Psychological morbidity in a clinic for sexually-transmitted disease

RICHARD MAYOU

Department of Psychiatry, The London Hospital

While it is widely assumed that psychological problems are common amongst attenders at clinics for sexually-transmitted disease, the few published accounts have been based upon small highly atypical groups referred to psychiatrists (MacAlpine, 1957; Kite and Grimble, 1965; Pedder, 1970). The findings from personality tests handed to clinic attenders have not been (and cannot be expected to be) helpful. However, a questionnaire designed to identify 'psychiatric cases' has suggested (Pedder and Goldberg, 1970) that the occurrence and nature of problems is very different from impressions derived from psychiatric referral and is probably comparable to that among other hospital out-patients (Culpan, Davies, and Oppenheim, 1960).

The present study is designed to meet the need for a description of the psychological and social morbidity in consecutive VD clinic attenders and is one of very few descriptions amongst hospital out-patients. It is hoped that such accounts may lead to the formulation of practical treatment programmes which may be quantitatively evaluated not only in terms of the effectiveness of therapy of the psychosocial problems, but also in compliance with medical advice.

Method and patients studied

In the Spring of 1973, regular half-day visits were made to the Whitechapel Clinic of the London Hospital and during these times all newly presenting patients who had not previously attended any VD Clinic were interviewed. The interviews were conducted privately in a side-room after the completion of the medical consultation and their nature was explained to the patients.

Information from the medical notes was supplemented by a semistructured interview and by a standardized mental state assessment, using the interview schedule devised by Goldberg, Cooper, Eastwood, Kedward, and Shepherd (1970), which has been found to be acceptable and appropriate to such populations. Those who score above 20 on a series of 5-point symptomatic and clinical ratings are regarded as 'psychiatric cases'.

The medical notes were scrutinized at the end of the study for follow-up and investigation details. χ^2 tests with Yates' correction were used for statistical analysis.

Results

100 patients were interviewed. There were no refusals, but eight further patients (3 Asian, 4 Cypriot, 1 Chinese) spoke too little English to be included. The findings are summarized in the Table (overleaf). Six patients with non-genital physical diagnoses whose characteristics were too heterogeneous to be classified are omitted.

The absence of any patient with syphilis or of a female with gonorrhoea indicates that these consecutive attenders cannot be regarded as an entirely true reflection of all new attenders at the Whitechapel Clinic at that time.

PSYCHOLOGICAL AND SOCIAL MORBIDITY

Twenty patients were rated as being 'psychiatric cases' using the interview criteria. A rather larger number were thought to show overt psychological disturbances and the diagnoses were classified as follows:

Anxiety	25
Depression	5
Mixed anxiety and depression	15

There was no severe affective or psychiatric illness but all except 26 were thought to show some degree of anxiety. In 44 this appeared to be related to the onset of symptoms or to sexual intercourse, while in 24 it was apparently unrelated and of longer standing. Chronic social problems (housing, work, relationships, etc.) were evident in 32, while 24 admitted recent stressful (pleasant or unpleasant) events.

There was, therefore, a substantial psychosocial morbidity, in part apparently related to the acute concern about possible VD but also substantially to longer term problems. None of the patients were, however, referred to psychiatrists.

COMPARISON OF THOSE WITH AND WITHOUT STD

On a number of parameters there were no differences between those who were and those who were not

TABLE Findings in 94 patients (73 male; 21 female)

Parameter		No physical diagnosis	Total STD	Diagnosis			
				NSU	Gonorrhoea	Trichomoniasis, Candidiasis	Warts, Pediculosis, etc.
Sex	Male	30	43	25	8	4	6
	Female	4	17	0	0	15	2
Age (yrs)	15-20	15	16	6	0	6	4
	21-30	12	33	12	4	13	4
	31-40	7	11	7	4	0	0
Marital status	Single	26	37	17	4	14	2
	Married	5	15	6	4	3	2
	Divorced/separated	3	8	2	0	2	4
Immigrants	West Indian	0	12	8	2	0	2
	Indian/Pakistani	4	2	2	0	0	0
	Other	4	2	0	2	0	0
Sexual partner (cited as source of possible infection)	Casual	24	30	15	4	7	4
	Regular	4	28	8	4	12	4
	Spouse	2	2	2	0	0	0
	No intercourse	4	0	0	0	0	0
No genital symptoms		22	0	0	0	0	0
Reason for consultation	Self-referral	30	34	15	6	7	6
	STD contact	2	2	2	0	0	0
	GP referral	0	18	6	2	8	2
	Second opinion having consulted GP	2	6	2	0	4	0
	Discussed with friends	15	43	21	4	12	6
	Attended with friends	10	12	8	0	4	0
Delay after symptoms or concern	Up to 1/52	17	20	10	4	6	0
	1/52-1/12	8	28	15	0	9	4
	1/12-3/12	5	8	0	2	4	2
	>3/12	4	4	0	2	0	2
Default	After initial visit	8	10	8	0	2	0
	Later	10	32	10	4	8	2
Psychosocial findings	History of previous psychological problems	8	12	6	2	4	0
	Previous illness fears	6	18	4	4	4	6
	Mean psychiatric score	11.5	9.6	7.5	17.2	9.2	10
	'Psychiatric case'	10	10	4	4	2	0
	Chronic social problems	6	26	6	8	8	4
	Recent life stresses	8	16	8	2	4	2
	Anxiety since symptoms/sexual intercourse	16	28	9	0	13	6
	Anxiety unrelated to symptoms	10	14	4	6	4	0
	No anxiety	8	18	12	2	2	2
	Guilt	10	4	0	0	2	2

Characteristics of patients classified by principal diagnosis. Six patients with a variety of non-genital physical diagnoses are omitted from the original 100 interviewed

diagnosed as suffering from a sexually-transmitted infection. There were no significant differences in mean age, delay in consulting, mean psychiatric score, history of past psychological problems, previous illness, or recent life events (pleasant or unpleasant). In the two groups psychological symptoms were of similar mixed neurotic nature.

Those without sexually-transmitted disease were significantly ($P < 0.01$) less likely to be female, and more likely to have had a casual sexual partner, to

feel guilt, not to have consulted a general practitioner, and not to complain of specific genital symptoms. They were also less likely to describe chronic social problems. The group did not fit the description of 'venereophobia' and there was a spectrum of clinical features: at one extreme a number of young men relatively inexperienced sexually but from a promiscuous peer group in which venereal disease and its treatment is accepted and discussed; at the other extreme older men, often married or with a steady

relationship, who felt guilty about a casual sexual contact and who became fearful and ashamed. In three single men the fear of having acquired venereal disease caused them to restrict their social and sexual lives for more than a year before seeking advice and they were the only patients to display a truly phobic quality in their complaints.

CONSULTATION BEHAVIOUR

There was a wide variation in delay in consultation only partly related to the acuteness of symptoms or to anxiety about them. Those who first consulted general practitioners appeared to do so because they were uncertain as to the possible nature of the symptoms, whilst those who assumed that they had venereal disease came directly to the clinic.

Discussion of symptoms with friends was common and appeared to be of importance both in suggesting to patients a venereal cause and in deciding them to attend the clinic. In a number of instances, friends (as well as sexual partners) decided to attend together after such discussions. Those who had not mentioned their fears to others delayed longer before consulting and often spent a considerable time looking for a clinic, which in seven instances was deliberately far from their homes.

While apprehension about attendance was common, relief was expressed at the routine nature of the clinic. Defaulting after the first visit or at any time before medical discharge was unrelated to any factor. Apart from those who defaulted immediately, roughly one-half of those diagnosed as having STD eventually failed to attend follow-up appointments.

Discussion

The findings of this investigation broadly confirm and extend those of Pedder and Goldberg (1970) in revealing a high prevalence of psychosocial problems comparable to findings in general practice and in hospital out-patient clinics (Culpan and others, 1966). As in a similar survey of a cardiac clinic (Mayou, 1973), there was no specific characteristic psychiatric pattern, but rather mixed neurotic symptoms with evidence that, in a significant proportion of patients, substantial and untreated psychosocial problems precede medical symptoms.

The proportion of 'psychiatric cases' is somewhat higher than that described using the same interview schedule in general practice but rather less than in new cardiac out-patients.

Although present numbers are too small to allow conclusions about individual diagnoses, it is apparent that there are many similarities between those who do and do not have a physical illness. The various

syndromes of 'venereophobia' that have been described by other writers appear to be artefacts of very low referral rates to psychiatrists of less than 1 per cent. of clinic attenders. It is reasonable to think that physicians will in such circumstances have selected those with the most severe or dramatic psychiatric disorders. As with chest pain (Mayou, 1973), it would appear from the study of consecutive attenders that, while psychosocial facts are major factors in consultation behaviour and response to illness, there are no specific psychological patterns.

The present findings are based upon first attenders and one would expect to identify various sub-groups of psychological, social, and sexual problems amongst recurrent attenders with or without venereal disease. It is likely, however, that they would prove a difficult group as a whole to interview and assess without prejudicing future attendance, and even in the present study it proved impossible to obtain adequate information about possible sexual problems because some patients appeared reluctant and evasive.

The value of any psychosocial investigation must be judged by the implications for practical management of the individual patient and also in this instance for public health. The present study shows that attempts to define arbitrary syndromes in small numbers of patients have ignored the considerable morbidity in the everyday clinic. This leads to a number of questions:

- (1) What is the outcome for those psychologically disturbed? Analogy with chest pain (Mayou, 1973) suggests persistence of psychological problems and somatic symptoms in a large number.
- (2) Would attention to the emotional aspects by physician, psychiatrist, or social worker be helpful in reducing morbidity?
- (3) Would such attention also be helpful in improving the rather low compliance with medical therapy?

Such general questions can be asked in any medical setting and cannot as yet be answered. For sexually-transmitted disease, there are specific questions in relation to sexual anxieties and interpersonal relationships, such as those described by Gibbens and Silberman (1960) in their report on the clients of prostitutes. There is a need for further definition and reliable description of problems so that those patients who are the most psychologically vulnerable may be identified, and treatment programmes may be assessed by social and medical criteria. In view of the large numbers of patients involved, we should perhaps be particularly concerned with the problems of recognition by physicians of psychological difficulties and of attempting to distinguish those who may be most usefully referred to psychiatrists and social workers from the larger number which may be managed in the medical clinic or general practice.

Summary

100 first attenders at a clinic for sexually-transmitted diseases were interviewed using a semistructured schedule. 20 per cent. were regarded as probable psychiatric cases and a considerable amount of psychosocial morbidity was observed. Whilst the majority reported anxiety about their possible illness, in a quarter the anxiety and distress appeared to be of long standing, having arisen before the genital symptoms or risk of infection and being related to chronic social and psychological difficulties.

There were no significant differences between those diagnosed as having or not having STD in such characteristics as psychological symptoms, mean psychiatric score, and delay in consulting. Whilst those without a sexually-transmitted infection were less likely to be female, and more likely to feel guilty, to have had a casual sexual partner, and not to complain of specific genital symptoms, there was

no evidence to support the concept of a syndrome of 'venereophobia'.

I should like to thank Dr. E. M. C. Dunlop and the staff of the Whitechapel Clinic, The London Hospital, for their help, encouragement, and advice.

References

- CULPAN, R. H., DAVIES, B. H., and OPPENHEIM, A. W. (1960) *Brit. med. J.*, **1**, 855
- GIBBENS, T. C. N., and SILBERMAN, H. (1960) *Brit. J. vener. Dis.*, **36**, 113
- GOLDBERG, D. P., COOPER, B., EASTWOOD, M. R., KEDWARD, H. B., and SHEPHERD, M. (1970) *Brit. J. prev. soc. Med.*, **24**, 18
- KITE, E. DE C., and GRIMBLE, A. (1963) *Brit. J. vener. Dis.*, **39**, 173
- MACALPINE, I. (1957) *Ibid.*, **33**, 92
- MAYOU, R. (1973) *J. psychosom. Res.*, **17**, 353
- PEDDER, J. R. (1970) *Brit. J. vener. Dis.*, **46**, 54
- and GOLDBERG, D. (1970) *Ibid.*, **46**, 58