Women's treatment decisions for genital symptoms[1]

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Summary: A study of illness behaviour and sexually transmitted diseases (STDs) investigated the ways in which women with symptoms potentially attributable to STD reached a decision on whether or not treatment should be sought. It was found that non-treatment of genital symptoms is partially explained by women classifying symptoms as normal: 53% among those not seeking treatment did so, compared to 12% and 10% in the two treated groups. When people are uncertain about symptoms there is a motivation to seek treatment. Thus, nearly all women in this category thought treatment necessary. Even among women who do seek treatment, the majority do so only after a period of waiting. Only 45% and 43% in the two treated groups reported seeking treatment immediately. The biological and sociological background relevant to treatment decisions indicate that it will be difficult to achieve changes in these percentages.

Introduction

In any disease, symptomatic or asymptomatic, only a small proportion of patients present for treatment to qualified medical practitioners (Wadsworth *et al.* 1971). This is of considerable importance to the control of sexually transmitted diseases (STDs) since untreated disease can lead to long-term morbidity in the sufferers, and increases the possibility that other members of the community will also be infected. An understanding of how treatment decisions are made by people with the symptoms attributable to STDs is important; although some work has been undertaken on male patients, the study discussed in this paper concentrates upon women.

Methods

Three groups of women were obtained by giving a screening questionnaire to 4057 consecutive patients attending three family planning clinics and a clinic for the treatment of STDs. The three groups comprised: 75 women with symptoms potentially those of STD who had not sought treatment (Experimental); 75 women with symptoms potentially those of STD who had sought treatment from general practitioners, family planning clinics and other medical agencies (Control 1); 75 women with symptoms potentially those of STD who had exclusively sought treatment at an STD clinic, James Pringle House, Middlesex Hospital (Control 2).

Women in the treated groups were matched with the untreated group for age and social class. Respondents were interviewed using a questionnaire based upon a decision-making model (Figure 1) which enables a step-by-step examination of treatment decisions. This was developed following the findings of a pilot study (Harrison 1979). Initially, a decision must be made to classify the way in which the body is functioning as symptomatic or not. The next stage involves a response to the classification of normal or abnormal. Sometimes the initial perception of a symptom may suggest a treatment decision, but not always. Some spots, rashes and discharges may be regarded as abnormal but, nonetheless, may be deemed medical trivia by lay persons.

The model has an intermediate stage labelled 'ought decision'. This concerns framing an intention to take action. People may intend to seek treatment yet hesitate or never carry out

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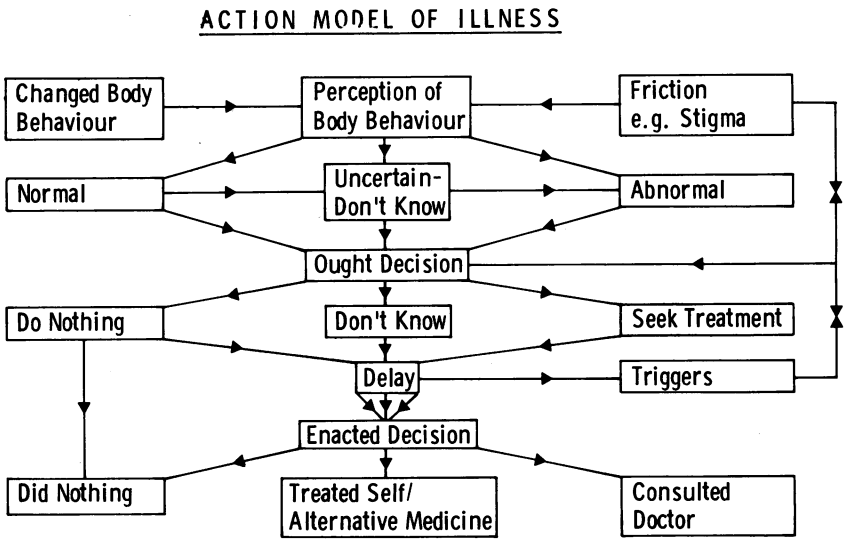

Figure 1. A guiding model for the study of illness behaviour

that intention. They may be frightened of medical procedures, ignorant of where to go, or fearful of a stigmatizing diagnosis.

Finally some patients may enact their intentions and seek treatment. This may, however, require some provocation. Their symptoms may become more pronounced, or they may receive advice. This aspect is considered in the section labelled 'triggers'.

Results

The response rate for the screened population was 85%. In Figure 2 the guiding model is presented with data. Examination of the top section indicates a large difference in the initial perception of symptoms. Symptoms were regarded as normal by 53% of untreated women compared with 12% and 10% of the treated groups. Correspondingly, 53% and 60% of the treatment seekers regarded symptoms as abnormal while only 26% of the untreated did so. Perhaps more noteworthy are the 35% and 31% of the two treated groups in the mid-point 'don't know' category; this suggests that bafflement and the designation of symptoms as abnormal both lead to treatment.

At the next stage, whether or not treatment is thought necessary, differences are more pronounced – underlining the observation of a relationship between uncertainty and treatment-seeking. Most women in the control groups who were uncertain about their symptoms believed they should seek medical advice. If the three groups in the box titled 'uncertain – don't know' are followed through the model (taking the figures from left to right), nearly all of the 21%, 35% and 31% moved to the 'seek treatment' group. Only 3% of the untreated group remained as 'don't knows'. These women combine with all those who felt their symptoms were abnormal, plus a 'play safe' element of 8% and 9% of the women from the two control groups who regarded symptoms as normal, to produce the figures 45%, 96% and 96% in the 'seek treatment' box.

The absence of a 'play safe' group among those who did not seek treatment may indicate a greater confidence about their self diagnosis. All but 1% of the 53% in the 'normal' box moved to the 'do nothing' group.

Among the women who did eventually seek treatment, only a minority did so immediately. Thus it may be seen, in the 'delay' section, only 45% and 43% of treatment seekers did so immediately. The largest group among delayers were women who tended to think that their

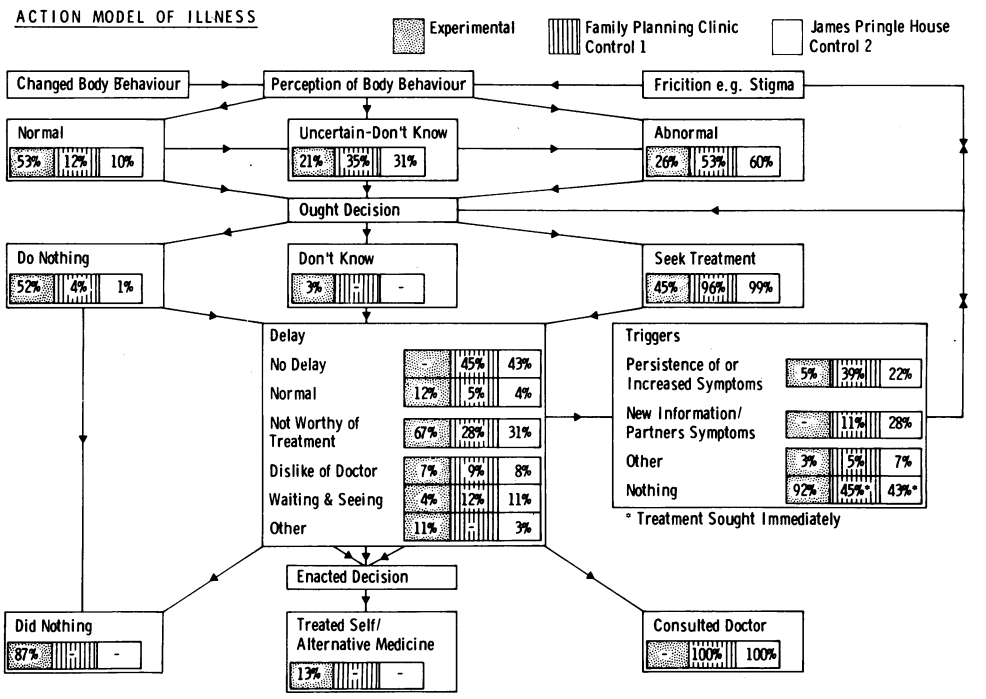

Figure 2. Guiding model with data of women with symptoms potentially attributable to sexually transmitted disease

symptoms did not warrant treatment. The belief that they should seek treatment is a moral one rather than medical. This is also the largest group, 67% amongst the group who failed to seek treatment.

By definition, all women in both control groups were treated. What terminated a period of symptom accommodation is presented in the section marked 'triggers'. Two predominant criteria emerged: 'persistence' and 'new information'. Persistence was more important for those treated by a variety of medical agencies, and new information for the group who exclusively attended the STD clinic. This was never a contact slip, but it did involve the use of the lay diagnostic test of quizzing one's partner, or a guilty confession.

Finally, 13% not seeking treatment used self-medication. This included naturopathic diets, yoghurt, patent medicines and borrowed prescribed medicines.

Discussion

This paper presents elementary analysis of data from a study of illness behaviour. While it is only descriptive it does provide some useful observations. A picture emerges of considerable difficulty, uncertainty and hesitation by women attempting self-diagnosis. A quarter of women who do not seek treatment believe their symptoms are abnormal. They do not seek care because they feel symptoms are insufficiently serious. Even for those women who do go to the doctor, procrastination is the norm. Indeed, delay may be as important in disease transmission as non-treatment. Women are only confident about the possibility of STD when the symptoms are very pronounced or they arise in a stereotypical behavioural context.

Several important questions are posed rather than answered. Why, for example, do women make the particular designations recorded in this study? The answers to these questions may relate to the particular presenting characteristics of STDs. Women harbouring STDs may fail to seek treatment primarily because the range, both in intensity and type, of STD symptoms

combined with their similarity to many common complaints (which women regard as part of their lot or trivial) make self-diagnosis extremely difficult. Indeed, diagnosis based upon symptoms alone is very difficult even for the medically qualified. This underlying feature of STDs creates a difficult problem in changing patterns of illness behaviour for women who may have a sexually transmitted disease.

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