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VENEREAL DISEASES AS A NATIONAL AND INTERNATIONAL HEALTH PROBLEM

PSYCHOLOGICAL, SOCIAL, AND CULTURAL ASPECTS OF VENEREAL DISEASES

There is general agreement among members of various health professions as to the influence exerted by social factors on the distribution and control of venereal diseases. Research on this relationship is scanty, however, although hypothetical propositions steeped in value judgments abound. Among the most outstanding of the various reasons for the lack of research in this field are methodological difficulties and the absence of a framework of psycho-sociological theory. It must also be taken into account that because venereal diseases are directly linked to sex, study of them brings us into a highly emotional area, which makes objective analysis of the problem difficult.

The following are the basic objectives of the present study: (a) to systematize the existing information on the psycho-socio-cultural factors influencing the distribution and control of venereal diseases; (b) to indicate the gaps in this information; and (c) to suggest lines of research which will help to shed light on the role played by psycho-socio-cultural factors in venereal diseases.

1. Existing Knowledge of the Psycho-socio-cultural Factors Affecting the Natural History of Venereal Diseases

Disease, viewed as a process, implies a number of successive phases which have been divided into two major categories, prepathogenic and pathogenic (1, 2). The prepathogenic phase comprises the preliminary interaction between the potential agent of disease, the host and the environmental factors. The pathogenic phase begins with changes in the structure and function of the organism, generated by the agent of disease, and ends with recovery, disablement or death.

In the case of the natural history of venereal diseases, there is an imbalance between the considerable progress made in knowledge of biological

factors and the meager information available on psycho-socio-cultural factors. The latter are of basic importance during the prepathogenic stage of venereal diseases because they affect the interaction between agent and host.

Since venereal diseases are transmitted mainly through sexual contact, it is worthwhile to inquire what type of relation entails the highest risks, and, subsequently, what factors are conducive to the type of sexual relationship identified as the most dangerous. The following are the three characteristics of sexual relations commonly mentioned in the literature of the subject as connected with the transmission of venereal diseases: the frequency of sexual relations; the choice of partner; and the number of persons with whom sexual contact takes place.

The greater frequency of sexual relations has been cited as a factor that might account for the increase in venereal diseases in recent years (3). Some writers attribute this increase to the availability of new and more effective contraceptives and to the use of antibiotics, since these mitigate against fear of pregnancy and of venereal diseases (4, 5, 6). The evidence afforded by such research, however, does not bear out the existence of a direct correlation between greater sexual activity and the increase in venereal diseases.

The widespread belief that sexual activity and promiscuity have increased in recent years has been called in question by several writers. According to Cagnon and Simon (7), there is evidence that sexual behavior had altered very little in the United States during the past four decades. The false impression of change may be due to a real change in the approach to sexual problems, discussion of which is no longer a private but a public matter.

It has also been postulated that the probability of infection and disease propagation increases with the rise in the number of sex pairs and in the number of persons with whom the partner of a specific individual has sexual relations. But as in the case of the characteristic discussed above, the important factor in the spread of disease would seem to be the indiscriminate choice of partner rather than the number of pairs, because it brings the person under study into contact with the highest-incidence groups.

Methodological problems such as ambiguity in definitions, variations in indicators, and the "ecological fallacy," as it is called, make it difficult to draw conclusions from research on sexual relations with reference to venereal diseases. An approach designed to pinpoint the elements in sexual relations relevant to the problem of venereal diseases is that suggested by Loeb (8, 9), who takes into account two of the characteristics analyzed above: the number of persons with whom a given individual has sexual relations over a specified period of time, and the degree of care exercised in the choice of partner. By combining these two variables, a matrix of sexual relations can be obtained which is useful for classifying sexual contacts in accordance with the degree of risk they represent as regards infection and the propagation of venereal diseases. Figure 1 presents a simplified adaptation of Loeb's system.

Figure 1  
Typology of Sexual Relations

Care Exercised in Choice of Partner	Number of Persons	
	One	More than One
Careful selection	A	B
Indiscriminate selection	C	D

The A-type of sexual relation is the one involving least risk of infection and propagation, because the persons concerned do not come into contact with groups in which the incidence of venereal diseases is high; it is the type found in stable relationships, such as marriage and consensual unions. Case D is at the opposite extreme, and may be termed a promiscuous relationship, with or without profit-seeking motives. Promiscuity will therefore be defined as sexual relations with several persons indiscriminately or casually chosen. Of the four types, D is the most risky and the most conducive to increased propagation of venereal diseases.

The C-type relation exposes the individual concerned to a high risk of infection, although it does not necessarily entail the spread of venereal disease.

The typology presented takes into account the sexual relations of one member of each pair, and when those of the other partner are considered, a combination of types may result. For example, situations involving little risk, as in type A, may become dangerous if one of the partners maintains indiscriminate sexual relations with other people. A case in point is supplied by Celia S. Deschin (10). A girl attending the university and living with her parents had occasional sexual relations with her fiancé. He transmitted the disease to her after he had had relations with a prostitute, to whom a quarrel with his fiancée had driven him.

In this case the relation maintained by the female partner was characterized by little risk of venereal infection, but the position became dangerous when the male partner indulged in a casual type of relation.

In order to be able to assert that the highest risk attaches to promiscuous behavior or a casual sexual contact, it is necessary to show that a large proportion of infected persons or the members of high-incidence groups have sexual relations of this type. Although no research on the sexual behavior of infected persons not under medical treatment is at hand, it can be inferred from various studies that a great many untreated cases maintain indiscriminate sex relations.

In view of the fact that promiscuous sexual relations, and in particular those based on casual choice, facilitate the propagation of venereal diseases, published research must be examined to see what factors have been detected as important in determining this type of sexual behavior. The explanations put forward will be classified under the following three heads: cultural, sociological, and psychological.

Promiscuity and indiscriminate sexual relations have cultural, social, and psychological facets. From the cultural standpoint, it is important to ascertain the prevailing values in relation to sexual behavior, and their variations within countries and from one country to another. The sociologist is interested in identifying the social factors which inhibit or encourage the behavior under study, and the psychologist is concerned with the motives that induce the individual to defy the prevailing codes of values and to take risks, despite his knowledge of the possibilities of venereal infection.

At the level of cultural explanations, several writers (11, 12, 13) agree that in the western world the prevailing values are in favor of sexual behavior based on love, i.e., on intimate acquaintance accompanied by a measure of stability. Block (14) notes the emergence of a sexual attitude consisting

in the belief that sexual relations are "right" if there is evidence of affection and fidelity; in the attaching of importance to sex experience in itself, irrespective of its reproductive function; in the recognition that sexual feelings are not "wrong"; and in increased acceptance of a single standard of morality. This new set of norms is commonest among young people, and particularly among those whose educational level is highest (15). Such findings would appear to contravene the opinion of some writers who interpret youth's adoption of more permissive sex standards as an attitude favorable to promiscuity.

Variations exist, however, in sexual norms from one country to another and within each society. Subgroups in a given social system may differ so widely as regards the prevailing standards and behavior patterns that they constitute clearly differentiated subcultures (13).

One of the subcultures to which most study has been devoted, owing to the emphasis placed on promiscuous sexual behavior, is composed of men in the lower classes and young men in general. A typical feature of the members of these groups is the so-called "virility complex" or "tenderness taboo" (16).

The tendency of these groups to show off their "manliness" seems to lead them to adopt a number of behavior patterns such as acts of courage, endurance of pain, displays of physical strength, the cultivation of a virile appearance, and casual and promiscuous sexual relations (16, 17, 18, and 19). For these people, the contraction of venereal disease may also constitute a badge of membership of the category of "real men." The explanation given for the "virility complex" would seem to be that lower-class youths and men belong to an underprivileged stratum of society, or, in other words, do not possess

accessible and approved means of social mobility, so that manifestations of manliness are among the few things that give them a chance of acquiring prestige in their group (16).

It is maintained that the high indices of premarital relations formerly found among men in the lower classes seem to be moving downward in the direction of middle-class patterns. The middle-class values that put a premium on the restriction and postponement of gratifications would appear to be permeating other social classes, in consequence of rising income levels and of the number of young people from different backgrounds that now enter secondary and higher education (7).

From the sociological angle, it is useful to know what factors produce or increase those types of sexual contacts which involve the highest risks of infection and propagation of disease: promiscuous relations and those in which the choice of partner is indiscriminate.

Circumstances which remove people from their primary group, such as their family, friends, and neighborhood, will facilitate an increase in casual or indiscriminate relations, since the primary group exerts some control over behavior, in line with its accepted standards. Among the middle classes, these standards and values repudiate the indiscriminate or casual type of relationship. Furthermore, people who have left their primary group have more free time, especially in transitional situations such as migration unaccompanied by the family, and this is conducive to casual contacts.

According to the theory set forth, the groups most exposed to risk would seem to be students newly arrived in a large town, recent immigrants without families, tourists, soldiers stationed away from their permanent place of



residence, sailors, and participants in conventions, world fairs, or sporting events. A high proportion of prostitutes' customers belong to these groups, and are to be found in the greatest numbers in big cities.

For the reasons given above, immigrants are a high-risk group, and in several countries represent a large proportion of the total number of cases of venereal disease. In England and Wales, half the cases of gonorrhoea and four out of every ten cases of primary and secondary syphilis receiving hospital treatment are immigrants (20). Their main source of infection is constituted by promiscuous women in the locality. Willcox states that immigrants have a greater propensity to contract venereal diseases, because in a foreign country they have difficulty - at least during the years they take to adapt themselves to their new way of life - in establishing stable sexual relations. They are often young and sexually active men who are out of reach of the influence of their parents, family, and other groups that might have an inhibiting effect on promiscuous relations. Their sexual needs are satisfied by the few immigrant women available and by promiscuous local women who generally have high indices of venereal infection. The same is true of in-migration. In a study of migrants to an urban area in the south of the United States, Butler finds that these people of rural origin have a greater number of casual sexual contacts (21) than when they lived in rural areas. The conclusion is reached that it is the type of sexual contact, rather than the number of partners with which relations take place, that determines the probability of contracting a venereal disease.

A great many students are also in a stop-gap situation, especially during the initial years of their course, which places them among the high-risk groups.

Arya and Bennett, in a study carried out among students at the University of East Africa, note that students from other parts of Africa behave like immigrants, and are exposed to a high degree of risk because they are away from their wives and other relatives who have a regulatory influence on their behavior (15). As a general rule, according to the above-mentioned writers, students who did not contract venereal diseases were more careful in choosing their sexual partners than those who did become infected. The increase in venereal diseases which seems to be observable among adolescents may be due to an increase in indiscriminate relations, owing to the fact that a larger number of young people live away from their families and travel more often than was customary in the past. Control of this factor reduces the significance of others, such as the number of partners and frequency of contacts. Various studies seem to bear out this hypothesis. A study of 100 adolescents infected with gonorrhoea, which was carried out in Copenhagen by Knud Ekstrom, showed that only one-half of the patients lived at home, i.e., a small proportion in comparison with the situation among the normal population in the same age group (22).

Knoebel (11) remarks that in almost all societies the immigrant is blamed for the transmission of venereal disease, and ascribes this fact to the social necessity of blaming someone who does not belong to the community. Knoebel's hypothesis, which is of a psychological nature and would be worth testing, is not at variance with the well-substantiated proposition that circumstances which remove the individual from his primary group may lead him into indiscriminate sexual relations and, consequently, into contracting a venereal disease.

Obviously, purely sociological or anthropological explanations cannot account for the whole of the phenomenon in question. For example, not all the women who emigrate from rural to urban areas end up as prostitutes, nor do all individuals who are cut off from their primary group indulge in indiscriminate relations; neither do all young people in the lower classes take to sexual promiscuity. Accordingly, what is needed is to introduce personality variables to complete the explanation of the variations in the sexual behavior with which we are concerned. Three of these personality variables should be discussed: (a) the relation between personality and certain sexual behavior patterns considered to entail high risks; (b) the relation between the home atmosphere and certain types of personality; and (c) the interrelationship between personality and social conditions permitting indiscriminate relations.

There are a great many studies on the personality of promiscuous individuals and patients suffering from venereal diseases. Most of them are based on clinical case studies, lacking systematic treatment of the available information, and abounding in interpretations dictated by different schools of psychological thought. A review of research in this area (23, 24, 25) reveals that the promiscuous, whether healthy or diseased, are people with manifest psychological conflicts, low levels of self-esteem, and underdeveloped inner controls which incapacitate them for steady sexual relations. They generally come from broken or conflict-ridden homes where an unsuitable father and an unloving mother prevent them from assimilating certain values and standards which enable individuals to restrain impulses that would violate the norms of society (10).

This lack of inner control means that the individual is completely at a loss when he moves away from the external control of his primary group, as happens in cases of emigration from rural to urban areas. Rapid cultural changes may lead to delinquency and prostitution, because the newcomer to the city ceases to comply with the standards learned in the rural environment without having assimilated urban norms. This disorientation, the product of a certain type of personality in combination with a rapid change of environment, makes such people easy victims of economic exploitation. Herein lies one possible explanation of the fact that many town prostitutes originally come from rural areas.

## 2. Existing Knowledge of the Psycho-socio-cultural Factors which Facilitate or Impede the Application of Preventive Measures

It seems beyond a doubt that when the factors intervening in the natural history of venereal disease are better known, new preventive measures will be suggested, in addition to those already in use. Many of the preventive steps recommended today, however, are not fully effective, owing to the operation of psycho-socio-cultural factors.

Preventive measures have been classified by Leavell and Clark (1) at different levels which are closely related to the above-mentioned phases in the natural history of venereal disease. The primary level of prevention corresponds to the prepathogenic phase and the secondary and tertiary levels to the pathogenic phase.

### 2.1 Preventive Behavior in Health

Among the preventive measures suggested at the primary level are sex education, hygiene, prenatal serological examinations, and the avoidance of sexual promiscuity. How far can health or sex education change those behavior patterns which represent risks for the individual and for the community?

Ignorance with respect to sexual questions and the transmission of venereal diseases is responsible for the contraction of disease in many individual cases, and for such people sex education will undoubtedly help to reduce the risks (26, 27). Nevertheless, several studies have shown the inefficacy of health education programs (27, 28). For example, Arya and Bennett (15) discovered in the course of their research on students that the advice and the group discussions which accompany the treatment of patients with venereal disease do not reduce the probability of reinfection. Ekstrom makes a similar observation with respect to patients of another type.

The studies cited appear to suggest that the mere possession of knowledge is not enough to determine rational behavior vis-à-vis disease. Unquestionably, emotional elements are involved which are hard to change because they have their roots at such deep levels of the personality.

## 2.2 Preventive Behavior in Disease

Early diagnosis and prompt treatment are the basic principles of control of venereal diseases at the secondary preventive level. One of the procedures required is the tracing and treatment of contacts (30). Dr. King (31) asserts in a recent article that the properly organized tracing of contacts by a sufficient number of capable and devoted workers under hospital direction affords the best hope of first reducing and then eliminating syphilis and gonorrhoea. Contact tracing, even when suitable organization and staff are available, presents difficulties resulting from psycho-social factors which can be classified under the following heads:

- a. Insufficient cooperation on the patient's part;
- b. Negative attitude of health personnel towards patients with venereal diseases; and
- c. Incomplete case reporting by physicians.

a. Insufficient cooperation on the patient's part

Only a few of the people exposed to infection seek immediate medical treatment (31). This state of affairs is not peculiar to venereal diseases, although it would seem that the percentage of those who fail to seek medical assistance is much higher than in other types of ailment. The following are factors which were found to be closely related to application for medical assistance in the case of several diseases: the severity of symptoms; and their interpretation as indicators of disease, so that the more serious the early symptoms, the more likely it was that the patient would consider consulting a physician and would in fact do so immediately. In cases where the symptoms were felt to be less acute, self-treatment such as the use of home-made remedies or patent medicines was resorted to (32). Again, if the symptoms were interpreted as indicators of disease, it was more likely that the affected person would consider consulting a physician and would actually do so.

Carlson (33), in research on factors connected with immediate recourse to medical assistance, finds four explanations for failure to seek medical attention voluntarily: a) disregard of early symptoms of venereal disease, especially in women; b) the patient's idea that a stigma is attached to venereal disease; c) lack of sufficient information on the course and possible consequences of venereal infection; and d) fear of treatment and general

mistrust of physicians and of specialized treatment centers. As in the case of other diseases, Carlson found that the influence of the primary group carried great weight in the decision to seek medical assistance. Identification with the primary group and close dependence on it - described by other writers as forms of localism - deterred the patient from seeking medical advice and were conducive to treatment at home or by other acquaintances.

Lack of information on the symptoms, causes and consequences of venereal diseases is very common, as has been shown in various studies (27). This finding becomes important if it is borne in mind that the initial diagnosis is made by the infected or probably infected person and that his subsequent line of conduct will depend upon the diagnosis he arrives at. This is why, once a contact has been traced and a diagnosis made by a physician, the patient will have to be persuaded to cooperate in the treatment. A high proportion of the contacts located do not follow the treatment prescribed because they have not defined the disease for themselves and are unaware of its implications.

In another study, Morsell finds that the perception of symptoms is of basic importance in the decision to seek treatment, but that 15% of those who voluntarily sought medical advice had not observed any symptoms and that 29% of non-voluntary patients had noted definite symptoms, but had ignored them.

In the above-mentioned study, the sense of personal vulnerability - awareness of venereal disease as a personal anxiety - constituted an important factor in the seeking of medical assistance when no symptoms were present.

Generally speaking, there was a positive relationship between the level of information and the suspicion of infection and application for treatments. Among young men, however, there was a negative correlation between a higher level of knowledge and the speed with which medical advice was sought. Perhaps the explanation is that the knowledge possessed by members of this group may lead them to suppose that they are "in control of the situation", mitigating their fear of disease and, therefore, inducing them to defer consulting a physician.

The findings of Carlson and Morsell on the determinants of different behavior patterns with respect to seeking medical assistance have also been corroborated by studies of other diseases. This suggests that the psychological and social barriers which prevent people from consulting a physician are much the same for all diseases, but are more marked in the case of venereal infections.

b. Negative attitude of health personnel towards venereal disease patients

Both the population at large and professional health workers view venereal diseases as a social stigma (10). This negative attitude may be reflected in the treatment which some professional personnel give to patients, thereby creating in them an uncomfortable feeling possibly leading to rejection of diagnosis or treatment. The iatrogenic effects of mistaken diagnoses (34) of venereal diseases have been reported and reveal the impact which a diagnosis of venereal disease may have on certain persons who regard these diseases as synonymous with sin and personal debasement.



c. Incomplete case reporting by physicians

Another aspect of the effect which professional health workers may have on venereal disease control is the failure to report cases even in countries where venereal diseases are compulsorily notifiable. In a study made by the American Social Health Association in 1963, it was found that in the United States of America private practitioners reported only a small percentage of the cases they treated (35).

According to a study made by the National Opinion Research Center of the University of Chicago, in 1965, the problem did not lie in the fact that some physicians reported such cases and others did not, but that all physicians indulged in selective reporting (36). The physicians interviewed were more aware of their role in the physician-patient relationship and less of their role as protectors of the community.

The physician faced with the dilemma of protecting either his client or the community solves the problem by reporting some cases and not others (37). One explanation of this attitude may be a defect in professional training, which puts more emphasis on the protection of the patient as an individual.

3. Research on the Psychological, Social, and Cultural Aspects of Venereal Diseases

A survey of the scientific literature available to us on the psychological, social, and cultural aspects of venereal diseases shows (Annex A):

(a) A limited number of empirically confirmed scientific propositions and an abundance of untested explanations.

(b) Very imprecise definitions and variation in the use of indicators for measuring relevant concepts such as sexual promiscuity, frequency of sexual intercourse, and degree of care in the selection of a partner.

(c) Existence of "ecological fallacies" in many of the interpretations of research findings.

(d) Almost complete lack of research on these aspects of venereal diseases in Latin America.

(e) Lack of interdisciplinary studies leading to a partial understanding of the problem.

(f) No comparative studies have been undertaken, designed to test very general hypotheses.

It would therefore appear necessary and urgent to encourage research studies in Latin America on the psychological, social, and cultural aspects of venereal diseases, with the dual purpose of helping to discover more effective means of controlling these diseases and of contributing new knowledge in the field of the behavioral sciences.

The most relevant and urgent problems susceptible to investigation, especially as far as Latin America is concerned, may be divided into two groups: (a) the psychological, social, and cultural aspects of the natural history of venereal diseases; and (b) preventive behavior factors in health and in sickness.

### 3.1 Psychological, Social and Cultural Aspects of the Natural History of Venereal Diseases

The psychological, social and cultural aspects of the natural history of venereal diseases are related to factors which, in the prepathogenic stage, discourage or encourage contact between the agent producing the disease and the host. Although studies have been made of this point, the results are not conclusive and since they were made in other cultural contexts, they should be replicated in Latin America.

If suitably designed, studies of the problem should be able (Figure 2):

(a) To identify the types of sexual relations which involve the greatest risk of contagion and spread of venereal diseases, through a detailed analysis of characteristics of the sexual relationship that facilitated the contagion in some persons and endangered others (noninfected "contacts").

(b) To describe the sexual behavior of sick individuals during the period of infection, thus making it possible to identify foci or sources of infection in a given society. This type of study should also provide us with information about the psycho-sociological mechanisms which lead many of these sick individuals to continue their sexual activities even when they know or suspect that they are endangering other persons.

(c) To ascertain the distribution of relations identified as high risk relations in different groups and strata of a given society.

By means of sociometrical techniques and starting from diagnosed cases, the highest risk groups in a given society could be discovered. Knowing that sick persons come from or are in touch with promiscuous groups, these could be traced by obtaining from sick persons the identity of the members of those primary groups with which they maintain relations of any kind, such as friendly, work, recreational or sexual relations. This method has been used successfully by several research workers (38).

(d) To determine the psychological, sociological and cultural factors which affect the type of behavior regarded as high risk behavior. These include prevailing values and standards concerning sexual relations and venereal diseases, personality traits such as "propensity to expose oneself

Figure 2  
Research on psychological, social and cultural aspects  
of venereal diseases

A. Psychological, social and cultural aspects of the natural history of the disease



FACTORS THAT DISCOURAGE OR ENCOURAGE CONTACT BETWEEN  
THE AGENT PRODUCING THE DISEASE AND THE HOST

1. Identification of types of sexual relations which involve the greatest risks of contagion and spread of venereal diseases
2. Description of the sexual behavior of individuals with a venereal disease in the infectious stage
3. Ascertainment of the distribution and degree of institutionalization of the sexual relationships identified as major risk relationships in different countries and in different strata and groups in each society
4. Determination of the psychological, social and cultural factors that affect the type of sexual behavior regarded as high risk behavior

to the risk of contagion"; situations that place the individual outside the primary group temporarily, such as geographical mobility, family breakup, and financial situation.

### 3.2 Psychological, Social and Cultural Factors Involved in Preventive Behavior in Health and in Sickness

The psychological, social and cultural factors of preventive behavior may be classified according to the state of health or sickness of the individual, the state of health corresponding to the level of primary prevention and that of disease at the secondary and tertiary prevention levels.

#### a. Preventive behavior in health

Many of the preventive measures recommended at the primary level presuppose appropriate behavior on the part of individuals, who should take care not to expose themselves to situations of risk and use measures to protect themselves against venereal diseases. We know for sure that this is not so and that, on the contrary, many persons act irrationally in the face of the danger of venereal diseases.

To discover the reasons why some persons take preventive measures and others do not would facilitate the discovery of new preventive measures and the improvement of existing measures. (Figure 3).

One of the simplest theories in this area is that which postulates a relationship between beliefs, attitudes, or knowledge and the adoption of preventive measures. Health education and sex education are based on this type of proposition. However, behavioral sciences have shown that this association is not always present, since some individuals do not behave in the face of venereal diseases in accordance with their knowledge and beliefs, due in part to social pressures and for psychological reasons.

Figure 3  
Research on Psychological, Social and Cultural Aspects of Venereal Diseases

B. Psychological, social and cultural factors involved in preventive behavior in health

-----Primary prevention-----

FACTORS THAT LEAD INDIVIDUALS TO TAKE PREVENTIVE MEASURES

1. Influence on the adoption of preventive measures of:
  - (a) opinions, attitudes, beliefs;
  - (b) personality characteristics, such as "personal vulnerability"; and
  - (c) social pressures arising from primary groups.
2. Evaluation of the degree of effectiveness of different information media, and study of the route followed by communications about venereal diseases, with special reference to the functions of opinion makers.

There are two psychological factors which discourage rational conduct that should be studied more thoroughly: (a) the degree of concern about the possibility of contagion; and (b) personal vulnerability or the belief that a person may contract the disease. When these two factors are associated with knowledge about means of preventing the diseases, it is possible to predict appropriate behavior. To what extent these sociological factors are an expression of a type of personality and how this personality is shaped are questions to which we do not yet have precise answers. However, we can state with a fair degree of certainty that changes in attitude and behavior are difficult to bring about and that they do not occur as a result of mere exposure to information media.

In this connection, Dr. Theodore J. Bauer some years ago reported that "the results of our initial efforts to evaluate the effect of press, radio, and cinema were inexplicably discouraging. Only a small percentage of the subjects who attended the clinic for diagnosis of their disease had seen a film or read a booklet or heard a radio program. The reason most frequently given by persons attending the clinics was that a friend or acquaintance had mentioned them to them. The most curious thing was that the friend or acquaintance gave them correct information (39).

The findings described by Bauer have been confirmed in other areas and are in accordance with regular patterns of behavior which may be stated as follows:

"Mass communication media exert an indirect influence through opinion makers. Opinion makers are individuals who read and listen to communication media, and subsequently transmit

information to relatives, friends, and acquaintances. This phenomenon is described as a two-stage communication flow. Consequently, communications will be more effective if they are directed at the opinion makers of the group rather than at all the members of the group."(40)

Except for few isolated observations, we have very little knowledge of how opinion makers act with respect to information about venereal diseases.

The discussion above reaffirms the importance of the primary group in modelling and changing attitudes and the behavior of its members. However, despite the amount of knowledge accumulated by the behavioral sciences in this field, little or nothing has been applied in the area of diseases in general and of venereal diseases in particular.

The influence of the primary group is probably fundamental in behavior with respect to venereal diseases, since we know that these are discussed only with their intimate friends.

### 3.3 Preventive Behavior in Sickness

The behavior of a sick person or a person exposed to the contagion has consequences for the individual and for society insofar as he constitutes a focus of infection. For the purposes of the study, the behavior of the patient, the sexual contact, and the physician will be discussed separately and in their interrelations (Figure 4).

#### a. Preventive behavior of the sick person

The sick person goes through a number of stages, in each of which he will have to take decisions that will have repercussions on the development of his affliction and the spread of the disease. These decisions have been



Figure 4

RESEARCH ON THE PSYCHOLOGICAL, SOCIAL AND CULTURAL ASPECTS OF VENEREAL DISEASES

C. Psychological, social and cultural factors involved in preventive behavior in sickness or danger of sickness



PROFESSIONAL HEALTH  
WORKER LEVEL

- 1. Decision to report cases of venereal disease to health authorities

Factors that intervene in:

PATIENT LEVEL

- 1. Conviction of being ill and needs medical care
- 2. Conviction that a person is sick and needs medical care
- 3. Decision to visit a physician
- 4. Decision to collaborate in contact tracing
- 5. Decision to accept and follow the prescribed treatment
- 6. Decision to abandon the role of patient

CONTACT LEVEL

- 1. Conviction that he has been exposed to a situation involving a risk for his health
  - 2. Conviction that he needs medical care in order to learn whether or not he is sick
- Reintegration into normal activities

described by Schuman (41) for diseases in general and will be applied, with some modifications, to the study of persons suffering from venereal diseases. In each of these decisions the goal of the investigator is to discover the psychological, social, and cultural factors determining it.

I. Conviction that he is ill

The perception of symptoms and their interpretation are basic elements in initiating the process of medical care. So far we do not know what type of symptoms are considered by the healthy and the sick as being most serious in venereal diseases, nor the extent to which they influence the decision to obtain medical attention.

II. Conviction that he is sick and needs medical care

During this phase the presumptive patient tries to alleviate the symptoms, to obtain information and advice as well as temporary acceptance of his condition by members of his family and his friends. In view of the social stigma attaching in many societies to venereal diseases we must ask ourselves which group the presumptive patient consults and which measures he takes to alleviate his symptoms.

III. Decision to visit the doctor

In this phase the patient tries to obtain a medical diagnosis and a prescribed course of treatment. In the case of venereal diseases many persons resort unwillingly to a physician and may refuse the initial diagnosis or treatment and begin to look for other sources of care, generally "lay" persons who are better suited to their needs and preconceptions. In this phase it is important to study the influence of the attitude and behavior of health personnel on the rejection of medical diagnosis or treatment.

IV. Decision to collaborate in contact tracing

The notification of sexual contacts, as we said earlier, is one of the most important elements in venereal disease control. At the same time, it is, for the individual concerned, one of the most difficult decisions to make. To overcome this resistance some physicians have suggested various approaches, but the truth is that we do not know what conflicts the patient must resolve in arriving at a decision and the factors that determine it (42). Since the act of notification is viewed in our societies as highly reprehensible, since it implies disloyalty, we may suppose that reporting of contacts also involves a conflict of the same type. Knowledge, social pressures, and personality may be brought to bear to induce an individual to furnish the names of the persons with whom he has had sexual relations.

V. Decision to give the address to a physician and to accept and follow the prescribed treatment

It is in this phase that the sick person becomes a patient. However, to visit a physician does not necessarily mean that the person is prepared to accept his recommendations. There are a number of psychological, social and cultural factors which may interfere with the course of treatment and which should be studied, such as different conceptions of the disease, administrative obstacles, and the attitude of the physician towards the patient.

VI. Decision to give up being a patient

In the convalescence phase the former patient must again learn how to live among the healthy. We do not know what problems of adjustment face persons suffering from venereal diseases, but it seems probable that concealment of the disease plays an important role in the process of readaptation.

b. Preventive behavior of sexual contacts that have been traced

The sexual contact that has been traced, like the patient, goes through a series of decisions which may lead him to adopt the role of patient or to readapt to normal life.

The decisions which the contact must make are:

i. Conviction that he has been exposed to a situation of risk. The contact, once traced, must be convinced that he should attend a specialized clinic. The absence of symptoms makes it very difficult for him to make this decision.

ii. Conviction that he may be sick and needs medical care. In this decision, as in the others, the primary group should play a very important role.

iii. Decision to visit a physician. In this phase, the individual will try to obtain a diagnosis which may turn him into a patient or return him to his activities.

c. Preventive behavior of professional health workers and in particular of physicians

The most important decision for this group is that of the reporting of diagnosed cases. From other investigations we know that physicians usually make a selective notification but we do not know the criteria they use in reporting some persons and not others. Professional education will have to be studied, as will be attitudes towards specialized clinics, since in the latter case it might happen that the lack of confidence in these clinics would determine the decision to report.

#### 4. Summary and Conclusions

An analysis has been made of the scientific literature available on the psychological, social and cultural aspects of venereal diseases, and attention has been drawn to some of the knowledge accumulated by behavioral sciences, which has been ordered in accordance with models of the natural history of disease and preventive behavior in health and in sickness.

The examination of scientific literature shows:

a. The existence of a small number of scientific propositions that have been confirmed and of an abundance of explanations which have not been tested.

b. Very imprecise definitions and variations in the use of indicators for measuring relevant concepts such as sexual promiscuity, frequency of sexual relations and degree of care in selecting a partner.

c. Existence of "ecological fallacies" in many of the interpretations of the findings of research studies. Thus, positive correlations by countries, cities or regions between indices of the frequency of sexual activity and the frequency of venereal diseases, may not support the hypothesis that the individuals who are most sexually active are those who are most exposed to the risk of contracting venereal diseases. In other words, the analysis of social groups is inappropriate when the hypothesis relates to individuals.

d. There is a lack of comparative studies designed to test very general hypotheses.

In view of the findings of this survey of research on the psychological, social and cultural aspects of venereal diseases, it is recommended that

research on these aspects be undertaken in Latin America without delay.

Examples of possible areas of research have been submitted and divided into two major groups: (1) psychological, social and cultural aspects of the natural history of the disease; and (2) factors involved in preventive behavior in health and in disease.

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