



BEHAVIOURAL DIAGNOSIS AND EDUCATIONAL TREATMENT^a

INDEXED

Some notes on the control of Venereal Diseases

by

John Burton, M.A., M.R.C.S., D.P.H., F.R.S.H.



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1. DEFINITION OF HEALTH EDUCATION

Health Education is that part of medicine, public health and general education concerned with the interpretation and use of scientific knowledge by individuals and communities. The term embraces a state of health consciousness, a process of learning and teaching and a relationship between laymen and health workers.

Health consciousness is the product of people's customs, experience and values. It is expressed in their levels of recognition and awareness; knowledge and belief; attitude and expectation; behaviour and skill regarding matters of personal and social health.

Learning and teaching about health are processes which go on unconsciously during the transmission of tradition, beliefs and customs, and consciously through the study of health and the experience of choice and action. They take place between individuals, and in the family, the school, the workplace and in the community; also through the legislation, services and educational activities of official, professional and voluntary agencies.

Human relations in the educational process are the interactions between laymen and professional workers. They are manifest in the quantity and quality of consultation, co-operation and joint responsibility in solving personal and public health problems.

2. THE PROBLEM AND THE PARADOX

The treatment of gonorrhoea and syphilis is effective and quick but in spite of this, the incidence of both diseases appears to have increased in all countries in recent years - and particularly among youth.^{1,2,3} This paradoxical situation is probably real but may be partly the result of improved statistics in one of epidemiology's most difficult areas. Schofield⁴ in his study of sexual behaviour in England casts doubt on the theory that promiscuity has increased to any significant extent in recent years. Whatever the real situation, two things seem clear: there is still much we need to know about the epidemiology of syphilis and gonorrhoea⁵ and new approaches are required if the effective use of modern treatment is to be matched by corresponding epidemiological success. We have all been aware for many years of the socio-economic influences in the VD problem but practice has only dimly reflected this awareness.

A review of the literature is not encouraging, but does force on us the conclusion that rather than blame health education for its failures, we should admit that in spite of much lip service, it has hardly been tried.

The present generation of young people and, to a great extent, their parents, have had very little opportunity to learn, discuss and form attitudes which would protect them from VD. Even in those enlightened programmes of sex and family life education which grew up in many countries, VD was often ignored as it was considered to cast an ugly shadow over an already difficult subject and few teachers felt competent or inclined to deal with it. Unlike other diseases, the public does not have the opportunity to learn from popular literature or drama. Heroes and, even villains, never suffer from VD, while whole novels and operas have been written about tuberculosis. Celia Deschin⁶ found that only 10 per cent. of teenagers in New York had a good knowledge of VD. In addition, they have experienced many social forces such as broken family life, migration, affluence, unemployment and isolation, which put severe strains on their psychological stability. Juhlin⁷ gives a similar picture from Sweden.

Luther Terry, Surgeon-General of the United States of America in 1962, is reported as stating that sex education is forbidden by law in 10 out of 16 large cities with 40 per cent. of all reported VD cases.⁸

Dalzell-Ward (1960)⁹ in a very interesting report on group discussions with male VD patients in London, brings out a variety of attitudes to sex, women and prostitutes, some of which appear ignorant or neurotic, others more or less reasonable but dangerous. Many traditional beliefs about man's need for intercourse and the essential role of the prostitute in fulfilling this need were expressed. He notes the enthusiasm of the patients in discussing their sex problems with a non-moralizing but qualified person. He considered the discussions had a therapeutic effect apart from VD.

Dr Lambo¹⁰ describes the effect of transition from tribal to urban life in producing emotionally disturbed adolescents and delinquency "The most constant feature of the transitional societies of Africa today is some degree of social disorganization, especially of the primary institutions, e.g. the family." He then goes on to describe the effects and reactions to social disorganization which, in the main, tend towards a promiscuous way of life and particularly affect adolescents by providing the environment in which a variety of social ills can flourish.

Though these studies do not tell us anything very new, they serve to underline the need for more penetrating epidemiological information and the essentially environmental and educational nature of this health problem.

3. A QUESTION OF CLASSIFICATION

The traditional grouping of disease as infectious, neoplastic, nutritional, etc. no longer satisfies completely our notions of the etiology and epidemiology of many conditions. However, these groupings still influence heavily our thinking and dominate the clinical, departmental and administrative framework of our practice. Like all classifications they were a reflection of our knowledge at a particular time. As knowledge and techniques advance and as the social environment changes a traditional classification can become a serious limiting factor on thought and inhibit the adoption of new approaches. Traditionally, we classified gonorrhoea and syphilis as infectious; more recently the term communicable has been added or substituted. Though these terms underline important aspects of causation, they no longer appear to be the aspects of greatest importance in our future work.

Gonorrhoea and syphilis are typical of many conditions for which preventive measures and treatment are available and effective but which remain among us because the underlying causes are related to human behaviour. The time has come to consider their re-classification under a new grouping of behavioural diseases.^a By so doing, we give value and importance to the intellectual, emotional and social factors which constitute the major impediment to their prevention and treatment and which should be uppermost in our minds when planning research or conducting services. By considering them as behavioural diseases, we cut across traditional boundaries and put ourselves in a position to perceive hitherto unrecognized connexions between them and other medico-social problems. Gonorrhoea and syphilis are classical examples of behavioural disease.

4. DIAGNOSIS BEFORE TREATMENT

Health education is based on essentially the same premises as medicine. There is a diagnostic phase devoted to exploring the states of health consciousness, and a treatment phase designed to influence behaviour. Both phases are susceptible to evaluation, both phases require a suitable organizational plan and a staff properly prepared to carry out the work. In the diagnostic phase are included consultation, observation and surveys, and under treatment teaching and learning, motivational activities, publicity and environmental manipulation.

^a Behavioural diseases may be defined as pathological conditions in which human behaviour plays a leading etiological role or which can be managed or eliminated by modifying behaviour.

The diagnosis

May we start then within our own camp. If we are to educate, we must know more precisely who to educate and who does the educating. Perhaps the most important single item we need to explore is who is at risk? Is everyone at equal risk from venereal disease as our mass approaches to education would imply, or are there some who are more at risk than others? Clearly those who get a venereal disease are most at risk and we need to know what kind of people they are. This implies not only their age, sex, race, geographical location, etc., but their social, psychological and economic characteristics. Do they constitute definable groups? Is the apparent increase in prevalence in many countries real or apparent; if real, is it due to an increase in the size of these groups or to an increase in the number of infections experienced by each member of a hard core group? If it is the former groups which are expanding, we need to find out to which new people the disease is spreading so that preventive action can be taken in the places where it is most likely to be effective. If it is the hard core who is getting the disease more frequently, we need to know as much as possible about the characteristics of the people who compose it. On the side of the educators, we need to know more about the attitudes and competences of school and university teachers in this field. We must find out what is being done about health education in VD clinics and services and what clinicians consider to be their role in educating patients.

From the point of view of psychological and sociological study, the venereal diseases offer certain important advantages as a large sample of patients presents itself (or is known to) a centre through which studies can be carried out.

This is no new idea. In the literature as far back as the 1940's several papers have described fairly detailed social and psychological studies of clinic patients, the results of which the authors conclude have been helpful in treatment.¹¹

From army studies, it appears that those most at risk - i.e. patients - do present certain characteristics. Watts & Wilson (1954)¹² described: (1) unstable men who do not control themselves in any aspect of life; (2) heavy drinkers; (3) promiscuous men who are immature in attitude and behaviour; and (4) men who are too dull to be good soldiers. The equivalent in the teenager is the bad attender and the dropout from school.

Wittkower¹³ and Dongier go deeper in analysing the VD patient's make-up. They focus attention on promiscuity which they characterize as an attempt to relieve psychological stress; an incapacity to amalgamate affectionate and sexual feelings. Promiscuity, they assert, is not a sexual problem, but one solution to deeper psychic trouble.

In a series of revealing epidemiological studies of VD transmission courageously published by the USPHS¹⁴ many of the features of the sexual life of people in rural and urban areas of the United States of America are described, and highlight the common factors of ignorance and promiscuity which cut across social, educational, and age group boundaries.

Knowledge in greater depth about the epidemiology of the disease will put us in a better position to decide whether the educational activities should be extensive or intensive. The tools for such epidemiological work are already well developed but still need to be applied more thoroughly.

Though epidemiology is extending its sphere of interest towards the social, psychological and cultural determinants of disease, and some social scientists are reaching out towards epidemiology, there is still a substantial methodological gap between the two approaches. However, the social sciences are essential to the study in depth of the groups selected by the epidemiologist and until such time as the gap has been bridged the next stages in the investigation of behavioural disease will require the skills of sociologists, psychologists, and cultural anthropologists. To make the best use of their skills health workers

must prepare themselves to ask the right questions. The information health education requires about patients and educators and on which the health workers can base their questions to the social scientists may be grouped for practical purposes under three main headings:

States of health consciousness

Social environment

Patterns of communication

Health consciousness includes those intellectual and emotional factors which condition people's behaviour about health. This applies as much to the health authorities and the professional workers as to the patients and the public at large. We need to know:

- (1) The level of awareness of the problem among those professionally concerned, among patients and among the general public.
- (2) The knowledge and beliefs they have concerning sexual behaviour and the causation, prevention and treatment of sexually acquired diseases.
- (3) Their attitudes regarding the diseases and the value they attach to controlling them. These would include attitudes to sex, promiscuity, homosexuality, and the value system of patients regarding members of the opposite sex.

In the attitude studies we should pay particular attention to motivational factors favouring or restricting the spread of infection.

- (4) Lastly, we should endeavour to find out about professional and patient behaviour which increases or diminishes the risk of spreading infection. Among the professional workers in question we wish to know what steps they take to provide patients with some protective education; among patients we need a detailed breakdown of the behaviour which led to the infection and what kinds of precaution, if any, they take.

Such information constitutes the essential base-line data on which the planning, the training of staff, the educational activities and the evaluation of health education depend. Though studies of this kind are inevitably costly and the information laborious to collect, it is technically possible to make a start using the existing research methods of the social scientists.

Social environment

In exploring the social environment of patients, we need to know particularly about the social structure of the milieu from which they come, their family situation, peer groups and those persons who influence them. We also need to find out about patients' affiliation to other social groups such as work groups, professional and recreational associations, voluntary bodies and religious organizations. We should also inform ourselves about legal and economic pressures which favour promiscuity or prostitution. These may be of particular importance where homosexuals are concerned. On the health service side we need to study the provisions made by the health authorities with particular reference to their convenience and acceptability to patients.

Patterns of communication

Communication takes place through personal exchanges such as conversations, interviews and discussions and through impersonal means such as radio, films, notices and newspapers. Communication also has recognizable patterns such as meetings of groups for recreation, views expressed by an accepted family or social authority, regular reading of chosen publications

which may circulate widely after purchase, pamphlets distributed at health centres the contents of which are retailed to the family or to friends, school lessons which are discussed with parents, film shows followed by discussion, gossip groups, etc.

In order to reach a chosen group of the population, we need to know the communication patterns used by that group and, if possible, the importance the group attaches to particular modes of communication. In the first place, professional workers must master the language used by the patients and the public in relation to sex and the venereal diseases and the style in which the language is used. Secondly, the educator must be proficient in the use of the media through which the individual is most likely to receive this kind of information. Those we most wish to reach are often the most inaccessible. The richer sections of the population are generally those best supplied with sources of information, whether it be the spoken word, the newspaper or television. The poorer sections may only be reached effectively by a single medium or are not reached at all.

Market research workers are well aware of the problem and have developed fairly precise methods of investigation, but the value of the market research approach depends on the ability of the health authorities to define the group they wish to reach.

The approach is long term, but this is inevitable in any problem where human behaviour plays a leading role. Though health educators like general practitioners are often compelled to act on inadequate evidence, there is a basic minimum below which no professional person will feel ethically justified in taking decisions. Diagnosis must come before treatment.

The treatment

Health education in the behavioural diseases is presented with three main opportunities: in the primary prevention of risk; in secondary prevention through early treatment, and in tertiary prevention of transmission and recurrence. The defences against VD are within the people and all types of prevention in VD ultimately depend on the decision of individuals. Making a decision depends on their knowledge, motivation, and convenience. The imparting of knowledge is mainly a question of organization and technique and is within the power of health and education authorities to arrange. Motivation is a product of an individual's feelings, his personal identification with the problem and the social pressures to which he is subject. These are only partly and occasionally within the ambit of influence of health and education authorities. Convenience being mainly a question of making it easy for the individual to use the services, is almost entirely within the competence of health and VD authorities. Thus, it is possible for local health and education agencies to provide two of the main elements which enable people to take sensible decisions about VD which may be enough to protect many from risk and to cause others to report early for treatment.¹⁵

The only practical methods that can be used by health workers to modify the behaviour of individuals or groups involve compulsion, changing the environment, and education.

Compulsion is an ambivalent weapon in the hands of health authorities. It has been used widely in attempts to control prostitution, homosexuality, and the spread of VD but its benefits, if any, appear to be of very short duration and its scars take long to heal. It is certainly not a method with which health workers should become identified. Changing the environment and education are inter-related methods which can be used by health workers and which have shown promise in the limited applications of which accounts have been published.

5. THE EDUCATIONAL ROLE OF HEALTH WORKERS AND TEACHERS IN THE CONTROL OF VD

What part can the public health services and the schools play in improving the health consciousness and social situation of the people of their area? Which groups of workers in the health and education field should be contributing and what allies will they need to make their educational work effective? What educational methods are at their disposal and how can they best be adapted for the groups at risk?

6. PRIMARY PREVENTION THROUGH HEALTH EDUCATION

In seeking answers to these questions with regard to primary prevention among youth, health education is only one element but it is an element which can be applied immediately if the responsible authorities are prepared to undertake the necessary organization. Pierre Chambre in his book "Les Jeunes devant l'Education Sexuelle"¹⁶ gives an excellent report of the problems encountered by a French schoolmaster in organizing this work and the rewards it brought to him and his pupils.

The Department of Health of New South Wales has received a report from its Health Education Advisory Council putting forward a sound proposal for developing a venereal diseases programme. The Council saw as its main problems the education given to teachers in training and to college medical officers; the university students and the hard to reach adolescents.¹⁷

In a report^{18,19} on the incidence of syphilis in the 15-19 years age group in Los Angeles, it is stated that a 73 per cent. reduction took place following intensive educational efforts between 1962 and 1966. A reduction was also recorded in the 20-27 years age group. No significant change was recorded in the gonorrhoea incidence among these age groups during the period.

This significant finding raises the important point that the short and long incubation periods of gonorrhoea and syphilis must be taken into account when deciding on the emphasis the educational work should have.

A good example of a comprehensive programme is described by Donald Campbell, a health education consultant in the State of Ohio.²⁰ The essential feature of the Ohio programme was the involvement of all the community agencies concerned in long-term planning and the effective inclusion of VD education as part of the classroom work of teachers. The two major co-operating agencies were the departments of health and education. The State Director of Health set up a committee which included classroom teachers, parents, health education consultants, a local health commissioner and representatives of the medical profession in the State and one or two other interested persons. It was decided to focus attention on the high schools. An inquiry revealed that little VD education was undertaken throughout the school system. Three reasons appeared to account for this: teachers did not feel adequately prepared to introduce the subject in the classroom; there were very few educational aids and materials on VD which were suitable for classroom use; teachers and school administrators doubted whether VD education of secondary school children would be accepted by parents. These three essential aspects were then tackled systematically. In-service training of teachers was started. By using discussion methods, teachers began to use the technical words without embarrassment. Materials including brochures and an excellent film were produced and carefully tested for acceptability on teachers and pupils. Meetings were held with parents at which the intentions of the programme were explained and their support solicited. Contrary to the anxieties expressed by the teachers, parents welcomed the initiative.

Schools were approached and a good response was obtained for introducing the subject of VD into the curriculum as part of health education. Assistance from the health department was often necessary in getting teaching started and building up confidence of the teachers in their ability to handle the subject. The reception by students was very favourable and the programme has gradually spread to cover most schools in the State. In this case, VD education was recognized as a legitimate part of health education in school and community. Though the focus was on the pupil, the involvement of all the professional and voluntary groups concerned provided a much wider educational coverage.

Programmes of this kind would have to be worked out, taking account of the local cultural setting. This should not be impossible in any area where the urgency of the problem demands it and the will to protect young people exists.

7. THE LIMITATIONS OF HEALTH EDUCATION IN PRIMARY PREVENTION OF VD

Such a programme of information and discussion can lay the foundation on which enlightened public opinion can grow. It cannot be expected to deal with the behaviour problems of the high risk groups such as the children of low intelligence, the neglected, the maladjusted and the homosexuals. Though we can reasonably hope that information and discussion will help the majority of youngsters, it may not have much effect on the 'problem children' who, as Loeb (1960)²¹ puts it, "act out their fantasies in promiscuity." Special diagnostic and preventive action is needed from the school health service in detecting particularly the maladjusted girls and boys whose promiscuity and failed treatment can have such wide social and epidemiological consequences. Their education, social rehabilitation and psychological treatment merits a high priority in school health work for more reasons than that of preventing VD.

8. SECONDARY AND TERTIARY PREVENTION

Clearly, those most at risk are patients who contract VD. Among these there is an increasing number of young people. For many patients this may be the first occasion on which they come in contact with anyone with sufficient knowledge, sympathy and time to discuss their problems. In secondary and tertiary prevention, therefore, the first place to be considered from an educational point of view is the VD clinic, and the most important educator the physician or other non-moralizing but well informed person.

If we agree with this proposition several questions arise, however: Does the public at large know about clinic services? What sort of reputation has the VD service acquired? What efforts are clinic staff prepared to make during treatment to tackle the educational problem? Recent enquiries by Morton in England show that a large proportion of VD specialists do not consider that the education of the patient is part of their responsibility and a large proportion of clinics carry out no educational activities of any kind.

Publicity for the VD service still leaves much to be desired in most countries. The limited usefulness of posters and notices is well known. Since early treatment is one of the most important preventive measures, the public relations side of the VD service must be developed in such a way as to attract the potential patient. Apart from traditional mass media, have confidential services such as telephone inquiries been organized?

In the VD clinic itself, the aim is twofold: securing adequate treatment and preventing recurrences.

The interview with the doctor is undoubtedly the most impressive educational opportunity. Does he have time for conversation? Are simple illustrations and persuasive leaflets ready at hand for the doctor to give the patient? Is the doctor willing and able to use the language of the patient and to provoke questions? Has the doctor any facilities for referring disturbed patients for psychological guidance? The nurse and the social worker can ascertain from the patient by questioning whether he has understood what the doctor has said and can follow up and interpret the doctor's advice. In some cases, as illustrated by Dalzell-Ward, discussions with patients can be arranged so that the educational treatment can be taken to a deeper level and even a group solidarity built up. Such discussions have psycho-therapeutic value and may go a long way to meet social problems of disturbed patients. The clinic is also the best place for attempting to tackle the problem of the "chronic repeater".

9. THE WORK OF THE HEALTH EDUCATION CONSULTANT

These activities within a clinic and in the wider field of public health and education require careful organization and their planning and development will benefit from the advice of a health education consultant. Such a professionally qualified person may also serve the school programme and any out-of-school youth activities that may be going on through youth clubs, the Junior Red Cross and other voluntary bodies.

The availability of the health education consultant to work in the wider social context and even across departmental frontiers can be a potent force in what Popchristov²² in Bulgaria has described so eloquently as building up public opinion and social customs which are unfavourable to promiscuity and prostitution and support a constructive way of life for youth. If vaccines are developed against gonorrhoea and syphilis the existence of an enlightened public opinion will be a major element in gaining their acceptance by the public. The investment in health education now will pay a worthwhile dividend in speeding what experience has shown can be a very slow process.

The World Health Organization is actively encouraging governments to establish within their ministries of health departments with qualified staff in health education. Their work includes carrying out inquiries, planning and organizing health education in all fields of public health and general education in co-operation with other departments. Among the problems with which they would be concerned, the educational aspects of preventing VD would have a high priority.

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