Some Factors Involved
in the
Spread of Venereal Disease.

by
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Preface

This study is an attempt to find some of the major factors involved in the present day prevalence of venereal disease; emphasis is given to some of the psychological factors that are too often omitted from discussion of this topic.

The subject of venereal disease can be, and has been approached from many points of view: some approaches have stressed economics; others, morality; and still others such particular problems as alcoholism, too much sex-knowledge, too little sex knowledge, lack of parental control, lack of legislation, and a host of others. Some of the studies have been very influential and have paved the way for action on the part of various interested individuals and groups, but no single study has concerned itself with all the aspects. This paper is a far cry from such an attempt; however, mention will be made of the recognized major factors known or thought to be involved in this complex problem.

It must be pointed out that this paper is in no way an attempt at a statistical survey, nor is it an attempt to find common factors predisposing to the spread of infection; if such attempts were feasible, they would not be valid in this study because of the inadequacy of the data. Although the paper is based on numerous clinical records, accounts of interviews with patients, actual interviews with clinic patients and a mass of reports from all parts of the world dealing with the problem of venereal disease control, most of the records are of free clinic patients and thus any serious statistical study would be of dubious value if its conclusions were applied to B. C. as a whole. On the other hand, criticism that the conclusions given in this paper can apply only to clinic patients of a lower economic and social class, would be too harsh.
Clinic patients under treatment for venereal disease are from all social and economic strata: in B. C. Clinics there is no question raised whether one can afford to pay for treatment, and, more importantly, the treatment at a clinic is always as good as, or better than, the treatment given by private physicians. (In many cases, this latter point is not considered by some infected persons who fear that they would be seen visiting a clinic by someone they knew. A discussion of the pros and cons of such attitudes need not be gone into in this paper; it suffices that such attitudes are prevalent; and prominent (self-thought or real) men and women usually prefer private physicians. The files on such patients are not complete enough to warrant a statistical survey, but are complete enough to give information of value in formulating general factors responsible for the spread of venereal disease.)
Introduction:

Within the eight year period (1938-1945 inclusive) in B. C., 28,021 new cases of venereal infection were reported; the term 'reported' should be emphasized, because there is evidence that private physicians are not reporting all cases as required by the Venereal Disease Suppression Act of 1924. (Estimates that the actual number of new cases is about twice the figure given, are of little consequence in this paper because even the given figure is startling enough.)

Whether there is an annual increase in the number of new cases is an important, but difficult point to determine. Because the reporting of new cases by private physicians is thought to be improving in B. C., there is often doubt whether the figures given in annual reports reflect an actual increase or decrease in the number of new infections. However, if it can be assumed that the Vancouver Clinic statistics reflect the true situation, it would appear that there is a fluctuating annual attack rate of venereal disease and that this attack rate is increasing annually.

From the outset, venereal disease control is concerned primarily with sexual activities. However, the domain of sex being as extensive as it is, for the purposes of investigating the problem of venereal disease, heterosexuality can be considered as the essential field of study. In this investigation, only heterosexuality in the form of coitus will be considered, because it is from coitus that the vast majority of infections are acquired. (Cases of homosexually acquired infections have been reported, but they will not be considered in this work; neither will those infections, sexually acquired, of very young children who have been criminally assaulted by adults.) Even further, every case of venereal infection, with the main exception of prenatal syphilis and parturiently acquired syphilis and
and gonorrhoea, and a few other rare exceptions, indicates that there has been promiscuous sexual behaviour on the part of at least one member of the pair acquiring infection. Possibly the use of the term "promiscuous" is not clear, so for the purposes of discussion, it will be defined as 'sexual (probably copulatory) behaviour with at least two persons within a period of four years'.

Disregarding any moral or ethical principles involved, the control of venereal disease is concerned primarily with the control of promiscuity rather than with the control of sexual activity between two persons, married or unmarried.
Chapter I: The Problem:

1. The Nature of the Problem:

The term "venereal disease" is one generally applied to two distinct infections, syphilis and gonorrhoea. (It is also applied to a number of other infections of a venereal nature, but they are quite rare in British Columbia.) At the present time, these two infections, combined, are the most prevalent of the serious communicable diseases in British Columbia, and in most western countries. They constitute a serious health problem, not merely an individual health problem, but especially a public health problem -- several authorities have stated that they constitute the most serious public health problem of today. (1) (2).

The serious consequences that may result from these diseases are themselves important fields of study for medical practitioners, psychiatrists, and social workers; for it is the consequences that remove venereal disease from the realm of an individual health problem to that of a public health problem. However, it is not the intention of this paper to dwell upon the problems which may follow the acquisition of an infection, but rather to explore some of the existing factors which precede infection.

Before discussing these factors, a broader enquiry into the problem must be made: such an enquiry must include the geographic origin of the infections, and some information concerning the individuals who have acquired infections. The information elicited from such an enquiry is far from sufficient to warrant any immediate conclusions being drawn concerning the control of venereal disease, but it does narrow the field of enquiry to limits within which control can be exercised.

(1) Parran, T., Shadow on the land, p. 53.
(2) Snow, W.F., Venereal Diseases, p. 13.
2. The Extent of the Problem:

In British Columbia, adequate records concerning the prevalence of venereal disease exist only from 1938; prior to this time, no satisfactory reporting system operated. Since then, however, the reporting of new infections by medical practitioners throughout the province has improved, although it is still far from being complete.

The passing of the first Venereal Disease Suppression Act in British Columbia in 1924, made it compulsory for medical practitioners in the province to report to the Provincial Board of Health all cases of venereal disease (syphilis, gonorrhoea, and chancroid) which came under their care. Nevertheless, despite this legislation, there is evidence that in many instances full reporting of new infections is not being made.

Furthermore, due to the ignorance which still surrounds venereal disease, many infected persons resort to quacks and charlatans, purchase some home remedy from their drug store, or else do nothing. How many untreated or improperly treated infections exist cannot be even approximated, but that there is a large number is evidenced by the number of positive tests for syphilis which appear in mass blood testing surveys such as those in employment examinations at large industrial plants, and in the medical examinations of the armed forces.

Thus, considering these few points, it can be readily seen that the official figures regarding the prevalence of venereal disease do not reveal the true situation. However, as they are the only ones available, and are the ones used in all official surveys, for the present they will have to suffice.

The following tables indicate the number of infections of gonorrhoea and syphilis acquired in British Columbia from 1938 to 1945 inclusive. These figures are the official totals as reported by clinics,
private physicians, hospitals, the armed forces, and some minor reporting agencies.

Table I indicates the total number of new notifications in B. C. from all the reporting agencies. It should be pointed out that though the figures given are notifications for the first time in B. C., they are not necessarily new infections. A person might have had treatment outside of B. C. and then on coming to this province continued his treatment; such a person would be considered a new case for statistical purposes. However, such cases are few, and the number of new notifications is considered as the criterion of the venereal disease problem in a given area. For general purposes, the number of new notifications and the number of new infections are synonymous.

### Table I

<table>
<thead>
<tr>
<th>Year</th>
<th>Syphilis</th>
<th>Gonorrhoea</th>
<th>Total Venereal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1938</td>
<td>1430</td>
<td>1604</td>
<td>3034</td>
</tr>
<tr>
<td>1939</td>
<td>1222</td>
<td>1391</td>
<td>2613</td>
</tr>
<tr>
<td>1940</td>
<td>996</td>
<td>1502</td>
<td>2498</td>
</tr>
<tr>
<td>1941</td>
<td>998</td>
<td>1747</td>
<td>2745</td>
</tr>
<tr>
<td>1942</td>
<td>1002</td>
<td>2409</td>
<td>3411</td>
</tr>
<tr>
<td>1943</td>
<td>1183</td>
<td>2555</td>
<td>3738</td>
</tr>
<tr>
<td>1944</td>
<td>1379</td>
<td>3358</td>
<td>4737</td>
</tr>
<tr>
<td>1945</td>
<td>1534</td>
<td>3711</td>
<td>5245</td>
</tr>
</tbody>
</table>

Table I: Total Notifications of Venereal Disease in B. C. from all Reporting Agencies.

Source: Division of V. D. Control, Vancouver, B. C.

Tables II and III indicate the numbers of new notifications from private physicians, free clinics of the Provincial Board of Health and other sources. These tables indicate that with the passage of time, reporting of venereal disease is improving, and that each year the figures published by the Provincial Board of Health give an ever improving portrayal of the actual prevalence of the diseases in the province. The
improvement in the completeness of reporting by private physicians is due
in part to education, to the supplying of drugs by the Government, and to
the growing realization on the part of the private physicians of the impor-
tance of complete reporting in the control of venereal disease.

TABLE II

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Syphilis Notifications from Private Physicians</th>
<th>No. of Syphilis Notifications from B. C. Clinics</th>
<th>No. of Syphilis Notifications from Other Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1938</td>
<td>597</td>
<td>717</td>
<td>116</td>
</tr>
<tr>
<td>1939</td>
<td>522</td>
<td>549</td>
<td>151</td>
</tr>
<tr>
<td>1940</td>
<td>465</td>
<td>358</td>
<td>173</td>
</tr>
<tr>
<td>1941</td>
<td>483</td>
<td>331</td>
<td>184</td>
</tr>
<tr>
<td>1942</td>
<td>562</td>
<td>271</td>
<td>169</td>
</tr>
<tr>
<td>1943</td>
<td>688</td>
<td>340</td>
<td>155</td>
</tr>
<tr>
<td>1944</td>
<td>708</td>
<td>492</td>
<td>179</td>
</tr>
<tr>
<td>1945</td>
<td>700</td>
<td>632</td>
<td>202</td>
</tr>
</tbody>
</table>

Table II: Total notifications of syphilis in B. C. from all reporting agencies.

Source: Division of V. D. Control, Vancouver, B. C.

TABLE III

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Gonorrhoea Notifications from Private Physicians</th>
<th>No. of Gonorrhoea Notifications from B. C. Clinics</th>
<th>No. of Gonorrhoea Notifications from Other Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1938</td>
<td>523</td>
<td>1059</td>
<td>22</td>
</tr>
<tr>
<td>1939</td>
<td>482</td>
<td>871</td>
<td>38</td>
</tr>
<tr>
<td>1940</td>
<td>524</td>
<td>826</td>
<td>152</td>
</tr>
<tr>
<td>1941</td>
<td>600</td>
<td>779</td>
<td>368</td>
</tr>
<tr>
<td>1942</td>
<td>952</td>
<td>842</td>
<td>692</td>
</tr>
<tr>
<td>1943</td>
<td>958</td>
<td>863</td>
<td>734</td>
</tr>
<tr>
<td>1944</td>
<td>1143</td>
<td>1176</td>
<td>1039</td>
</tr>
<tr>
<td>1945</td>
<td>1329</td>
<td>1565</td>
<td>817</td>
</tr>
</tbody>
</table>

Table III: Total notifications of gonorrhoea in B. C. from all reporting agencies.

Source: Division of V. D. Control, Vancouver, B. C.
Private physicians, who probably treat the majority of venereal disease in B.C., do not always notify the Provincial Board of Health as required by the Venereal Disease Suppression Act of 1924. It has long been suspected that many private physicians have not been so doing.

One source of suspicion of their failure to report all venereal infections coming under their care is obtained from a comparison of the ratio of syphilis to gonorrhoea reported by private physicians to that reported by government clinics. It can be safely assumed that all infections coming under the care of the Venereal Disease Clinics in B.C. are fully reported; and it can be seen in the tables that the ratio of syphilis to gonorrhoea infections is more than 1:2 in all years since 1940. The ratio of syphilis to gonorrhoea as reported by private physicians is less than 1:2 in all years since 1938. If it can be assumed that approximately the same ratio of both diseases come under the care of private physicians and free clinics, there is certainly evidence that many infections are not being reported. However, by these premises, it is also evident that reporting by private physicians is improving. (No conclusions are drawn from the ratio of syphilis to gonorrhoea as reported by "other" sources, because the ratios of the disease vary greatly; e.g., the ratio of syphilis to gonorrhoea as reported by hospitals is far greater than 1:1; as reported by the Armed Forces, it is far less than 1:1.)

Another indication of the lack of full reporting by private physicians is occasionally shown by clinic patients themselves. When a patient visits the clinic a brief case history is taken. If the patient reports a previous venereal infection treated by a private physician, that infection should have been reported to the Division of V.D. Control, and a record of it should be on file. When no such record can be found, it becomes evident that all infections are not being reported as required by
the Venereal Disease Suppression Act.

A third and probably more reliable indication of the lack of complete reporting of new infections is obtained from the laboratory reports sent to the Division of V. D. Control by the Division of Laboratories. The latter Division monthly furnishes the Division of V. D. Control with a list of the positive and doubtful serological tests for syphilis, and of the positive smear and culture examinations for gonorrhea, with the name or identification of the patient from whom the sample was taken, and the name of the physician who took the sample. These lists are checked with the records of the Division of Venereal Disease Control, and when a suspected infection has not been reported the physician responsible is requested to send in a Notification of Infection or an explanation.

The foregoing evidence is presented merely to indicate that the available statistics concerning the prevalence of venereal disease in the province are incomplete. The combined totals of infections not reported by private physicians, of those treated illegally by unqualified persons, and of those totally neglected are inestimable.

The laxity of reporting of venereal infections by private physicians is not solely a problem of B. C.; it is present in the other provinces of Canada, in the United States, and probably in every other country. Thus when a comparison is made of the prevalence of venereal disease in different provinces or countries, the degree of reporting in those provinces or countries must be considered.

Table IV shows the number of cases of syphilis (all types) in the provinces of Canada and the rate per 100,000 of syphilis in 1944 and 1945.
<table>
<thead>
<tr>
<th>Province</th>
<th>Cases 1944</th>
<th>Cases 1945</th>
<th>Rate 1944</th>
<th>Rate 1945</th>
</tr>
</thead>
<tbody>
<tr>
<td>CANADA</td>
<td>16,475</td>
<td>15,278</td>
<td>137.8</td>
<td>126.2</td>
</tr>
<tr>
<td>P.E.I.</td>
<td>35</td>
<td>34</td>
<td>38.5</td>
<td>37.0</td>
</tr>
<tr>
<td>N.S.</td>
<td>496</td>
<td>664</td>
<td>81.0</td>
<td>106.9</td>
</tr>
<tr>
<td>N.B.</td>
<td>573</td>
<td>413</td>
<td>124.0</td>
<td>88.2</td>
</tr>
<tr>
<td>Que.</td>
<td>7,120</td>
<td>7,037</td>
<td>203.4</td>
<td>169.5</td>
</tr>
<tr>
<td>Ont.</td>
<td>5,365</td>
<td>4,930</td>
<td>135.3</td>
<td>123.1</td>
</tr>
<tr>
<td>Man.</td>
<td>663</td>
<td>622</td>
<td>90.6</td>
<td>84.5</td>
</tr>
<tr>
<td>Sask.</td>
<td>360</td>
<td>410</td>
<td>42.6</td>
<td>48.5</td>
</tr>
<tr>
<td>Alta.</td>
<td>573</td>
<td>599</td>
<td>70.0</td>
<td>72.5</td>
</tr>
<tr>
<td>B. C.</td>
<td>1,290</td>
<td>1,569</td>
<td>138.4</td>
<td>165.3</td>
</tr>
</tbody>
</table>

Table IV: Incidence and Rate per 100,000 per annum, of Syphilis, all types; Reported by Provincial Health Departments to the Dominion Bureau of Statistics.

Source: Division of Venereal Disease Control, Department of National Health and Welfare, Ottawa.
Table V shows the number of cases of gonorrhoea in the provinces of Canada and the rate per 100,000 of gonorrhoea in 1944 and 1945.

<table>
<thead>
<tr>
<th>Province</th>
<th>1944</th>
<th>1945</th>
</tr>
</thead>
<tbody>
<tr>
<td>CANADA</td>
<td>22,282</td>
<td>25,237</td>
</tr>
<tr>
<td>Rate</td>
<td>186.3</td>
<td>208.5</td>
</tr>
<tr>
<td>P.E.I.</td>
<td>20</td>
<td>42</td>
</tr>
<tr>
<td>Rate</td>
<td>22.0</td>
<td>45.7</td>
</tr>
<tr>
<td>N.S.</td>
<td>1,663</td>
<td>1,176</td>
</tr>
<tr>
<td>Rate</td>
<td>271.7</td>
<td>189.4</td>
</tr>
<tr>
<td>N.B.</td>
<td>913</td>
<td>1,079</td>
</tr>
<tr>
<td>Rate</td>
<td>197.6</td>
<td>230.6</td>
</tr>
<tr>
<td>Que.</td>
<td>4,259</td>
<td>5,106</td>
</tr>
<tr>
<td>Rate</td>
<td>121.7</td>
<td>143.4</td>
</tr>
<tr>
<td>Ont.</td>
<td>7,908</td>
<td>8,224</td>
</tr>
<tr>
<td>Rate</td>
<td>199.4</td>
<td>205.4</td>
</tr>
<tr>
<td>Man.</td>
<td>1,737</td>
<td>2,336</td>
</tr>
<tr>
<td>Rate</td>
<td>237.3</td>
<td>317.4</td>
</tr>
<tr>
<td>Sask.</td>
<td>1,123</td>
<td>1,685</td>
</tr>
<tr>
<td>Rate</td>
<td>132.7</td>
<td>199.4</td>
</tr>
<tr>
<td>Alta.</td>
<td>1,522</td>
<td>1,881</td>
</tr>
<tr>
<td>Rate</td>
<td>186.1</td>
<td>227.7</td>
</tr>
<tr>
<td>B. C.</td>
<td>3,137</td>
<td>3,708</td>
</tr>
<tr>
<td>Rate</td>
<td>336.6</td>
<td>390.7</td>
</tr>
</tbody>
</table>

Table V: Incidence and Rate per 100,000 per annum, of Gonorrhoea, Reported by Provincial Health Departments to the Dominion Bureau of Statistics.

Source: Division of Venereal Disease Control, Department of National Health and Welfare, Ottawa.
"Prior to 1944, the machinery for collecting statistics on the incidence of venereal disease for Canada as a whole did not exist. Each province had a different notification form, using different nomenclatures. In some provinces, the notification of venereal disease did not become compulsory until 1941." (1)

(It is seen that the numbers of cases given in Tables IV and V do not concur with those in Table I. Those in Table I are correct: those in Tables IV and V are totals of the cases reported weekly to the Department of National Health and Welfare by the various provincial departments of health.

The discrepancy arises from minor errors that occur in the weekly reports to the Department of National Health — cases are reported more than once, known old infections are reported as new infections. Later these errors are discovered and the corrections made in the provincial statistics, but the Department of Health statistics remain unchanged.)

Tables IV and V indicate that the venereal disease problem in British Columbia is serious; in fact, the rate per 100,000 in British Columbia is the highest of all the provinces, for both total syphilis and gonorrhoea.

In the case of syphilis acquired early, (syphilis of less than five years' duration) primary and secondary stages only, in 1945 British Columbia again had the highest rate per 100,000; this is shown in Table VI.

(1) Division of Venereal Disease Control, First quarterly statistical report on the incidence of venereal disease in Canada.
<table>
<thead>
<tr>
<th>Province</th>
<th>Cases</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>5,695</td>
<td>47.1</td>
</tr>
<tr>
<td>P.E.I.</td>
<td>27</td>
<td>29.3</td>
</tr>
<tr>
<td>N.S.</td>
<td>31</td>
<td>5.0</td>
</tr>
<tr>
<td>N.B.</td>
<td>200</td>
<td>42.7</td>
</tr>
<tr>
<td>Que.</td>
<td>1,594</td>
<td>44.8</td>
</tr>
<tr>
<td>Ont.</td>
<td>2,455</td>
<td>61.3</td>
</tr>
<tr>
<td>Man.</td>
<td>295</td>
<td>40.1</td>
</tr>
<tr>
<td>Sask.</td>
<td>220</td>
<td>26.0</td>
</tr>
<tr>
<td>Alta.</td>
<td>210</td>
<td>25.4</td>
</tr>
<tr>
<td>B. C.</td>
<td>663</td>
<td>69.9</td>
</tr>
</tbody>
</table>

Table VI: Incidence and Rate per 100,000 per annum, of acquired Syphilis, Primary and Secondary, Reported by Provincial Health Departments of the Dominion Bureau of Statistics.

Source: Division of Venereal Disease Control, Department of National Health and Welfare, Ottawa.
Of those individuals reported as being infected in British Columbia, it is of interest to note the age at which the infection was diagnosed. Table VII shows the number of venereal disease cases reported for the first time in British Columbia, classified according to diagnosis, sex, and age-groups for 1944 and 1945.

**TABLE VII**

<table>
<thead>
<tr>
<th>1944</th>
<th>Sex</th>
<th>Total</th>
<th>Gonorrhoea (All Types)</th>
<th>Total</th>
<th>Syphilis</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>4737</td>
<td>3358</td>
<td>1379</td>
<td>254</td>
<td>126</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>3388</td>
<td>2460</td>
<td>928</td>
<td>190</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1349</td>
<td>898</td>
<td>451</td>
<td>64</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Under 15 yrs.</td>
<td>Total</td>
<td>57</td>
<td>37</td>
<td>20</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>24</td>
<td>12</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>33</td>
<td>25</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>15-19 yrs.</td>
<td>Total</td>
<td>426</td>
<td>362</td>
<td>64</td>
<td>23</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>221</td>
<td>193</td>
<td>28</td>
<td>14</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>205</td>
<td>169</td>
<td>36</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>20-24 yrs.</td>
<td>Total</td>
<td>1141</td>
<td>974</td>
<td>167</td>
<td>63</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>741</td>
<td>659</td>
<td>82</td>
<td>37</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>400</td>
<td>315</td>
<td>85</td>
<td>26</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>25-29 yrs.</td>
<td>Total</td>
<td>772</td>
<td>629</td>
<td>143</td>
<td>48</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>572</td>
<td>487</td>
<td>85</td>
<td>42</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>200</td>
<td>142</td>
<td>58</td>
<td>6</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>30-34 yrs.</td>
<td>Total</td>
<td>481</td>
<td>341</td>
<td>140</td>
<td>36</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>365</td>
<td>282</td>
<td>83</td>
<td>28</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>116</td>
<td>59</td>
<td>57</td>
<td>8</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>35-39 yrs.</td>
<td>Total</td>
<td>347</td>
<td>216</td>
<td>131</td>
<td>18</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>284</td>
<td>180</td>
<td>104</td>
<td>17</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>63</td>
<td>36</td>
<td>27</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>40-44 yrs.</td>
<td>Total</td>
<td>330</td>
<td>197</td>
<td>133</td>
<td>14</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>267</td>
<td>164</td>
<td>103</td>
<td>12</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>63</td>
<td>33</td>
<td>30</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>45-49 yrs.</td>
<td>Total</td>
<td>176</td>
<td>83</td>
<td>93</td>
<td>11</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>140</td>
<td>68</td>
<td>72</td>
<td>10</td>
<td>6</td>
<td></td>
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<tr>
<td></td>
<td>Female</td>
<td>36</td>
<td>15</td>
<td>21</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Age Group</td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-------</td>
<td>------</td>
<td>--------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 54</td>
<td>260</td>
<td>221</td>
<td>39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Stated</td>
<td>582</td>
<td>422</td>
<td>160</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Total</th>
<th>Gonorrhoea (All Types)</th>
<th>Total</th>
<th>Syphilis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5245</td>
<td>3711</td>
<td>1534</td>
<td>450</td>
</tr>
<tr>
<td>Male</td>
<td>3769</td>
<td>2682</td>
<td>1070</td>
<td>360</td>
</tr>
<tr>
<td>Female</td>
<td>1476</td>
<td>1029</td>
<td>447</td>
<td>90</td>
</tr>
<tr>
<td>Under 15 yrs.</td>
<td>53</td>
<td>36</td>
<td>17</td>
<td>-</td>
</tr>
<tr>
<td>Male</td>
<td>16</td>
<td>4</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>Female</td>
<td>37</td>
<td>32</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>15-19 yrs.</td>
<td>441</td>
<td>380</td>
<td>61</td>
<td>33</td>
</tr>
<tr>
<td>Male</td>
<td>217</td>
<td>184</td>
<td>33</td>
<td>21</td>
</tr>
<tr>
<td>Female</td>
<td>224</td>
<td>196</td>
<td>28</td>
<td>12</td>
</tr>
<tr>
<td>20-24 yrs.</td>
<td>1233</td>
<td>1017</td>
<td>216</td>
<td>106</td>
</tr>
<tr>
<td>Male</td>
<td>786</td>
<td>674</td>
<td>112</td>
<td>69</td>
</tr>
<tr>
<td>Female</td>
<td>447</td>
<td>343</td>
<td>104</td>
<td>37</td>
</tr>
<tr>
<td>25-29 yrs.</td>
<td>853</td>
<td>693</td>
<td>160</td>
<td>59</td>
</tr>
<tr>
<td>Male</td>
<td>610</td>
<td>508</td>
<td>102</td>
<td>46</td>
</tr>
<tr>
<td>Female</td>
<td>243</td>
<td>185</td>
<td>58</td>
<td>13</td>
</tr>
<tr>
<td>30-34 yrs.</td>
<td>600</td>
<td>431</td>
<td>169</td>
<td>59</td>
</tr>
<tr>
<td>Male</td>
<td>460</td>
<td>343</td>
<td>117</td>
<td>51</td>
</tr>
<tr>
<td>Female</td>
<td>140</td>
<td>88</td>
<td>52</td>
<td>8</td>
</tr>
<tr>
<td>35-39 yrs.</td>
<td>467</td>
<td>296</td>
<td>171</td>
<td>55</td>
</tr>
<tr>
<td>Male</td>
<td>373</td>
<td>250</td>
<td>123</td>
<td>44</td>
</tr>
<tr>
<td>Female</td>
<td>94</td>
<td>46</td>
<td>48</td>
<td>11</td>
</tr>
<tr>
<td>40-44 yrs.</td>
<td>345</td>
<td>211</td>
<td>134</td>
<td>38</td>
</tr>
<tr>
<td>Male</td>
<td>287</td>
<td>182</td>
<td>105</td>
<td>36</td>
</tr>
<tr>
<td>Female</td>
<td>58</td>
<td>29</td>
<td>29</td>
<td>2</td>
</tr>
<tr>
<td>45-49 yrs.</td>
<td>235</td>
<td>98</td>
<td>137</td>
<td>31</td>
</tr>
<tr>
<td>Male</td>
<td>204</td>
<td>86</td>
<td>118</td>
<td>31</td>
</tr>
<tr>
<td>Female</td>
<td>31</td>
<td>12</td>
<td>19</td>
<td>-</td>
</tr>
</tbody>
</table>

1945
### Table VII: Persons with Venereal Disease Reported for the first time in British Columbia, according to diagnosis, sex, age group, for the years 1944 and 1945.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-54 yrs.</td>
<td>160</td>
<td>140</td>
<td>20</td>
<td>49</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>52</td>
<td>91</td>
<td>17</td>
<td>52</td>
<td>17</td>
</tr>
<tr>
<td>Over 54</td>
<td>294</td>
<td>249</td>
<td>45</td>
<td>61</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>67</td>
<td>188</td>
<td>39</td>
<td>67</td>
<td>39</td>
</tr>
<tr>
<td>Not Stated</td>
<td>564</td>
<td>427</td>
<td>137</td>
<td>430</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>134</td>
<td>86</td>
<td>48</td>
<td>134</td>
<td>86</td>
</tr>
</tbody>
</table>

Source: Division of V. D. Control, Vancouver, B. C.

It is seen in Table VII that the modal age group for both sexes for gonorrhea and for primary and secondary syphilis is the 20-24 years group. In the older age groups, the number of gonorrhea and primary and secondary syphilis infections decreases.

It is interesting to compare the age distribution of gonorrhea and primary and secondary syphilis in New York City, from 1940 to 1943 inclusive: in all these years the modal age group is also the 20-24 years group. (1)

From Table VII, it is found that in 1944 and 1945, 67 percent and 64 percent of gonorrhea infections, and 56 percent and 46 percent of primary and secondary syphilis infections were acquired by individuals under thirty. Here then is an indication of the widely made observation that the majority of venereal infections are acquired by men and women in their teens and twenties. (An exception is to be noted in the case of primary and secondary syphilis in 1945. However, the Health League of Canada probably exaggerates somewhat when it states: "Fully 75 percent of all venereal disease is spread among persons between the ages of

fourteen and twenty-nine". (1)

Despite the doubt that such a high percentage of infection is acquired in the under 30 years group, the general observation still remains: venereal disease is a disease of youth, and thus it is among the young people that attention and preventive action is most required.

3. Geographical Distribution of Cases:

Tables IV and V show that in 1944 and 1945, British Columbia had the highest reported rates in Canada per 100,000 population, of primary and secondary syphilis. Whether British Columbia had the highest actual rate of these infections is not known, mainly because there is no assurance that the standards of reporting infections in the other provinces are equal to the standards in British Columbia. However, despite the absence of adequate data for comparing the venereal disease problem here with that in other provinces or countries, the essential point remains: British Columbia does have a high rate of infection.

In British Columbia, as elsewhere, venereal disease is most often acquired and spread in the cities, because it is in the cities that promiscuity is rampant. The Scandinavian countries, which made such significant progress in the reduction of syphilis, also have their greatest number of infections in the larger cities. For example, Sweden, one of the most cited instances of a country which has developed successful syphilis control, from 1930 to 1934 reported 4,106 cases of primary and secondary syphilis for the whole country and 1,437 cases of primary and secondary syphilis for the city of Stockholm. The population of Stockholm was estimated at 533,884 and of all Sweden 6,249,489. (2)

(2) Harrison, L.W., Dudley, C.L.W., Ferguson, T., and Rocke, M.; Report on anti-venereal measures in certain Scandinavian countries and Holland, p. 41, Ministry of Health.
Thus Stockholm which has only 8.5 percent of the population of Sweden, has 34.9 percent of all early syphilis cases.

In British Columbia, the one large city, Vancouver, has more than one-half of all venereal infections and in addition to the infections reported in Vancouver, there is evidence that a large number of the infections reported elsewhere in British Columbia are acquired in Vancouver.

Table VIII indicates the cities in which twenty or more venereal infections were reported during 1945. The figures given represent only those cases reported for the first time in British Columbia; they do not include known cases that were acquired in British Columbia but discovered in another province or in another country.

<table>
<thead>
<tr>
<th>City</th>
<th>No. of Infections</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancouver City</td>
<td>2712</td>
<td>316,496</td>
</tr>
<tr>
<td>Victoria-Esquimalt</td>
<td>330</td>
<td>86,890</td>
</tr>
<tr>
<td>Prince Rupert</td>
<td>147</td>
<td>12,000</td>
</tr>
<tr>
<td>New Westminster</td>
<td>124</td>
<td>25,000</td>
</tr>
<tr>
<td>Kamloops</td>
<td>73</td>
<td>8,500</td>
</tr>
<tr>
<td>Richmond</td>
<td>64</td>
<td>9,160</td>
</tr>
<tr>
<td>Burnaby</td>
<td>63</td>
<td>32,500</td>
</tr>
<tr>
<td>North Vancouver City</td>
<td>43</td>
<td>19,943</td>
</tr>
<tr>
<td>Vernon</td>
<td>42</td>
<td>8,667</td>
</tr>
<tr>
<td>Trail</td>
<td>39</td>
<td>12,711</td>
</tr>
<tr>
<td>Nanaimo</td>
<td>33</td>
<td>9,918</td>
</tr>
<tr>
<td>Chilliwack City</td>
<td>32</td>
<td>7,078</td>
</tr>
<tr>
<td>Nelson</td>
<td>30</td>
<td>7,165</td>
</tr>
<tr>
<td>Port Alberni</td>
<td>29</td>
<td>5,500</td>
</tr>
<tr>
<td>Delta</td>
<td>23</td>
<td>2,651</td>
</tr>
</tbody>
</table>

(Populations are from the Provincial Directory and are estimates based on 1941 census.)

Table VIII: B. C. Cities Reporting more than twenty venereal infections during 1945.

Source: Division of V. D. Control, Vancouver, B. C.
During the period covered by Table VIII, there were 5,245 reports of venereal disease; of these 520 did not state the city or area from which the disease was reported.

It is seen from Table VIII that Vancouver and the surrounding municipalities and cities of Richmond, North Vancouver, Burnaby, New Westminster, and Delta, are responsible for by far the greatest amount of venereal disease in the province, approximately 65.5%.

It is quite probable that most of the infections reported in the areas around Vancouver were actually acquired in Vancouver. Although the attack-rate of infection is not proportional to the population, it is seen that ports, railheads, and industrial centres are the areas in which venereal disease most often attacks.

That the source of venereal disease spread is in the larger cities of a country is to be expected. In Vancouver, conditions are excellent for the introduction and spread of venereal infections: Vancouver is an international port and a continental railhead; numerous visitors and transients are received at all times during the year. No other city in the province offers conditions so conducive to the spread of infection. (Victoria is a seaport but receives a far smaller number of visitors and transients than Vancouver; as seen in Table VIII Victoria ranks a poor second in the provincial venereal disease prevalence.)

In the city of Vancouver, which accounts for about 57.5% of all reported infections in the province, a small area is responsible for most of the venereal infections because it is this area that is responsible for the largest number of pick-ups leading to the acquisition of venereal disease. This area is the downtown business section of the city where housing conditions are probably the poorest. It is this social area, too, that has the highest combined rank (indicating that it is the area of
of greatest need) on five economic and social indices, as determined in 1945 by Norrie and his staff. The indices used were crowded households, family income, low rental, ratio of persons divorced and separated, to persons married, and juvenile delinquency. The boundaries of this area are from Burrard Street to Main Street, and from False Creek to Burrard Inlet. (1)

Thus, a survey of the province indicates that venereal disease strikes most often in the larger centres, and particularly centres which have a large transient population. Such an observation is borne out by surveys in other communities: one study made in the United States indicated that the chief venereal disease control problem to be met was "the occurrence of unusual industrial activity... This is understandable when we think of... the almost necessarily transient nature of the present day industrial portion of the population". (2)

Within the larger areas of infection, smaller areas, the foci of infections, are to be found. In Vancouver, the mentioned area of greatest need accounts for the largest number of infections, but it in turn can be analyzed to discover the specific premises that make it easy for healthy persons to meet or become exposed to infected persons. Such premises are called "places of facilitation".

It is these places of facilitation that are considered of great importance in any city's venereal disease control program. It is true that facilitation is not the fundamental factor involved in the spread of infection, but it is certainly of importance in any consideration of undesirable or unwholesome spots in a community, and indicates where immediate corrective measures can be taken.

4. **Occupational Status of Infected Persons:**

Because of the widespread aversion of many people to the mere mention of the venereal diseases, there is a serious difficulty in obtaining an adequate knowledge of infected persons. Most of those who are infected or who suspect infection, if they can afford it, seek examination and treatment by a private physician, rather than at a public clinic. In British Columbia, reporting of patients infected with syphilis or gonorrhoea is required by the Venereal Disease Suppression Act of 1924, but it is unquestionable that all cases are not reported; also since initials or other identification rather than the full name of the patient may be used if the physician does report the case, any infected persons who wish to hide their identity from everyone except their physicians can do so by attending a private physician.

In addition to these points, it must be noted that the Notification Cards used in the reporting of infected persons do not require that the occupation be stated. (Until 1944, the notification cards in B.C. did request this information, but the present cards, issued by the Dominion government, do not.) For this reason, a survey of the occupational status of infected patients can only be made on clinic patients, because clinic records contain information not given on the notification forms.

As was previously suggested, clinic patients do not represent a fair sampling of the infected population. However, one study has been made at the Vancouver Clinic of patients infected with early syphilis, primary and secondary; and as these particular stages of the disease are often referred to the clinic by private physicians for diagnosis and treatment, probably such a clinic study offers the best basis for generalization. Table IX shows the occupational status of patients diagnosed
with early syphilis, primary and secondary, during the years 1944 and 1945. When a man infected his wife, or vice versa, and both were diagnosed at the Vancouver Clinic, only the one first acquiring the infection is included in this study. (In this way, only infections acquired from non-marital sexual exposures are involved.) The occupational groupings used in the table are from the Dictionary of Occupational Titles. (1)

<table>
<thead>
<tr>
<th>TABLE IX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof.</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>1944</td>
</tr>
<tr>
<td>1945</td>
</tr>
</tbody>
</table>

Table IX: Occupational Status of Persons Diagnosed at the Vancouver Clinic in 1944 and 1945 as having acquired Early syphilis, primary and secondary stages. (Non-marital exposures.)

Source: Division of Venereal Disease Control, Vancouver, B. C.

It is seen from Table IX that among males, the greatest number of infections is to be found in the "Laborer" grouping, and among females, in the "Service" grouping.

Other studies substantiate these clinical findings. One of these, a survey of positive serologic tests for syphilis in 531,236 men of draft age in the United States, indicated a correlation between the prevalence of syphilis and occupation; among single white men the professional class had the lowest rates.

(1) U.S. Department of Labor, Dictionary of occupational titles.
There is a considerable jump to the next group, and it is found that the rates for proprietors and managers, clerical workers and salesmen, are all about the same. There is a sharp rise then, and the three groups — craftsmen, operatives, and service workers — have much higher rates. The highest rate of all occurred among laborers, though they are not much higher than those of the nearest three groups". (1)

Another study, made of 172 white females admitted to a Missouri rapid treatment centre, showed that 152 of the 172 were engaged in service or laboring occupations. (2)

This undoubted correlation between occupation and the prevalence of syphilis does not imply a causal relationship. It does suggest, however, that those engaged in unskilled or semiskilled occupations are in the lower wage earning brackets and hence may have less opportunity for medical information or care. Education concerning the diseases, ability to pay for treatment, accessibility of medical services (particularly in rural areas), are other factors involved, particularly for the low wage earner.

More closely related to the actual job, and also applying to the semiskilled worker, tedium, boredom and dissatisfaction all play a role in the acquisition of infection. Many workers, especially female workers, who are unemployed or employed in ill paying humdrum routine, seek exciting recreation which too often leads to exposure to infection. In such cases the occupation may be a causal factor in the acquisition of disease, as well as a concommitant factor.

(2) Rachlin, H.L., A sociologic analysis of 304 female patients admitted to the Midwestern Medical Centre, St. Louis, Mo.: V.D.I., vol. 25, pp. 265-271.
5. **Marital Status of Infected Persons:**

The discussion here of the marital status of infected persons is concerned with the marital status on acquisition of the disease and not necessarily on discovery, the intention being to discover the number of infections acquired apart from marital relations. (It is assumed that an infection acquired maritally implies infidelity on the part of the marital partner.) This, of course, does not imply that the marital status of persons already infected is unimportant in the spread of venereal disease; such a view would be quite erroneous, especially in the case of prenatally or parturiently acquired infections. However, since it is the intention of this paper to discuss the factors responsible for the spread of infection, it is of more value here to survey the marital status of persons on acquiring infection. For this reason, it is of little value to investigate the marital status of individuals involved in mass blood testing surveys; such surveys uncover many hitherto unsuspected cases of syphilis, but give little direct information concerning the patient at the time of acquisition of the disease.

However, even when the marital status of the individual at the time of acquiring infection is known, there is often confusion as to whether some persons should be classified as "married" or "separated". Some married persons, especially during the war years, are separated from their mates for long periods of time, and might well be considered as being "separated", even though they are legally married. At this point, only the broad headings of "married", "single", and "other" will be used; consideration will be given later to the influence of long separations on the acquisition of venereal disease by married persons.

Table X summarizes the marital status of persons diagnosed at the Vancouver Clinic during 1944 and 1945 as having acquired primary
and secondary syphilis. "Married" implies that a person is married either legally or by common-law; "single" implies that a person is not and never has been married; "other" implies that a person is separated, divorced, or widowed.

In Table X, the cases used are those in which the infections were acquired extra-maritally.

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Other</th>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>48</td>
<td>15</td>
<td>4</td>
<td>Male</td>
<td>97</td>
<td>43</td>
<td>12</td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
<td>12</td>
<td>3</td>
<td>Female</td>
<td>22</td>
<td>26</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>27</td>
<td>7</td>
<td>Total</td>
<td>126</td>
<td>69</td>
<td>21</td>
</tr>
</tbody>
</table>

Table X: Marital Status of Patients Treated at the Vancouver Clinic during 1944 and 1945 for Primary and Secondary Syphilis.

Source: Division of Venereal Disease Control, Vancouver, B. C.

It is seen, as would be expected, that among both males and females, the single person is more prone to acquisition of syphilis; but it is also noted that a considerable number of married persons do acquire infection. Some of the factors involved will be discussed on other pages.

It is of interest to note that there are differences when the marital status of infected persons found in surveys of recently infected individuals is compared with that found in mass serologic surveys for syphilis.

One of these mass surveys made on inductees into the United States Armed Forces, is given in Table XI. The table includes the results of white men only; the figures relating to negroes are omitted.
<table>
<thead>
<tr>
<th>Age</th>
<th>Single</th>
<th>Married</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number Examined</td>
<td>Number Positive</td>
<td>Rate per 1,000</td>
</tr>
<tr>
<td>18</td>
<td>87,751</td>
<td>300</td>
<td>3.4</td>
</tr>
<tr>
<td>19</td>
<td>106,324</td>
<td>334</td>
<td>3.1</td>
</tr>
<tr>
<td>20</td>
<td>48,609</td>
<td>181</td>
<td>3.7</td>
</tr>
<tr>
<td>21</td>
<td>12,379</td>
<td>157</td>
<td>3.7</td>
</tr>
<tr>
<td>22</td>
<td>9,762</td>
<td>142</td>
<td>14.5</td>
</tr>
<tr>
<td>23</td>
<td>8,311</td>
<td>149</td>
<td>17.9</td>
</tr>
<tr>
<td>24</td>
<td>6,611</td>
<td>133</td>
<td>20.1</td>
</tr>
<tr>
<td>25</td>
<td>6,049</td>
<td>135</td>
<td>22.3</td>
</tr>
<tr>
<td>26</td>
<td>5,347</td>
<td>144</td>
<td>26.9</td>
</tr>
<tr>
<td>27</td>
<td>4,934</td>
<td>146</td>
<td>29.6</td>
</tr>
<tr>
<td>28</td>
<td>3,533</td>
<td>108</td>
<td>30.6</td>
</tr>
<tr>
<td>29</td>
<td>4,913</td>
<td>191</td>
<td>38.9</td>
</tr>
<tr>
<td>30</td>
<td>3,666</td>
<td>165</td>
<td>45.0</td>
</tr>
<tr>
<td>31</td>
<td>3,300</td>
<td>149</td>
<td>45.2</td>
</tr>
<tr>
<td>32</td>
<td>3,123</td>
<td>151</td>
<td>48.4</td>
</tr>
<tr>
<td>33</td>
<td>2,882</td>
<td>154</td>
<td>53.4</td>
</tr>
<tr>
<td>34</td>
<td>2,794</td>
<td>155</td>
<td>55.5</td>
</tr>
<tr>
<td>35</td>
<td>2,633</td>
<td>154</td>
<td>58.5</td>
</tr>
<tr>
<td>36</td>
<td>2,327</td>
<td>155</td>
<td>66.6</td>
</tr>
<tr>
<td>37</td>
<td>2,087</td>
<td>137</td>
<td>65.6</td>
</tr>
</tbody>
</table>

Table XI: Prevalence of Syphilis among men aged 18-37 years by marital status and age. (Only white men are included.)

Source: Journal of Venereal Disease Information, October, 1945. p. 221.
It is seen, except in the 18-20 age group, that the infected rate per thousand is lowest in the "married" group and highest (with one exception) in the "other" group. Note that of the total 6,503 infections reported, less than 52% were in men under the age of thirty; this is especially significant because of the very limited age group involved. Here, then, is an example of the inadvisability of using serological survey results as a basis of determining the age or marital status of an individual at the time of disease acquisition, for undoubtedly many, if not most, of the men in their thirties acquired their infections when they were younger.

The foregoing has been a general discussion of the problem of venereal disease and of the persons infected. One aspect of the problem, important in controlling the disease in some areas has been omitted: this is the racial origins of the infected persons. Despite its many shortcomings, the "color" classification of individuals is almost universally used; and a knowledge of the color or "race" of infected persons is often of some value.

In the United States where discrimination against the Negroes is common, venereal disease among the colored population constitutes a complicated problem. Ignorance and poverty are widespread, and necessary treatment neglected; there is a lack of trained Negro health personnel, a lack of free treatment centres, and where they do exist there are separate or no facilities for Negroes; Negro physicians are often disqualified from working as clinicians in free clinics; these are a few of the factors that are involved in the Negro venereal disease problem in the United States.

In British Columbia, Negro discrimination is not so noticeable, and the comparatively small colored population does not constitute a
separate venereal disease problem. But British Columbia does have a significant Indian population, and discrimination against the Indians is present. Promiscuity is common among some of the Indian girls who go to the cities. They are looked upon by some white men as common property, and many of the Indian girls believe that through indiscriminate sexual relations, they will be able to marry a white man. Other factors involved in a discussion of venereal disease among the Indians will be mentioned in other places, but because the Indian population is small and because it has comparatively few infections, there will be no separate consideration of the Indians or of the many other minority racial or 'color' groups found in the province.
Chapter II. Factors Involved: Prostitution and Promiscuity:

Prostitution, no matter what form it may take, is a problem that is a source of discomfort to many individuals and organizations in a community. In this paper, there is no need to deal with the undesirability of the practice of prostitution other than its being responsible for the spread of venereal infection.

It is not easy to arrive at a satisfactory definition of prostitution because of the diverse forms that it may take. Flexner states the prostitution is characterized by "three elements variously combined: barter, promiscuity, emotional indifference. The barter need not involve the passing of money, though money is its usual medium; gifts or pleasures may be the equivalent inducement. Nor need the promiscuity be utterly choiceless; a woman is not the less a prostitute because she is more or less selective in her associations. Emotional indifference may be fairly inferred from barter and promiscuity". (1)

Garle maintains that prostitution must involve venality and promiscuity. "There must be both, and whilst the lack of emotional motives raises a presumption of venality, it is only when these two elements are present, that the sexual act is prostituted, and only that person whether male or female, who has habitual recourse to sexual practices for venal motives may fairly be called a prostitute. It is the presence, or the absence of these two essential elements, which makes an identical act, mutually performed by two persons, an act of prostitution in the one and not in the other. Both parties may be equally blameworthy, but it is the one who habitually barters the favours of the body, who is the prostitute." (2)

(1) Flexner, A., Prostitution in Europe, p. 11.
(2) Garle, H.E., Social Hygiene Today, p. 20.
In both these definitions it is apparent that the criteria of prostitution vary in degree, and that on the basis of these definitions, the term "prostitute" can be applied not only to girls and women working in bawdy houses and soliciting on the streets, but also to the many promiscuous girls who make no formal charge but exchange themselves for a night's lodging or a few meals. (The term "prostitute" can be applied to males but male prostitution is a rare phenomenon and, so far as is known, is not a significant factor in the spread of venereal disease. Thus, in this paper, the term "prostitute" will be used as applying only to females.)

1. Organized or commercialized prostitution:

For purposes of this paper a distinction is made between organized prostitution and unorganized prostitution, the former refers to prostitution which is practised in a house of prostitution, brothel, or bawdy house and which involves a monetary transaction. This form of prostitution usually involves persons, other than the prostitute who reap profits directly or indirectly from the practice -- landlords, lessors or agents of the houses of prostitution, madams or keepers, "pimps" and procurers. This distinction is irrelevant for legal purposes but is important for the control of venereal disease, because it is the contention of most health departments that organized prostitution is the greatest single menace towards the successful control of venereal disease. (It must be emphasized that the term "bawdy house", as here used, is somewhat more restricted than the one defined in the Criminal Code of Canada: "A common bawdy house is a house, room, set of rooms, or place of any kind kept for purposes of prostitution or for the practice of acts of indecency, or occupied or resorted to by one or more persons for such purposes". (1)

(1) The Criminal Code of Canada, 1917, c. 14, s. 3.
The term as used in this paper refers to a house or place of any kind where the entire premises are kept solely for purposes of prostitution; thus one room used for purposes of prostitution in a hotel accommodating non-prostitutes would not be considered as a bawdy house.)

Organized prostitution has long been recognized by most Canadian Health Departments as a constant barrier to the successful control of venereal disease. Williams states: "Commercialized prostitution is the illegal exploitation of venereally disease young women in bawdy-houses. It is a purely mercenary business intimately associated with the criminal elements of society in which the more evident exploiters are madames, pimps, and procurers. The profits emanating from this illegal business, however, do not stop with these exploiters. The monetary streams in their diverse ramifications reach persons so remote that their participation in the business is only recognized by their indignation when the source of profit is disturbed by the activity of a health department." This, then, briefly describes the exploiter. The exploited are physically attractive young women who represent the merchandised product. As in any business, volume is an important factor in creating lucrative monetary returns. The merchandise must be kept fresh and attractive and this entails the constant procuration of new young women from the ranks of the unemployed and the less well remunerated occupations and the discarding of worn-out merchandise to add to the already large volume of street walkers and other prostitutes who work on their own. This is the purely monetary side of this illegal business and as such is not a direct problem or interest of a health department. In this unsavoury commerce, however, there is inseparably associated a serious public health problem. In this illegal business there lies a prolific source of fresh venereal infections. This fact has long been recognized by public health authorities. Rosenau (1) has

(1) Rosenau, J., Preventive Medicine and Hygiene, p. 438, ibid.
considered it so important in the problem of venereal disease control that he writes as follows: "Any sanitary measures taken for the prevention of venereal diseases which do not include some method of handling the problem of prostitution are doomed in advance to failure, since they will ignore the main source and root of these diseases." Flexner (1) in his monumental study on "Prostitution in Europe" came to the conclusion that: "It is everywhere purely mercenary, everywhere rapacious, everywhere perverse, diseased, sordid, vulgar, and almost always filthy." Numerous are the other authorities who support these statements. Indeed one is impressed with the unanimity of opinion among experts regarding the public health menace which commercialized prostitution constitutes. (2)

This description specifically associates commercialized prostitution and venereal disease, and it typifies the attitude of most health authorities in Canada and the United States. From a public health standpoint, commercialized prostitution implies the spread of venereal disease, and this alone is sufficient to condemn prostitution.

However, stressing of this intimate association of prostitution and venereal disease has been mainly responsible for the popularly held opinion that prostitution is undesirable solely because of such association. That it is undesirable apart from its association with venereal disease has, of course, been stressed for many years by numerous individuals and organizations, including health authorities. However, despite commercialized prostitution being an indictable offence under the Criminal Code of Canada, and despite its being proved as a breeding ground of disease and crime, there are still some who advocate its continuance under state control.

(1) Flexner, A., ibid., p. 33.
Many of these apologists realize the intimate relationship between prostitution and venereal disease, but believe that by segregating bawdy houses and by legally forcing the prostitutes to have regular medical examinations, the venereal disease rate will decrease, and the undesirability of prostitution will be for the most part removed. The underlying premise, sometimes stated, sometimes not, is that the continued practice of prostitution is inevitable -- "It is the oldest profession in the world" -- and that it might as well be made as safe as possible.

It is not the intention here to answer the various arguments raised in favor of "controlled prostitution", numerous authorities have successfully shown that commercialized prostitution can neither be made safe, nor be satisfactorily controlled. Among the authorities the universally accepted conclusion is that if venereal disease is to be eradicated, commercialized prostitution must be abolished. (1) (2) (3) (4)

The ensuing discussion on the bawdy house situation in British Columbia is based almost entirely on various records of the Division of Venereal Disease Control. These records are compiled only after an individual is diagnosed as having acquired a venereal infection and has given a history to his physician of having been allegedly exposed in a bawdy house. It must be emphasized that notification of disease reports on which the source of infection is actually stated, constitute only a minority of the notifications of venereal infections; thus the given number of infections allegedly acquired in a bawdy house is only the minimum number, and probably a far cry from the actual number of infections acquired there.

During 1945, the Division of Venereal Disease Control received information that venereal disease was allegedly acquired in bawdy houses in only four cities in British Columbia, Vancouver, Nelson, Prince George and Prince Rupert. Of these four cities, Vancouver presented by far the

(1) Flexner, A., ibid. (2) Parran, T., ibid.
(3) Snow, W.F., ibid. (4) League of Nations, Report by committee on traffic of women and children.
most serious problem.

Table XII indicates the number of infections allegedly acquired in bawdy houses in Vancouver from 1939 to 1945 inclusive.

**TABLE XII**

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Reported Infections</th>
<th>No. of Bawdy Houses Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>1939</td>
<td>9</td>
<td>(1 House)</td>
</tr>
<tr>
<td>1940</td>
<td>26</td>
<td>(9 Houses)</td>
</tr>
<tr>
<td>1941</td>
<td>46</td>
<td>(11 Houses)</td>
</tr>
<tr>
<td>1942</td>
<td>49</td>
<td>(11 Houses)</td>
</tr>
<tr>
<td>1943</td>
<td>42</td>
<td>(13 Houses)</td>
</tr>
<tr>
<td>1944</td>
<td>19</td>
<td>(10 Houses)</td>
</tr>
<tr>
<td>1945</td>
<td>37</td>
<td>(12 Houses)</td>
</tr>
</tbody>
</table>

Table XII: Number of infections allegedly acquired in Bawdy Houses in Vancouver City from 1939-1945.

Source: Division of Venereal Disease Control, Vancouver, B. C.

Bawdy houses have been in existence in Vancouver from very early times. A report published as early as 1912 deplored the existing commercialized prostitution and urged that action be taken by the appropriate authorities to completely eliminate it. (1) But until 1936, when the Division of Venereal Disease Control in British Columbia was reorganized, comparatively little publicity was given to the relationship of community prostitution and venereal disease. Shortly after the reorganization, however, ". . . commercialized prostitution was uncloaked in its true light as a serious public health menace. This was due chiefly to an efficient epidemiological service in the City of Vancouver. The Provincial Board of Health drew the attention of citizens and civic officials to this matter. The bawdy houses which had been flagrantly violating the Criminal Code of Canada were closed in February, 1939. In the first few months thereafter the houses remained almost completely inactive; gradually, however, a number of these disease dispensaries began to operate surreptitiously and

(1) Moral and Social Reform Council of British Columbia, Social Vice in Vancouver, p. 16.
have continued to do so since, though to a far lesser degree than previ­
ous to the institution of the policy of suppression." (1)

After the closing of the bawdy houses, noticeable reductions
in reported venereal disease became evident. From a median monthly level
of 58.5 male gonorrhoea admissions for a period of 14 months before
suppression, the level dropped to 41.5 for a period of 28 months after
suppression; and for male primary and secondary syphilis admission, the
median monthly level dropped from 9.5 to 4.

Although an examination of Table XII would seem to indicate
that bawdy houses are not so serious a source of venereal disease as
here implied, several points must be remembered in evaluating these figures.
In only a small minority of diagnosed infections is a report of the
alleged source of that infection furnished to the Division of Venereal
Disease Control. Most men frequenting such places can afford to pay a
private physician for treatment and private physicians (in the majority
of cases) do not report the source of infection. There is also evidence
(verbal only) that prostitutes in bawdy houses have told their clients
to attend a particular physician if venereal symptoms appeared, and all
expenses would be paid.

When these points are considered, and when it is realized that
prostitution can never be made "safe" until venereal disease is eradicated,
the anxiety of public health organizations to abolish prostitution is
understandable. Yet, there are still some persons and organizations who
relegate bawdy houses to a minor position as a source of venereal infec­
tions; for example, Rae, Inspector in Charge, Morality Branch of the
Vancouver City Police Department stated in a report: "It is my opinion
that the large increase in venereal disease reported in the City (Vancouver)
is due to the loose, immoral conduct of persons in the "non-prostitution"
category, and this opinion is substantiated by statistics of the Venereal Disease Control Division". (1)

In discussing organized prostitution one last point must be considered: a bawdy house, in order to maintain itself, must have a large clientele and if one infection is acquired from a bawdy house, at least one of the prostitutes is infected -- and being infected, she exposes infections to everyone of her customers until she is rendered non-infectious. This, in itself, is the major indictment of bawdy houses, from a public health standpoint: the bawdy house is a constant threat to the health of the community because it is at least a potential source of infection which can be spread in a geometric progression throughout the population.

2. Clandestine Prostitution and Promiscuity:

Although prostitution is divided, in this paper, into two types: organized or professional, and unorganized or clandestine, the division is made only to indicate that commercialized prostitution, as conducted in bawdy houses, represents a zenith in the selling of vice, and that all other forms of prostitution do not approach its level of efficiency. These other forms of prostitution are herein considered as clandestine or unorganized; i.e., they are not practised in a bawdy house as previously defined.

Clandestine prostitution involves a large number of persons: it includes all prostitutes, other than those in a bawdy house who make a formal charge (usually monetary). However, to classify one woman as a prostitute because she makes a formal charge and another as being promiscuous because she exchanges her body for a meal or two, for a room for a night, or for some other favor, serves only to demonstrate that (1) Rae, S., Report on control of venereal disease in Vancouver.
prostitution and gross promiscuity are too closely linked to be clearly defined.

Prostitutes and grossly promiscuous girls do not form a "class" or "type": they are individuals. "Even the most confirmed commercial prostitutes drifted into their trade for widely differing reasons. Many of them would never have become part of this dangerous community swamp if we had realized what was happening to them as children or young girls... We know now that there are profound psychological as well as economic reasons for their sinking into this morass." (1)

"The girl in the red-light district, the girl who plays the hotels, the adolescent who hangs around street corners after school, the servicemen's wife who distributes her favors in return for a good dinner are simply more or less acute sufferers from the same dangerous tangle of different kinds of social, economic, psychological, and sometimes mental lacks." (2)

These girls and women, whether or not they make a formal charge are exploited by the unscrupulous: as in the case of organized prostitution, pimps, landlords, taxi-drivers, and others glean a profit from the girl who earns from prostitution. In the case of the non-charging prostitute, the free pick-up or Victory girl, the profit-taking is less obvious and involves the recently coined concept of "facilitation". Facilitation is the process by which it is made easy for an infected person to meet or become exposed to a healthy person; and anyone who is responsible for such facilitation is called a "facilitator". Thus restaurants, dance halls, theatres, beer parlours, and other premises that constitute easy meeting places; hotels, rooming houses and other places that offer no encumberances to exposure are places of facilitation, and their owners and managers are facilitators.

(2) ibid., p. 5.
Table XIII summarizes the facilitation records for Vancouver during 1943 to 1945 inclusive. It will be noted that the totals of "met" and "exposed" do not coincide: this is because the information gathered is not always complete -- often there is information about only the place of pick-up, or the place of exposure. (The low totals for most facilitation premises in 1943 are due to the lack of information concerning such premises during that year: the first complete records are those kept during and after 1944.)

**Table XIII**

<table>
<thead>
<tr>
<th>Where Met</th>
<th>1943</th>
<th>1944</th>
<th>1945</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dance Halls</td>
<td>98</td>
<td>375</td>
<td>207</td>
</tr>
<tr>
<td>Cafes</td>
<td>25</td>
<td>300</td>
<td>407</td>
</tr>
<tr>
<td>Beer Parlours</td>
<td>123</td>
<td>159</td>
<td>221</td>
</tr>
<tr>
<td>Hotels and Rooms</td>
<td>no information</td>
<td>98</td>
<td>261</td>
</tr>
<tr>
<td>Private Homes</td>
<td>no information</td>
<td>26</td>
<td>64</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>8</td>
<td>397</td>
<td>586</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where Exposed</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hotels and Rooms</td>
<td>98</td>
<td>1149</td>
<td>1688</td>
</tr>
<tr>
<td>Private Homes</td>
<td>no information</td>
<td>121</td>
<td>231</td>
</tr>
<tr>
<td>Bawdy Houses</td>
<td>42</td>
<td>19</td>
<td>37</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>5</td>
<td>243</td>
<td>252</td>
</tr>
</tbody>
</table>

Table XIII: Summary of Facilitation Reports for Vancouver from 1943 to 1945 inclusive.

Source: Division of Venereal Disease Control, Vancouver, B. C.

It is to be emphasized that in all such premises, no matter how rigidly they are supervised and no matter how sincere the owners or managers may be in attempting to keep their establishments unblemished, some facilitation will exist. It is not the intention of health authorities to criticize such places, but there are a few premises (in comparison with the total existing number) that are repeatedly reported as being the place of meeting or exposure resulting in the acquiring of an infection. The responsibility for these new infections lies indirectly with the owners.
or managers: they seldom, if ever, take an active hand in preventing such facilitation, rather they encourage it because it brings new customers and new revenue.

It might be pointed out in passing that the location and "grade" of such facilitation premises, especially of cafes and rooming houses, bear little relation to their amounts of facilitation: cafes of equivalent "grades" and within the immediate vicinity of one another may have contrasting reports -- in one, the manager prevents promiscuous pick-ups and discourages loitering; in another, he silently encourages or carefully disregards them.

Clandestine prostitution and gross promiscuity constitutes a problem numerically far more serious than that presented by professional prostitution, but fundamentally secondary to it. True, clandestine prostitution and gross promiscuity account for the vast majority of new infections; but each individual involved is exposed to only a fraction of those reached by the professional prostitute.

It can be concluded then that the best preventative for venereal disease lies in the prevention of gross promiscuity, whether that promiscuity is found in paid or non-paid prostitutes, and whether in males or females. It is clear that if gross promiscuity is to be abolished, the present day practice of fining or imprisoning the prostitute is merely palliative: it removes, for a short time, the symptom of the basic problem, but accomplishes nothing in correcting the underlying factors responsible. It is some of these factors that will now be considered in this paper.
Chapter III. Factors Involved: Economic.

1. Housing:

Housing conditions are important both as a concommitant and a predisposing factor in the spread of venereal disease. The present day critical shortage of adequate housing serves only to accentuate conditions present before the war.

Poor housing is not only a factor in the spread or acquisition of venereal disease; it is also a factor involved in delinquency. Glueck reports that of 367 delinquent girls under the care of the Massachusetts Reformatory for Women, "only 24% of the girls lived in homes the physical conditions of which might be termed 'good', in that they contained adequate space for wholesome living (not more than two people, excluding an infant, to a bedroom), were light, clean, and well ventilated, and had at least the minimum of furniture needed for comfort; 44.3% of them spent their childhood in 'poor' homes which were overcrowded, filthy, scantily and shabbily furnished, and not infrequently even lacking ventilation and light. Almost a third (31.7%) of our girls grew up in homes that might be considered 'fair' in that they had some features of the good home and some features of the poor one." (1)

Since the presence of venereal disease implies the presence of promiscuity, and since promiscuity and delinquency are both "manifestations of human and social maladjustments" (2), it is not surprising that there should be at least some overlapping between factors involved in delinquency and the acquisition of venereal disease. Thus it was found in a study of promiscuous girls in San Francisco that "approximately two-thirds of the promiscuous patients were living alone or with friends, usually in third or fourth rate hotels. Patients would sometimes begin living with a girl friend immediately following their chance meeting on a street car

(1) Glueck, S. and E.T., Five hundred delinquent women, p. 68.
(2) ibid., p. 308.
or in a dance hall. No semblance of home life or family life was possible, and such living arrangements were conducive to unstable, promiscuous behaviour". (1)

In the particular case of the spread of venereal disease, poor housing is a factor. In Vancouver, the areas in which housing is most unsatisfactory (2) are responsible for the greatest amount of venereal disease spread.

When there is overcrowding and squalor, there can be no room for relaxation or recreation; relaxation and recreation must be found elsewhere. Permanent residents, and their families, new comers to the city, and transients find no incentive to remain in an unattractive room of a hotel or rooming house. It is people living in such conditions that constitute a source or potential source of venereal disease spread.

Time after time, newly infected persons have reported that they had left their rooms in boredom and had picked up, or had been picked up by someone on the street, in a cafe, dance-hall, or beer par-lour. These men and women regretted their having acquired infections, but inevitably asked, "What else was I to do?" The statement of a San Francisco promiscuous girl can well be applied elsewhere: "I go crazy staring at the four walls of that hotel room. I get so lonesome that I go out to bars just to have someone to talk to." (3)

In one study made by Fraser of fifty boys and girls diagnosed at the Vancouver Clinic as having acquired early syphilis, primary and secondary stages, it was found that: "Forty or eighty percent of the whole group of fifty live alone in a rooming house or cheap hotel. With the exception of three, all of these rooming houses and hotels are situated in the centre or at the edge of the slum area in Vancouver on the border of Chinatown, where they are exposed to the activities of organized

vice, such as molestation, gambling, prostitution and other underworld activities. There cannot possibly be even a semblance of decent home life or stable behaviour in such surroundings. The proprietors of these hotels and rooming houses are almost without exception Orientals or Eastern Europeans whose standard of living is low". (1)

Young girls, especially, have reported that they had left their homes, had been picked up, and subsequently had acquired venereal disease. In many cases they had left because their homes were so unattractive, because there was no room to entertain their friends, or for numerous other reasons and perhaps, rationalizations, reflecting on the inadequacy of their dwelling places for recreation and relaxation.

It is significant that venereal infections appear most often, not among members of a family, adults or children, living in their own homes or in several roomed suites, but among adults and youths living in single rooms, usually in cheap hotels and rooming houses.

The problem of housing is complex, but even more complex is the facilitation associated with it. When unscrupulous, money-eager landlords, own and manage hotels or rooming houses, promiscuity and prostitution may quickly become rampant. Unmarried couples can easily acquire a room for the night; visitors of either sex can come and go at their leisure; guests can pick up other guests in the halls; these and other activities can be condoned or abolished at the whim of the landlord. If condoned, as so often they are, promiscuous sexual exposures multiply and commercialized vice is encouraged.

Poor housing, then, is of importance in the spread of venereal disease: it concerns the family, in which the child, eager for normal relaxation, privacy, and room to entertain, is thwarted; it concerns the single man or woman, who is actually encouraged to have illicit sex

(1) Fraser, J., Study of the social factors involved in the acquisition of venereal disease.
relations; it concerns the transient, who, bored with the squalor, seeks more exciting surroundings; and it concerns the community because it is the community that pays for the damage caused by venereal disease.

2. Lack of Recreation:

Recreation is considered in this section only from an economic standpoint, and as such, it is of interest in a consideration of the venereal disease problem, but to what extent recreation is involved is not fully known.

For a great many individuals, recreation implies attending theatres, dances, cabarets, beer parlours, or other commercialized recreational establishments; for such persons, recreation requires money. When money is lacking, substitute forms of recreation are found, and in some cases, erotic activities result. However, heterosexual activity in such circumstances is probably not very common.

In the case of the adult male, it is most unlikely that a lack of funds is conducive to his finding entertainment with some woman or girl off the streets; he must have some sort of inducement to offer. If he can afford a bottle of cheap liquor, he can probably pick up an interested female, and probably, a venereal disease.

In the case of women and older girls, the problem of recreation is usually a social not an economic one. When it is an economic one, some sort of prostitution is usually in the offing.

Younger girls whose families are in poor economic circumstances, who are still associated with their parents or guardians, and who are prohibited by school attendance from earning legitimate wages, often have no money available for recreation. In such cases, the girls may become promiscuous with school mates or with older youths and men, and usually receive, at most, an inexpensive evening's entertainment in exchange for
for their favors. Girls such as these constitute a serious problem in the control of venereal disease because they are not legally considered as being prostitutes, and when their promiscuity is known they are in demand by many, and hence become a serious potential source of infection.

Poor economic conditions and the association between money and recreation may start very early in life. When this is so, when there is a lack of funds for recreational purposes, when there is ennui associated with the monotonous life of a young single man or woman dissociated from the home, or when one earns a living in a tedious job, a reaction will often occur. At the present time, the reaction all too often results in promiscuous sexual relations as being the easiest and most satisfying or tension releasing of the means available.

3. Lack of Educational Opportunities

When an inspection is made of Table IX, it is seen that students and professional persons acquire the smallest number of infections; it is also noted that these two groups are rated lowest in the acquisition of venereal disease in studies of serological studies. (1) Other studies and surveys bear out the conclusion that the acquisition of venereal disease and occupation correlate.

Just why the professional and student groupings escape the attack of venereal disease is for the most part a matter of conjecture; it is probably not because these two groups have a higher moral standard or expose themselves less often. One reason that might be offered to explain this phenomenon is that both professionals and students necessarily have a certain amount of formal education, and a somewhat broader understanding of most matters than individuals in other occupational groupings. When this broader understanding is applied to sexual matters it does not presuppose continence, but it does presuppose care, care not only in the

(1) Usilton, L.J., and Bruyere, M.C., ibid.
choice of a partner, but also in the taking of precautions when such are deemed advisable. Such men and women are seldom promiscuously indifferent because they have a well grounded fear of infection (and possibly conception); and if they are involved in some dubious exposure, usually chemical or mechanical prophylaxis is used. Certainly, errors of judgment are made, and infections are often acquired, but to a strikingly less degree than in other occupational groupings.

Whether or not the reason offered is sound, is of little consequence; the basic correlation between the attack of venereal disease and the occupational grouping (or educational attainment) holds.

In the study of Fraser at the Vancouver Clinic, only four boys and five girls entered High School, and one boy and three girls of 8% of the group completed Grade XII. (1) Here then, is one indication that a large number of boys and girls leave school long before there is any opportunity to learn even the basic facts about venereal disease, its nature, mode of transmission, and other essential information. (This statement implies that the school is the only source of information regarding the venereal diseases: such an implication applied to the total juvenile population is admittedly unsound but when applied to the many boys and girls who have had little or no home training, it is quite sound.)

If the assumption that the venereal disease attack rate diminishes with increased education is sound, there seems to be no immediate solution: to raise the minimum number of school years might be of some value, although this would increase the economic difficulties probably responsible for the early leaving of school. No mention is made of mental inability to progress further.) Another suggestion has been to give sex education and venereal disease information in earlier grades: whether this is advisable is a matter far from being satisfactorily (2) Fraser, J., ibid. p. 37.
settled. Both those in favour of such instruction and those against it are vehement in their assertions and both offer reasonable arguments. For the time being, it is assumed that such instruction would be unsatisfactory, if only because of the lack of cooperation from some parents, religious groups and educators.

Barriers to the obtaining of information concerning sex and the venereal diseases apply not only to the school age population but also to the adult population. If the family is too economically insecure to allow the child to continue his education, the chances are that the family itself is unable to afford either the time or money for a continuation of its own education in order to instruct the child in the home. Thus it is that often the only source of such vital information is from companions, as ignorant of the facts as the child himself.

It is true that anyone can obtain adequate information on these subjects from several sources, but a knowledge of the sources is often obtained in one's education or, too late, after one has become infected. Scientific information concerning the venereal diseases does offer some prevention in the acquisition of venereal disease. (1) When this information is not obtained because of economic insecurity, the latter is the fault; and with its remaining ramifications, economic insecurity plays a vital role in the continuation of the prevalence of venereal disease.

4. Necessarily High Age of Marriage:

It has been seen that the largest number of new infections is acquired among single, divorced, or widowed men and women; fewer cases are found among married persons, and even fewer among married couples living together.

This relationship of venereal disease acquisition to marital status has long been known, and the necessarily high age of marriage is

cited as one of the reasons for the present day rise in attack rate in comparison with the attack rate of a few generations ago. Actually, with the many changed conditions, it is unfair to compare the attack rate of these two periods, and even more so when it is remembered that the reporting of new infections has only recently been encouraged by health departments.

A satisfactory marital adjustment as a preventative of promiscuity has been a precept of most religions. The Church states that it is a sin for anyone to have sexual relations outside of marriage; thus marriage is encouraged among young people. However, with the ever-increasing number of years required by today's youth to prepare for economic security when they leave the homes of their parents, unless financial assistance is forthcoming from some source, marriage is a serious risk.

If a couple contemplating marriage is forced to postpone, almost indefinitely, the marriage, the taboos concerning premarital intercourse are often broken. This premarital intercourse when confined to the two persons involved, plays no part in the spread of venereal disease, but when one or more other persons enter the picture a threat to the health is present.

When this unmarried couple, engaged in intercourse, is unable to have regular exposures because of any number of intervening and thwarting circumstances, or if the two are separated from one another, one or both may give in to the temptation of a promiscuous exposure. (It can be argued that such a situation can just as readily occur with a married couple; this is quite so, but the factors of irregularity of intercourse and of the rationalization that one is not morally bound by marriage vows, do play a role that is not so often found with the married couple.)
"It must be admitted that continence beyond the age of about twenty-one may not be good for the individual, but apparently is required by social structure. This puts man in a dilemma from which it is difficult to extricate him, for all civilization seems to be tending toward city life and late marriage, both of which are contrary to normal sex hygiene. The roots of sex hygiene lie deep in economic and social structure." (1)

Certainly, it is admitted that there are arguments against very early marriage -- the high failure rate among them is an excellent one, but at the present time young men and women in this society are supposedly faced with two alternatives, sexual continence or marriage. It is quite obvious that a significant part of the physiologically mature population is accepting neither, but is seeking sexual gratification outside of marriage. Whether such behaviour is good or bad, advisable or not, need not be discussed here, but if the mores of the society are to be obeyed, early marriage is to be considered as at least part of the solution in the prevention of promiscuity.

(1) Rosenau, M.J., ibid., p. 490.
Chapter IV. Factors Involved: Social:

1. Lack of Social Relationships:

To suggest that a person who acquires a venereal disease has lacked any social relationships appears absurd when it is quite obvious that he or she has experienced what is probably the most intimate of social relationships. However, what is intended to be conveyed here is that individuals who lack social relations with the opposite sex for any of the numerous possible reasons, are inclined to be easy marks for the prostitute, professional or clandestine, or for the promiscuous pick-up, male or female.

A common reason found for lack of friends and acquaintances is that one is a stranger: he knows no one, he is not interested in various social or religious organizations that might assist, and so wanders the streets, drinks in a bar, or visits a theatre. If he gravitates to the slum or near-slum areas, he may be approached by some prostitute; or if he actually desires a female companion, he merely has to inquire from taxi drivers until he finds one. These are but two methods which are in vogue with the non-aggressive male. If he be aggressive, his opportunities are unlimited, and it would be exceptional for him to fail to find a prostitute.

It is just this sort of situation that can be applied to seamen, visiting members of the armed forces, and other travelling men: they arrive in a city and being strangers are less prone to criticism than if in their own home cities. The attraction of a uniform undoubtedly adds to the facilitation of a promiscuous exposure. (For the professional prostitute, the absence of a uniform of the armed forces would be more satisfactory, because of the fear of repercussions by the Federal Government if she infected a member of the Armed Forces.) Under such circumstances, both
the prostitute and the bored stranger are satisfied, and the spread of infection continues.

There are, however, quite different cases existing: these are the men, young and old, who may have lived in a city for years, and still have formed no friendships with women or girls. Probably, personality or appearance difficulties are responsible for their inability to find friends, but the friendless man will find little comfort in such knowledge. If he is young, he may associate himself with a local social or religious group, but beyond this, little presents itself. If he can dance, he might find companionship at some of the public dances, but if neither of these suggestions appeal to him, he is in a position parallel to that of a stranger, and the next steps are easy to take.

In the case of the female, the conditions are somewhat reversed: she is permitted by social convention to adopt only a passive, or at most a cooperative role in the making of male friendships. To be too aggressive elicits bitter criticism from her female friends, and often disgust or a false sense of pride from her male pursuer. If she be unattractive, and unable to obtain male companionship, she can, if she wishes, be picked up on the street, in a cafe, or elsewhere, and be quite convinced that she has passively acquired a man. Unfortunately, she may also have acquired a venereal disease.

The variations of the finding of companionship when one lacks friends are almost infinite, and all do not end in sexual exposure or in infection. The ones that do end in promiscuous sexual exposure are those that are of interest here.
2. Lack of Education and Interests:

In suggesting that education, or the lack of it, is a factor in the spread of venereal disease, it is the intention that a broad education and resulting broad interests serve as effective weapons in combating ennui.

Education, as the term is used here, does not necessarily mean formal education or academic education; it may be a self-acquired, purely cursory knowledge of a few fields of knowledge or activity. With that knowledge, one can find new interests, new things to do or learn during leisure hours. For many, these interests may become hobbies that can afford great pleasure and often financial returns for the efforts expended in acquiring them. The opportunities for such education are almost unlimited, and the individual who has formed various interests and hobbies is indeed fortunate, for he usually finds that with them the passage of time is almost too fast. For many of these interests and hobbies, money is unnecessary; materials, if necessary, are easily available.

However, one of the prime necessities for such multi-interests is the expenditure of some effort on the part of the seeker. It is at this point that a great many young men and women, faced with no other responsibility than their own existence, fail to make such an effort. For them, pleasure is found only in basic physiological satisfaction; when such satisfaction is sexual satisfaction, then unless other circumstances prevent it, promiscuity often results.

In this suggestion that the cultivation of interests and hobbies might serve to prevent the acquisition and hence the spread of venereal disease, it is to be noted that the sublimation in the Freudian sense is not being discussed here; rather, what is being suggested is that interests and hobbies might remove, perhaps only temporarily, ennui,
and that the sexual drive might not be so easily aroused as during periods of complete boredom.

3. Lack of Recreation:

The factor of recreation is broad: it involves economic, social and individual psychological factors. Here it is loosely considered as being purely a social matter, in which more than one person is involved.

For the very young, the elementary schools offer physical and some mental relaxation in recreation: it is almost compulsory to take part, and even the poorest players or participants are reluctantly allowed to play. From about the Junior High School level onward, however, definite distinctions arise, and the poor and mediocre would-be participants are eliminated. These distinctions apply both in and out of school, to both boys and girls, and in both physical and mental activities. Only the best are welcomed, and only the best take part.

The good players are always in demand, but it is not they but the mediocre players who constitute any problem in the organizing of recreational activities. It is the latter who probably need the recreation most, and it is they who, failing to find satisfaction in one type of activity, will find other activities which often border on delinquencies. When such delinquencies manifest themselves as sexual promiscuity, they become vitally important in the venereal disease control program.

In Fraser's study, (1) only two of the total group, both boys, belonged to any organized recreational group; the others professed to have no desire whatever to take part in any organized activities. This same report shrewdly points out that although there are now three clubs catering to boys between eight and eighteen existing in areas of high delinquency rates, "in the downtown rooming house and cheap hotel areas where 80% of

(1) Fraser, J., ibid.
our group live and where many more congregate, there is not one boys' and girls' club or any organized recreational activity".

In all fairness to the boys' clubs in Vancouver, it must be said that efforts are made to include all who want to take part regardless of special skills; however, the few that exist cannot possibly meet the needs. (2)

Recently, mixed clubs have come into prominence, under the title of "Teen Towns", or something similar. At this early time of their existence it would be unfair to evaluate their worth, but from discussions with teen aged boys and girls in various parts of the province, it is apparent that the Teen Town is not a panacea for juvenile delinquency. Many of the boys in their early teens are physiologically, mentally, and socially less mature than girls of their own chronological age and find no pleasure in dancing. Some offer unusual rationalizations to explain their lack of enthusiasm for the plan. One of the best criticisms offered is that the Teen Towns are not operated often enough, and thus do not allow one to give them all the support one would like.

Whatever criticisms are made of the Teen Towns, and no matter how useful or useless they may prove to be, still their formation does constitute a positive step forward in meeting some of the needs of the teen aged population. It is such positive measures that are needed, measures that furnish sound prevention by offering enjoyable, wholesome activities for everyone concerned.

In the problem of venereal disease control, although the young persons in their teens are worthy of serious consideration, those in their twenties, thirties and older age grouping must also be considered. With them, the problem of recreation is more complex than with those in their younger years: sports, for the most part, become highly specialized,
and other recreational outlets are unsuitable because of the sophistication
brought on by maturity. For many of these more mature persons, sports
and social clubs are synonymous with drinking and gambling organizations.
Thus even if the boys' clubs, girls' clubs, Teen Towns, and other asso-
ciations solve the recreational problem for boys and girls under twenty,
the problem remains for single men and women over twenty.

4. Alcohol:

The relationship of alcohol to the acquisition of venereal
disease demands attention: the majority of pick-ups, preliminary to
sexual exposure resulting in the acquisition of a venereal infection are
made while one or both parties are at least partially under the influence
of alcohol. This is quite understandable when it is remembered that
alcohol not only releases the higher inhibitions, which include the sexual
inhibitions, but also acts as an aphrodisiac.

To determine why an individual was intoxicated, or why he had
been drinking prior to exposure, would be to uncover the numberless rea-
sons for dissatisfaction with life -- thwarting, repressed desires, ennui,
and countless others. If suffices here to state that alcohol is an
important factor in the spread of venereal disease.

The use of alcohol is both an individual and a social problem;
an individual may drink because alcohol furnishes a means of escape, or
he may drink because everyone else is drinking. Whatever the reason,
a great many individuals do drink, and as a direct consequence of their
drinking, sexually expose themselves with less discrimination and pre-
caution than they would had they not been drinking.

The importance of alcohol in the spread of venereal disease
is suggested in the "facilitation" records. Table XIII, which gives the
relative frequency of pick ups in various premises in B. C., resulting
in infection for the years 1944 and 1945, shows that in both years beer parlours account for a significant number of pick-ups. This is particularly noteworthy because escorted and unescorted women drink on one side of the parlor, and unaccompanied men on the other. There is supposed to be no traffic from one side to the other, although its existence is quite apparent. (In most licensed premises in the larger cities, however, it is kept to a minimum by the various managements who with but a few exceptions have discouraged facilitation in their premises.) But in evaluating the true role beer parlours play in facilitation, two points must be stated: firstly, a woman can be escorted into a beer parlour with almost any number of men, and once inside the women's section pick-ups by her escorts might be relatively easily arranged (although this is supposed to be especially watched for by management) and secondly, some pick-ups that are attributed to beer parlours are probably made on the street just outside them -- these latter cases should not be considered as pick-ups occurring in beer parlours; they would not be with careful reporting.

In this consideration of the role of alcohol in the spread of venereal disease only a few observations have been made, and these only to indicate that in many cases where an infection has been acquired, alcohol has played a part and -- if the statement of numerous clinic patients can be accepted -- had it not been for alcohol the sexual exposure would not have occurred. As Rosenau has said: "Alcohol is the bedfellow of syphilis and gonorrhoea. It is intricately interwoven into the warp and woof of sex hygiene. The story of many cases of sexual immorality begins with the influence of drink." (1)

(1) Rosenau, M.J., ibid., p. 576.
5. **Influence of Companions:**

In this brief discussion of the extent to which companions are responsible for an individual's exposing himself in non-marital sex relations, the assumption is made that those being discussed here are at least in their later teens and have not hitherto been tempted to experiment in any such relations. This introductory assumption is made to eliminate factors which might have been influential during earlier years.

There is great range in the young adult's susceptibility to a companion's influencing him to have illicit sex relations. With the male, especially, a chance suggestion made while drinking, that female company be sought, often meets with instantaneous agreement. Possibly this is due to the heightened suggestibility, the lowered inhibitions, and the aphrodisiac effects produced by alcohol. The suggestion of the companion may have had but little influence on an inevitable process.

At the other end of the scale is the young woman (usually) who firmly maintains that such erotic behaviour is wrong, and who even under the influence of alcohol remains adamant. She is continually pleaded with, and even coerced, by her inamorato, and argued with by his friends, male and female, so that eventually she may succumb to the majority. In such a case, and it is not rare, the influence of one's companions probably is primarily responsible for submission.

Between these extremes, the first merely a precipitating factor, the other tantamount to a conditioning factor, are infinite variations: in some cases the influence of the companions might be merely supplementing other environmental influences, or vice versa. Thus among men in the armed forces or in the merchant navy, the influence of the older men on the younger ones may be important. For instance, some younger men, unable to bear the taunts of the older companions, are almost
forced to take part in activities which are quite foreign to them and their desires. But even here the influence of the companions is to be questioned. One study made in the American Army states: "The sex habits of the man of military age have been largely determined before he enters the Army. The man who has been promiscuous in civil life will probably not change his habits upon entering military life. A study at one Army post showed that half of all the soldiers contracting venereal disease gave a history of having had a similar infection before entering the Army." (1)

Another American article states: "The men in a successfully trained army or navy are stamped into a mold. Their barracks talk becomes typical, for soldiers are taught in a harsh and brutal school. They cannot, they must not, be molly coddled, and this very education befits nature, induces sexual aggression, and makes them the stern, dynamic type we associate with the men of the armed forces. ... This very sex drive is ... exaggerated by the salacious barrack talk." (2)

It would be unfair to generalize on the influence of companions, casual or otherwise, because a careful individual case study would have to be made to determine just what part each factor played in the pattern of the person prior to sexual exposure. Certainly, clinic interviews would be valueless, because most of the patients regret having acquired a venereal disease and are only too willing to find a scapegoat -- projection is inevitable.

Chapter V. Factors Involved: Psychological.

1. The Sex Drive:

The sex drive and its heterosexual manifestation, coitus, are fundamental to the spread of venereal disease. It is a truism that if sexual intercourse were avoided in persons not married to each other, within a generation the venereal diseases would almost entirely disappear. Of course few authorities believe that the necessary continence outside of marriage can be universally attained, but most do believe that every effort should be made to dissuade incontinence.

For the purpose of venereal disease control, only one of the numerous and diverse manifestations of sexual activity, coitus, need be considered: homosexuality and other perversions play such a limited role in the spread of venereal disease that they need only be mentioned.

Homosexuality, especially among incarcerated men, is responsible for the spread of a limited amount of venereal disease. In Oakalla Prison Farm in 1945, two inmates who had been prisoners for some time showed symptoms of early syphilis. Questioning of one of these men revealed that he had had several homosexual exposures with other prisoners. These exposures, which had all occurred in one particular part of the prison, were quickly halted, and all the men involved examined and, when necessary, treated.

Some clinic patients too, have given a history of homosexual activities, but infections arising from such activities when they do appear are so few that they invite special attention. Heterosexual perversions, usually only suspected by the examiner and rarely admitted by the patient, are not responsible for a significant number of infections. In the control of venereal disease, they need not be considered separately from copulatory behaviour, because both are essentially sexual exposures which can
constitute a source of infection.

In considering the relationship between coitus and venereal disease, it should be stressed that, except in rare instances, at least three persons are involved. That is, in order to acquire a venereal disease, an individual must be sexually exposed to another person who has previously acquired an infection probably not longer than five years before, because untreated late syphilis is relatively non-infectious. (1)

Then this involvement of more than two persons is recognized, it is seen that the venereal disease attack-rate is not an index to the amount of non-marital sexual intercourse in a given area, but an index to the promiscuity. (The term promiscuity as here used is arbitrarily defined as "the act of having sexual relations with more than one person within a period of five years". This definition is admittedly unsuitable for general usage: it omits entirely reference to marital status. It is intended only to convey the involvement of more than two persons in sexual activity within the period of time in which infection can be spread.) It can be seen that if one infected person in a community is promiscuous, he or she may start a chain of infection which can be spread in a geometric progression.

From this brief discussion it might appear that, from a venereal disease control standpoint, it is unnecessary to discourage sex relations between any two individuals married or unmarried, providing those sex relations are confined to the two individuals. However, because there are no means available to control absolutely any person, and because the factors responsible for promiscuity are so numerous, to advocate such a policy would invite chaos, not only from a health standpoint, but from the opposition of numerous individuals and organizations.

Despite the veil of secrecy, the prudery, and denials of many well meaning organizations, and despite their threats and pleas concerning continence, the basic fact remains that the sex drive exists and must somehow be satisfied. "Biology indicates that with the exception of some few individuals, men and women require expression of the sex impulse as a physiologic necessity." (1) When this drive is strong, and is satisfied by sexual intercourse, gross promiscuity (especially among the unmarried) may result. The problem arises whether this promiscuity is a manifestation of nymphomania or satyriasis. Most authorities maintain that these conditions are rare, and that most cases appearing to be hypersexualism are nothing more than manifestations of individual maladjustment. Even among prostitutes, cases of hypersexualism are rare. (2)

But other cases, not of gross promiscuity, but of regular exposure are often found among single, divorced, or widowed men and women. These persons assure the questioner that they must have intercourse regularly, that it is vital to their health. The expressions they use to describe their needs are much the same, all stress the absolute necessity of intercourse. With such people a complex problem is present: the sex drive apparently can be gratified only by a promiscuous exposure, and for them, no other solution -- or no easy solution presents itself: they are firmly convinced that their behaviour is the only possible behaviour.

Here then are two apparently different situations, gross promiscuity and "regular" exposures: both are responses to a powerful sex drive and except in degree they are identical. "The sex urge is so deeply implanted in living beings that complete repression is impossible." (3)

Concerning the sexual aggressiveness of men in the armed forces; it has been suggested that "This sexual aggressiveness cannot be stifled... This very sexual drive is amplified because of fresh air,

(1) Rosenau, M.J., ibid., p. 479.
(2) Kemp, T., ibid., p. 51.
(3) Rosenau, M.J., ibid., p. 479.
good food and exercise, and exaggerated by salacious barracks talk. It cannot be sublimated by hard work or the soft whinings of Victorian minds.” (1)

In addition to the physiological tensions evoking sex activity, there are emotional tensions that can often be released, or partially released, through sex activity. Because sex activity seldom requires much effort, it furnishes an excellent means for some to make an adjustment, albeit an unsatisfactory one, to their environment.

True nymphomania and satyromania are rare; promiscuity, on the other hand, is common, because tension, can and often does appear as sexual tension. The release of this tension is easily accomplished through erotic behaviour -- in adults it is usually through sexual intercourse -- thus this easy method is used in preference to other, more socially acceptable methods.

For purposes of venereal disease control, this matter is of concern: mass public education would be of doubtful value -- explanations, advice, and guidance can be given only after individual analyses and studies have been made; and unless control can be exercised over the individual concerned, measures to counteract promiscuity will often be wasted effort. “The very nature of the sex urge itself... tends to cancel out much of the effects... educational efforts.” (2)

2. Lack of Satisfactory Substitute Activity:

Much of the available data concerning persons suffering from venereal disease is purely introspective, and from the persons themselves; this data is often obtained from the clinic patients only as a voluntary statement, or as an admission after careful questioning. This is because the work of the Division of Venereal Disease Control is concerned primarily with the treatment (or rendering non-infectious) of venereal disease.

(1) Boone, J.T., ibid., p. 118.
diseases, not the criticizing of patients for moral laxity. However, when a patient is diagnosed, the social history taken often reveals some of the underlying problems involved; and special case studies made at the Division of Venereal Disease Control are intended to discover what factors are involved, in order that any possible remedial measures may be taken.

That "sexual energy" can be directed from a personal, tension releasing response into altruistic and social channels was stressed by Freud in his concept of sublimation. Numerous other individuals, even if they do not agree with the psychoanalytic theory, have agreed that sublimation, in varying degrees, is possible. In this paper, the sex drive is assumed to be a tension, capable of arousing diffuse organismic activity, and that such activity can be channelized, within limits, into socially acceptable behaviour through the process called sublimation.

That the mores requiring continence on the part of the unmarried man and woman are being ignored is quite obvious from the venereal disease attack rate and illegitimate birth rate. Young men and women do have sex tensions, and they do require a release of those tensions, but the society in which they live has sex mores. "It would be difficult to invent a convention more directly opposed to biologic realities than the insistence of sexual abstinence, especially during the long period when virility is most active... Biologic teaching leans toward self-expression, indicating that the problem is individual, while the pressure of the social code is toward self-repression, demanding group conformity. The pendulum swings from one extreme to another in a futile attempt to reconcile or compromise these two conflicting disciplines." (1)

Rather than supplying facilities for such substitute activities, Stokes argues that modern civilization is ever removing them.

(1) Rosenau, M.J., ibid., p. 497.
"For a very sound physiologic reason well borne out in psychosomatic medicine, the disappearance from a civilization of the need for muscular effort as a means of neural tension discharge, leads inevitably to an overbalancing of the individual economy toward the emotional side. To bring this principle to the American scene, no ice to break on the pitcher in the morning; no chores; no 2-mile walk to school; no field to plough; no axe to wield -- in their place, the running hot and cold water, the inner spring mattress, the soft car-seat, without even the necessity for twiddling a thumb to shift a gear, the sit-down job, the over-sized meal -- all such devices tend to create or to accumulate instead of draining off, the emotional potential of which sex forms so large a part. In the life of today, massive physical weariness obliterating all titillative stimuli from ankles to curvesome lips under a thick pall of muscular exhaustion, forms just no part at all. A rise in sexual tension and tempo would therefore seem inevitable. Nor does the upswing in the worry curve of modern life exert a necessarily compensatory depressant influence. In fact, one of the paradoxical things about worry is its direct drive into sexual hyperactivity and abnormal sexual practice. Sex activity is a major mechanism of escape. Another elementary critical reversal is that now developing between the role of man and of woman in the carrying of the physical load of life. Increasingly one sees the woman, liberated by marriage or a job from the time-honored but exhausting routine of washboard, iron, and kitchen sink, to say nothing of the children, pigs, and chickens, who has now become through accumulated and released emotional tensions, the sexual desirer, seeker and aggressor of the male-female combination in the family life. The man comes home from a bad day, flat, to meet the woman, with her warpaint on, ready for the night-club and what have you. The result -- adventurousness in sexual forms at an
age and in social groups in which the good older days sheer fatigue applied its damper, and the integrity of the home was assured, at least, of the stability of inertness and exhaustion." (1) This viewpoint of Stokes serves to stress the need for finding satisfactory substitute activities for all concerned.

The task of finding these substitute activities has been taken on by Social Hygiene as one of its duties: Social Hygiene must: "endeavour to direct sexual relationships into higher paths instead of trying to deny their existence or to trample them out.

Unless Social Hygiene succeeds in this, the volume of male and female incontinence will remain high; it will continue to form that nucleus of supply and demand which is fundamental as regards prostitution and the venereal diseases, which are the blossoms of promiscuity, will persist." (2)

3. Loss of Security:

In the following brief discussion, it is to be made clear that only a most superficial and incomplete survey will be made: the individuals being considered are mature, i.e., in their late teens or older.

With these individuals who are, or legally can be independent of their parents, behaviour problems occasionally arise: freedom from parental or guardian control brings responsibilities, and one of the most important responsibilities is that of economic security -- security, not necessarily for the distant future, but security for the present. When this security is absent -- and admittedly its absence is only one of the causes of behaviour problems -- problems arise so diverse in constitution and content, that they might, if listed, be a catalogue of social and individual ills throughout the world. One of these problems may:

(2) Garle, H.E., ibid., p. 173.
manifest itself, directly or indirectly, as promiscuous sexual behaviour: directly in the case of some professional prostitutes, indirectly in the case of some neurotic patterns.

However, economic security is not always all that is lost in the bid for independence: a form of social security is often lost. Gone too are the intimate familial relations, the friends and acquaintances, the associations, the recreation, the sympathetic solving of personal problems. These losses are usually overcome, but in some cases they are not. Just what adjustment the individual makes to the new conditions is important to him, and sometimes to the community. If perchance the adjustment entails promiscuity, it may become of importance to the health authorities.

Another form of security, somewhat related to the last mentioned, is often absent in the recently widowed man and woman: here, though, sexual activities are involved. The readjustment in such a case, especially if the person is young, may involve promiscuity.

Here then are examples of loss of economic or social security: probably the variations of, and additions to these are numerous: they serve only to indicate that loss of security may be related to promiscuity and thus to the spread of venereal disease. Despite the probability of this, there are no actual studies available to indicate that it is so. There is far insufficient available material concerning the factors predisposing to the exposure to venereal disease -- the general clinical material is usually too superficial, and special clinical studies are slow to appear.

What should be pointed out concerning the relationship of loss of security to the spread of venereal disease (or promiscuity) is that it, in itself, is probably negligible but combined with other factors,
becomes of special significance.

4. Lack of Marital Adjustment:

It is almost a truism that venereal disease mainly attacks single, separated, and divorced persons, and married persons who have failed to adjust themselves satisfactorily either to their mates or to the institution of marriage itself. The actual reasons for the maladjustments of the latter are not important here, but they embrace every aspect of a man's life. Testimony to the numerous causes for such maladjustments may be found in the grounds for divorce cited, particularly in the U.S.A. Various polls of both men and women also indicate that there are almost countless faults that one finds with husband or wife, which can and do lead to separation or divorce when an unsatisfactory adjustment is made.

In British Columbia, most of the grounds considered satisfactory for divorce in the U.S.A. are not permissible. In British Columbia, adultery must be proved. (It is of course understood that a great many cases in which adultery is "proved" are arranged solely to procure the divorce, whereas the factors leading to the desire for the divorce may be any one or more of numerous causes.) Still, divorces in British Columbia, even though the grounds required are repugnant enough to discourage many persons, are increasing every year.

In considering the number of infections acquired due to marital maladjustment, it is probably permissible to include not only the married persons who are living with their mates, but also those persons who are separated or divorced, although it is admitted that other factors are involved in these latter cases. During the war years, particularly, with many husbands and wives separated for long periods of time, the number of infections acquired by married persons rose startlingly. This was
to be expected, but if would be fairer to count many of these men and
women as "separated" rather than "married" because the latter usually
implies living with one's mate. For this reason, it becomes very diffi­
cult to determine just how many extra-marital exposures resulting in infec­
tion were acquired by married persons directly because of marital malad­
justment. (The notification of venereal disease sent to the Provincial
Board of Health states the marital status of the infected person, but
except for clinic cases and isolated ones from private physicians, no
mention is made of the whereabouts of the husband or wife.)

In a survey of 292 consecutive cases of venereal disease
among male soldiers in one military district of Canada, it was reported
that "the percentage of marital incompatibility (divorce, separation or
frequent quarrelling) was three times as high" among the venereal patients
as in the control group. The "control group was secured by making com­
parative personality studies of 153 soldiers selected at random from a
group of 1000 consecutive files in the Depot personnel Selection office".
(1)

One factor that is responsible for some infections among
married men more than among married women is exposure while under the
influence of liquor. This group, relatively small, does not include those
men who are using alcohol as a substitute for marital adjustment, but only
those men who are apparently happily married and who, for some reason or
another, become intoxicated and are picked (rather than pick up) by a
prostitute. When an infection is acquired in this manner, the man is
usually regretful and makes every effort to conceal his infection from his
wife. Such an infection, however, generally serves as an object lesson
for extra-marital continence, and so long as his marital status and ad­
justment remains constant the man can seldom if ever be expected to

(1) Watts, G.O., and Wilson, R.A., A study of personality factors among
venereal disease patients. C.M.J., vol. 53, p. 120.
become infected in the future. Thus, such men are of only limited importance in a consideration of the factors responsible for the spread of venereal disease.

In conclusion, then, it can be stated that because of the inadequacy of the available statistical material, a consideration of the relationship of marital adjustment to the acquisition of venereal disease is unfair when only married men and women living with their mates are considered (and only incomplete material is available), marital maladjustments account for but a few infections. However, if those individuals who are divorced, or separated by choice are included, marital maladjustment can be considered as accounting for a significant number of infections, and hence as constituting an important factor in the spread of venereal disease.

5. Lack of Fear of Infection:

Of the two diseases, syphilis and gonorrhoea, the former has usually been recognized as a serious disease, the latter as "nothing worse than a bad cold". Since 1910, a successful but long treatment for syphilis has been known, but it is only relatively recently (since about 1940) that a rapid, effective treatment for gonorrhoea has been available. Prior to that time, local treatment was given, which was often quite painful.

With the advent of the sulfa drugs, medical authorities looked for the eradication of gonorrhoea (the drugs were ineffective against syphilis); but after widespread use the rate of cure of gonorrhoea began to fall -- sulfa resistant strains of gonococci had developed. At about this time, penicillin became available for general use and its remarkable properties were soon made known throughout the world. One of these properties was emphasized more than any other to the general public --
penicillin could be successfully used in the treatment of both gonorrhoea and syphilis, and treatment time was only a matter of hours or days whereas formerly it had been a matter of weeks, months or even years. Hardly any popular magazine in existence has not had some article at least mentioning the miraculous treatment of venereal disease with the "wonder drug"; and hardly any of these articles suggested that the results of syphilis treatment with penicillin are still largely experimental, and that no valid evaluation of syphilis treatment with it can be made for several years to come. Nor have these articles stressed the possibility that penicillin-resistant strains of the etiological factors might be produced if the drug is carelessly used. What has been stressed is that penicillin affords a quick, almost painless, and almost certain cure for either syphilis or gonorrhoea; the limitations and faults of the drug, more and more of which are being discovered, are seldom stated -- they would probably now be disbelieved by the public, even if they were stated.

One of the immediate results of the publicity given to penicillin was that many individuals who formerly dreaded the possibility of acquiring a venereal infection, especially syphilis, have now become indifferent. Such an attitude is relatively prevalent among the younger men and women, among boys and girls in high school and among those who are quite unfamiliar with the serious complications which might result from the diseases. Among older men and women, a respect for the disease has remained.

Thus penicillin brought with it a removal of fear of the venereal diseases; paradoxically, this has been one of the objectives of venereal disease education, but to a somewhat less degree. In an effort to counteract early venereal disease education, which concerned itself mainly with ghastly illustrations of untreated syphilis, and with rash
statements about the infectiousness of the diseases, modern venereal disease education has stressed that venereal disease should be considered as merely another communicable disease and that as such it should be regarded objectively. In addition, an effort has been made to use the positive approach of exemplifying good health rather than the negative approach of fearing infection. In addition, however, a healthy fear of the venereal diseases has always been stressed in this province's educational program; but since the arrival of penicillin, fear of the venereal diseases among the younger people is disappearing. Evidence for this last statement appears strikingly in interviews with individuals and groups but evidence of a more material type is found in the large number of reinfections being acquired at the present time.

In a three month period, February 1 to April 30, 1946, 741 persons, 476 male and 265 female, were diagnosed at the Vancouver Clinic (including Oakalla). "200 (42%) of the men are known to have or have had more than one venereal disease. These 200 men have had a total of 506 infections which is an average of 2.5 each. One man has had syphilis once and gonorrhoea nine times. Another man has had gonorrhoea ten times."

"113 (42%) of the women are known to have or have had more than one venereal infection. These 113 women have had a total of 310 infections, which is an average of nearly three each. One woman has had syphilis once and gonorrhoea nine times." (1) Later investigation indicated that several more of the patients in this group had had previous infections, thus the percentage of reinfections are only minimal.

Clarke has this to say concerning penicillin in the treatment of venereal disease: "Under penicillin treatment a person can be cured of gonorrhoea and get a new infection, all in the period of one week. As a matter of fact, case records in rapid treatment centres and

(1) Division of V.D. Control, Vancouver, Patients diagnosed at the Vancouver Clinic from February 1, 1946 to April 30, 1946.
clinics abundantly show that many patients are infected, cured and reinfected over and over again."

It must be admitted by those who are honest enough to face the known facts, that gonorrhea has lost some of its terror if 85% of cases can be cured in a few hours of only mildly uncomfortable treatment, and that fear of infection may not continue to be a potent deterrent to exposure -- if it ever was one. There will have to be other strong motives for avoiding promiscuous sex relations which spread gonorrhea, otherwise there will be such an epidemic of gonorrhea as the world has not seen in modern times. It is interesting to note that concomitant with the introduction of quick easy methods of treatment there has been an increase in the incidence of gonorrhea, but just what the relation may be between these two phenomena is not known at present.

"At least it appears that penicillin has not solved and is not likely to solve the public health problems of this infection. Its solution must be found in other approaches to the problem including those which influence the conduct which leads to infection, i.e., sexual promiscuity." (1)

In addition to the possible influence of penicillin in removing fear of infection there has been the wide spread distribution, particularly among personnel of the armed forces, of information concerning prophylaxis and early preventive treatment. Prophylaxis and early preventive treatment are undoubtedly effective in the prevention of infection, but have been criticized as encouraging promiscuity by removing fear of infection from promiscuous exposures. (In addition, prophylaxis and early preventive treatment may build a false sense of security in individuals, and thus be responsible for symptoms being overlooked or discounted by infected persons who made use of these health measures.)

It is impossible to predict the future trend of attitude towards the diseases, but with the indications that strains of penicillin-resistant gonococci have developed or are capable of being developed, it is certain that unless new drugs are developed, the venereal diseases must be considered to be well worth avoiding and at least healthily feared. (1)

6. Lack of Recreation:

The factor of recreation, discussed earlier, is seen to be of importance in the control of venereal disease. From the individual point of view, recreation can be a factor predisposing to either the acquisition or the avoidance of venereal disease. If the recreation be socially and morally acceptable, the chances are that it will assist in the avoidance of promiscuous sexual contacts; but if it be socially and morally unacceptable or doubtfully acceptable, such recreation may encourage, directly or indirectly, exposure to infection.

Which forms of recreation are socially acceptable constitutes a problem which will not be solved here. The problem is an individual one: what might prove to be satisfactory for one person might be most unsatisfactory for another. Thus, although the individual, young or old, requires some recreational outlets, the choice of such recreation, if it is to be applied in the control of venereal disease, cannot be indiscriminate. Recreation must be constructive, wholesome, and enjoyable.

The need for recreation by everyone has long been known, and some effort has been made to provide organized recreation in special cases: playgrounds exist for the young, physical recreational courses for adults, even some industrial plants have recreational facilities for employees. These are private or public contributions: many more and many more varieties are required.

Organized group recreation sponsored by the community can do much to overcome boredom, and perhaps prevent promiscuous sex exposures, but such recreation is often shunned by those who do not consider it to be sufficiently exciting or who may be too shy to take part. Among the girls studied by Lion and his assistants, it was found that the "major recreational activities for the group as a whole were frequenting bars; attending movies; public dances, and beach concessions; and read 'pulp' romances and detective stories". Recreation such as this can never be considered constructive or wholesome, but for many it is all that appeals. Unfortunately, unless provisions are made for the young, it will be just such forms of recreation that will serve the coming generations of adults.

A solution is needed, and at least a partial one is offered by Fonde: "The school recreation centre, the playground with adequate field house, the church, library, settlement, Y.W.C.A., Y.M.C.A., Scout House, or what have you, will offer every adolescent, with every member of his family, the chance to exercise and further develop his interests and skills -- during all of the leisure hours every month in the year. These places will be veritable temples of culture and happiness -- of games, music, drama, art, and crafts, literature, current affairs, comradeship, congenial grouping, adventure, romance, enthusiasm and creative effort."


7. Lack of Interests:

The relationship between interests and recreation is probably very close: those who have numerous interests can find recreation at almost any time, those who have few interests, and rely on occasional group activities for recreation, may become involved in socially undesirable activities, including promiscuous behaviour. The latter are more inclined to seek activities of any exciting sort to compensate for their (1)
otherwise dull or routine existence. In the case of both men and women, promiscuity may become common in such instances, and venereal disease may be spread.

Dominating interests or numerous interests on the parts of men and women will not alone solve the problem of promiscuity, but combined with other factors they will serve to circumvent some individuals who might otherwise have become promiscuous.

8. Conditioning Influence of Environment:

Probably at no other time in history has there been so many opportunities to reach the population in diverse ways; radio, motion pictures, newspapers, magazines, billboards, and numerous other media can be used directly or indirectly for advertising and propaganda. With the development of these media there has been an ever increasing use of "sex-flavoured" material: sometimes obvious, sometimes veiled. Manufacturers of cosmetics, soaps, wearing apparel, patent medicines and almost every other marketable product have linked their produce with the sex drive -- the advertised product is essential to a satisfactory sexual adjustment. Wylie (1) has stressed this relationship of commercial advertising to sex in a blunt by effective manner.

Many of the motion pictures from both the United States and Great Britain are dominated by an emphasis on sex, either by scantily clad women, a specialty of Hollywood, or by risque references, a specialty of London. The complex narratives connecting the sex material are often little less than transparent covers for pornographic swamps. The presence of provincial and state censoring officials in addition to filmdom's own censor office is an indication of the number of films considered unsuitable for public consumption. Although it is true that censor boards do not exist solely for passing judgement on the "moral" content of films, such judge-

(1) Wylie, P., Generation of vipers.
ment is an important duty.

In the case of British Columbia, sympathy can be extended to the Board of Censors who must approve or reject a film designed for public entertainment. "All films or slides to be used in connection with any kinematograph shall, before being exhibited for public entertainment, be inspected by the Censor, who shall determine and pass upon the fitness for public exhibition of all such films and slides, with a view to the prevention of the depiction of scenes of an immoral or obscene nature, the representation of crime or pictures reproducing any brutalizing spectacle, or which indicate or suggest lewdness or indecency, or the infidelity or unfaithfulness of husband or wife, or any other such pictures which he may consider injurious to morals or against the public welfare, or which may offer evil suggestions to the minds of children, or which may be likely to offend the public." (1)

The wording of this section might suggest that only the most innocuous films would be shown in the province, but with the close proximity of Canada to the United States, and the strong influence of American advertising on the Canadian public, a well advertised film is assured of a large attendance long before its arrival, especially if the showing of that film might be, with careful interpretation, contrary to the Moving Pictures Act.

The films, the advertising of films, and the private lives of the actors and actresses taking part in them are factors in influencing the audience. If the influence is in the direction of an undesirable stress, on sex, then there is the possibility that some members of the audience will through identification or direct visual stimulation, seek promiscuous exposures.

(1) British Columbia Legislature, Moving pictures act, R.S. 1924, c. 178, S. 7.
It would be difficult to measure accurately the influence of moving pictures and related advertising on audiences, especially juvenile audiences, but Van Waters early mentioned the matter, pointing out cases in which young persons through emulating their movie heroes and heroines, have faced charges in juvenile court. (1)

Related to moving pictures is vaudeville, which often degenerates into nothing more than pornography. The dialogue, action, and dress in some vaudeville probably has a much more direct and pronounced effect in encouraging sexual immorality than do moving pictures. It is significant that both of the theatres that have vaudeville in Vancouver are in the immediate vicinity of known bawdy houses and street walkers, and that the one which advertises "burlesque" is situated in the same block as some of the city's most notorious centres of vice.

Newspapers, too, are open to criticism when they luridly give accounts of "human interest" stories, stories which often include intimate details of sex crimes, divorce actions, and other matters tainted by illicit sex relations. If these stories serve to offer some vicarious satisfaction to frustrated sadists, they may have some controlling value, but if they influence anyone, particularly young people, to adopt an undue or undesirable interest in sex, their continued existence is not to be condoned.

Like the foregoing, many radio programs, comic strips, books, magazines, and other media of entertainment also stress sex, and do so in a lewd or suggestive manner; many of today's best-sellers are but thinly veiled accounts of sex orgies. These types of relaxatory entertainment may be responsible for little delinquency among most adults, they may ever serve as means in which identification may assist in the release of repressed desires. With children and youths, however, this

(1) Van Waters, M., Youth in conflict.
substitute response may become a substitute stimulus and actually be responsible for over aggressive sex activity contrary to the sex mores. Such sex-laden materials were considered to constitute one of the important factors in counteracting health education among U. S. Army personnel. Larimore and Steinberg describe it as "education for venereal disease. Writing of this they stated: "This is comprised by the sexually stimulating motion picture, the sex comic strips, the pin-up girls, and the mass use of sex as a selling agent in certain advertising. All of these tend to glamorize and romanticize sex and its ever-present by-product, promiscuous sexual intercourse. Unfortunately, this propaganda for sex exerts the greatest influence on the younger, more easily impressed groups." (1)

Stokes, discussing some of the considerations affecting present day sex problems, states: "One's chief concern in thinking about the sex coloring of modern life must be not to forget his own youth, lest he substitute an endocrine atrophic viewpoint for a just psychologic and social appraisal. The thinning and disappearance of clothes, the ribaldries of and near pornographies of 'cheese-cake', beauty parades, and pin-up girls, the literature of erotic frankness, and the under-the-counter stuff which we have always had with us can be discussed pro and con, ad infinitum. Sex in the barnyard, in the school out-house, in the hay-mow, has been replaced by sex in the school club, sex in the all-night theatres, sex on wheels, in the rooming house, and in the bush. As civilization takes on a more and more frankly sensuous nature, it is to be expected that the mode of dealing with the placement of sex in human conduct must undergo change." (2)

(1) Larimore, G.W. and Steinberg, T.H., ibid., p. 802.
(2) Stokes, J.H., ibid., pps. 197-198.
In Vancouver, a spokesman for one of the churches deplored the ever spreading "sexualization of civilization". He stated that the causes of the high prevalence of venereal disease included: "Photographs in our daily press, almost every edition, of undressed or under-dressed girls in shameless poses.

"Vice-ridden movies with their unspeakable ads"...

'Suddenly nothing else mattered except that she was a woman... and he a man.' 'Blazing beacons of desire that led her to the dark brink.'

"Lewd magazines: we are always going to stop them, and they fill our news-stands still.

"Indecent floor-shows... at the regular Cabarets and at the Society Cabarets. The latter should set a better example than they do, when they produce their immodest 'leg shows', which are no less offensive to morality than the lower-type productions of places run for profit. And for weeks ahead, the papers are disgraced with the photographs of the 'fun in store'. ... All such are incentives to lust." (1)

This brief discussion has suggested some of the means in the environment which can and do build undesirable sex attitudes among the population, especially among the young or unstable. However, the population is for the most part stimulated by not one but all of these entertainment media: in toto, they exert an influence from which no one can escape. They, by means of sustained stimulation, sway the population to a broader and more tolerant attitude towards sex. Undoubtedly, this has been of value in the progress and health of the society, but it has also been a factor in the disregarding of the sex mores by some members of society.

(1) Challoner, Monsignor F., Remarks prepared for panel discussion of venereal disease control, Vancouver, November 16, 1945.
When the population is conditioned by many parts of the environment towards an attitude to sex leading to activities contrary to the mores, a serious problem arises: the mores will have to be changed, satisfactory substitute responses will have to be formulated and practised, or the stimuli will have to be changed.

9. Increasing Disregard for Sex Mores:

As has been stated, venereal disease is transmitted almost entirely by means of sexual intercourse with an infected person, and every infection must come from another infection; thus every acquired infection (omitting prenatal and accidental infections) will show a history of promiscuity on the part of at least one of the two persons involved in a newly reported case of venereal disease. Since this is so, the attack rate of venereal disease in any area is a reliable index to the amount of promiscuity in that area.

On the basis of these observations, it is readily seen that the increasing prevalence of venereal disease during the past few years is an indication of a rising rate of promiscuity. One objection to such a conclusion as this is immediately raised by some health authorities: they state that the rising attack rate of infection is mainly due to improved reporting on the part of private physicians; to improved self-referral of persons who may have been exposed to infection (due to increased knowledge of the diseases); to improved case-finding; and to population increases. One must agree that these reasons are of some value in explaining the rise in the number of reported infections, but there is a general rise of attack-rate throughout the nation, and in cities, towns, and villages where there is a population increase, the rise in the reported attack rate is usually above the expected rise due to populational increase.
A popular misconception is that returning of the armed forces is responsible for the spread of many infections, but it should be remembered that members of the armed forces have a complete examination before being discharged, in addition to periodic examinations for venereal disease; thus men returning from overseas, even though infected, would not constitute a serious infection source problem, even though reports from the European Countries indicate that venereal disease is rampant. (It is of course possible that some of the infections acquired overseas are not discovered, and are transmitted in Canada, but these are few.)

The matter of improved reporting by private physicians probably accounts for part of the increase, but it is difficult to believe that a large number of physicians who were lax during previous years of practice would suddenly cooperate with the health authorities and begin reporting infections. (Physicians, however, who have been in the armed forces and are being discharged, will probably report all infections coming under their care, take routine blood tests, and perform any other measures required in the control of venereal disease that are asked of them -- they probably will cooperate in this way because of the stress laid on venereal disease control in the armed forces. At the time of writing, however, these younger physicians have not had sufficient time in private practice, or have not been discharged in sufficient numbers to make a marked impression in the number of cases reported by private practitioners.) The matter of improved case finding is of some importance, because public health nurses all over the province are lending their assistance in the finding of contacts to known or suspected infections and are having those contacts examined, and where necessary, treated. The last point is that persons who may have been exposed to infections are reporting to private physicians and clinics more often than in the past --
with an increased stress on education, this is hoped to be so, but there is no statistical proof as yet.

In conclusion, then, it is suggested that despite the objections of some authorities to the belief that the statistical increase in the prevalence of venereal disease is not a true one, the increase is a true one and that the spread of venereal disease is, in reality, becoming more and more serious. If this conclusion and the long established belief that the venereal disease attack rate is a reliable index to the amount of promiscuity in an area be accepted, then promiscuity is increasing rapidly.

Promiscuity, in turn, is an indication of a disregard for the sex mores, and particularly for the mores that prohibit sexual intercourse out of wedlock. But promiscuity is only one indication of this; in addition, there is evidence that this particular sex mores is frequently disregarded by young men and women in sex activity confined to the two persons. Just how many of these latter mentioned cases there are can be only a conjecture. Questionnaires on the subject are open to serious criticism; what results they do give can be considered as only an absolute minimum. For example, in a questionnaire survey concerning the sex life of women, Davis found that only 7.1% admitted premarital sexual intercourse. Davis admits that "Our own judgment would be that the figures given on the questions relating to eroticism may be taken as a minimum for the group studied." (1) The group studied in this case was a superior one, and not a fair sampling of the adult female population.

The matter of the disregard for the sex mores is of importance in the venereal disease problem, whether an individual confines his sexual activity to one other person or whether that individual is (1) Davis, A.B., Factors in the sex life of twenty-two hundred women, p. xiv.
promiscuous, because he or she usually does not know anything about the health of the partner.

Parents are interested in the children's disregard of the sex mores for other reasons in addition to the possibility of acquiring infection, but in most cases, they believe that these mores are being broken by persons outside their own families. To suggest to most parents that their children, at any age, may be taking part in "illicit" sex relations would be considered an insult, yet on the basis of the venereal disease attack rate alone, it can be seen that illicit sex relations are more prevalent than most parents realize.

In considering the disregard of the sex mores as a factor in the spread of venereal disease, a question arises: do the mores command obedience from a large part of the population because they are moral laws, or because other more influential factors are present which increase or decrease the effectiveness of the mores as a means of controlling the population?

For some individuals, it is somewhat futile to suggest that disregard for the mores is at any time increasing or decreasing. However, since the mores are imposed upon the entire population, increasing disregard for them can be considered as a factor in the spread of venereal disease, and, at the same time, as a challenge to interested individuals and organizations to attempt to enforce them. If they were enforced, obviously the attack rate of infection would decrease.

Churches differ in their attitudes: some recognize the prevalence of moral infractions, and agree that although they are to be discouraged, they are committed and health information should be available; others insist that to admit the prevalence of moral infractions is to indirectly condone them; health information can be given under
specified conditions but continence is the only true prophylactic.

Certain it is that most health authorities recognize the importance of the moral factor in the control of venereal disease. However, health authorities do not accept the responsibility of teaching morals to the population: as was pointed out in an editorial in the Canadian Journal of Public Health: "It is true that emphasis has been placed by public health authorities on methods of control apart from moral control, but this does not necessarily mean that the importance of moral restraint is not appreciated; rather, that the responsibility for moral instruction is not a function of the health department. Moral teaching is primarily the duty of the Church and of parents and children; and in this effort all the resources of the community, including the press, should be utilized... The control of venereal disease cannot be achieved by public health measures alone." (1)

10. Wartime Philosophy:

Homes temporarily broken, an abnormal amount of transiency, disruption of normal family life, social unrest, are all present to some degree during wartime, and one of the resultant effects is seen in the wartime increase of promiscuous sex relations and venereal disease. This increased attack-rate of venereal disease becomes more significant when it is remembered that during war years, various precautions which are normally disregarded, are enforced. In the late war, for instance, such measures as education, prophylaxis, suppression of prostitution and the placing of facilitation premises out-of-bounds for the armed forces were taken to assist in maintaining a physically fit armed force and a productive home front; yet all this did not prevent a serious upsurge in the venereal disease attack rate.

The factors involved in this upsurge are obviously complex, but one which arises pronouncedly during war time is the reaction of the people to tensions of various forms. Tension, psychological or physiological, may be released by sexual activity. This being so, the combination of other factors with the war time tensions offers an explanation for the increase in venereal disease during the war years, and the following years of reconstruction.

During the recent war, a new phenomenon appeared, the Victory Girl. She usually was nothing more than an adolescent or young woman who devoted herself to the task of furnishing erotic enjoyment to men of the armed forces. These Victory Girls were usually completely promiscuous: for them promiscuity was a more or less indiscriminate experience. The explanations offered by many of these young women for their conduct often are rationalizations involving the duty of girls to keep the boys in the armed forces happy; all such rationalizations, however worded, not only exonerate the girl from any criticism but laud her for her sexual promiscuity.

In addition to the appearance of these self-admittedly promiscuous girls there was a rise in promiscuity among the remainder of the population. Whatever the true factors were which predisposed this rise in promiscuity, a common explanation came from the individuals involved: 'during times of stress, one never knows if one must leave tomorrow, probably to face dangers and death; therefore it is advisable to have some pleasure while one can'. This explanation and those similar to it are no more than expressions of pessimistic hedonism.

Larimore and Sternberg in their study of 8,000,000 men in the U.S. Army, considered this attitude as one of the important factors influencing motivation to avoid venereal disease. They called it "war
psychology": "It is the same mass reaction that has brought about an increase in juvenile delinquency and a flood of the so-called 'Victory Girls'. Basically of course, this prevalent trend is to a great extent a current variant of the old 'eat, drink, and be merry' proverb of long standing, accentuated through a wartime release of inhibitions. Translated into terms of our problem (the teaching of soldiers to avoid venereal disease), we observe men throwing aside what they have been taught in a burst of so-called last fling activity, or giving vent to a flood of pent-up emotions upon returning from the months of arduous and often dangerous duties". (1)

This pessimistic hedonism is both a predisposing factor in the spread of venereal disease and a rationalizations to explain behaviour brought about by other factors. To what extent it is a predisposing factor or merely a rationalization would be difficult to determine, but it does appear that during times of social unrest, it arises prominently to reflect the tensions among the population, and thus becomes a factor in the rise of promiscuity and the spread of venereal disease.

11. Mental Qualities of Infected Persons:

The intelligence, as determined by various intelligence tests, of infected persons has received comparatively little attention. Various surveys of intelligence have been made in clinics, prisons, and other institutions, using patients and prostitutes as subjects, but unfortunately, no such surveys have been made of venereally infected persons in British Columbia. The information available is from elsewhere.

Kemp, writing of his findings among 530 prostitutes in Copenhagen, found that 22.2% were slightly retarded, 19.1% retarded (dullards) 6.8% slightly feeble-minded (debits morons) and 0.8% imbeciles: 22.5% were pronounced psychopaths, 7.9% had other mental diseases such as venereal disease. (1) Larimore, G.W., and Sternberg, T.H., ibid., p. 802.
demention paralytica, hysteria, cyclothymic temperament or schizoid tendencies, pronounced nervousness, neurasthenia, marked psycho-infantilism, climacteric insanity, dipsomania or psychogenic depression of a more or less transitory nature... Only 29.4% were mentally normal and without defective intelligence". (1) Kemp also reports various other European studies of prostitutes and states, "The majority of writers on the subject have therefore found that over 50% of all prostitutes must be classed as backward, dull, or feeble-minded". (2)

At the Midwestern Medical Centre in St. Louis, Missouri, a group of five hundred venereally infected females were given intelligence tests. "The intelligence of the patients was determined by the Beta Test, Form A and B, of the Otis Series (for grades IV to IX) to reduce the likelihood of reading difficulties that a more advanced form of test might cause. Furthermore, preliminary study revealed that the majority of the group fell between the fourth and ninth grades limits in their educational achievement. That this decision was sound is seen in the fact that none of the group 'cracked' the test and only one of the patients was able to approach that point." (3) Of the 500 females, 340 were white cases falling at 20 years and 10 months (4 months greater than that of the Negroes and 2 months greater than that of the group.) All the patients were admitted between February and August, 1944 and all had been approached by community health authorities and directed to the Centre for treatment. (No voluntary patients were included in the study.)

"The mental ability of both the white and Negro patients was found to be well below normal. The median intelligence quotient for the 340 white cases was found to be 84, whereas the 160 Negro girls showed a median I.Q. just below 70... Approximately 24% of the (whites)

and 51% of the (Negroes) showed defective intelligence"; i.e. I.Q. was below 70. Only 63 of all the patients, or 12.6% reached or exceeded a 100 intelligence quotient; of these 63, 56 were whites and 7 were colored. "In other words, approximately 16% of the white girls and 4% of the Negroes reached or exceeded the mid point of the normal mental ability range. (1)

In another study at the Midwestern Medical Centre, Rachlin made a study of 304 consecutive uns-selected patients. "Two sets of tests, the Stanford-Binet (Terman-Merrill Revision, form M) and the Otis Beta B, were given to two separate groups. The Stanford-Binet was given to a group of 93. The Otis B was given to a group of 200... On the Stanford-Binet, Form M, the patients achieved a median mental age of 11 years 2 months, and a median I.Q. of 75.3, on the Otis the results were somewhat higher, as they usually are in a group test. In the latter they achieved a median I.Q. of 80.3... This reveals that we are dealing in the main with the intellectually inferior individuals in the community." (2)

Among 100 violators of the May Act committed to a federal reformatory for women, only eight showed normal intelligence, (I.Q. 90-110). Sixteen were classified dull normal (I.Q. 80-89), eleven borderline defectives (I.Q. 70-79), fifty-seven morons (I.Q. 50-69), and eight as imbeciles (I.Q. under 50). (3)

The results of these studies of prostitutes and venereally infected female clinic populations cannot be generalized to apply to all prostitutes or all venereally infected females, for the obvious reason that prostitutes apprehended by the police and female clinic patients do not necessarily constitute fair samplings of the respective total groups. It is the non-representative samplings in clinic studies that make any generalized conclusions open to question.

(1) ibid. p. 301. (2) Rachlin, H.L., ibid., p. 266. (3) Hironimus, H., ibid., p. 32.
Among venereally infected men in the armed forces, some studies have been made of psychiatric factors, and the results tend to agree with those found in clinic studies. In the armed forces, the opportunities of comparing studies of infected personnel with a control group are better than in civilian life; thus, conclusions obtained can be more safely generalized than those obtained from studies of clinic patients.

Watts and Wilson in their Canadian Army study found that 43% of the venereally infected group compared with 5% of the control group had been referred to the psychiatrist (for reasons other than being infected.) "Ninety-five percent of the men in the V. D. group who had been psychiatrically examined were found to have emotional or intelligence handicaps existing in a chronic state. This handicap was sufficient to lower their categories and seriously impair their usefulness to the Army. Approximately one-half of those referred for psychiatric examination were discharged from the Army with a diagnosis of psychopathic personality..."

(1)

In a somewhat similar study of 200 infected men in the U.S. Army, Wittkower and Cowan had a control group of 86 skin cases. These investigations found a much higher percentage of immature personalities among the infected men than among those in the control group. They also found a much higher percentage of criminals and heavy drinkers in the infected group. (2)

These various studies suggest that the mental ability and adjustment of the individual are fundamental factors in the venereal disease problem. The intelligence and adjustment of the individual are important not only as factors predisposing to the acquisition of infection, but also as factors in the continued existence, hence the spread of venereal disease. This latter point has been stressed by Fessler in his

(1) Watts, G.O., and Wilson, R.A., ibid., p. 120.
(2) Wittkower, E.D., and Cowan, J., Some psychological aspects from promiscuity, Psychosomatic Medicine, vol. 6, 1944.
consideration of defaulters from treatment. He states: "Defaulters are regarded usually as persons with antisocial tendencies. It seems that in the majority of cases these antisocial tendencies are the outcome of a subnormal mentality." (1)

On the basis of these observations, it can be seen that the intelligence of the individual, a factor seldom mentioned in discussions of venereal disease problems, is of importance in the control of infection. Fessler adds, "As general experience has shown little can be expected from the imposition of a fine or even from imprisonment (of subnormal infected persons). It is suggested, therefore, that we should approach the problem of the defaulter -- or, to use a wider term, the problem of the uncooperative venereal disease patient-psychologically." (2) Possibly a further step can be taken: the psychological approach might be applied, not only to the control of infection, but also to the prevention of exposure to infection. Some action has been taken in studying the possibilities of this approach, for example by the San Francisco Department of Health, but far more work will have to be done.

12. Promiscuity as a Compensatory Response:

That promiscuity, in many cases, is an adjustment mechanism has been stressed by many authorities. The study made at the San Francisco Department of Public Health by Lion and his assistants (3) substantiates this viewpoint. They classified the promiscuous patients according to motivation of promiscuity.

a. Affectional group -- Promiscuity is primarily an expression of affection. (10%)

b. Episodic group -- Promiscuity is an episodic, circumstantial experience. (20%)

(2) ibid., p. 27.
(3) Lion, E.G., ibid.
c. Habitual group — Promiscuity is a habitual and more or less indiscriminate experience. (57%).

1. Non-conflictional group — Promiscuity is a means of satisfying sexual desires and presents no known conflicts within the patient or between her and her social group. (5% of the total group or 8% of the Habitual group).

2. Dependent group — Promiscuity is an expression of dependency and immaturity causing relatively few concerns since responsibility for behaviour is placed on sexual partners. (9% of the total or 17% of the Habitual group).

3. Conflictual group — Promiscuity is an expression of intra-psychic conflicts. (28% of the total or 49% of the Habitual group).

4. Maladapted group — Promiscuity is an expression of maladapted behaviour characteristic of the unstable patient who lacks social responsibility and self restraint. (11% of the total or 19% of the Habitual group).

5. Undetermined group — Basis for promiscuity is undetermined, although promiscuity is known to be habitual and more or less indiscriminate. (4% of the total or 7% of the Habitual group).

d. Not Classified — Motivation for promiscuity was not classified either because the patient's story was questionable or because there was insufficient information. (13%).

In this study, an arbitrary criterion was set up to differentiate promiscuous from non promiscuous females. Promiscuous patients were diagnosed as:

1. Married women who had engaged in any extramarital sexual relations within six months prior to registration in the Psychiatric Services.

2. Single women who had engaged in sexual relations with more than one man within the six months preceding registration.

3. Single women who had engaged in sexual relations with one man more than twice within the same period.

A distinction was made between those patients who were habitually promiscuous and those who were not. Patients who did not fit into the above definition, or who were considered likely because of
personality and situational factors to become promiscuous during a year's period following their registration, were classified as 'potentially promiscuous'. In addition, those patients who were not promiscuous or were unlikely to become so, were classified as 'not promiscuous'.

This criterion of promiscuity is somewhat different from the one used in this paper, but the essential difference is the inclusion of single women who prior to registration had engaged in sexual relations with one man more than twice within a six months period. However, this difference will not interfere with the discussion at this time, because only the Habitual group is involved, and it would not include these girls.

Two groups in the San Francisco classification serve to reinforce the suggestion that promiscuity is often an adjustment mechanism: these are the Conflictual and the Maladapted groups, both sub groups of the Habitual group. Probably some of the patients included in the Episodic and Dependent groups could also be considered, but this would require a complete reclassification.

In the Conflict group, "Promiscuity was an expression of intra-psychic conflicts, usually of a sexual nature, among one-half of the habitually promiscuous girls. Promiscuity was a symptom of personality maladjustment, and neurotic disturbances were present from a mild to marked degree. There was no homogeneity among the patients as far as psychosexual development was concerned; some patients had remained at an infantile level whereas others were relatively mature in their emotional development..." (1)

Among this group of patients unmistakable neurotic symptoms had occurred. It was noted that on some occasions the patient would show, instead of neurotic symptoms, an outbreak of promiscuity.

(1) 'Lion, E.G., ibid., p. 37.'
In this case it seemed as though promiscuity were a neurotic equivalent. Promiscuity appeared to be one way of attempting to solve conflicts concerning the repressed sexual perturbations. For a time expression of these conflicts would be held in abeyance, but under certain conditions of stress they would periodically surge forth to the point that promiscuity would develop. (1)

In the Maladjusted group, "promiscuity was an expression of non-adaptability among some of the patients where restraint in personal behaviour was either lacking or so poorly developed as to be inoperative in the face of inner drives and environmental stimuli. The outstanding personality characteristics of patients in this group were extreme emotional instability, lack of self-restraint, faulty judgement, impulsiveness, inability to assume responsibility. There was a disregard for social controls. Hostility and distrust were usually present, and in some instances there were strong paranoid tendencies. In carrying out their desires, and in behaving according to their impulses, these patients disregarded the feelings of others and frequently exploited others. Poor personal relationships were conspicuous, and the relationships that were established were not lasting. In the extreme of this group was the psychopathic personality, although not all patients within the group were diagnosed as such.

"Promiscuity was only one expression of the non-adaptability which had been characterized since early childhood. Difficulties with authority were evident from the number of juvenile court, jail and institutional experiences among patients in this group." (2)

Here then has been an outline of some possibilities of promiscuity manifesting itself as a compensatory response, direct or indirect, and often as only one small part of a gross compensatory response.

(1) Lion, E.G., ibid., p. 37.
(2) Lion, E.G., ibid., p. 41.
Chapter VI: Factors Involved: Early Life of Individual.

1. Home Life:

Of all the factors associated with the acquisition of venereal disease through promiscuous behaviour, none is mentioned more often by investigators that the early home influence on the individual concerned. Actually the statement can be made much broader if promiscuity is considered as a form of delinquency, and it can be said that the early home influence is the most important contributing factor to delinquency and crime.

In surveys of sexual delinquents, which are of course made after the delinquency has appeared, an analysis is made, and some common factors are assumed to be the ones responsible for the delinquency. Such a method of determining the factors involved could probably be greatly improved or revised, but it does offer a relatively quick method of determining some of the more obvious factors.

Generally, the assertion is made that poor home conditions are primarily responsible for the development of delinquency, but "poor home conditions" appears to be a label capable of almost any interpretation. What actually constitutes poor home conditions is a complex problem; in addition to the need for economic security, social adjustment, and an acceptable moral standard, the manner of living of the parents is of great importance in judging whether the home is "good" or "bad". Some of the factors involved in evaluating the home conditions can at least be estimated by an investigator: the economic standard can be judged; the moral standard may be indicated by church affiliation and attendance (and by other means); and the social standard can probably be evaluated from data of club affiliations, neighbourhood gossip, and other means.
Adjustment of the parents to each other and to their children is often almost impossible to estimate without prolonged and objective observations. A casual observer visiting the home once or twice could conclude that conditions were very satisfactory when, in reality, the parent's adjustment was most unsatisfactory. The concealing of the actual adjustment difficulties from an investigator might well be unintentional if parents and children did not recognize the factors involved.

The foregoing brief discussion is given only to suggest that possibility that many homes of delinquents might be classified as "good" or "satisfactory" on the basis of partial investigation, whereas they might rate only as "fair", "unsatisfactory" or "poor" if a careful investigation were made; and similarly, homes rated as "unsatisfactory" or "poor" might equally unwarrantably be raised to a higher bracket.

Rappaport in discussing her work with prostitutes in Baltimore points out: "It seems clear that the homes from which they (the prostitutes) have come have not made it possible for them to begin to solve their problems there. There is an economic base for prostitution but it is a subtle one. Girls do not prostitute, we find, so much because they need money to live one -- but rather they get into difficulty because there has not been enough sound substance in their lives and in the lives of their families to help them become useful citizens to live as happy and free people, creating something in their work and play." (1)

Fraser (2), whose unpublished survey of fifty consecutive cases of early syphilis treated at the Vancouver Clinic is a pioneer effort in this field in B. C., did careful case work studies on each. Her study, the survey made in the San Francisco Clinic, and many other studies on promiscuous women agree that the home life of the individual, especially in the early years of life, is the most important factor in the formation

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(2) Fraser, J., ibid.
or prevention of delinquent sexual behaviour leading to the acquisition of venereal disease.

In the case of the San Francisco Clinic patients, "no appreciable differences were found between the promiscuous patients and those potentially promiscuous as regards family background. A majority of patients in both groups came from families of marginal incomes, some of whom had received public or private assistance during the depression years. Lack of social and economic advantages was characteristic of a majority of the group..."

"Family disorganization was characteristic in the case histories. Approximately 40% of the patients' parents were married and living together, although among these many had marital difficulties, including separations followed by reconciliations. Among 60% of the patients, parents were either separated, divorced, or deceased. In many of these broken homes the parents had remarried one or more times. In a few instances the patients had no knowledge of their fathers, and illegitimacy of the patients was known or suspected. To this story of broken homes there was the sequel of placement in boarding schools, foster homes, or in the homes of relatives for varying periods of time.

"The effect of broken homes was evident in a majority of cases, especially in those instances where the parents had remarried and patients had been reared in homes with stepfathers or stepmothers. The patients reported difficulties in adjusting to successive changes in the family pattern. Inconsistencies in training and discipline were frequently the result of constant shifting from the care of one parent to that of another. Divided loyalties between parents who were incompatible were common. Emotional ties to one parent and rejection of the other were frequently seen. In some instances there was an absence of loyalty to the
family group and affectional ties to any member of the family. Those patients whose familial pattern was most disrupted were more inclined to express strong preferences for one parent or another during childhood. Many who preferred their fathers in childhood identified themselves with men and rejected women and their own feminine role.

"Most patients had siblings, the number ranging from one to twelve. Among the broken homes there were frequently step and half-siblings, in addition to full siblings. Except in a few cases, birth order did not seem to be an important factor in the patient's psychological development or in their promiscuity. Sibling rivalry was present in many instances but seemed to be important only in the presence of other factors such as rejection by parents and preferential handling of siblings.

"Patients who experienced material and social deprivations during childhood due to limited family resources were inclined to feel less privileged than their companions and schoolmates, and frequently feelings of inadequacy and insecurity developed out of such situations. Economic deprivations during childhood affected the personalities of some patients and was a remote contributing factor in their promiscuity.

"Approximately 80% of the patients had unresolved conflicts regarding their families. This was observed among patients who had been away from home several years as well as among those who were living with their families. In the instances where familial conflicts were most pronounced, there was a strong feeling that parents had been too strict and repressive regarding sex and companionship with boys in the cases where the family life had been unstable and the patient had been entrusted to the care of first one person and then another."
Fraser's study concludes: "The family is the fundamental unit of society and it is the basic training in the family group which determines in which direction the child will go. Every child has a deep seated emotional urge to belong in a normal family with two parents living in harmony together, having an adequate income and opportunities for recreational and social activities. He has a natural desire for affection, security, approval and recognition in his home. The family group is a complex relationship of different individuals and the anti-social behaviour trends which sometimes develop in its members are frequently a symptom of conflicts, frustrations and disappointments which were suffered during childhood." (1)

In a survey of the early lives of prostitutes from all parts of the world, it was noted that "the general impression of the homes and childhood of the women... is that their moral environment was less favorable than their material environment. It is true that only a minority appear to have had parents who were comfortably well off, but the majority came from ordinary working-class families and only a small percentage from the most poverty-stricken section of the community. The moral atmosphere in which the children grew up was on occasion actively harmful; far more often though, it was simply defective or unsuitable. This was due sometimes to neglect or lack of control, sometimes to excessive strictness. Often the homes were troubled by disagreement between the parents or between the parents and children; this occurred frequently when there was a step-parent.

"A considerable fraction of the women were brought up in homes, by relatives or by strangers, and many more were brought up by only one parent. About 45%, in fact, said that they had lost one or both parents before they were 14. This does not necessarily mean, of course, (1) Fraser, J., ibid., p. 17."
that they were all neglected; some indeed, are said to have had good homes, but a feature that recurs so constantly cannot be disregarded." (1)

Among clinic patients, male and female, and prostitutes, the early home life has been observed to be a factor predisposing to their later promiscuity (or probable promiscuity.) Among venereally infected men included in a study made in the Canadian Army, it was found that 36% of the infected men, compared with 18% of the men in the control group, had had an 'abnormal childhood environment': "the term 'abnormal childhood environment' is intended to include cases where at least one of the parents was dead, or was markedly unstable emotionally, or where there was separation or divorce". (2)

Thus it is with all studies of the early lives of infected individuals: the early home life is a factor in the spread of venereal disease.

The common conclusion of all surveys is stated by Fraser in her own study at the Vancouver Clinic: "From our study of the home life and family background of fifty young persons with new syphilis infections, we find that the basic disabilities are the same and that the roots of their present behaviour are in their home training and family relationships where both physical and emotional needs were lacking." (3)

2. Parental Maladjustment

It has been pointed out previously that some sexually delinquent children are reared in broken homes or in homes in which the parents are incompatible. Broken homes, however, are often concomitant with or actually preceded by serious maladjustment on the part of the parents.

(1) League of Nations, Prostitutes: their early lives, p. 36.
(2) Watts, G.O., and Wilson, R.A., ibid., p. 120.
(3) Fraser, J., ibid., p. 17.
Fraser, in her study at the Vancouver Clinic, states: "It is known that one or both parents of seventeen girls and five boys, and there may be many more, have for many years continually exhibited anti-social and immoral conduct before their children..." (1) Such conduct included extra-marital sexual relationships, alcoholism, prostitution, boot-legging, incest, and various other types of criminal behaviour.

A study of 100 May Act violators committed to a U.S. reformatory for women reported that "the social histories are replete with recitals of domestic difficulty in the parental background. Forty-three came from broken homes, and in many of these, as well as in the other cases, delinquency, alcoholism, neglect and cruelty were common... In many instances the mother is reported to have been sexually promiscuous, cohabiting with various men and rearing illegitimate children in the home." (2)

These and other available studies stress the influence of home life and parental adjustment on the child who later acquires a venereal disease or is promiscuous. The home life and the parental adjustment are often equivalent. Both are important in the development of the child; if one or both is unsatisfactory, there is a potential threat that the child will be maladjusted and perhaps manifest his maladjustment in the form of promiscuity.

3. Ignorance:

As a result of the ever-increasing publicity being given to the venereal diseases, relatively few persons are totally unaware of the existence of these infections or know nothing of their nature and mode of transmission. However, there are still many persons who, for one reason or another, have a dearth of information and make no effort to obtain more. When such persons are parents, their children will be just

(1) Fraser, J., ibid., p. 13.
(2) Hironimus, H., ibid., p. 32.
as ignorant, until the information is acquired from some other source.

At the present time, most children who graduate from high school do receive at least a smattering of information about the venereal diseases from reliable sources, and judging from various surveys made, these children are less prone to infection than those who do not attain graduation. But if venereal disease education is to be of any value, it must be given to all children, and particularly to those who do not reach the high school level. This does not imply that the information should be given in the earliest school grades, nor that it should be given before a child is physiologically old enough to comprehend it. But it does imply that there should be some individual or organization that will give adequate, factual, and wholesome information to children at an age when it can be understood.

Of the various institutions available for educating the juvenile public, the home, school, church and youth organizations can all serve a purpose; but only one of these institutions can reach the greatest part of the juvenile population at a suitable time, and that institution is the home. If the parents were well versed in the facts about venereal disease, and would pass on those facts to their children, ignorance and possibly promiscuity, would decline.

However, such postulation is not entirely warranted: those parents who do give information about these infections to their children, probably also guide them carefully in most other matters dealing with adjustment to the environment, and particularly in social adjustment so far as sex is concerned. From clinical records of interviews with young persons acquiring infection, it is observed that they themselves had little factual information concerning the venereal diseases, and what they did obtain was from unreliable sources, usually friends or acquaintances.
In almost no case is there evidence that information was given by parents; frequently, indeed, there is evidence that the parents themselves were ignorant.

Ignorance of factual information concerning the venereal diseases is often cited in pamphlets and lectures on the subject as one of the major reasons for the prevalence of venereal disease. However, all that is probably necessary for a lay person to know is that syphilis and gonorrhea exist, that they are transmitted from one person to another usually by sexual contact, and that they can be detected and successfully treated by competent physicians. Extensive knowledge of the infection is in itself no guarantee of immunity: the records of the Armed Forces serve as ample evidence to this. That the number of venereal infections among members of the Armed Forces has been the lowest in history is not a reliable indication that the intense venereal disease education given to them actually prevented many infections, because mechanical and chemical prophylaxis was an integral part of all such education. It is quite possible that many persons are motivated by fear of the infections and thus abstain from promiscuous sexual exposures. But if one were to state that education prevented sexual exposures which might have resulted in infection, he is to say that education and fear of motivation are synonymous.

Whether education is directed toward preventing promiscuous sexual exposures or toward urging exposed persons to have examinations, it is generally agreed that adequate factual information concerning the venereal diseases should be had by the entire population, and that such public enlightenment will assist measurably in the eradication of these infections.
The evaluation of ignorance as a factor in the spread of venereal disease is difficult; certainly the number of late syphilis infections discovered in routine serologic tests do give an indication of infections hitherto unsuspected, and ignorance of the infections was responsible in many cases for the infections not being discovered in their early stages, but other factors are often involved.

If there is to be widespread education concerning the venereal diseases, probably that education should be had by young people before they are exposed to infection. If this is to be done, the children must be reached, at the latest, during the early teens. This is not being done, except by parents, because the schools in British Columbia do not have a program covering all pupils. For several years the Division of Venereal Disease Control has supplied speakers and films to schools throughout the province, and has given lectures to the pupils from Grades X to XIII (the assumption was that the pupils of Grade X were about sixteen years), and in the near future, the Department of Education is expected to integrate venereal disease information into the health course. But it is not just the students from Grade X onward who should have information concerning the venereal diseases. Those boys and girls who leave school before Grade X must be reached -- it will be remembered that in Fraser's study, only 18% of her group entered High School and only 8% completed High School. (1)

In conclusion, it can be pointed out that if ignorance is an important factor in the spread of venereal disease, and if education will dispel this factor, then education must be given to the young people, before they are exposed to infection, not after they have acquired it.

(1) Fraser, J., ibid.
4. Prudish Attitudes in the Home:

Many children grow up in a home atmosphere in which sex is an unmentionable subject. The children in such homes receive no satisfactory answers to their questions on sex matters, and may even be reprimanded for mentioning the subject. Naturally when a child meets with a rebuff from his parents on the mention of sex, he will probably not broach the subject again to them, but will gain his information from other quarters, sometimes reliable, sometimes not.

However, it is not the information on sex, nor its source that is of primary concern at this point, but the secrecy, prudery, and shame that is associated with it in the home. Whatever the motivation of the parents be in shielding the child from such knowledge, it is the child that suffers. He or she now has faced a sex taboo, not on any rational ground, but solely on the basis that the entire subject is "not nice".

The ramifications on the child of parental prudery are many and diverse. Only one of the possible results is of interest in the problem of venereal disease, and that, of course, is promiscuity. It is to be emphasized that parental prudery is only another factor contributing to the onset of promiscuity, and that it must be combined with other factors. Whether it is a major factor, in many cases could only be determined after careful case histories were taken. It is noteworthy that the report of the San Francisco Experiment, discussing the Conflictual group states: "In general, the patients who were most promiscuous were those whose parents had been most repressive regarding sexual matters. Family attitudes that sex was sinful were reflected in the patients' attitudes and anxieties. Repressive handling of sexual matters in the homes did not deter those patients from sexual experience, but rather if
the repression was excessive, it often contributed to their promiscuity". (1)

5. Sex Education:

The matter of sex education for children has recently been mooted by various individuals and organizations. The subject is not new, but the names given it are: education for life, education in social living, and others. These newer names are apparently to indicate that the subject of sex education is not solely confined to information concerning the human reproductive system, but includes the adjustment of the individual to all sexual matters.

As was mentioned earlier, there are at least two opposing viewpoints: sex education should be taught in the schools, and sex education should not be taught in the schools. There are no apparent objections by any religious organization to a belief that some sex education should be given to children, but there are objections raised by religious advisers and lay authorities of various creeds to the public teaching of such information to children. Those who advocate public teaching point out that most parents are totally incapable of giving the information to the children, and since the information is necessary, the school should assume the duty. Those against public teaching point out that there are varying developmental ages of children, and maintain that such intimate and important information must be given on an individual basis by qualified persons, preferably by the parents, at the appropriate time, which depends upon the maturation of the child. The point of interest here is not in the disagreement of the method of sex education but in the agreement of the need.

With the broad scope of sex education, it is clear that if it achieves its objective, sex education will be effective as a
preventative of exposure to venereal disease. (It is to be pointed out that "sex education" as considered by most authorities, does not include 'venereal disease information', a subject which is to be taught as a communicable disease.) (1)

Since sex education involves "education on the positive side of sex and morality as a basic principle of character", and strives "to provide new opportunity for youth to grow up 'physically strong -- morally straight', and for the creation of a broad new realization of the strength and permanence which may be given to marriage and family life", it will, if the motivation be sufficient, serve as a deterrent to exposure to infection, and thus be effective in curbing the spread of venereal disease.

(1) e.g., Pigelow, M.A., Education and guidance concerning human sex relations: J.S.H., vol. 31, p. 231.
Conclusion:

In the preceding pages an effort has been made to note some of the factors involved in the spread of venereal disease. There are other known factors and probably many more unknown, but those named serve to indicate the complexity of the problem. When a man or woman is treated for a venereal disease, should only the disease be treated, or should not the disease be treated as but a symptom, and the underlying factors be the real target for therapy? Certainly, it would appear that the presence of the venereal disease is but a part of the problem.

Prevention, too, apart from medical means, must concern itself with correcting the underlying factors. There must be a realization that the diseases are symptoms of promiscuity, and that promiscuity and the factors responsible for promiscuity must be corrected if the venereal diseases are to be eradicated. The task will not be easy; the state, the family, and the individual must all assist.
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