses at Ndola Teaching Hospital towards sexual health needs of people with mental health problems. A general descriptive qualitative study design was utilized and data were collected using three focus group discussions (FGDs) that were recorded and later transcribed verbatim. Purposive sampling was used to select 21 nurses who participated in the study. Nine were male, while 12 were female. Each FGD comprised seven participants. Thematic analysis was used to analyze the data, and six major themes: 1) physiological interplay among different body systems, 2) disease process and effects of psychotropic, 3) participant differences in age, gender, educational level, and cultural backgrounds, 4) staff shortages in mental health units, 5) deficient record keeping, and 6) Social stereotypes and labelling theories emerged. Despite acknowledging the existence of sexual activity among people with mental health problems; participants had both positive and negative perceptions. It is, therefore, recommended that interventions aimed at strengthening implementation of SRH guidelines among nurses caring for people with mental health problems should be put in place.

Keywords

Sexuality, Sexual and Reproductive Health, Mental Health, Mental Health Problems, Nurses, Perceptions

1. Introduction

Sexual health needs are among the fundamental requirements of most living individuals, including people with mental health problems [1]. These needs include presence of sexual feelings, desire to have sexual gratification and responsiveness during sexual intercourse [2] [3]. Other sexual health needs are the ability to attract the opposite sex, maintaining intact intimate relationships through open communication, and sexual abstinence. Before meeting the higher needs in a person's hierarchy (safety and security needs, love and belonging, self-esteem and self-actualisation), a human being must, first of all, address the basic physiological needs, among which is sex [4].

A number of studies on sexual activity in the general population indicate that the vast majority of individuals engage in romantic relationships with a spouse, partner, or significant other for the majority of adult life. A national survey in the United States of America (USA) reported that 88% of adults had at least one sexual partner in the past year [1]. Other community surveys have reported 50% - 86% of adults were sexually active in the past month [5]. However, this pattern differs among people diagnosed with a mental illness. A systematic review of 52 studies reported a weighted mean prevalence of 44.9% of individuals diagnosed with mental illness as being sexually active in the past three months [6]. Various people have different perceptions of sexual health needs in individuals with mental problems; hence, it is essential to understand perceptions of nurses because they are among frontline health workers that offer health care to patients who seek health services from mental institutions [7]. One such institution where people with mental health problems seek health services is Ndola Teaching hospital located in Ndola district, Zambia.

2. Background Information

The sexual dimension is part of a person's overall functionality. It encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction [3]. In some instances, a person's sexual health needs can be temporarily or permanently affected by illness or treatment. In such instances, communication is crucial for a functioning sexuality of a client [7]. Since nurses are among the frontline health care providers, they are often called upon to talk to clients about their sexuality and sexual concerns. The perpetual contact and the close relationship that nurses have with clients provide an opportunity to discuss sexual issues and sexual health [8]. Globally, there is a tendency by most health care providers to omit sexual history taking [1]. The usual behaviour of family members, nurses and social acquaintances of people with mental health problems is essentially the repression of any manifestation of sexual behaviour or complete denial of its existence [3].

Society members in many instances avoid discussing sexual aspects of people with mental health problems because the subject is perceived to be taboo.

Moreover, some nurses may feel uncomfortable discussing matters related to clients' sexual lives due to feelings of embarrassment for both the client and themselves [9]. The omission of sexual assessment can lead to late or non-detection of sexually transmitted infections (STIs) among people with mental health problems [1]. The presence of undetected and untreated STIs can lead to complications such as deterioration of the mental condition or sexual and reproductive complications [10]. For example, most patients with mania in health institutions as well as in their homes have an increased risk for STIs owing to their hyperactive behaviour and vulnerability that predisposes them to unprotected sex, yet, most of the cases are undetected, unreported or not researched upon [11].

3. Methods and Materials

A general descriptive qualitative study design was utilised in this study. This is a type of design widely used in healthcare and nursing-related phenomena, if the qualitative study does not fit into the typology of phenomenology, ethnography, or grounded theory [12] [13] [14]. It is based on the general premises of naturalistic inquiry and its focus is to offer a description of phenomenon under study for the sake of knowledge and not manipulation. Therefore, this research design was found to be appropriate for this study because the focus was to offer a description of nurses' perceptions of sexual health needs in people with mental health problems for the sake of knowledge and not manipulation.

The study was conducted at Ndola Teaching Hospital which is a referral centre for mental health cases, as well as other medical-surgical and specialty cases from the Copperbelt and northern regions of Zambia. The study population comprised of all nurses that provided health care to people with mental health problems at Ndola Teaching Hospital. The target population was 52 nurses from the psychiatric unit at the institution, as well as nurses who handled clients with mental health problems in the postnatal, OPD and general medical wards.

Purposive sampling was used to select Ndola Teaching Hospital on the basis that the hospital is the largest health facility offering mental health services in the northern region of Zambia. Purposive sampling was also used to select participants for the study based on the diversities that existed among the nurses in terms of age, sex, marital status, culture and educational levels.

To have been included in the study, nurses had to meet the following criteria:

- At least six months of working in a psychiatric unit or experience of attending to clients with mental health problems.
- This experience should have been current, not spanning back more than five years prior to data collection time, due to reforms in health care.

Nurses were excluded from participating in the study if:

- Working in a managerial position.
- Not available in Ndola during the period of data collection.
- Not willing to participate in the study.

Sample size depended on data saturation, where 21 participants were derived

from hospital departments that deal with clients with mental health problems out of the [14]. Data was collected using three focus group discussions (FGDs) comprising of seven participants each, guided by an interview guide. Each discussion started with an open-ended question: 'what are your views concerning sexual health needs of people with mental health problems?' The opening question was followed by subsequent questions such as: 'Describe a situation when you had to deal with sexual health needs in a person or people with mental health problems?'; 'Have you ever thought of the existence of sexual health needs in people with mental health problems?'; 'Explain your answer'; 'How did that make you feel? The questions allowed participants to provide explanations and descriptions for their answers. In order to focus on the phenomenon under study, there was need to utilise prompts such as: 'Does it happen?'; 'What do you think?'; 'What was your reaction?'; 'How did you address the situation?' Notes from the FGD proceedings were taken. The FGDs lasted between 30 to 45 minutes. Attention was paid to the non-verbal cues among participants and recorded appropriately; for use during data analysis.

Each participant signed a consent form. Confidentiality, privacy and anonymity were ensured by keeping obtained information in the custody of the researcher, and not shared with anyone, apart from the supervisor for supervision purposes.

Trustworthiness was achieved through maintenance of credibility, transferability, dependability and confirmability. Credibility was ensured through use of direct participant quotes from the FGDs and participant debriefs, as well as by availing audio recordings and transcripts to research supervisors. Transferability was ensured by having a variety of demographic characteristics of study participants. For dependability, the researcher was accountable and allowed peer review of data and supporting documents. Confirmability was achieved by probing some responses further using follow-up questions.

4. Presentation of Findings

Thematic analysis was used to analyse the data. Six major themes emerged with each having sub-themes. The major themes, subthemes and supporting verbatim statements are presented in **Table 1**.

4.1. Socio-Demographic Characteristics of Participants

Twenty-one nurses participated in the study; nine were male, while 12 were female. All of them were mental health nurses with Certificate, Diploma or Bachelors qualifications. Their ages ranged between 22 and 54 years, and all were licensed with the Nursing and Midwifery Council of Zambia (NMCZ) with over six months working experience in the psychiatric unit and Ndola Teaching Hospital. The participants had varying professional credentials ranging from Certificate to Bachelor's Degree in Nursing. Eighteen of the participants were married and three were single. Most of the female participants were married. All the

Table 1. Major themes, sub-themes verbatim statements.

MAJOR THEME	SUB-THEME	KEY STATEMENT
1. Physiological interplay	Sex being a basic physiological human need	<ul style="list-style-type: none"> • <i>“Mental illness is just like any other illness, it is just that the brain is affected... but in terms of their sexual life, they are still active, so no wonder you find that most of the times, some of the patients will have sexual advances towards the opposite sex.”</i> • <i>“Yes I have seen them having sexual gratification. They masturbate.... playing with their private parts.”</i>
2. Medical factors affecting sexual behaviour	Mental disorder and drugs given affect sexual activities	<ul style="list-style-type: none"> • <i>“If the patient comes in with mania, definitely you expect that patient to be hypersexual. If the patient comes with depression, of course you expect that patient to have Anhedonia, they will have no interest in any sexual activities.”</i> • <i>“Some clients become sexually active or sexually inactive because of the drugs that they take, they have got side effects that affect libido. You find that some will make them high, others will make them low.”</i>
3. Differences in demographic characteristics of nurses as well as clients affect therapeutic relationships between clients and nurses	<p>Educational level and work specialty affecting nurses' perceptions</p> <p>Age of the nurse affects nurses' perceptions</p> <p>Gender of nurses and clients affecting therapeutic relationship</p>	<ul style="list-style-type: none"> • <i>“I think one of the factors is education....if you are knowledgeable, you understand that these people are also human beings and what is just affected is their thinking capacity, but otherwise, the rest of their body is just working normally.”</i> • <i>“Also age, when you have old age, when you are mature enough you will be able to know that it is normal, for someone to have sex.”</i> • <i>“If a person of opposite sex enters a ward in psychiatric unit, especially when a male enters female ward, the female patients will start advancing sexually. They will even be saying things such as “I want my husband, it is you who has come, you are my husband, come here.” So they are also human, and they have sexual desire.”</i>
4. Deficient health system and environment as a cause of sexual misdemeanour	<p>Staff shortage causes sexual misdemeanour by patients</p> <p>Poor record keeping causes disruption in patient history analysis</p>	<ul style="list-style-type: none"> • <i>“Due to the low staffing levels that we have, it really creates a negative impact. You find that as they make advances some female staff are alone on duty and have small stature, they cannot even defend themselves. So as the male clients make advances this staff cannot defend themselves and they can be raped. Even the male staff working in the female wards, they can be enticed.”</i> • <i>“There is a problem everywhere...it is very important that records are kept intact because we deal with the history of the patients... it is very important that the records are intact in case a patient is transferred. Maybe Smart care is more important than what we have now, it is very important that we have that.”</i>
5. Existence of social stereotypes	Presence of labelling theory in the community against mental patients	<ul style="list-style-type: none"> • <i>“These people in the communities, when they just see a mental patient maybe in the neighbourhood....they always say... Take them so that they can be castrated, because it is them who rape people. They feel their school going children are not safe by having a male patient just living nearby their home or those who roam the street. Sometimes they will tell the relatives to the patient to be locking up the patient so that they are not having access to the sex.”</i>
6. Need for psychosexual support and advocacy by the nurses	<p>Need to provide non-judgemental care</p> <p>Recognising sex as an aid to recovery</p> <p>Human rights advocacy</p>	<ul style="list-style-type: none"> • <i>“When the time comes if they marry, they are free to have sex, and we shouldn't judge, and the community should not perceive it wrongly to say she is not supposed to get married.... as long as they are educated, they are counselled, they can manage to take care of a home and take care of the spouse, the patient has got the right like anyone of us.”</i> • <i>“And also sex plays an important role in stabilising our patients because if you look at the functions of sex, it is not just for reproducing but it also helps to relieve some stress.”</i> • <i>“These are people like any other; we shouldn't deprive them the conjugal rights.”</i>

participants were Christians belonging to different denominations such as, Roman Catholic, Seventh Day Adventist, African Methodist Episcopal, and Evangelical. The participants were from different cultural and ethnic Zambian backgrounds. Among them were Tongas, Lozis, Bembas, and Kaondes. The diversities were significant because they enabled eliciting of views from an assorted pool of nurses.

4.2. Actual Findings

4.2.1. Theme One: Physiological Interplay

This theme entailed participants' perception that mentally ill persons too have sexual feelings and thus, intercourse was also normal to them as it is for those who are mentally stable. This was despite society's view that it was abnormal:

“In my opinion, these people are not functioning well mentally, so allowing them to have sex will make them feel that they can do whatever they want, it is not normal....” (Mrs T.T, FGD3)

Physiological interplay relates to the interaction among different systems in the body such as the nervous, endocrine and cardiovascular systems in the regulation of sex. These systems complement each other in regulation of sex. Participants acknowledged having witnessed mental health clients having sexual gratification by seeing them masturbate; indicating that people with mental health problems were indeed sexually active. Some of the statements from participants relating to sexual gratification were as follows:

“Yes I have seen them having sexual gratification. They masturbate. They will be masturbating, playing with their private parts. Others will just openly say... Come and sleep with me; I am also a human being. I also want...you have locked me up...” (Mr L.P, FGD1)

The theme was supported by the subtheme namely; “Sex being a basic physiological human need”.

1) Sex being a basic physiological human need

Participants related sex to basic physiological human need irrespective of one's mental state. This line of thought was based on the scientific reasoning that human beings possessed hormones that give them the sex drive, and the central nervous system (CNS) that controls the sexual cycle [12]. One of the participants said:

“Mental illness is just like any other illness, it is just that the brain is affected... but in terms of their sexual life, they are still active, so no wonder you find that most of the times, some of the patients will have some sexual advances towards the opposite sex.” (Mr T.F, FGD1)

When asked what their reactions would be if they encountered a client with mental health problems who had sexual desires, the response from a one participant was:

“I think for me my opinion will be just to think that, he is also just a human being like I am, so he can express himself in that manner. If you understand what mental health is, then you will not have any bad opinion about that person...” (Mrs T.T, FGD3)

In addition, when tactile gestures such as touching a woman’s bums by a male person take place, this creates a psychological trigger on the mind of the people involved, thereby triggering the physiological interplay among the body systems:

“Male patients will beat your bums, or they will just express how they are feeling. You find that even if you are with colleagues they will start saying oh that sister.....I like her, I would like to have sexual relations with her, or they will just express themselves the way they are feeling there and then...” (Mrs P.B, FGD2)

“There was one incidence in female ward, there was a female patient, one of the men came to visit her, I don’t know whether it was a boyfriend, or they just know each other. So now, that patient started saying that Hey, my boyfriend, and they locked themselves in one of the rooms. So that patient expressed their feelings. Sex didn’t take place, they were discovered in time and the door was unlocked, but they were naked.....the matter was reported to the police and he was taken there for questioning...” (Mrs Y.C, FGD3)

4.2.2. Theme Two: Medical Factors Affecting Sexual Behaviour

Sexual behaviour in people with mental health problems can be affected by many factors, including the disease process itself as well as effects of drugs being used to manage specific mental conditions. These perceptions are substantiated in the following responses from participants:

1 Mental disorder and drugs given affect sexual activities

According to Mr S.M of FGD3, the nature of mental illness can have an effect of the sex drive of the patients. Some patients may even be taken advantage of by fellow patients or people without mental health problems. This is what Mr S.M had to say:

“Depending on the condition that the patient comes with; affective disorders which comprises of the mania and the depression; if the patient comes in with mania, definitely you expect that patient to be hypersexual. If the patient comes with depression, of course you expect that patient to have anhedonia, they will have no interest in any sexual activities. So like in our ward, the male ward, you find that patients they will openly express their sexual health needs by just telling you that I want to have sex with you, but due to the layout, they may not do it, they will just mention it.”

To support this response, another participant said:

“Some patients may engage in sexual activities not at will, but because they have got sexual disorder. So now our role will be to diagnose sexual disorders so that at least since they have sexual desires it shouldn’t disturb the

environment where they are. Those who have got sexual issues, they have to be treated for sexual disorders...” (Miss N.M of FGD1)

In order to substantiate the earlier arguments, some participants explained that people with mental health problems can be taken advantage of by people without mental health problems whether in the community or inside a mental institution. This was attributed to the fact that these clients did not have a sound mind to make an informed decision regarding sex. There were reported incidences of when the mentally ill were sexually violated, as in the following account by one of the participants:

“There was another incidence, there was a security guard, sometime late in the evening, he enticed a patient to go with him in the kitchen and the patient agreed, so it happened, they enjoyed themselves (at this point all participants broke into laughter). There were two patients taking vigil, one was guarding to see if people are coming. So that security guard was reprimanded by management, and I think he was punished.” (Mrs T.T, of FGD3)

Concerning the effects of drugs, it was perceived that the prescribed psychotropic drugs which these patients take affect their libido. These drugs can make a patient to be sexually hyperactive or have low libido as narrated by some participants:

“Some clients become sexually active or sexually inactive because of the drugs that they take, they have got side effects that affect libido. You find that some will make them high, others will make them low.” (Mr B.C, of FGD2)

Another participant said:

“So it is our work to tell them that this medicine you are taking, whether it is prescribed or not, it has side effects such as these. So you can come so that we substitute it with another one if it becomes worse. We explain and we give them IEC on the drug side effects.” (Mrs M.P, of FGD2)

4.2.3. Theme Three: Differences in Demographic Characteristics of Nurses as Well as Clients Affect Therapeutic Relationships between Clients and Nurses

Demographic characteristics include qualities such as age, gender, education level, occupation and race among others. Demographic characteristics in medical research are important because they provide a broad understanding of different features of a population that have a bearing on the care provided to clients [11]. This theme gave rise to three subthemes: “Educational level affecting nurses’ perceptions”, “Age of nurses affecting nurses’ perceptions” as well as “Gender of nurses and clients affecting therapeutic relationship”. Therapeutic relationship refers to the relationship between a health care professional and a client or patient. It is the means by which a therapist and a client hope to engage with each other and effect beneficial change in the client [15].

The nurses caring for people with mental health problems at Ndola Teaching Hospital are of different ages and gender as well as education level. The theme related how the educational level, age and gender of the nurse influenced their perception of sexual need among people with mental health problems. The following are the discussion contents, from FGDs comprising nurses of different ages and educational levels.

1) Educational level and work specialty affecting nurses' perceptions

In response to a question on factors that affected participants' perceptions of sexual health needs in people with mental health problems; the responses given included work specialty and educational level. One of the responses during the discussion was:

“I think one of the factors is education. So people who don't understand the conditions, they wouldn't know. They would think that the mentally ill are mad, therefore everything is gone. You see uh? So if you are knowledgeable or specialised, you understand that they are also human beings and what is just affected is their thinking capacity, but otherwise, their rest of their body is just working normally.” (Mrs B.C, 53 years old, of FGD3)

2) Age of the nurse affecting nurses' perceptions

In relation to age of the nurse affecting nurses' perceptions, a participant had this to say:

“Also age, when you have old age, when you are mature enough you will be able to know that it is normal, for someone to have sex”. (Mrs B.B, 50 years old, of FGD1)

3) Gender of nurses and clients affecting therapeutic relationship

This subtheme brought about issues to do with gender of clients and nurses affecting nurses' perception of sexual health needs in people with mental health problems. It was explained that some patients with mental health problems make sexual advances to people of the opposite sex, whether these people are fellow patients, members of staff or indeed the community, indicating that they want to fulfill their sexual desires. This was also mentioned by one of the participants in the FGD, who was 25 years old:

“If a person of opposite sex enters a ward in psychiatric unit, especially when a male enters female ward, the female patients will start advancing sexually. They will even be saying things such as “I want my husband, it is you who has come, you are my husband, come here. So they are also human, and they have sexual desire...” (Miss M.M, FGD2)

4.2.4. Theme Four: Deficient Health Systems and Environment as A Cause of Sexual Misdemeanour

In any given ward there should be enough nurses to look after patients effectively if quality health care is desired. Ndola Teaching Hospital psychiatric unit in particular has a deficit of about 16 nurses as per establishment, thereby con-

tributing to poor observation and control of clients [16]. In psychiatric wing, staff shortage can contribute to deficient observation of clients, coupled with the antique layout of buildings that compromise safety of both staff and clients. Participants related their perceptions about client sexual behaviour on staffing levels per working shift, as well as on the existing infrastructure and record keeping as health systems described in the following information:

1) Staff shortages cause sexual misdemeanour by patients

From the discussions, this subtheme emerged in that staff shortages also created a situation where a nurse worked alone in a shift, especially making the female nurses vulnerable to sexual assault and harassment by patients. A participant said this:

“Due to the low staffing levels that we have, it really creates a negative impact. You find that as they make advances the female staff is alone on duty, someone who cannot even defend themselves. So as the male clients make advances this staff cannot defend themselves and they can be raped. Even the male staff working in the female wards, they can be enticed...” (Miss M.M, 25 years old, of FGD2)

Sometimes, health workers tend to ignore the associated medical-surgical conditions that a patient with mental health problems can have, rather health workers concentrate on over-sedating the client to the extent that the medical-surgical conditions are ignored or not attended to, leading to health complications. This is what Mr M.D of FGD3 and 27 years old had to say:

“When you are working alone on shift and a patient wants to assault you or other patients sexually, or if he is behaving in a sexual way, I can just give a high dose of sedatives to prevent it...”

2) Poor record keeping causes disruption in patient history analysis

Owing to staff shortages, nurses reported being overwhelmed with work, a situation that caused them not to collect enough patient history that includes sexual history. There was also a problem with record keeping system for the patients, since client records are hard copy files. Some participants had this to say:

“I think with records, there is a problem everywhere, but I think that here, it is very important that records are kept intact because we deal with the history of the patients. We cannot collect comprehensive sexual history because of compromised infrastructure. History is very important, so it is very important that the records are kept intact in case a patient is transferred. Maybe Smart care is more important than what we have now, it is very important that we have that.” (Mr T.M, 40 years old, of FGD2)

4.2.5. Theme Five: Existence of Social Stereotypes

‘Existence of social stereotypes’ defined the way society generally believed and regarded people with mental health problems regarding sexual intercourse. This theme was constituted by one subtheme namely “Presence of labelling theory”.

1) Presence of labelling theory in the community against mental patients

Participants discussed that people with mental health problems are mocked and mistreated by people in the community. People may not want to associate with the mentally ill, they think these patients belong to mental institutions and that is where they should be kept to avoid social nuisance. One of the participants, Mrs N.M, 30 years old, of FGD1, said to this:

“These people in the communities, when they just see a mental patient maybe in the neighbourhood, or these which just roam around the streets, they always say: ‘Take them so that they can be castrated, because it is them who rape people. They feel their school going children are not safe by having a male patient just living nearby their home or those who roam the street. Sometimes they will tell the relatives to the patient to be locking up the patient so that they are not having access to the sex.’”

Asked what their reaction would be upon encountering a person with mental health problems wanting to get married, some participants responded in the negative while some affirmed as shown in the following response:

“They are not allowed to marry, I can’t encourage them”. (Mrs M.M, 25 years old, of FGD2)

“Me I would ask the patient if they can manage to go for counselling, in the presence of the spouse, to be counselled together, so that together, in case the patient breaks down in future, the spouse has to know how to take care of the patient. But they have to openly disclose to their partner about the condition that I have a mental condition, sometimes I have episodes of madness”. (Mrs B.B, 50 years old, of FGD1)

Some participant, however, explained that stereotypes on people with mental health problems were not fair, because some of their decisions regarding their sexual lives made a positive impact in society. Mrs T.T, 52 years old, of FGD3 had this to say:

“There was a girl in Masaiti District who used to stay with the grandmother, she used to trouble the grandmother that she wants to get married, and consequently she became pregnant, she safely delivered and the child has grown, and the child is the one taking care of the old grandmother now”.

4.2.6. Theme Six: Need for Psychosexual Support and Advocacy by the Nurses

Nurses play a big role in counselling clients about their sexual lives and sexual conditions. Participants acknowledged the need to help people with mental health problems by advocating for them on issues relating to sexuality and sexual behaviour, as well as offering professional counselling and psychosexual support as described in the following information.

1) Need to provide non-judgemental care

This subtheme “Need to provide non-judgements care” reflected the need to

be neutral in addressing the sexual health needs of people with mental health problems. Some participants emphasised the need to apply non-judgemental approach when addressing client sexual health needs. This is how Mr T.F expressed himself:

“When the time comes if they marry, they are free to have sex, and we shouldn’t judge, and the community should not perceive it wrongly to say she is not supposed to get married they are mentally ill, as long as they are educated, they are counselled, they can manage to take care of a home and take care of the spouse, the patient has got the right like anyone of us”. (Mr T.F, 27 years old, of FGD1)

2) Recognising sex as an aid to recovery

Some arguments that arose indicated that nurses really cared about their clients without discrimination, including people with mental health problems. In view of this, one of the participants had this to say:

“And also sex plays an important role in stabilising our patients because if you look at the functions of sex, it is not just for reproducing but it also helps to relieve some stress. So our patients are supposed to be having it, especially the ones who are married, it is important that you should be allowing them to have sex. We had a situation in my ward where a patient’s wife had a baby. So the moment the wife decided to go to the mother after delivery, the husband broke down, he became sick. But the moment the wife returned, the husband became well again.” (Mrs B.T, of FGD2)

3) Human rights advocacy

From the discussions by participants, it was evident that nurses working in psychiatric units understood the sexual health needs in people with mental health problems, and advocated for human rights in these people. There are some arguments from participants which supported this phenomenon, thereby indicating that nurses did advocate for human rights of people with mental health problems as follows:

“These are people like any other, we shouldn’t deprive them the conjugal rights”. (Mr L.P of FGD1)

Another participant continued with the advocacy saying:

“And sometimes, grant them leave as you are taking care of them, so that they can have their conjugal rights. Assess that they have over stayed, they are married, you let them go for two weeks, then come back. You find that they will even stabilize at home, and finally they will be discharged. Not only that, some of us are here working and when we knock off we go home to enjoy our conjugal rights, so what about these patients, why can’t we accord them such an opportunity also, because this condition can happen to anyone, and will also need appropriate treatment if it happened to us.” (Miss L.T of FGD1)

5. Discussion of Findings

5.1. Physiological Interplay

Many participants in this study acknowledged that people with mental health disorders engaged in sex or some form of sexual activity, as argued, for instance, by a participant who said “in terms of their sexual life, they are still active.... some of the patients will have some sexual advances towards the opposite sex”. This participant in other words was acknowledging that sex is physiological and inevitable, since people with mental health problems are human too. These arguments are in congruence with present day scientists who acknowledge that sexuality is part of being human; so if someone is not having a healthy sex life or has been raised to believe that sex is taboo and avoids it, this can certainly have long-term consequences on a person’s mental health [15]. It is for this reason that quality sexual and reproductive health care should be implemented in mental health care units, preferably by midwives because they have knowledge in SRHR. In this case, midwives would be able to provide quality pre-conception reproductive counselling as well as perinatal care, thereby preventing perinatal complications as well as STIs [17].

On the other hand, allowing people with mental health problems to procreate simply because it is their right to do so can lead to undesired societal problems, such as Streetism for the children [18]. When there are street kids, even criminal activities such as pick-pocketing, murder and rape among other misdemeanours can increase, because street kids are known for such vices due to lack of parental and social guidance. Consequently, intersectoral collaboration will be necessary to try and mitigate the effects of Streetism, and this will put a strain on the national budget and economy at large. It is for this reason that experts should be involved in assessing and determining whether consensual sexual intercourse among people with mental health problems is safe, because there seems to be equilibrium between the risks and benefits.

5.2. Disease Process and Treatment

Sexual dysfunction is sometimes prevalent among mental health patients and may be attributed to both the psychopathology and the pharmacotherapy as described in the following information derived from participants of this study. Participants alluded that there is a connection between a person’s mental condition and the way they behave sexually. They attested that mental conditions such as depression, anxiety disorder and mania can have an effect on someone’s libido and social behaviour that is sexually inclined. These assertions are supported by a study that stated that depression puts a damper on desire to have sex. The author went on to say that people with depression may feel less interested in creating intimate social interactions, thereby lessening their chances of creating opportunities for love and intimacy [15].

The impact of this is that it may perpetuate depressive conditions, especially in females where depression is common. There is also a connection between ob-

sessive compulsive disorder (OCD) as well as mania with sexual misconduct. Patients with these conditions report a feeling bombarded by sexual obsessions, or unwanted sexual thoughts such as an attraction to children, family members or even animals [19].

The phenomenon of uncontrolled sex puts mental health patients at risk of acquiring STIs, and if untreated, the condition may deteriorate and complicate serious reproductive health issues such as infertility and pelvic inflammatory diseases (PIDs) in females [20]. This puts a burden on the country's efforts to provide quality effective reproductive health for all.

Substance abuse has also been attributed to alteration in libido. Drugs and alcohol, especially if chronically consumed, can alter the brain so that the person cannot have sex without consumption of these substances, for example, methamphetamine because of the addictive effects [21]. Some substances can also rob someone of their sexual arousal, and cause problems such as erectile dysfunction (ED) [19].

It was, however, interesting to note that throughout the FGDs there was no instance when any participant linked the specialty of mental health to midwifery. In relation to midwifery, depression, anxiety and stress can also affect the hormones that control ovulation, thereby making it difficult for a woman with a mental health condition to become pregnant if she intends to procreate [20]. Positive mental health is critical in helping women transition into motherhood. It is for this reason that midwives need specialist mental health training in order to support women with mental health problems beyond screening and referring. In this regard, thorough history taking is necessary when midwives are booking perinatal clients, as well as when attending to clients with mental health problems [15].

Psychotropic medications are administered to help manage or treat people with mental health disorders. However, these medications can have adverse effects. Some participants argued that treatments that are given to manage mental conditions have been inclined to influence sexual behaviour in people who are mentally ill. These assertions can be validated by findings explained in a study where the author said that psychotropic drugs increase serotonin in the brain that tempers depression, but reduces libido as well as ability to experience sexual pleasure. The author further quantified that 46% of women and 41% of men with mental disorders experience postcoital dysphoria, a feeling of tearfulness and negative emotions after sexual intercourse [13]. Other authors attributed the first generation antipsychotics as well as anti-depressants to causing deterioration in erectile and orgasmic function in animals [19]. Therefore, it is vital that nurses explain the effects of drugs that they administer to clients with mental health problems, so that clients are afore-warned about what to expect and how to cope.

5.3. Differences in Demographic Characteristics of Nurses as Well as Clients Affect Therapeutic Relationships between Clients and Nurses

Perception of nurses towards sexual needs of clients can be affected by factors

such as age, gender and education level. One participant said: “I think one of the factors is education...if you are knowledgeable, you understand that these people are also human beings and what is just affected is their thinking capacity....” The older the nurse, the more capability they had in helping clients deal with sex and sexuality [21].

To support the above argument, results from a qualitative study that was done to compare two cohorts of participants with age groups between 18 - 21 years and over 43 respectively was used. The results were such that the younger midwives had little experience dealing with client sexual matters, as opposed to their older counterparts [22]. Older midwives explored more during history taking, and during counselling [22]. This could explain why mostly during the FGDs in the current study, older respondents who were also married participated more. The much younger participants aged below 25 years were less active in discussing client sexuality.

Participants acknowledged that being educated or specialised played a role in the way health professionals perceived client sexuality. Findings from one study stated that midwives have an essential role to play in the provision of effective SRH services even in the most unusual situations owing to their unique knowledge and skills. One of the unusual situations could be mental health illness [23].

5.4. Advocacy as Part of Treatment Package

Nurses are expected to be the voice of the voiceless when it comes to accessing quality health care. One of the components of quality health care is provision of quality sexual and reproductive health for all. Participants in this study tried hard to showcase this role. They ascribed to the view that people with mental health problems should be given the option to gratify themselves sexually in order to promote quick recovery. One participant said “*sex plays an important role in stabilising our patients!*” This is in line with the publication which stated that having sex helps the immune system, lowers blood pressure and burns calories [19].

There is also evidence that having sex can lower stress levels by triggering release of dopamine, endorphins and oxytocin, all which increase motivation and trigger feelings of compassion [23]. Following an orgasm, the body releases the hormone prolactin, which often leads to drowsiness and a feeling of relaxation, comfort and sleep. This effect is very essential in helping mental disorders to abate [15].

In congruence to the aforementioned views, there is evidence that lack of sex is associated with feelings of depression and low self-worth, therefore, sex boosts that self-esteem. Eminent psychologist Abraham Maslow suggested that there were five categories of fundamental human needs [4].

Therefore, nurses and midwives are mandated to provide professional care to all patients, regardless of the condition, in all matters related to sex and sexuality so as to facilitate informed consent and protection from abuse and exploitation.

Examples of specific interventions should include psychosexual counselling, provision of a conducive in-patient environment, provision of condoms for dual protection, dispelling harmful myths and misconceptions regarding sex in the communities. There should also be treatment of STIs and provision of quality pre-conception and perinatal care that are currently not being provided at Ndola Teaching Hospital psychiatric unit. Mental health clients should also not be denied comprehensive abortion care services, provided the international and national legal frameworks are respected.

6. Conclusion

Participants acknowledged existence of sexual activity among people with mental health problems and there were diverse negative perceptions. SRH should be addressed systematically and holistically in people with mental health problems because the phenomenon constitutes part of their fundamental human rights. Physiological interplay among different body systems such as the nervous, endocrine and cardiovascular systems in the regulation of sex, for the sake of pleasure or procreation was cited. Others attributed the sexual activity to disease process itself as well as effects of psychotropic. Participant differences in their age, gender, educational level and cultural backgrounds contributed to differences in perception. Furthermore, staff shortages in mental health units and deficient record keeping were cited as deficiencies in the health care system that contributed to poor monitoring and management of clients. Social stereotypes and labelling theories were mentioned as societal contributions to sexual misdemeanours by people with mental health problems. Mental health specialists equipped with knowledge in SRH should be at the centre of this care provision as well as facilitating advocacy. This would in turn reduce morbidity and mortality from sexually engineered illnesses and conditions among people with mental health problems. Demographic characteristics of the nurse such as age, gender, educational level and culture have been attributed to affecting nurses' perceptions towards sexual health needs in people with mental health problems.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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