Theme 4: New trends in the epidemiology of STDs

Illness behaviour and sexually transmitted diseases

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Introduction

No matter what talent or scientific skill, no matter what resources are devoted to the development of services for the treatment of sexually transmitted diseases (STDs), they may only operate effectively if those who can benefit present themselves for treatment. Endeavours to improve the quality of service in relation to sexually transmitted diseases, therefore, require that some attention be given to the question of illness behaviour.

For a long while it has been known that in general only a small proportion of people with treatable complaints actually bother to present themselves for treatment by a qualified medical practitioner. Even though this has been known, attempts to explain why some do and some do not go to the doctor have met with little success.

Attempts to find explanations, particularly in the more obvious and commonsensical directions such as the seriousness, the painfulness, or the inconvenience of the complaint, have failed; neither do the usual demographic variables such as age, sex, social class, nor ethnic background account for the major variations in illness behaviour. It is true that these variables do discriminate to some extent, but within any particular cultural or socioeconomic group variation exists, which, as yet, students of illness behaviour have largely been unable to explain.

There have, however, been some signs of hope in studies which have broken away from focusing on individual characteristics—be they psychological or socioeconomic—to focus on symptoms as perceived by potential patients in their everyday lives. That is, temporarily, the notions of sickness and health which belong primarily to professional medicine have been placed aside and attention has

been given to notions of what constitutes sickness and health, normal and abnormal, within the mind of the lay public. Alongside this has been the study of the ongoing relationship patients have with various members of the medical profession and, in particular, of their perceptions of the capabilities of medicine. Even though these lay notions might be regarded as mistaken or wrong by professional medical workers, they seem to offer the key, at least in the first instance, to understanding patients' behaviour.

Method

In order to test this framework, an investigative study of illness behaviour and STDs was carried out. For practical reasons, it was decided to work with a group who had delayed, rather than failed, to seek treatment. From an examination of records in a London clinic, it was noted that 75% of women consulted a doctor within six weeks of noticing a symptom, and men, within two weeks. A small group of men and women who had delayed seeking treatment beyond these time intervals were then interviewed. Interviews were unstructured and were tape-recorded with the consent of participants.

Results

The results of the pilot study showed that the approach outlined was of considerable value, and indicated the main areas on which further study should be focused; such as, the interpretation of bodily changes and the factors influencing these interpretations; alternative actions other than consulting a doctor; and the reasons for not pursuing an appropriate line of action.

Comment

The first task confronting individuals is to decide whether something is normal or abnormal. Changes

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in themselves are not always regarded as abnormal since a certain amount of variation is usual, particularly for women. Similarly, men may explain penile irritation as due to sexual vigour or excess.

Time is a very important criterion in diagnosis. If the lay diagnosis attributes the bodily changes to a specific situational event, such as excess sexual intercourse or wearing tight jeans, then making the appropriate adjustments to these situations should cure the problem. Time may defeat attempts to regard changes as normal. Changes can sometimes be accommodated on the basis of lay medical knowledge for an unlimited time. Hence, a man may explain away the growth on his penis because he tended to have growths elsewhere on his body.

Other people remain concerned about the context even when time defeats or challenges the initial diagnosis. Even though they may come to doubt their initial interpretation, if they do not regard themselves as appropriate candidates for certain types of diagnosis, then they may dismiss certain interpretations. To have a STD, they or their partners must have had a change of sexual contacts. If they do not believe this situation to exist then it may be difficult for them to contemplate STD as a diagnosis.

When someone finds their own lay medical knowledge exhausted, they do not always at that point rush to the doctor but instead may seek the advice of a friend. For example, they may consult a friend whom they regard as more knowledgeable than themselves. Similarly, girls may consult with their friends who have had similar problems.

It is known that people treat themselves. With STDs they may have pills left over from a previous attack, they may share pills, or they may resort to lay remedies, such as one girl who treated her

vaginal discharge by taking a bath with cider vinegar. We know that some ethnic minorities in Britain may consult a hakim or herbalist.

After going through these processes some people conclude that they may be suffering from something worthy of professional medical attention but do not seek such attention or delay in doing so. This may be for a variety of reasons. Obviously, some people have practical difficulties and if they do not regard themselves as in great medical danger will wait until it is convenient to seek care.

Fear and anxiety can be the basis for not seeking treatment sooner and may be categorised as follows:

- (1) Fear that they may have some serious illness, for example, cancer;
- (2) Fear of the treatment they might receive;
- (3) Fear of the stigma;
- (4) Fear of 'VD' as an illness itself.

Conclusion

Although a further large scale study is now under way to test the ideas outlined in a systematic and qualitative fashion from this small amount of work, tentative statements for health education may be suggested.

Health education in relation to sexually transmitted diseases will need to be finely balanced; that which may encourage some will discourage others. Certainly programmes which attempt to use fear to provoke people into action may be counter-productive.

Simple knowledge about the nature and effectiveness of treatment for STDs would be useful. Finally, there is a need to tackle the problem of stigma and sexually transmitted diseases.