A SOCIAL WORK APPROACH TO THE VENEREAL DISEASE PROBLEM IN BRITISH COLUMBIA

An Analysis of the Social Problems involved in Controlling the Infected Individual, with particular reference to Recidivism at the Vancouver Clinic, Division of Venereal Disease Control, British Columbia.

by

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ABSTRACT

Because the venereal diseases are acquired as the direct result of behaviour, this study takes as its focus the infected individual, and analyzes the venereal disease problem in British Columbia in terms of the incidence of infection, the treatment procedures as they affect the individual patient, and the unsavoury community conditions that facilitate promiscuous behaviour.

The study reveals that in spite of the great advances that have been made in the medical treatment of gonorrhoea and syphilis, in 1948 in British Columbia, there was one case of venereal disease for every 250 people in the province. The ratio between male and female patients was approximately two to one, and gonorrhoea was four times as prevalent as syphilis. The community problem has always been concentrated in Vancouver, and in 1948, 76 percent of the facilitation reports received by the Division related to premises in Vancouver.

In 1948, patients treated at the Vancouver Clinic accounted for almost half the total venereal disease population in the province, and a review of the new admissions to this clinic for the first six months of the year revealed that approximately every third patient had been previously infected. To determine why these people had failed to learn from the clinic experience, the medical records of each of the 215 men and 130 women in this repeater group were analyzed. While there was little specific information in the charts about these patients as people, in general the repeater group was made up of young adults who were living a rootless existence; they had no close personal relationships and most of them described their sex partners as casual friends or strangers. Broken marriages and marital discord were reported by a large proportion of these repeaters, and alcohol was an important factor in the acquisition of repeated infections. More than half the group were chronic repeaters. The majority of the male repeaters were unskilled workers and 40 percent of the women had no gainful employment. Among the female repeaters, approximately three out of four had police records; one out of three had had illegitimate children; and 19 out of the 130 were described as chronic alcoholics. For most of these repeater patients, the acquisition of a venereal disease was a relatively minor complication in their disordered lives.

The study then reviews the facilities available in British Columbia for controlling the venereal diseases. The policy of the Division of Venereal Disease Control is outlined and the programme of the various sections of the Division are discussed. The development of the Social Service Section is described from its inception in 1936 when it was responsible for the epidemiological activities of the Division until 1949 when the case work skills of the members of this section were directed toward making the treatment process a more positive personal experience for the infected person.

Studies relating to the psycho-social aspects of the venereal disease problem in other countries are examined. As with the Vancouver Clinic repeater study, these projects show that the promiscuous behaviour which results in a venereal infection is usually symptomatic of more serious social ills.

The present set-up at the Vancouver Clinic, where case work services are now an integral part of the treatment process, is described. This shows the unique contribution that social work can make in a venereal disease control programme. Now at the Vancouver Clinic, at the time of a patient's first infection, he is helped to gain a better understanding of himself and of the cause-and-effect relationship between his infection and his pattern of behaviour. In this way recidivism is being reduced among those patients who are capable of taking responsibility for themselves. This study points out that treatment of the infected individual is not enough; it is society that is sick. The venereal diseases are rooted in poor human relations; to attack this problem, an expansion of the mental hygiene programme is recommended. To give every person his rightful place in the community, the development of more neighbourhood projects is advocated.

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CHAPTER 1

THE VENEREAL DISEASE PROBLEM IN BRITISH COLUMBIA

Because the venereal diseases are usually spread through promiscuous sexual behaviour, the problem in venereal disease control is not the disease, but the person who has the disease. Today the causative organisms of each of the venereal diseases have been identified; medical science has produced effective therapeutic agents for their control; and yet in spite of this, in Canada in 1948 the venereal diseases ranked second only to chicken-pox among the communicable diseases. In the City of Vancouver, the venereal diseases headed the list.[1] In British Columbia, with a total of 4534 new cases of venereal disease reported during the year, oneout of every 250 persons in the province was infected in 1948.

Beginning in 1940 the rate per 100,000 population of new venereal infections reported in the province increased steadily from 310.3 in that year to 677.0 in 1946. In actual cases reported, the increase was from 2498 to 6790 in this six year period. From this all-time high, the incidence of venereal disease in British Columbia has declined. In 1947 there were 5999 new notifications, indicating a rate per 100,00 of 574.6; with 4534 new cases reported in 1948, the rate of 419.0 is the lowest since 1943. While venereal disease in British Columbia has decreased almost a third since 1946, the 1948 rate is still nearly 32 percent higher than the 1940 rate of 310.3 per 100,000 population.[2]

[1]British Columbia, Annual Report of the Division of Venereal Disease Control 1948, page 13.

[2]Ibid, page 20.

The declining incidence of venereal disease in the province is more significant than appears from a study of the Division's statistics, because the rate has continued to drop in spite of better reporting of newly diagnosed cases by private physicians in the province, and improved methods of case finding such as the operation of the diagnostic examination centre at the Vancouver City Gaol and the small blood-testing surveys carried out in 1948 among certain occupational groups in the province. In the 1948 Annual Report of the Division, most of the credit for the improved situation in the province is given to the increased efforts made in case finding, and the earlier and more rapid treatment of cases and of contacts.

In 1948, patient's between the ages of 20 and 29 contributed almost half of the total new cases reported in the province for the year. Gonorrhoea infections among this group accounted for 55 percent of the total gonorrhoea notifications and about 40 percent of the early syphilis cases diagnosed in British Columbia in 1948. (See Table 1.)

TABLE 1

AGE DISTRIBUTION OF VENEREAL INFECTIONS

BRITISH COLUMBIA - 1948

Age	Gonorrhoea (a)	Syphilis						Other V.D.	Total V.D.
		Early	Latent	Tertiary	Pre-Natal	Other	Total		
Under 5	7	1			9		10		17
5 - 14	12	2	1		1		4		16
15 - 19	329	24	26		5		55	2	386
20 - 24	1143	53	64	2	3	2	124	5	1272
25 - 29	841	39	62		1	3	105	7	953
30 - 34	424	32	30	3	1	2	68	2	494
35 - 39	284	23	46	12	2	4	87	2	373
40 - 44	171	15	40	16		2	73	3	247
45 - 49	113	9	36	13		8	66	4	183
50 - 54	58	10	38	21		5	74	4	136
55 - 69	60	10	71	47		7	135	1	196
70 - over	7	2	18	8		3	31		38
Not stated	159	18	32	2	1	1	64		223
Total	3608	238	464	134	23	37	896	30	4534

Source: Annual Report, Division of Venereal Disease Control, 1948 Table III.

(a) Including one report of Opthalmia Neonatorum. Diagnosed in 1 - 4 years age group.

In the distribution of venereal infection, male patients outnumbered females by more than two to one. (See Table 2.)

TABLE 2

SEX OF PERSONS AFFECTED AND TYPE OF DISEASE

BRITISH COLUMBIA - 1948

Age	Gonorrhoea		Syphilis		Rate per 100,000
	Male	Female	Male	Female	
Under 15	6	13	4	10	14
15 - 19	133	196	11	44	523
20 - 24	777	366	60	64	1413
25 - 29	642	199	51	54	1036
30 - 34	333	91	40	28	555
35 - 39	227	57	55	32	495
40 - 44	138	33	45	28	361
45 - 49	95	18	48	18	308
50 - 54	50	8	54	20	238
55 - 69	56	4	115	20	121
70 - over	7		26	5	62
Not stated	111	48	38	26	
Total	2575	1033	547	349	419

Source: Annual Report, Division of Venereal Disease Control, 1948, Chart II, Chart III, and Table IV.

THE DISEASES

The present study is primarily concerned with the incidence of gonorrhoea and syphilis and not with the less common venereal diseases. In 1948 gonorrhoea infections accounted for 79.0 percent of the total new cases reported, syphilis cases contributed 19.7 percent and the other venereal diseases 0.7 percent. All of these are communicable diseases,

usually acquired through intimate contact with an infected person. Accidental infections from contaminated articles have been known to medical science but are rare in clinic practice. Syphilis infections do sometimes occur among doctors, dentists, and nurses, through faulty techniques in working with infectious lesions; and infants and young female children may become infected with gonorrhoea through careless handling by a person who has touched material fouled by a gonorrhoeal discharge. As is well known, the eyes of newborn infants may become infected in the birth process, if the mother has gonorrhoea.

Gonorrhoea

Until the discovery of the sulphonamides and later penicillin, the treatment for gonorrhoea was a long and often painful process, consisting of repeated irrigation of the genitals followed by the application of medicated packing. Sometimes the patient had to stop work and there were unhappy social and economic consequences to the acquisition of gonorrhoea. The sulphonamides made it possible to give treatment orally, by pills taken at regular intervals throughout each 24 hours for a period up to two weeks. Even this treatment was not without discomfort for those patients who were unable to tolerate a sulpha compound. Today penicillin is the drug of choice for the treatment of gonorrhoea because it is rapid, highly effective, non-toxic and practically painless. It is administered in one injection in the buttock, symptoms usually disappear and the patient is rendered non-infectious in a matter of hours. If the recommended three tests of cure taken at weekly intervals are negative, the patient is discharged as having been cured of gonorrhoea. He is advised to report back for a blood test four months after treatment and again at six months in order to rule out the possibility of syphilis having been

acquired concurrently with the gonorrhoea infection, because the developing symptoms of syphilis may have been masked by the dosage of penicillin used to treat the gonorrhoea. Where there is any suspicion of syphilis (as in the case of a penile or other genital lesion), streptomycin is used rather than penicillin, since the latter might delay or prevent an early diagnosis of concurrent syphilis. With this rapid treatment, from the point of view of the patient, gonorrhoea is less disabling than the common cold.

From the standpoint of public health, it is the undetected reservoir of gonorrhoea among the female population that is the problem. Whereas with a man the symptoms of gonorrhoea are usually so insistent that the patient seeks medical care without delay, with a woman the symptoms may be so slight as to go unnoticed. In British Columbia in 1948 the ratio of new gonorrhoea cases between males and females was slightly more than five to two, with most of the female patients reporting for examination at the suggestion of their infected male sex partner, or as a result of the case finding activities of the Division of Venereal Disease Control. These women rarely complained of symptoms but on examination were found to be infected.

Syphilis

Like gonorrhoea, syphilis is a communicable disease that is spread through intimate contact, but it is the more insidious enemy because its early symptoms may be hidden or so inconspicious as to escape detection, while the organism of syphilis carries on its destructive processes against the various organs and tissues of the body. Indeed a syphilis infection can imitate any of the bodily ills. Improved methods of syphilology are beginning to bear fruit in the reduced morbidity of

syphilis. In 1948, of the 896 cases of syphilis reported in British Columbia, only 18 percent related to tertiary syphilis - that is, late syphilis with complications involving the central nervous or cardiovascular systems, the bone structure, or the skin. Now early and adequate treatment is preventing these disasters.

Primary and secondary syphilis accounted for 26 percent. The public health significance of this is important, because syphilis in the early stages is highly infectious. Serum removed from a primary sore, (or chancre) and examined under a special microscope, will show the presence of living, moving spirochaetes. From such a lesion, which usually occurs on the genital area or occasionally in the mouth, these organisms can be transmitted to another person, if the infected part of the diseased person is brought in contact with the soft mucous membrane parts of the healthy person. The warm, moist mucous membranes of the genitalia, or of the mouth, are ideal media for the growth of the spirochaete. According to medical authority, the organism of syphilis cannot enter the body through unbroken skin. However even an infinitismal break in the skin can serve as the site of infection. Similarly a person with syphilis in the secondary stage is a menace. Any moist lesions appearing on the skin or in the mouth or around the genital area are very infectious. Like the chancre, they usually occur in sites where only intimate contact, as in sexual intercourse or in kissing, is likely to result in the transmission of the disease.

In latent syphilis, which in British Columbia in 1948 accounted for 52 percent of the reported cases, the disease is quiescent and can be detected only by blood tests showing a positive reaction. In the early years of latency, the disease may be transmitted by sex contact, but such

a patient is not infectious to ordinary contact; the longer the disease remains latent, the less likely that patient is to be a menace even to a sex partner.[3] In this stage however, a mother may infect her unborn child, the disease being transmitted from the mother to the child through the placental circulation. This tragedy is now 100 percent preventable by adequate treatment of the syphilitic mother early in pregnancy. It could be wiped out if all pregnant women were routinely blood-tested as part of their prenatal care. A syphilis infection acquired by a child while still in the mother's womb, can have very serious social implications. Interstitial keratitis causing blindness, is one later manifestation of prenatal syphilis which continues to baffle syphilologists. Various therapeutic agents have been tried, and sometimes the condition responds and sometimes it does not, without any apparent reason. It can occur in childhood or it can manifest itself as late as early adult life. Similarly prenatal syphilis can result in an involvement of the central nervous system causing insanity, or a defect in the motor nerves of the body (called tabes dorsalis), or deafness. This preventable form of syphilis, therefore, can cause problems of serious social consequence to the patient, and to his family, and to the community as a whole.

[3]According to a publication of the Division entitled Venereal Disease Information for Nurses published in 1948: "The first two years is the significant period of communicability in untreated syphilis and the infectivity then declines rapidly, so that at the end of five years the danger of transmission is slight. In general it may be stated that the lesions of early syphilis are infectious and those of late syphilis are not .... in most instances treatment renders the patient non-infectious very rapidly. One injection of an arsenical or penicillin may render surface lesions non-infectious within a few hours, but continued, regular, adequate therapy is necessary to maintain and establish permanent non-communicability."

In tertiary syphilis, transmission of the disease is rare, except by a pregnant mother to her child. Even open skin lesions resulting from the syphilis infection having destroyed the body tissues, while they are unsightly, are not infectious. The idea of a person "in the last stages of syphilis, covered with horrible sores, and constituting a dreadful public health menace", is popular misconception. The chancre, the infectious lesion of syphilis is small and usually hidden.

While syphilis in the primary, secondary and early latent stages is a public health problem , the patient may not feel any particular ill-effects. The most dramatic manifestation of early syphilis, which may occur in the secondary stage is a condition known as "alopecia", or patchy loss of hair. The syphilis rash which may be another symptom of secondary syphilis is most commonly seen on the trunk, palms of the hands and soles of the feet, or around the hair margin. But not all patients can give a history of such a rash and not until the infection had succeeded in destroying some organ or tissue did the patient become aware of his syphilis.

While treatment for syphilis varies with the stage of the disease, great strides have been made in simplifying anti-luetic therapy. In 1948, treatment for primary and secondary syphilis, for syphilis in pregnancy and for congenital syphilis, as well as for certain types of tertiary syphilis, was a hospital procedure, with penicillin being administered at two or three hour intervals for a period of from seven and a half to 15 days, depending on the diagnosis. Latent syphilis, both early and late was treated on an ambulatory basis, with daily penicillin injections being given for ten days. To reinforce the effects of the penicillin, follow-up courses of mapharsen and bismuth (the drugs of

choice for the treatment of syphilis before the advent of penicillin) were prescribed for nine weeks with bi-weekly treatments, or 26 weeks with weekly treatments, again depending on the type of syphilis infection being treated.

Now in 1950, at the Vancouver Clinic syphilis of all types (with the exception of cardiovascular syphilis) is being treated with penicillin alone, on an ambulatory basis, over a period of from ten to twenty days. However, although penicillin now seems to have proven itself the wonder drug for the treatment of syphilis, there are still treatment failures, and syphilis patients are kept under medical surveillance for at least five years after treatment, in order that any signs of relapse may be detected. For the first six months, blood tests are taken monthly. If the patient's condition is showing improvement at the end of this period, the blood is tested every three months for a year. Again if there is no indication of trouble, the tests are repeated every six months for the balance of the five year period. In order to detect any involvment of the patient's central nervous system, his spinal fluid is checked before treatment is commenced or early in the course of treatment, at two and a half years after treatment, and again at the end of the surveillance period. This spinal fluid examination is done by means of a lumbar puncture which is distressing to many patients because of an innate fear of any interference with the spinal column, and because of the severe headache which sometimes follows a lumbar puncture. At the end of the five year period, the patient is given a thorough physical examination including an investigation of his cardiovascular system. If the results of all the various examinations are negative, the patient is then discharged as having had sufficient treatment. However, he is advised to have yearly blood tests because the medical experts are unable to give

positive reassurance that a specific syphilis infection is completely cured. They can only say that according to the latest methods of treatment and of scientific testing, and in the absence of physical manifestations, the patient appears to have had adequate treatment. The longer a patient remains free from symptoms, the less likelihood there is of the infection becoming reactivated. However, for a sensitive person, this kind of guarded medical prognosis may cause him to live under the shadow of a fear that can inhibit all of his social relationships. For the female patient, syphilis is the spectre that haunts every pregnancy; old anxieties are re-experienced; and irksome treatment must again be undertaken for the sake of the unborn child. No measure has been taken of the emotional impact of this treatment on an expectant mother, but there may be serious ramifications in terms of the relationship of the mother to her child.

Treatment which cures the venereal diseases does not give the patient any immunity. Indeed, the whole course of the disease can be re-experienced following exposure to an infected person. To date medical science has not produced an anti-toxin for either syphilis or gonorrhoea. Only the patient, by his behaviour can safeguard himself against re-infection.

The Community Problem

Wherever there is a high incidence of venereal disease, there are unsavoury community conditions facilitating the spread of these diseases. This "facilitation process" described as the "intermediate means whereby the bearer of a venereal infection gains access to the healthy individual"[4] is under constant surveillance by the Division of Venereal Disease Control. All newly diagnosed patients are questioned as to the source of their infection, the place of meeting and the place where the exposure occurred.

[4]British Columbia, Annual Report of the Division of Venereal Disease Control, 1942.

This information is then summarized and presented at quarterly meetings called by the Division of Venereal Disease Control and attended by the senior medical health officers of Vancouver and Victoria, and by representatives of the Provincial Police, Vancouver City Police, Vancouver Licensing Department, Provincial Liquor Control Board, B.C. Hotels Association, and other interested organizations. These meetings provide an opportunity for frank discussion of the problems in venereal disease control and the action that can be taken by the various authorities to improve conditions in the province. It is recognized that the community control of venereal disease is a problem requiring the concerted efforts of all those who are responsible for safeguarding the health and welfare of the people.

According to the records of the Division, in British Columbia, hotels and rooms have always been the most frequently reported type of facilitator, with the greatest number of facilitation reports relating to premises in the City of Vancouver. In 1948, out of 4266 reports received by the Division, 3251 or 76 percent related to places in Vancouver.[5] (See Table 3.) Infections diagnosed in Vancouver for the same period amounted to 61 percent of the total infections reported in the province, which would indicate that some of the infections reported in the rest of the province were acquired in Vancouver. This is to be expected since Vancouver is the holiday centre for the surrounding area.

[5]In discussing facilitation reports it must be borne in mind that they do not represent the number of infections acquired, since a patient with one infection may report having been exposed to several contacts in various premises. Neither do the facilitation reports indicate the actual number of facilitating premises, because the same premises may be reported by several different patients. The object in obtaining such information from infected persons is to keep track of the places in the province where venereally diseased persons are coming in contact with healthy persons and spreading their infection.

TABLE 3

VENEREAL DISEASE FACILITATORS

BRITISH COLUMBIA - 1948

Type of Facilitator	Distribution Between Vancouver	Rest of Province	Vancouver Proportion (Percent)	Total Reports(a)
Hotels and Rooms	1759	300	85	2059
Miscellaneous Places (b)	727	390	65	1117
Beer Parlours	257	53	83	310
Private Homes	129	131	49	260
Cafes	186	65	74	251
Dance Halls	190	61	76	251
Bawdy Houses	3	15	17	18
Total	3251	1015	76	4266

Source: Summary of Facilitation Reports, 1948, Division of Venereal Disease Control, British Columbia.

(a) Excluding 482 reports relating to infections innocently acquired from a diseased marital partner.

(b) In Vancouver 370 out of 727 miscellaneous reports related to street pick-ups.

In Vancouver in 1948, reports naming hotels and rooms accounted for more than half the total city reports. For the most part these premises are cheap hotels and rooming-houses in the problem area of the city, which is located in the older downtown business district. They present great difficulties in community control, since they are usually owned by "absentee" landlords or corporations, and they are operated for quick profits by a continually shifting management. They are frequented

by promiscuous women and are the headquarters for an itinerant male population comprised of loggers, sailors, miners, and other mobile workers who come to Vancouver to spend their money. Whether or not any hotel becomes a facilitator of venereal disease, depends on the management. The records of the Division show premises side by side in the worst section of the city, one of which will be frequently named while the other will not be reported at all. What is required is a tighter control in the licensing of such premises. As it stands now, the only reason for a license being refused to an applicant seems to be a record of police convictions for an offence such as violation of the liquor or morality laws. It is not necessary for the proprietor to speak or even understand English, or to adhere to Canadian ways of life. While the housing problem remains acute, it is difficult to have any action taken to close premises, even when they are known to the authorities to be a public health menace. Meanwhile, the Division is pressing for action by way of local by-laws to make possible the enforcement of proper standards of management and supervision in hotels and rooming-houses, particularly in Vancouver.

During the year, streets and other miscellaneous places such as parks, fields, boats, cars, constituted approximately 26 percent of the reports relating to the means by which a healthy person met or was exposed to the person who was spreading infection. This represents a serious problem in community control, since there is no law that prohibits these casual encounters. Similarly there is no public action that can be taken to prevent private homes from being used to facilitate the spread of venereal disease, and yet in 1948, according to Table 3, they were more frequently named as the place of meeting or exposure than either cafes

or dance-halls.

In 1948, in spite of excellent cooperation from the Liquor Control Board of the province, beer parlours continued to be a serious facilitation problem. Now by arrangement with the Commissioner of the Liquor Control Board, whenever a report indicates that the pick-up occurred when a male patron improperly entered the ladies' section of the premises, this information is forwarded to the Commissioner for immediate disciplinary action against the operator of the beer parlour, who is responsible for the proper supervision of his premises.[6] Despite this constant check on the management of beer parlours in the province, because these premises are the social centre for a certain group in the community, they are repeatedly named as the place in which a patient met the infected person to whom he was later exposed.

As with beer parlours, in cafes and dance-halls even under the most careful management, pick-ups take place between men and women who are legitimate customers of such premises. Vigorous action to disperse the promiscuous element in beer parlours, cafes, and dance-halls only increases the number of encounters made on the street. Among certain types of men and women, casual meetings - and just as casual sexual relations - are going to occur, and this situation will persist as long as each individual in the group finds that his or her need are met by

[6]Under the regulations governing beer parlour operations in British Columbia, a male customer who is not accompanied by a woman must use the section of the beer parlour that is reserved exclusively for men. This segregation only serves to increase the number of women picked up outside the beer parlours by men who want to enjoy the convivial atmosphere of the ladies' section, where mixed parties as well as unescorted female patrons are served.

this kind of relationship.

By 1948, established houses of prostitution had ceased to be a serious venereal disease menace in the City of Vancouver, according to the facilitation reports of the Division of Venereal Disease Control. Although the Division received three reports during the year in which the patient described his place of exposure as a bawdy house in Vancouver, prompt investigation by the staff of the Division and by morality officers of the Police Department failed to reveal any evidence of organized prostitution in the premises named. Until 1947 there were several well known houses of prostitution operating in Vancouver, and they were continually reported to the Division as venereal disease facilitators. Each time, a complaint was forwarded promptly to the Police Department but no effective action was taken to close these "disease dispensaries" until there was a change in the police administration and law enforcement against morality offenders became an important part of the war against vice. Now Vancouver has demonstrated that by sincere and persistent activity by the police, organized prostitution can be suppressed in a large urban sea-port.

In other parts of the province, the problem of bawdy houses showed very little improvement. During the year the Division received fifteen reports naming established premises in both Nelson and Trail as the source of a venereal disease. Although the Division advised the local authorities each time such a report was received, very little was done to improve the situation. As both Nelson and Trail had their own municipal police force at that time, there was little pressure that could be applied from the provincial level to enforce the law against the operators of these houses of prostitution. Since 1948, however, police administration in Trail has been taken over by the Provincial Police, and

cooperation with the Division of Venereal Disease Control has improved. In Nelson the bawdy house problem will likely remain chronic until the citizens themselves demand police action to protect them from this threat to their health and welfare.

In any programme to control the spread of the venereal diseases, the facilitation process is a problem that demands attention. It is not enough to treat the diseased individual. Community trouble spots, like festering sores, are persistent foci of infection and must be cleared up if the control programme is to be effective.

CHAPTER 2

RECIDIVISM AT THE VANCOUVER CLINIC

Although the 1948 statistics of the Division of Venereal Disease Control showed a venereal disease rate of 419.0 per 100,000 population in British Columbia, the records of the Vancouver Clinic indicated that a nucleus of problem patients were reporting time and again for treatment of newly acquired infections. Nothing was known about the repeater rate and this present study was undertaken to determine what proportion of the venereal disease problem in the province was attributable to patients who had been previously known to the Division, and what kind of people became repeater patients.

The only patients about whom there was any specific information were those who were diagnosed at the Vancouver Clinic. Here the complete medical history was available on each patient, as was all the epidemiological notations and social service interviews carried out during the course of the patient's clinic experience. Accordingly, the records of the Vancouver Clinic were selected for study. An analysis of the new cases reported to the Division during the first half of 1948 showed that Vancouver Clinic cases accounted for approximately 45 percent of the total new infections reported in the province during this period, and 73 percent of all notifications received from the Vancouver Metropolitan area. (See Table 4.)

TABLE 4

NEW NOTIFICATIONS OF VENEREAL DISEASE

JANUARY - JUNE 1948 SHOWING REPEATERS

Month	Male		Female		Total Vancouver Clinic	Total Met. Area (c)	Total Province
	Vancouver Clinic	Repeaters	Vancouver Clinic	Repeaters			
Jan.	172	58	68	19	240	326	530
Feb.	127	39	67	20	194	282	444
Mar.	157	32	69	32	226	297	422
Apr.	127	32	60	24	187	239	411
May	83	27	42	21	125	183	329
June	95	35	52	26	147	197	331
Total	761	223 (a)	358	142 (b)	1119	1524	2467

Source: Division of V.D. Control monthly statistics January to June 1948

(a) Diagnosed in 215 individuals.

(b) Diagnosed in 130 individuals.

(c) Includes notifications from provate physicians and clinics in metropolitan area of Greater Vancouver.

In order to get some idea of the size of the repeater problem, the notifications of new infections diagnosed at the Vancouver Clinic for a six months period from January to June of 1948 were checked against the central index. For the purpose of the study, a repeater was defined as a person reported as a new case by the Vancouver Clinic between January 1st and June 30th, 1948 who had had a previous diagnosis of venereal disease in British Columbia. Patients who gave a history of venereal disease diagnosed elsewhere than in this province were not included in the study. In this period, out of 1119 new infections diagnosed at the

Vancouver Clinic, 365 occurred in people who had been previously known to the Division of Venereal Disease Control. In other words, at this clinic approximately one out of every three patients was a repeater. Some of these repeaters were treated for more than one infection during the six months period, and the 365 new notifications related to 345 individuals - 215 men and 130 women. (See Table 4) Among the female patients treated at the Vancouver clinic in this period the repeater rate was 36 percent, while that for men was 29 percent.

In an effort to determine whether or not repeater patients were more characteristic of the Vancouver Clinic case load, the records of new patients diagnosed by private physicians in Vancouver for the month of January, 1948 were checked, and out of 67 reported cases only three could be classified as repeaters. Recidivism, therefore, seemed to be more of a problem among the people who came to the free clinic than to those who received private medical care.

What kind of people comprised this repeater group? From the clinic records, all the available information about each of the 345 patients was analyzed in terms of age, racial origin, family status, place of residence, occupation, number of infections, type of contact usually reported, and certain other particulars relating to criminal convictions, drug addiction, and alcohol as a precipitating factor in the acquisition of a venereal disease. For the women patients, a history of illegitimate pregnancy and of prostitution was recorded. None of the charts gave any indication of the patient's educational achievement or mental ability, and only in isolated instances was there any notation with regard to the patient's family relationships, work adjustment, leisure-time activities. Although the records were scrutinized in

detail, nothing could be learned from them about the impact of these infections on the individual as a person. Chart after chart contained only the briefest statistical information about the patient, recorded at the time of his first admission to the Clinic, and consequently out-of-date at the time of the study. Subsequent admissions were entered on the chart with little more than the comment of the examining physician relating to the patient's current symptoms. Judging from the charts of the male repeater patients, many of them appeared to have presented themselves at the Clinic for examination and gone through the diagnostic and treatment process without any exploration by the clinic staff of the significance of their repeated infections. Indeed in so many instances, these male repeaters seemed to have preserved their status as a "number" throughout their entire clinic experience. They were not a problem to the Epidemiology Section because theyreported with symptoms before they could be named as contact by their sex partners; then after treatment they returned for the required number of tests of cure and in due course were discharged from the clinic records. Each time they returned with a new infection, the whole process was repeated - medical examination, diagnosis, treatment, then contact history, tests of cure, and again discharged. The clinic had a revolving door.

With regard to the female patients, more detailed information was available from their clinic charts, and more often they were personally known to the clinic staff. Usually these women reported to the clinic for treatment as the result of epidemiological investigation after they had been named as a contact to a known infection, rather than because they had symptoms of a disease. From the medical standpoint, diagnosis and treatment of a female patient is more individualized than for a man. The pelvic

examination which is routine for detecting venereal disease in a female is an internal procedure and is more comprehensive than the usual external examination required by a male patient. Because in the female, symptoms may be hidden, the doctor must take a more specific medical history and in this way the female patient tends to get more individual medical attention. Sometimes in the course of an examination for a venereal infection in a woman, a diagnosis of pregnancy is confirmed for the first time and this involves a more detailed explanation of her condition from the doctor. In the treatment process, the female patient receives more personal consideration than is given to a man. On the women's side of the clinic there is less crowding and more privacy; in the male treatment room, the case-load is heavier; pressure of time on the medical and public health nursing staff make it impossible to devote much time to each individual patient.

With repeaters, the repetition of the experience of acquiring a venereal infection should indicate a need for something more than a routine examination and an injection of penicillin. Because the acquisition of a venereal disease is the direct result of the behaviour of the individual patients, unless the patient in the course of the treatment process is helped to see the connection between his behaviour and the end results of it, he will not learn from the treatment experience.

In spite of the fact that the information about these repeater patients was not specific, a general picture of this patient-group was obtained.[1]

Age Grouping

Vancouver Clinic repeaters were predominately from the younger adult group, with two-thirds of them between 20 and 29 years of age. This

[1]For a statistical analysis of characteristics of repeater patients see Appendix A.

is considerably higher than the proportion of this age-group in the total venereal disease population for the year, which was just less than 50 percent. (See Table 1). As a group the female repeaters were more homogeneous. They were younger than the men, with 70 percent of the women as against 58 percent of the men in this 20 to 29 age-group. Out of the 130 female repeater patients, 18 or almost 14 percent were under 19 years of age, while there were only 5, or approximately two percent of the men in this youngest group.

Racial Origin

With regard to racial origin, of those for whom this information was available, all the women and over 70 percent of the men were Canadian born. Almost half the total group were of British origin, with Indians and half-breeds as the largest minority group accounting for less than 15 percent of the total group. However, the proportion of Indians to the total female repeater group was nearly three times the proportion for the men. The study showed that Indian girls in an unprotected urban setting constitute a real problem because, like the negroes in certain areas in the United States, these girls are living outside their own social group; they are anxious to associate themselves with white people and they gain favour by being sexually accessible. Having tasted city life they are not content to return to the reservation way of living; they are not trained to do anything but menial work; and they can exist on the generosity of their casual men-friends easier than they can find a place for themselves in the economic life of the city.

About 15 percent of the total repeater group came from northern or central European stock. There were very few negroes only three percent of the repeater group being so classified. With the exception of the

Indian women patients, cultural conflicts did not appear to play any real part in precipitating repeated venereal infections among these repeaters.

Family Status

In our culture, the family is still the basic social unit, and the better integrated an individual is in his family group the less need there is for him to seek satisfactions in anti-social behaviour.[8] For the venereal disease repeater group the nomenclature "attached" and "unattached" was used to describe the patient's position in relation to his family group. A patient was considered to belong to the "attached" group if he or she was single and living with parents, or married, or living in common-law relationship. In the "unattached" group were included the single people living apart from their families, and those who were separated, divorced or widowed. Although there was no specific information on the charts about the quality of the patients' family relationships, most of the records indicated the patients' marital status and whether or not they were living at home with their families. The accuracy of this information in terms of the current situation at the time of the repeater study may be questioned however, as on many of the charts no entry regarding change of status had been made since the patient's first admission to the clinic.

Judging from the particulars that were available, approximately 72 percent of these people belonged to the "unattached" group; their

[8]Family instability as a contributing factor in the acquisition of a venereal disease was the concern of over half the experts who participated in a poll of professional opinion conducted in 1948 by a joint committee of the Department of Public Health of Yale University and the V.D. Division of the U.S. Public Health Service. The report of this study committee, entitled The Social Control of Venereal Disease, is referred to in more detail in Chapter 4.

family ties had been severed; they lived a rootless existence; and what they did was important to nobody but themselves. The history revealed by the charts of John T. and Mary L. was fairly typical of the repeater patients.

> John was 22 at the time of the study, and had been known to the clinic for over a year during which time he had acquired gonorrhoea twice. He was born in Canada to parents who had come from Central Europe. His parents were divorced and their present whereabouts was not indicated. He had two sisters and one brother but there was no information about them on his chart. John lived by himself in a room in the slum area of Vancouver and gave his occupation as that of a logger. His first infection manifested itself after a drinking party where he said he had "blacked out" so that he could give no particulars about his sex contacts. At the time of his second infection a year later, he described his sex partner as a girl about whom he knew nothing, although he had been introduced to her by a friend. That is all that could be learned about John from his clinic record, and this record contained more information about John as a person, than most of the male repeater charts.
>
> Mary L. was 21 and had been known to the clinic for a year, during which time she also had had gonorrhoea twice. She was Canadian born, of Russian background. She lived in the downtown area but not in the slum section; She was the eldest of a large family who lived in Vancouver, but Mary visited them infrequently. She was irregularly employed although she was a trained power-machine operator, and she spent most of her time hanging around the cafes and beer parlours in town. She had never been arrested, but she was known to the police because the crowd she was with were usually on the fringe of petty crime. She was one of the "good-time girls" who lived from week-end to week-end on the bounty of their American servicemen boyfriends. Mary had been reported to the Division of Venereal Disease Control seven times as a contact during the year prior to the study, and she was being sought continuously by the epidemiology staff of the Division. The second time she was admitted to the clinic, she came in because she was worried about the possibility of pregnancy, and on examination she was found to be three and a half months pregnant, as well as infected with gonorrhoea. The facilities of the Maternity Out-patient Clinic of the Vancouver General Hospital were explained to her and she readily accepted referral for prenatal care. However, when the services of the appropriate social agency were interpreted to her, she

> indicated that she did not want that kind of help but would make her own plans. She named as the father of her baby a man whom she described as her fiance, but in the contact history given by the man he described Mary as a casual street pick-up. Mary was intermittent in her attendance at the Maternity Clinic and this agency lost track of her before the baby was born. There was no information on her venereal disease chart to indicate what happened to her or the baby, or whether she ever availed herself of the community resources for helping unmarried mothers.

Among the female repeaters, nearly 80 percent belonged, like Mary, to the "unattached" group. The percentage of the male repeaters who were "unattached" was slightly lower, being 70 percent of the total male repeater group. Among the male repeaters single men accounted for almost 75 percent of the group as against 45 percent for the women, and a higher proportion of the single men lived at home with their families than was the case with the single girls. Out of the total female repeater group, there were only three single girls living as part of a family group.

Approximately 14 percent of the repeater group were married and included in the "attached" group. However, among these married patients, three out of five of them blamed their infections on extra-marital sex partners. Where there was any specific information available, it indicated that most of them had a history of marital discord in which sexual infidelity was only one of many contributing factors. Nothing was recorded about the meaning to the individual family group, of the experience of a venereal infection being brought into the marital relationship through the extra-marital exploits of one of the partners. Yet in some cases this happened repeatedly. Such a family were the J's.

> The J's. had been known to the clinic since 1941 during which time Mr. J. had had gonorrhoea four times. Each time that he reported to the clinic with symptoms, his wife accompanied him, and three

> out of the four times she was found to have acquired the infection from her husband. Although Mr. J. and his wife were living together, each time a diagnosis was made, his contact history read "dance-hall pick-up, exposure in his automobile", or "cafe pick-up, exposure later in contact's room", or "prostitute in bawdy house in a small town in the interior of British Columbia" or "pick-up in cheap hotel, drinking". Each time he admitted exposing his wife to the dangers of infection following these episodes. All that was noted on either of their charts was that they were living with Mrs. J's. parents and helping operate a rooming-house in the downtown area of Vancouver. The last entry related to a letter which the Epidemiology Section received from Mrs. J. stating that she and her husband were now living in a small mill-town up the coast and they would both report for tests of cure the next time they were in Vancouver.

Broken marriages resulting in separation or divorce were recorded for approximately 30 percent of the female repeater group and 9 percent of the male group.

Place of Residence

To determine whether or not any particular area in the City of Vancouver contributed the major share of the repeaters, the city was divided roughly into three zones.[9] Zone 1, which took in the slum area known as the "skid-road", is characterized by cheap rooming-houses and poor hotels situated above small stores or other business property. In the days when the Division received frequent reports involving exposures which had occurred in bawdy houses, most of these premises were located in this section of the city. Zone 1 is a congested area, with a heterogeneous population of orientals, Indians, half-breeds of various races, negroes, and single white men and women. The recreational facilities are all commercial and consist of cheap movie theatres, shooting galleries, pool halls and beer parlours. There are numerous small restaurants which

[9]For the street boundaries of the various Zones, see Appendix B.

cater to the itinerant population that crowds the poor hotels and rooming-houses in the vicinity. There are no parks or playgrounds, the only open green space being the grounds of the Canadian National Railway station. Zone 2 included the remainder of the downtown area and the East and West End of the city. Here there is a concentration of apartment blocks and large old houses converted into furnished rooms and housekeeping accommodation. In many sections of this zone, living quarters are crowded in among commercial property. In the East End there are some family dwellings but most of these houses shelter more than one family. In the West End section of Zone 2, the outdoor recreational facilities are very good, since the area borders on Stanley Park and English Bay bathing beach. The East End section does not fare so well, although it does have some small parks and playgrounds. For purposes of this study, Zone 3 included the suburban residential areas of the city. Those patients who gave an address outside the City of Vancouver were included in Zone 4.

Contrary to the popular conception that all venereal disease patients come from the slums, only 40 percent of the total repeater group gave their place of residence as Zone 1. Here it must be borne in mind, that while many of the male patients (like the loggers, miners, fishermen) made the hotels and rooming-houses in Zone 1 their headquarters when they came to town, they had no permanent residence in Vancouver. Twenty percent of the repeaters came from the residential districts of Zone 3, and 22 percent were from outside the City of Vancouver. With regard to the total venereal disease population in Vancouver there was no comparable break-down by zones.

Among the female repeaters a much higher percentage came from the slum area of Zone 1 than was the case with the men, 53 percent as

against 33 percent respectively, and out of the 40 women who were described as prostitutes among the female repeater patients, 33 of them lived in this Zone. Only 17 percent of the women repeaters came from the residential districts of Zone 3, and while they gave a street address as their place of residence, most of their waking hours were spent in the beer parlours, cheap cafes and poor hotels in Zone 1. Nine percent of the group indicated that they lived outside the City of Vancouver, and among these were many Indian girls whose homes were in rural areas adjacent to Vancouver but who slept in town wherever they could get a bed for the night.

In terms of venereal disease control, where these repeaters met their sex partners was more significant than their place of residence. As we have seen from the facilitation reports (Table 3) the problem area was that section of the city containing the cheap hotels and rooming-houses frequented by the sexually promiscuous group in the community.

Occupation

In considering the occupation factor of this repeater group, it must be remembered that the Vancouver Clinic is a free clinic, it is favourably known, and it is reasonably accessible. It is used by those who cannot afford private care or who do not object to coming to a free government clinic. As might be expected therefore, an analysis of the occupational characteristics of these repeaters showed a preponderance of unskilled workers. Taking into account the fact that the information on the charts was not always accurate or current, in cateloguing the patients by occupational groups, only three broad job classifications were used - unskilled, skilled, and clerical. A patient was considered to belong to the unskilled group if he was doing manual work that re-

quired no specific or technical training. This included those who were engaged in primary industries like logging, mining, fishing, longshoring, as well as those in the service trades in laundries, canneries, cafes, and in domestic service. In the skilled group were included all those who were required to have some special qualifications, such as workers in transportation services, in industrial or building trades, artisans of various kinds, cooks, barbers, hairdressers. The third classification of clerical workers included all the "white collar" people such as merchants, salesmen, clerks, stenographers, students, musicians. Because of the importance of Vancouver as a seaport and the specific problem of the transient seamen coming in and out of Vancouver, this group of patients was separately listed. Similarly patients who stated they were unemployed were so classified.

An analysis of the characteristics of the repeater group from the point of view of their occupational status showed that among the men, approximately two out of three were in the unskilled class, 12 percent were skilled workers, and only 2 percent were in clerical jobs. Seamen accounted for 12 percent of the male repeater group and 9 percent indicated that they were unemployed. The female repeaters showed a different grouping with a much higher percentage (41 percent) classified as unemployed. This included the women who had no visible means of support but lived from day to day on the generosity of their male friends. Very few of these women were interested in gainful employment; they enjoyed their promiscuous existence, and as a venereal disease control problem they were being sought continually by the epidemiology staff of the Clinic. Over 40 percent of the female repeaters were unskilled workers, and out of the total group of 130 there were only two women in skilled trades and two

doing clerical work. Housewives accounted for 14 percent of the female repeater group.

Table 5 shows the correlation between family status and occupational classification among the repeater patients. With the men, there was approximately the same proportion of unskilled workers in both the attached and unattached groups, while the percentage of clerical workers was considerably higher among the men who were living as part of a family group. Unemployed men constituted 12 percent of the unattached group as against 5 percent of the attached group. Among the unattached female repeater patients, 47 percent were engaged in menial jobs with the same proportion classified as unemployed. In the attached group over half the women described themselves as housewives with the remainder either unskilled workers or unemployed.

TABLE 5

REPEATER GROUP BY FAMILY STATUS AND OCCUPATION

Occupation	Unattached				Attached				Total	
	Male		Female		Male		Female			
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Unskilled	95	64	48	47	42	62	6	21	191	55
Skilled	17	12	1	1	10	14	1	4	29	8
Clerical	1	-1	2	2	4	6			7	2
Seamen	17	12			9	13			26	8
Housewives			3	3			15	53	18	5
Unemployed	17	12	48	47	3	5	6	22	74	22
Total	147	100	102	100	68	100	28	100	345	100

Multiple Re-infections

A repeater was defined as a patient who had acquired a venereal disease more than once, according to the records of the British Columbia Division of Venereal Disease Control, and out of the total repeater group 60 percent of the men and 32 percent of the women had repeated their infections only twice. For the majority of these patients, both male and female, the length of time between the first and second infections was from one to two years.

Multiple re-infections (or more than two) occurred in 52 percent of the totalrepeater group with, as we have seen, a much higher proportion of the women patients repeating their infections more often than was the case among the male patients. Only 9 percent of the male repeaters had more than four infections, while 22 percent of the women were so reported. One woman and two men had had eight different infections, and one female repeater was reported to the Division as having been infected nine separate times. Harry B. and Tom S. were fairly typical of the chronic repeater group.

> In 1948 Harry B. was in his late twenties, he described himself as a labourer, and he lived in the slum area of the city. He was single and nothing was known about him other than that he was Canadian born, his sex contacts were usually women whom he had met on the street while he was drunk. He had been in the Canadian army where he was twice diagnosed as having gonorrhoea but these infections were not included in his British Columbia medical record. In the six months period from January to June, 1948, he was treated twice for new gonorrhoeal infections. There was no recorded information about him as a person, his family background, his growing up experiences or his work adjustment. The root causes of his promiscuous behaviour were not known. Only his medical history was charted.
>
> Tom S. was an Indian who had been dishonourably discharged from the Canadian army. He lived in Zone 1, was an unskilled worker, and was in his middle twenties. Following his army discharge he had made the rounds of

> the social agencies, he had been provided with transportation to Eastern Canada where he said his home was, but he sold the warrant which had been issued to him, and he was sent to the provincial gaol. He was given a psychiatric examination, but was diagnosed as a chronic complainer and not one in need of psychiatric treatment. He described his sex partners either as prostitutes or as women whom he picked up on the street. At one time he stated that he was divorced and had four children who were living with his parents in northern British Columbia but it was felt that this information was not reliable. From the little that was known about this man he appeared to be completely irresponsible and incapable of much change in behaviour pattern.

The repeater patient with the highest number of infections was a woman who had been diagnosed as having a venereal infection nine different times over a period of six years.

> Jane L. had had syphilis once and gonorrhoea eight times. In 1948, when she was 24 years of age, she was described as a chronic alcoholic who spent most of her life in the beer parlours in Zone 1. She had been arrested twice on a charge of prostituting, and once for assault. She had two illegitimate children. From her clinic record, she had come to Vancouver from the prairies early in the war, and nothing was known about her prior to that time. She became illegitimately pregnant soon after she arrived in Vancouver and was under the care of a social agency. She managed to work and support her first child, but following the birth of her second illegitimate child two years later, she began to neglect her children. After a long and bitter struggle with her, the authorities finally obtained permanent guardianship over her children, on the ground of neglect. At the time of the study, she was rather an attractive white girl whose male companions were negro servicemen from the United States. According to her she married one of them, but because of her criminal record was prohibited from crossing into the United States to join her husband. Because of the way in which this patient is now living, she is under almost constant police surveillance and thus she can be examined frequently by the clinic staff at the Examination Centre at the City Gaol. Although she is a public health nuisance, she is not a problem because she is reasonably accessible. How can she be helped? Apparently the social agency resources were exhausted at the time her children had to be removed from her care. What can be done about her by the Division of Venereal

> Disease Control? At this point the only answer seems to be to keep her cooperating with the clinic, and so far this has been accomplished by the epidemiologist who is responsible for the operation of the City Gaol Examination Centre. This worker is particularly skilful in working with anti-social people who have lost their faith in humanity, and by her warmth and understanding she has been able to give this girl, for perhaps the first time in her life, the experience of a positive relationship with someone in authority. Actually, the only person in the world to whom this girl is important, is the worker who is concerned about her health. For this girl, her venereal condition is a relatively minor affliction but because of the regard she has for this worker, this otherwise completely anti-social individual has been able to cooperate in reporting for examination and treatment whenever requested to do so by the worker. So far as this patient is concerned, the effectiveness of the venereal disease control programme rests on the quality of the relationship which this one worker can maintain between the girl and herself.

Types of Contact Named

What kind of encounters resulted in a new venereal disease for these repeater patients? As might be expected 75 percent of them chose as their sex partners people who were strangers to them except for a chance meeting on the street or elsewhere, or who were casual friends. What was significant was the comparatively few professional prostitutes named as contacts by the male repeater group; before the war, the prostitute was regarded as a formidable obstacle to venereal disease control. In 1948 prostitutes were named as contacts by only 9 percent of the men in the repeater group. The promiscuous amateur, the "good-time girl" had replaced the prostitute as the chief venereal disease menace.

Other Problems

Alcohol as a precipitating factor was named by 54 percent of the male and 70 percent of the female repeater patients, and 19 out of the 130 females were described as chronic alcoholics.

With regard to police records, here again the female repeater group showed more homogeneity with 70 percent of them having been known either to the adult or to the juvenile court authorities while only 14 percent of the male repeaters had a police record. Most of the female repeaters were living on the fringe of crime; 30 percent of them were prostitutes,[10] and five were active drug addicts. The offenses with which these women were charged were primarily under the morality sections of the Code or those relating to drunkenness, although some of the women had been charged with other offenses such as theft, assault, breaking and entering, robbery with violence, etc. Many of them had been known to the juvenile court authorities before becoming adult offenders.

According to the clinic charts, only 14 percent of the male repeaters had a police record but this information may not be accurate since the male charts gave fewer details than the female charts. However, of those who were reported to have been in difficulties with the police, 73 percent of them had had multiple infections.

With regard to other problems manifested by the male repeater group only one patient was a convicted drug addict, and three were described as homosexuals. There was a history of mental illness in only six patients (four men and two women); three of the women were described as mental defective; and six repeaters (four men and two women) were diagnosed as having syphilis of the central nervous system. Among the women repeaters, nearly one-third of them had had illegitimate children while three of the men patients had been named as the father of children born out of wedlock.

[10]For the purposes of this study, a woman was considered to be a prostitute if she had been convicted of a morality offense under Sections 228 or 229 of the Criminal Code of Canada, or if she was described by her sex partners as having given favours in exchange for the payment of money.

A Non-Repeater Group

Are the patients who do not become re-infected with a venereal disease, very different from those who do? To answer this question a study was made of 100 consecutive patients, 50 men and 50 women, who were diagnosed as having a venereal infection in January and February, 1946, who were not previously known to the Division, and who, up to the end of April, 1949 had not been reported as having become re-infected. The repeat interval was taken as the length of time between the first and second infections of a repeater patient, and to arrive at an average repeat interval for the group, the record of every tenth repeater patient was considered. For the male repeaters, the median repeat interval was 15.5 months, and for the females 13.0 months. Therefore, any patient who was reported as a newly infected person in January, 1946 and who had not become re-infected by the end of April, 1949, was considered to be a non-repeater.

Among these hundred non-repeater patients, the highest proportion (63 percent) was still in the 20 to 29 year age-group. However, there were fewer unattached people among the non-repeaters, only 42 percent falling into this category whereas in the repeater group over 70 percent were living apart from their families. The racial origin of the patients was fairly comparable in both groups, but so far as residential area was concerned, almost half of the non-repeater patients came from the residential districts in Zone 3, and only 17 out of the 100 gave Zone 1 as their place of residence. Among the non-repeaters, 50 percent of the male patients were engaged in skilled or clerical jobs, while among the repeater group only 15 percent of the men were in these categories. Among the women, the difference was even more striking, with 10 out of the 50 in the non-

repeater group doing jobs that required special training, and only four out of the 130 women repeaters similarly engaged. In 1948, 20 percent of the repeater patients were either unemployed or had no regular occupation; in the 1946 non-repeater group, only 8 percent were so classified. Alcohol as a factor in facilitating the spread of venereal disease was much lower among the non-repeater patients, with only one-third of these patients indicating that they had been drinking prior to the incident that resulted in their infection. Among the repeaters, half of them stated that they were under the influence of liquor at the time. None of the men and only two of the women in the non-repeater group had any police record; only two of the female patients had had illegitimate children; and only one was described as a prostitute.

Patients who did not repeat the experience of acquiring a venereal infection, therefore, were about the same age as the repeaters, but their home background was more stable, and they were engaged in more skilled employment; fewer of the patients admitted that alcohol was a factor which influenced their behaviour at the time of the encounter which resulted in their infection; and there was less evidence among these patients of other symptoms of social disorganization such as police records and illegitimate pregnancies.

The present study makes clear that in a representative six months period at the Vancouver Clinic, nearly every third newly diagnosed patient was a repeater. Recidivism was higher among the female patients than among the males, with more of the female repeaters having multiple reinfections. From the little information that was available about these repeater patients, the majority of them appeared to have difficulties in personal relationships, as evidenced by lack of family ties, broken homes,

marital discord, casual sex partners. A higher percentage of the women were leading a rootless existence than was the case with the men. Most of the men coming to this free clinic were unskilled workers and almost half of the women were either unemployed or had no employment. In terms of age, two-thirds of the repeaters were between 20 and 30 years of age, the average age of the women being lower than that of the men.

Because the women were more often a problem in contact tracing, they were better known to the epidemiology section than the men, and their medical records contained more detailed information than the men's charts. Whereas the men usually reported to the clinic with symptoms which responded quickly to treatment, most of the female repeaters were brought in as the result of epidemiological efforts because they had been named as contact to a known infection. These women had no symptoms; treatment merely inconvenienced them; and the routine follow-up to ensure that they were free from infection was more important to the Division of Venereal Disease Control than it was to the women themselves.

The female repeaters were a more homogeneous group than the men. For most of them their venereal condition was a relatively minor complication in a life situation that included many more serious social ills - prostitution, illegitimacy, alcoholism, drug addiction. The majority of these women were living a precarious existence, which they preferred to a more ordered way of life because it made few demands on them.

This repeater study revealed how little was actually known about these patients as people, about their background, and about the underlying causes of the behaviour which was resulting in repeated venereal infections for them. Viewed as a group, they presented a bleak picture. The problem of a venereal disease was incidental to them, and the eradication of this menace would make little basic change in their lives.

However, a more individualized approach to the problem of venereal disease might have yielded information about resources within the personality structure of these people which could have been utilized in enlisting their cooperation in the programme of venereal disease control. How much of the problem of recidivism was due to lack of understanding on the part of the infected individual of the relationship between his behaviour and his repeated infections; how many of these repeater patients were confused and behaving in a sexually promiscuous way in a neurotic attempt to satisfy their basic needs? Was the acquisition of repeated venereal infections symptomatic of a more deep-seated personality disorder in which the self-destructive processes could not be reversed with the professional skills available either at the clinic or in the community? To find the answer, more information was needed. To be effective, treatment had to be geared to the needs of the individual patient and this could only be done when these needs had been assessed.

CHAPTER 3

THE PROVINCIAL CONTROL PROGRAMME

In British Columbia, since 1919 the government has been responsible for venereal disease control. Until 1936 the programme was under the direct supervision of the Provincial Health Officer. By then the growing incidence of these diseases called for a more specific direction to the programme and a separate Division of Venereal Disease Control was set up under the Provincial Board of Health in the Department of the Provincial Secretary. When the Department of Health and Welfare was established in 1947, Venereal Disease Control became one of the Divisions under the Health Branch of the new Department. Control measures are financed by funds from the provincial government, supplemented by an annual grant from the federal government. In 1948 the venereal diseases cost the taxpayers of British Columbia approximately $173,500 while $43,500 of federal tax money was diverted to this province for its venereal disease control programme.[11]

The venereal diseases emerged as a serious public health menace during the first World War. The human misery and destruction created by these whispered diseases had reached such proportions by 1919 that growing public opinion demanded government action on a national scale to institute proper control measures. Accordingly federal funds were made available to the provinces on a matching basis for the establishment of provincial venereal disease control programmes. British Columbia was one of the first provinces to take advantage of this federal offer, and in 1919 this province passed its first Venereal Diseases Suppression Act. This

[11] British Columbia, Venereal Disease Control Programme of the Health Branch Provincial Department of Health and Welfare, Victoria, B.C. 1948, page 3.

legislation provided for compulsory treatment of all persons suffering from a venereal disease and it required private physicians in the province to report all newly diagnosed venereal infections to the Provincial Health Officer. By 1920 British Columbia's venereal disease programme was well under way; two free clinics had been established in Vancouver and Victoria; in areas where there were no free clinics, doctors received payment from the provincial government for professional services to indigent patients suffering from a venereal disease; and even for their private patients, doctors received free drugs for the treatment of venereal diseases. Under the inspired leadership of Dr. Henry Esson Young, the Provincial Health Officer, the cooperation of professional and lay groups through the province was enlisted; the churches joined in the fight against these public enemies; and leading citizens throughout the province were given the responsibility of organizing public meetings at which information about the venereal diseases was broadcast to the people of British Columbia.

In 1930, reviewing the first ten years of the provincial programme, the Provincial Health Officer acknowledged the gains that had been made on the medical front by crediting the venereal disease programme with reducing the mental hospital admissions by 50 percent, but he deplored the lack of a preventive aspect to the programme. As Dr. Young saw it nearly 20 years ago, the problem in venereal disease control was "how to control the infected person". At that time Dr. Young felt that a programme of venereal disease prevention was more than just a public health measure and he looked to the influence of the home and the church to encourage young people to live in such a way as to avoid the risk of a venereal infection. He saw the role of the health department as one of treating and curing (or at least rendering non-infectious) every person in the province who

was suffering from a venereal disease, and his goal was, by education, to bring the venereal diseases out into the open where they could be dealt with in the same way as any other contagious disease.

By 1936 the venereal disease problem had outstripped the control facilities and a separate Division of Venereal Disease Control was set up within the Provincial Board of Health, with headquarters in Vancouver. The Vancouver Clinic became the main diagnostic and treatment centre for the province-wide activities of the Division.

The year 1938 was a banner one for venereal disease control in British Columbia when it brought Dr. Donald H. Williams to the post of Director of the Division. Dr. Williams was a visionary who recognized that venereal disease control was more than a medical problem, and that to be effective the control programme must attack the allied social, legal, and moral issues on a broad front. He saw the need for community action, and within a month of his appointment, he had formed an Advisory Committee on Venereal Disease comprised of representatives of all the health and welfare organizations in the province. An Educational Supervisor was appointed to the Division and public education about the venereal diseases became one of the Division's most important functions. Every medium for disseminating information was utilized and a veritable "blitzkreig" of venereal disease information was launched on the public.

An all-out campaign against organized houses of prostitution was launched. Labelled "disease dispensaries" by Dr. Williams, the fallacy of segregation of prostitutes into specific areas and of medical certification of these women, was vigorously attacked by the Division of Venereal Disease Control. The medical profession in British Columbia was urged to refrain from issuing certificates to women stating that they were

free from a venereal infection, and the Division based its arguments on the fact that while such persons might have no evidence of a venereal disease, they could become infected by their first exposure following the examination. It was pointed out that a certificate in the possession of a prostitute, only served to make her a greater venereal disease menace, by giving her customers a false sense of security.

In the early days of the war there was the closest working relationship between the military authorities in British Columbia and the Division of Venereal Disease Control, and when Dr. Williams was called to Ottawa to organize the national programme for the control of venereal disease in wartime, he used the British Columbia set-up as a model. In 1943 the National Venereal Disease Control Conference adopted a Four-Sector strategy against the venereal diseases by which they would be attacked simultaneously on the Health, Welfare, Legal and Moral Fronts. The battle on the Health Front was the responsibility of the various provincial Divisions of Venereal Disease Control, and a Six-Point programme was outlined. This included the provision of proper health education facilities, good medical care, laws to abolish quackery in the treatment of venereal disease, campaigns to encourage prenatal blood-testing and pre-marital examinations, and the development of efficient contact-tracing.

British Columbia's programme has continued to develop along the lines recommended by the National Conference, and in 1948 the objectives of the programme were outlined as follows:[12]

"1. Health

(a) Wholesome, dignified health education concerning syphilis and gonorrhoea.

[12]British Columbia Department of Health and Welfare, Division of Venereal Disease Control, Venereal Disease Information for Nurses, 1948, page 4.

(b) Adequate diagnostic and treatment facilities for all persons suffering from venereal disease.
(c) Skillful contact tracing and case holding.
(d) Early adequate prenatal care including blood tests for expectant mothers to prevent prenatal syphilis.
(e) General health examination including blood tests for syphilis before marriage.

2. Welfare

(a) Adequate minimum standard of living to ensure economic and social security.
(b) Proper housing facilities.
(c) Opportunity for wholesome recreation.
(d) Skilled case work service as part of medical care to help problem patients understand their medical condition and how it is directly related to their behaviour pattern.

3. Legal

(a) Effective legislation providing for compulsory examination for venereal disease and necessary treatment of uncooperative individuals.
(b) Vigorous law enforcement to suppress conditions of vice. Close cooperation between the health and law enforcement authorities is essential in order to control the promiscuous element in a community, since the spread of venereal disease goes hand in hand with other problems such as prostitution, bootlegging and illicit drug traffic.
(c) Cooperation with civic authorities to improve unsavory community conditions that facilitate the spread of venereal disease. There should be local by-laws to provide for disciplinary action by way of cancellation of license against owners and operators of premises frequently named as a place of meeting or exposure which resulted in a new venereal infection.

4. Moral

On the moral front the fight must be waged in the home, in the church, and in the school to raise standards of behaviour, to strengthen family ties and to encourage every citizen to accept his rightful responsibilities. The control of venereal disease, in the last analysis, must be the responsibility of the individual."

In the over-all programme of the Division of Venereal Disease Control in British Columbia, the aim of the Division is to seek out all the infected individuals in the province; to ensure that they receive early and adequate treatment; and to educate them to take responsibility for

safeguarding their health and the health of others by behaving in such a way as not to acquire a venereal infection.

ORGANIZATION OF THE DIVISION

There are five operating sections of the Division of Venereal Disease Control - Administration, Diagnostic and Treatment Services, Epidemiology, Education and Social Service. The Director of the Division meets once a week with the Assistant Director and the heads of the various sections, to discuss problems of operation and to formulate policy. The Assistant Director shares the executive responsibility and supervises the Diagnostic and Treatment Services Section of the Division. Both of these senior officers are fully qualified medical practitioners with special training in public health.

The base of operations of the Division is the Central Office, which is located in the old frame building on the Vancouver General Hospital grounds that has housed the Vancouver Clinic since 1920. From here the Director of the Division supervises the work of the Division staff, and coordinates the activities of the local health units and the private physicians throughout the province in controlling venereal disease. Central Office contains the provincial index of all venereal disease patients diagnosed and treated in British Columbia. Whenever a diagnosis of a venereal infection is established either by a private physician or at a public clinic, a notification form giving the name of the patient and other identifying information, together with particulars of the infection, is forwarded to the Central Office of the Division. Here each new case is assigned a record number, and an index card giving the name and number of the patient is inserted in the provincial index. The patient's medical history and any correspondence about him, bears the original record number

assigned to him at the time of his first diagnosed infection in British Columbia. Subsequent infections are reported to the Division and numbers assigned to them for statistical purposes; although these numbers are entered on the index card as they are assigned, the patient's record is filed under his original number.

Besides the provincial index, Central Office files contain the medical records of all patients examined or treated in the clinics at Vancouver, New Westminster, Oakalla, Girls' Industrial School and Juvenile Detention Home, and the Vancouver City Gaol Examination Centre. Medical records for the Victoria and Dawson Creek Clinics are kept locally, with identifying information only being sent to the central index. Similarly the only information which the Division has about patients of private physicians is what is on the notification form sent in by the doctor.

Administration

The smooth running of the entire organization depends on the Administration Section. It is responsible for the efficient operation of the records system of the Division, and it collects and compiles statistics relating to the incidence of venereal disease in the province. The purchasing and distribution of all medical and other supplies comes under the Administration Section.

Diagnostic and Treatment Services

This Section of the Division is responsible for the operation of the free clinics, for the distribution to private physicians of free medication for the treatment of venereal disease, and for arranging payment to doctors for professional services rendered to indigent patients in areas where there are no clinic facilities. This Section also provides consultative service in all branches of venereology to the practicing

physicians in the province.

Free out-patient clinics established in Vancouver and Victoria have been in continuous operation since 1920, and today there are also free clinics at New Westminster and Dawson Creek. Clinics staffed by members of the Vancouver Clinic are conducted at Oakalla Prison Farm, the Juvenile Detention Home and the Girls' Industrial School. At the Vancouver City Gaol, all persons in custody each morning are examined for venereal disease by public health nurses from the Vancouver Clinic, who have been specially trained in examination techniques.

The medical staff of the various clinics is composed of general medical practitioners in the local areas, who are employed on a part-time basis. In addition, specialist consultants in syphilology, urology, gynecology, neurology, cardiology, pediatrics, dermatology, and diseases of the eye, ear, nose and throat, are attached to the Vancouver Clinic. Any physician in the province can refer cases to the Vancouver Clinic for consultation by the appropriate specialist, or consultative service will be given by correspondence to doctors in the outlying areas.

The Vancouver Clinic, which is the medical nerve-centre of the Division, is staffed by ten part-time physicians besides the eight consultants mentioned above, seven registered nurses, eight public health nurses, and three social workers. At each clinic session, there are at least two general practitioners, one for the male clinic and one for the female clinic, and each consultant is at the clinic one day a week in accordance with a set schedule. The Clinic is in operation every morning (except Sunday), Monday and Thursday evenings, and Wednesday afternoon. In addition a special pediatricclinic is conducted every Monday afternoon. For diagnostic purposes there is a laboratory set up at the Vancouver

Clinic, but the general laboratory services for the Division are provided by the Division of Laboratories of the Department of Health and Welfare.

Weekly conferences of all the medical staff review the cases which present some diagnostic or treatment problem. The recommendations of the various consultants are discussed by the group and the patient receives the benefit of the combined thinking of the medical staff. These conferences also have an educational value for the staff members, and papers describing the latest advances in medicine as they relate to the venereal diseases are presented from time to time. The heads of each of the other Sections of the Division are invited to sit in on these medical conferences. The Division keeps in close touch with the medical profession in the province by means of letters, bulletins, and articles in the various medical journals, and in this way the Division keeps the doctors up-to-date on improved methods of diagnosing and treating venereal diseases. The aim of the Division is to keep its programme constantly before the practicing physicians, and to enlist their cooperation in the matter of complete reporting of cases to the Division.

Epidemiology

In a programme aimed at eradicating the venereal disease menace in British Columbia, it is not sufficient that medical care be made available, free of charge, to all infected persons. Aggressive action must be taken to seek out the undetected, untreated reservoirs of infection in the community, and to bring the spreaders of disease under prompt and adequate treatment. This is the work of the Epidemiology Section and its staff of public health nurses. The Provincial Supervisor of Venereal Disease Epidemiology directs case-finding throughout the province. Six of the public health nursing staff work in the City of Vancouver, while one

nurse travels throughout the rest of the province, acting as consultant in V.D. epidemiology to the local medical health officers, health unit personnel, and to the generalized public health nurses who are responsible for case-finding in areas outside Vancouver and Victoria.

As a venereal infection is usually acquired through intimate contact with an infected person, it is the newly diagnosed patient whose aid must be enlisted in locating the people in the community who are spreading venereal disease. Accordingly, whenever a patient is diagnosed as having a venereal infection, he is carefully questioned about the people with whom he was in contact during the probable incubation period of his infection, as well as during the period prior to treatment when the patient himself was in an infectious stage. In the clinics, this interviewing is done by the public health nurses. Private physicians are encouraged to take responsibility for examining the contacts of their patients, and on the notification form that is required to be sent in to the Division, there is space for the doctor to indicate whether he has taken this responsibility, or whether he prefers that the necessary follow-up be done by the staff of the Division. If the contact is outside the City of Vancouver, the information is forwarded to the appropriate health unit or public health nurse in the local area. If the contact is reported to be in Vancouver, then the Division epidemiologists take over.[13] Armed

[13]In Vancouver a small share of the contact-tracing and case-finding is done by the public health nurses on the staff of the Metropolitan Health Department. To coordinate this work one of the nurses from the Metropolitan staff works full-time at the Vancouver Clinic. In recent years efforts have been directed toward turning over more and more of the venereal disease epidemiology to the Metropolitan nursing staff, but there is now some question as to the efficacy of including this work in a generalized nursing service in an urban area as complex as Vancouver, where success in venereal disease epidemiology depends on a specialized knowledge of the problem areas in the city, and the people who inhabit them. It requires an accumulation of knowledge about the venereal disease population, to do an effective case-finding job among them. The public health nurses on the Division staff have this advantage.

with all the available information, they set out to find the person who has been reported to the Division as having been exposed to a known venereal infection. Once the contact has been located, then the nurse must persuade that person to have a proper medical examination. This takes great skill on the part of the nurse, for to achieve her goal (which is to have the person examined for venereal disease), she must establish a relationship of confidence with this person to whom she is a stranger. Often the nurse meets great hostility, because in talking to a contact, the nurse cannot reveal the identity of the patient who gave the contact information. If a person has been exposed to a known infection, that person is a potential new case until he has been examined, since absence of symptoms is no safeguard. Contacts are given the choice of going to their own doctor or reporting to a free clinic for the examination; if they go to a private physician, the Division checks with him as to the results of the tests.

Besides locating new cases, this section is responsible for seeing that old cases remain under care until they have completed the prescribed course of treatment and follow-up. This is known as case-holding and is another important part of the control programme. A patient who has been inadequately treated has a false sense of security; without the patient being aware of it, his disease may become active again, and he may become a public health menace once more. Because the manifestations of gonorrhoea and syphilis can be so slight as to escape the notice of the patient, he or she must be persuaded that treatment is required. Treatment can become an irksome burden, and much of the time and energy of the epidemiology staff are spent in tracing patients who have lapsed from treatment, or who require further surveillance before they can be discharged as having had sufficient treatment.

When all efforts to enlist the cooperation of a patient fail, the epidemiologists can refer the matter to the local medical health officer. He has power under the Venereal Diseases Suppression Act of 1947, to compel a person to submit to a medical examination whenever the medical health officer has reasonable grounds for believing such a person might have a venereal disease or might have been exposed to an infection. Failure to comply with the order of the medical health officer is an offence under the Act, and is punishable by imprisonment. Similarly the health officer can order a person whom he knows to be infected, to take and continue adequate treatment; again failure to comply is punishable by imprisonment. The Act also provides for compulsory examination, and if necessary, treatment of all persons in custody in the province, whether awaiting trial or serving a sentence. Imprisonment for failure to carry out the order of the medical health officer is usually set at the time required to adequately examine or treat the offender. In practice, action under the Venereal Diseases Suppression Act is used as a last resort, only when the person is known to constitute a public health menace. The primary function of the venereal disease control programme is not to punish, but to safeguard the general public from the dangers of infected, promiscuous persons.

Another responsibility of the Epidemiology Section is to keep track of the facilitation information that is gathered at the time the patient is asked to give a history of his contacts. The role of epidemiology in the programme of venereal disease control is today assuming major importance, because this is the means whereby infected persons are brought under treatment early in the course of their disease, and are supervised until they have completed the prescribed course of treatment.

Section of Education

Education about the venereal diseases is a job shared by the Division of Venereal Disease Control and the Division of Public Health Education, with all undertakings relating to venereal disease education being jointly planned by the two Divisions. The Venereal Disease Division has major responsibility for the professional education which includes keeping the medical practitioners throughout the province abreast of developments in venereology, as well as for organizing training courses for public health nurses from the University of British Columbia, and for nurses in training at the Vancouver General Hospital. In order to coordinate the educational activity of the Division, one of its public health nurses has been appointed Nursing Educator, and it is hoped that she will be able to help other nurses' training-schools in the province to organize their curricula to include lectures in venereology.

The Nursing Educator is also in charge of the distribution of the venereal disease literature available from the Division. The most recent publication to be distributed is a good example of venereal disease education geared to the tastes of the greatest proportion of patients who come to a free clinic for treatment. It is entitled "My Story", its format is that of a popular magazine, and the articles are written in a "true confessions" vein. They are very well done and get their point across in a way that a more formal pamphlet would not achieve. When copies first appeared in the waiting rooms at the Vancouver Clinic, they were read avidly by the patients. This kind of venereal disease literature is in line with the policy of the Division, which is, that education about venereal disease should be directed to the person who has the disease.

In the clinics, patient education is stressed, and the public

health nurses in all their work with patients, carry out on an individual basis, a continuous programme of venereal disease education. There is now some question as to the effectiveness of widespread propoganda about venereal disease directed toward the general public, since it is felt that the information often fails to reach that section of the public that is becoming infected. In the experience of the armed services, knowledge about the disease had relatively little effect on whether or not a soldier became infected. Judging from venereal disease studies made of military personnel during World War II, the problem seemed to be rooted in the personality of the individual soldier. Those who became infected were more immature, more unstable, more prone to drink to excess and more discontented with army life than the soldiers in the various control groups who did not acquire a venereal disease. With most of the soldiers who contracted venereal disease, promiscuous behaviour was precipitated by some acute emotional disturbance.[14]

Social Service

The specific contribution which social workers can make in a venereal disease control programme has been recognized in British Columbia, and three professionally trained case-workers from the Welfare Branch of the Department of Health and Welfare have been detailed to staff the Social Service Section of the Venereal Disease Division. Under this administrative set-up, social work in venereal disease control is included in the over-all programme of provincial social services. At the same time, these

[14]Lumpkin, Margaret K., The Individual and Venereal Disease, Cooperative Study, Department of Public Health, Yale University and Venereal Disease Control Division, U.S. Public Health Service, New Haven, Conn. July, 1948. (mimeo.) Chapter 4.

case-workers are regarded as an integral part of the staff of the Division and are responsible to its director in all matters except those relating to administration. Liaison between the Welfare Branch and the Division is maintained through the Medical Social Work Consultant on the Welfare staff who, at the present time, is assuming supervisory responsibility for the social services in the Division of Tuberculosis Control as well as in the Venereal Disease Division.

Within the Division, the senior worker acts as the case work supervisor and is responsible for planning the social work programme. Case work services are provided at all the sessions of the Vancouver Clinic; consultation on social problems arising at the other clinics is available to the workers staffing these clinics; and in areas where there are no clinics, the health workers who are responsible for venereal disease control utilize the services of the provincial social work staff for patients who present special problems.

When the Division of Venereal Disease Control was set up in 1936, it included a Social Service Section. At that time the concept of venereal disease epidemiology was new and the social workers, because of their knowledge of community conditions, were given the job of case-finding; they had to seek out the undetected reservoir of infection by bringing in for examination all persons who had been in contact with a known venereal disease. At the same time the social workers were responsible for seeing that known cases continued to take regular treatment. In 1936 with approximately 60 percent of the patients unemployed, the work of the Division had to be coordinated with that of the other social agencies and organizations in the community, and the Social Service Section took over the supervision of admissions and discharges at the Vancouver Clinic.

When time permitted, brief social histories were prepared on all new patients, and patients being discharged from the Clinic were given special counselling to ensure that they understood the recommended follow-up procedure.

The war years brought special problems in venereal disease control when young girls from all parts of the Dominion flocked into Vancouver to share in the excitement of war-time living in a big city. In cooperation with the City of Vancouver and the Vancouver Council of Social Agencies, the Division of Venereal Disease Control was instrumental in setting up a hostel to which girls who were just beginning a life of prostitution could be sent until they had been treated for a venereal disease or until some plan for their rehabilitation could be made. Admissions to the hostel were arranged through the Social Service Section of the Venereal Disease Division. The venture ultimately failed because the girls who needed to live under supervised conditions resented any attempt to redirect their energies; they were not economically dependent because work was easy to get; and they lived what seemed to them an exciting existence. By contrast plans designed to give them a more stable way of living had no appeal for them. After the hostel was closed, the social workers on the Division staff continued to maintain a case-work relationship with the girls who wanted help, and the resources of other agencies were utilized to help re-establish these girls in the community.

When the Division was re-organized in 1945, the Social Service Section was relieved of its case-finding and case-holding functions to allow the social workers to concentrate their efforts on the social problems presented by the individual patients, and on the community conditions that were impeding progress in controlling the venereal diseases. The

community problem of facilitation continued to be a responsibility of the Social Service Section until 1948, when it was taken over by the Epidemiology Section. At that time it was agreed that since it was the public health nurses and not the social workers who were doing the contact investigations and follow-up of patients in the community, facilitation was properly a function of the Epidemiology Section. The facilitation job is now shared by all the Sections, because the entire Division is vitally concerned with all community problems as they relate to the control of venereal disease.

Until May 1947, the social work staff at the Vancouver Clinic acted as liaison between the Division and the Vancouver Police Department in arranging to have women in custody examined for venereal disease. Many times, women being sought by the epidemiology workers were released from custody before the clinic staff knew these patients were in gaol. Those who were caught in the police net had to be brought up to the Vancouver Clinic under police escort; this interfered with their court hearing; it was time-consuming for the police officers, and it was embarrassing for the Clinic to have patients brought into the waiting-rooms under guard. Early in 1947 changes in the Police Department and the passage of the new Venereal Diseases Suppression Act made possible the setting up of a medical examination centre at the City Gaol, so that examination for venereal disease became a routine procedure for all women in custody. Later this was extended to include blood-testing of all male prisoners. When this examination centre was established, liaison with the Police Department became the responsibility of the public health nurse in charge of the centre.

By 1948 the focus of the Social Service Section had become the "problem patient" - that is, the patient whose medical condition was

complicated by some personal difficulty. For patients coming to the Vancouver Clinic, case work services were available to them from the clinic social workers; outside the City of Vancouver, patients with problems were referred to the social workers in the local area by the public health nurse who was arranging the patient's medical care. Private doctors were encouraged to use the social service facilities of the Division for Venereal disease patients under their care who needed help in working through some of their non-medical problems.

At the Vancouver Clinic, patients who were emotionally disturbed by their infection or who were upset by the diagnostic and treatment procedures were referred to the social workers by the medical and nursing staff. The social workers also gave special counselling to all the patients who were juveniles (that is, under 18 years of age), in an effort to redirect their energies into community recreational activities. If, in the course of the examination for a venereal disease, a female patient was found to be pregnant, the help of the Social Service Section was enlisted, particularly for the girl who was not married and for whom this diagnosis was the confirmation of her worst fears. In helping such a girl face her problem, the resources of the appropriate social agency in the community were interpreted to her, and she was reassured and encouraged in her planning to meet this crisis.

With all these problem patients, it was by means of the interpersonal relationship between the patient and the case worker that the patient was helped, to the limit of his capicity, to sort out his problems and to plan how he could begin to deal with them. While the case work service took the patient's venereal disease as its starting-point, it was recognized that the disease was only one of a constellation of problems

which the patient, in his present state of disorganization, was unable to face. The aim of the social worker was to work with the "whole patient" in such a way as to help him gain some insight into the causes of his difficulties, and if he needed outside help, to direct him to the community resources that were available to him.

In an effort to stimulate the referral of patients to the Social Service Section, much of the time of the social workers was taken up in interpreting to the doctors and the nurses on the clinic staff, the needs of these patients as people who, besides their venereal condition, had many problems far more pressing than their infection. All the staff were encouraged to become more sensitive in detecting personality disorders in patients which might be helped on a case work basis.

Since 1949, it has become routine procedure for all newly diagnosed patients to be interviewed by the Social Service Section at least once in the course of their clinic attendance. The interview is exploratory and serves to screen for a more intensive case work relationship, those patients who are emotionally disturbed. For those who are fairly well integrated personalities, the interview gives them an opportunity of gaining some insight into the cause-an-effect relationship between their behaviour and their infection. In September 1949, psychiatric consultation became available for patients with serious personality disorders, and this has expanded the scope of the Social Service Section, since it is now responsible for preparation of the social histories of all patients referred to the Division's psychiatrist.

CHAPTER 4

PSYCHO-SOCIAL CHARACTERISTICS OF PATIENTS IN OTHER COUNTRIES

What kind of people become infected with a venereal disease and what can be learned about them that will serve as a guide in planning an effective control programme? Much had been written about the medical aspects of venereal disease control, but nothing was done to bring together all the available information about the broader problems involved until 1948, when a joint committee of the Department of Public Health of Yale University and the Venereal Disease Division of the United States Public Health Service undertook to enquire into the social and educational aspects of venereal disease control. The results of their investigation have been published in a series of three Cooperative Studies. The first outlined the scope of the enquiry, and the second Study, entitled The Social Control of Venereal Disease, described the "climate of professional opinion" about the fundamental problems in controlling venereal disease. Here over 700 professional persons who were engaged directly or indirectly in venereal disease control participated in an opinion poll. The third Study, The Individual and Venereal Disease, analyzed all the available literature dealing with the psycho-social characteristics of patients. This project took as its starting-point "the individual as a patient or a potential patient and his relationships to disease, case-finding and medical care; to other community health, welfare and related facilities; and to the personnel involved."[15] All the material was scrutinized in terms

[15] Lumpkin, Margaret, Introduction to The Individual and Venereal Disease, Cooperative Study No. 3, Yale University Department of Public Health and U.S. Public Health Service Division of V.D. Control, New Haven, July 1948.

of five general criteria:

1. It must relate to individuals infected with a venereal disease.
2. It must deal with the psycho-social characteristics of patients.
3. The data must have been obtained primarily through personal interview by professionally qualified persons.
4. The analysis and interpretation of the data must have been made by professionally qualified personnel.
5. The data must have been treated objectively by the use of sound quantitative methods.

Although over 200 studies were reviewed by the Committee, only 26 were considered to be pertinent to a study of the psycho-social aspects of venereal disease control.

STUDIES RELATING TO VENEREAL DISEASE PATIENTS

The following studies related to individual patients under treatment for a venereal infection.

Lumpkin Study (St. Louis) 1942[16]

This study, made by a medical social worker in a part-pay genito-urinary evening clinic, analyzed the characteristics of 242 patients whom the worker had interviewed on their first admission to the clinic. In this group, male patients predominated, and negroes outnumbered white patients two to one. Fifty percent of the patients were under 25 years of age, and nearly 90 percent were 35 or younger. A little more than 40 percent of the patients were married. About half the patients had had some high school experience, and another 20 percent had grade school standing. Over a third of the male patients were labourers. Most of these people manifested some difficulty in personal relationships, some emotional complications, and some lack of understanding of the need for medical care.

[16]In the text these studies are identified by the name of the author, the setting and the date of the study. See Appendix C. for complete bibliography of the studies.

Fifty-two percent of the group had had more than one infection and the majority of these repeaters were married male patients with high school grades; they were engaged in manual jobs and had an adequate income. The negro repeater patients were in the 20 to 30 age-group and the white patients were slightly older. The repeater rate among these patients was higher than at the Vancouver Clinic. However the composition of the two patient groups was not comparable because of the preponderance of negroes attending the St. Louis Clinic. There, 69 percent of the patients were negro while at the Vancouver Clinic only a small proportion of the patients came from this racial group. While a broad generalization that negroes are more promiscuous than white people is not valid, experts in venereal disease control in the southern United States are of the opinion that the American negro is less inhibited sexually than the caucasian, and that he follows a different cultural pattern.[17]

The study recommended that there should be free medical care for indigent patients and psychiatric service available for those patients who were disturbed and wanted help with resolving some of their more basic difficulties. Only by a better understanding of the individual needs of each patient could case-holding become effective.

Rachlin and Weitz Studies, (St. Louis) 1944

Three studies were undertaken at a rapid treatment centre for women in St. Louis. One investigator was a psychiatrist and the other was a psychologist, and they examined the psycho-social characteristics of 304 women brought into this treatment centre by law-enforcement officers. The purpose of these studies was to determine what kind of person was

[17] The Social Control of Venereal Disease, Cooperative Study No. 2, Department of Public Health Yale University and the V.D. Division of the U.S. Public Health Service, New Haven, July 15, 1948, pages 35-36.

being dealt with in this setting, and what rehabilitation measures would be appropriate.

Although the study group included negro as well as white patients, the latter predominated. Over 80 percent were between the ages of 15 and 24; two out of three had been married before they were 16, and one out of three was either separated or divorced at the time of their examination. Their educational attainment ranged from no schooling to college level, with 125 out of the 304 in the high school group. On testing, they had a median I.Q. of 80. The majority of the girls were employed either as waitresses or as industrial workers.

Among the girls on whom there was sufficient data about their family background, over 50 percent came from broken homes. Only one girl in eight had parents who were living together and between whom there was no serious conflict. Most of the girls had had their first sex experience in their early teens; nearly half the married women had had premarital relations; and fifteen of the patients had illegitimate children.

The findings of the psychiatrist showed the majority of these young women were unstable, emotionally immature, intellectually handicapped, and without any "social consciousness". This was considered to be due to their early conflicts and environmental insecurity. It was his opinion that their indiscriminating sex behaviour was either an aggressive protest against society or a manifestation of their amorality. He concluded that any programme for controlling venereal disease should take into account the social pressures which were affecting these girls; also that community action to provide facilities to meet their more basic needs must accompany any medical control programme.

The same professional team carried out a programme of mental

testing of 500 consecutive female patients at this rapid treatment centre. Again the patients were both white and negro. The median age was found to be 20.8 years; the educational level, 8 years 4 months; the I.Q. ranged from 44 to 123, with the median I.Q. for white patients 84, and that for the negroes 70. Mental defectiveness was found in one out of every five white patients, and in over half the negro girls. At the same time 16 percent of the white patients were of superior intelligence while only 4 percent of the negroes were found to be in this category. This study pointed out that educational material on venereal disease had to be geared to a low intelligence level, and the recommendation was made that mental defectives should be institutionalized for their own protection, since educational efforts did little to affect any behaviour change among this group.[18]

The third study, undertaken by the psychologist on the team, compared the work adjustment of a group of 225 girls from the rapid treatment centre, with a group of applicants to the National Employment Service, selected to match the patient-group. The findings were that the patient-group changed jobs nearly twice as often as the applicant-group; there were no professional or managerial workers among the patient-group and very few skilled or semi-skilled workers. Most of the patients were engaged in service occupations (waitresses, bar-maids, domestics). In intelligence the patient group was below normal, the majority being in the defective or borderline classifications. There were no comparable data available on the applicant-group. The recommendation here was that since

[18]This seems like rather an academic proposal, with the problem of the female mental defective much larger than that of her sex deviations. The authors of the study did not seem to consider that a meeting of the basic needs of these handicapped girls in terms of emotional and other security might be effective in redirecting their sex drives into less hazardous channels.

work adjustment is a very important factor in rehabilitation, an adequate vocational guidance programme is a necessity in any venereal disease control set-up.

Andrews Study (St. Louis) 1947

This project described the emotional and environmental factors influencing the response to treatment plans of a group of ten female syphilis patients admitted to the St. Louis Rapid Treatment Centre. The average age of these women was 24 years; one patient was single, three were married, three had remarried, and three were separated. Half of them were engaged in unskilled jobs and their educational levels ranged from the third grade to high school graduation. Amongst the reactions to diagnosis and treatment, fear was the predominating emotion. The patients in this group were found to be emotionally unstable, most of them had had unhappy childhood experiences and very few of them had been able to establish a secure and lasting marriage. None of them responded to the educational material presented to them, and the conclusions were that before they could be helped to face the problems presented by their total life situation - including their venereal infection - they needed the understanding and expert counselling of a case work relationship.

Parker Study (St. Louis) 1942

The social, economic and emotional factors presented by 30 syphilitic pregnant women attending a free out-patient clinic in St. Louis, were analyzed in this study. Two-thirds of these patients were negroes. The majority of the women were ignorant of the facts about their disease and its implications, and the group as a whole were irregular in their clinic attendance. Ignorance was considered the greatest obstacle to effective treatment, and the need for an educational programme that was

geared to their intelligence level was stressed. Almost two out of every three patients were known to other social agencies in the community and most of the women in the group had problems in personal relationships, environmental difficulties and mental retardation.

Ross Study (United States) undated

This report by the physician in charge of an unidentified public clinic was concerned with the problem of redirecting the energies of promiscuous young girls who were referred to his clinic during the war years. In a three months period, this physician examined 42 girls who manifested some emotional problem. He found that most of these patients had developed a pattern of delinquent, promiscuous behaviour through which they acted out their hostility to authority of any kind. Their problems included marital maladjustment, unsatisfactory war marriages, poor family relationships, and economic difficulties. Each girl presented a "cluster of problems" common to young girls living away from their family groups during the period of social disorganization that is war-time living. This study pointed up the need for expert counselling and of these girls at the beginning of their promiscuous career, and for more community resources to give them practical help in re-establishing themselves in the community.

Torregrosa Study (Louisville) 1947

A rapid treatment centre at Louisville, Kentucky was the setting for a study project which analyzed the emotional problems that a diagnosis of syphilis created in 44 male patients. The group was almost equally divided between white and negro patients and over half of the patients were single. The majority were employed, and approximately one-quarter of the group were engaged in construction work. More than half of these men stated that their sex partner was either a casual pick-up or a prostitute.

All of the patients interviewed, agreed that they felt better after talking with the social worker and many of them were able to use this service to resolve some of their conflicts. The importance of understanding the individual patient was again emphasized as a necessary preliminary to any kind of effective treatment.

Wesoloske Study (St. Louis) 1947

The study related to 13 patients found to have latent syphilis at the time they were examined at a genereal medical clinic operated by an employees' union. Here the average age was 47, the patients had steady jobs and financial security. They were relatively stable individuals; nine out of the group were married, two were single and two were separated. The majority of these patients had had good family relationships and they reacted favourably to authority. The clinic facilities were excellent and each patient received individual attention from the physicians on the staff. Although all the patients were shocked at a diagnosis of syphilis being made in the course of their routine medical examination, they responded positively to the treatment outlined for them.

Stein Study (New York City) 1942

This thesis study which investigated the medical social problems presented by 20 patients in a syphilis clinic, found that syphilis patients had problems common to all types of patients, and that it was necessary for the social worker in the venereal disease setting to understand the ramifications of many illnesses in order to be able to help the syphilis patient work through his problems. It was felt that the social worker had to be free from personal prejudices and from emotional blocking about venereal disease before she could work successfully with these patients.

Rolison Study (Detroit) 1944

The role of the social worker in a quarantine hospital in Detroit was described in this study. Here the social worker interviewed all patients on admission and again later in their treatment process, to determine what could be done to prevent re-infections among these patients. The study included 681 female patients which the social worker had seen in one year. Over half this number were negroes and most of the patients came within the young adult age-group. Over 20 percent were prostitutes, many of them under the supervision of the courts. A large proportion were frankly promiscuous, without any deep affectional relationships. Most of the girls presented the usual problems basic to delinquent behaviour, such as broken homes, parental rejection, family conflict, lack of moral training, poor housing, marginal incomes, lack of recreational opportunities. Few of the girls had the capacity or the desire to be helped with resolving their underlying problems and only 2 percent would accept referral to other community agencies. Their behaviour was interpreted as an aggressive revolt against authority, and the only hope for them lay in community action to provide facilities to meet their basic needs and in this way to curb their delinquent tendencies.

Malzberg Study (New York State) 1945

In this study the characteristics of 684 patients admitted to the mental hospitals in New York State with a diagnosis of general paresis of the insane,[19] were compared with those of patients admitted during the same period with other mental diseases. The syphilis group was younger than any other group, with an average age of 48.7 years for men and 45.9 for women; urban admissions were higher than from rural areas; and the

[19] The mental disease caused by syphilis.

prevalance was greater among the foreign-born than among the native white population. The number of patients who were divorced or separated was high among the syphilis patients, most of whose histories showed some basic personality disorders before the diagnosis of general paresis was established. There was an inverse ratio between educational attainment and the incidence of this manifestation of syphilis and it was pointed out that this was not necessarily indicative of lack of education but of low economic status which tended to create an attitude of indifference to treatment among these syphilis patients. There was a high correlation between intemperance and general paresis, and it was concluded that certain life habits tend to lead to both alcoholism and the behaviour that results in the acquisition of a venereal infection.

Fessler Study (Great Britain) 1945

This patient-group study was undertaken by a medical practitioner in Great Britain in 1945. He studied 200 patients under treatment at public clinics in three adjacent areas, one industrial, one commercial and the third a seaport. Almost half of these patients were in the young adult age-group (21 - 30), and most of them came from the "working class".[20] Although over 50 percent of the patients were married, casual acquaintances were named as the sex partner in about 30 percent of the men and 20 percent of the women.

The problem of defaulters was considered. Although both male and female patient-groups had about the same defaulter rate, the women

[20] This was the only study that mentioned the low incidence of patients from the "middle class" in the community. It was suggested that such people either sought medical care privately, in which case their records would not be available for study; or they used more prophylactic measures; or they did not acquire an infection because they were more selective in their choice of sex partners.

patients were less responsive to case-holding methods. The promiscuous woman rather than the professional prostitute was named as the chief source of infection. The point was made that case-holding can only be effective if the needs of the individual patients are considered, and the approach made on a "psychologically sound" basis.

In the studies relating to civilian patient-groups, the majority of the patients were unskilled workers. This is to be expected since most of the studies were made at free or part-pay clinics. Nowhere does there seem to be any information about patients under the care of private practitioners, so that it is misleading to consider the findings of these studies as characteristic of venereal disease patients. They are characteristic only of that group of patients whose records are available for study. In British Columbia in 1948, patients reported by private physicians numbered 1992 out of 4534 newly reported cases diagnosed in the province during the year. This means that other than the most meagre statistical information, nothing is known about nearly 45 percent of the venereal disease patients in British Columbia. With regard to the patient-group studies reviewed by the Cooperative Study Committee, there is no information as to what proportion of the venereal disease population in each area was under treatment in the settings described. This must be borne in mind when drawing general conclusions from any of the studies that have been made to date.

STUDIES RELATING TO MILITARY PATIENT-GROUPS

Three studies described the characteristics of military personnel who acquired venereal diseases during World War II. In each of these studies, control groups were used for the purpose of comparison.

Wittkower and Cowan (Great Britain) 1945

This study, undertaken by medical officers in the British Army, was concerned with the psychological aspects of sexual promiscuity, and undertook to answer the following questions: In personality and attitude, do venereal disease patients represent a random sample of the army population? Is there any particular personality type among these patients? What are the motives for promiscuous behaviour? What factors affect the use of prophylactics? Promiscuity was defined as "transient sexual relationship which ends after intercourse". Two hundred venereal disease patients were compared with a control group of patients under treatment for impetigo. Among the venereal disease patients, 59 percent were found to have an immature personality pattern, 30 percent were borderline cases, and only 11 percent were rated as mature. Of the immature group, about half the men were described as being unaggressive; the borderline cases were labelled "latent aggressive personality types"; and only those in the mature group were "controlled" in their behaviour pattern.

In the use of alcohol, 30 percent were heavy drinkers; 68 percent were moderate in the use of alcohol, and 2 percent said they were teetotallers. More than half of this group of patients expressed themselves as being discontented with army life, only 17 percent being keen soldiers. One-third admitted habitual promiscuity, one-third said they were occasionally promiscuous, and the others stated that they had not been promiscuous until they joined the army. Nearly 70 percent said that they did not use any prophylactic measures following exposure, and less than 10 percent stated that they used adequate precautions. Over 50 percent of the men stated that their promiscuous behaviour was precipitated by their unhappiness at being in the army; about 30 percent said that

they were promiscuous when they were drunk; about 20 percent laid the trouble to family worries; and only 2 percent admitted active seduction. The majority of those who were only occasionally promiscuous, said their lapses were caused by some acute emotional disturbance.

Accordingly, this study concluded that venereal disease patients were not representative of army personnel; that among them there was a higher percentage of malcontents, and more heavy drinkers; they were more immature, more promiscuous, and more irresponsible with regard to prophylactics supplied by the army. In the opinion of these medical officers, the promiscuous behaviour of this soldier patient-group was not the result of a mature interest in the sex partner, but an immature attempt to relieve themselves of some acute psychological stress. Like absenteeism and drunkenness, the incidence of venereal disease in the army was considered to be more a matter of "morale than morals".

Watts and Wilson (Canadian Army) 1945

This study analyzed of the personality factors contributing to the acquisition of a venereal disease among Canadian soldiers. Using as "controls", a group of men from the depot personnel office, these Canadian Medical officers found that a significantly larger proportion of the venereal disease patients had personality difficulties. The soldiers in the patient-group were more immature and more unstable than the control group; they were heavier drinkers and duller in intelligence than the soldiers who did not have a venereal disease. The majority of these soldier-patients had had abnormal childhood experiences; many of them gave a history of marital incompatability; and most of them had made an unsatisfactory army adjustment. This study recommended psychiatric help for soldiers whose infection was precipitated by an anxiety neurosis

and expert counselling for those who were temporarily upset by some marital or family crisis. The importance of environmental factors which promote the acquisition of a venereal disease through lowering morale, was emphasized.

Brody Study (U.S. Army Hospital, Italy) World War II

The other military study which the Cooperative Committee reviewed related to American soldiers in an army hospital in Italy. There 200 venereal disease patients, 100 surgical cases, and 50 psychoneurotic patients were analyzed. In contrast to the British and Canadian reports, the results of this study showed that the majority of these venereal disease patients were no different in personality pattern from any other group of normal individuals. The number of venereal disease patients with constitutional psychopathology was no greater than would be found in any hospital ward. There was no correlation between neurotic personality and the acquisition of a venereal disease except in isolated instances. The most distinguishing characteristic of the venereal disease patient was that he was younger than the other members of his group; he was less restrained, more irresponsible and ready to take chances in all areas of his life, and was more easily influenced. He did not make as good an adjustment to any life situation as the ordinary soldier; he was more often drunk or guilty of military misdemeanours. He started his sexual experiences earlier, and sex relations were more important to him than to other men. He was more often solicited than selective in his sex partners, and he did not learn from his experiences. The medical officer making the study found the venereal disease patient was more often mentally healthy because of his positive libidinous nature, than manifesting the inhibitions of the psychoneurotic. In this study venereal disease patients were con-

sidered to be more the concern of the padre or of the sociologist than of the psychiatrist, because these patients were normal men living under abnormal conditions.

STUDIES IN PROMISCUITY

These studies related not to venereal disease patients but to promiscuous people who were referred for medical care by law enforcement officers or other social agencies.

Vecker Study (Chicago) 1932

The first of these studies enquired into the environmental, economic, and social opportunities of 558 women between the ages of 16 and 20 who were referred for examination to the Illinois Social Hygiene League of Chicago in 1932. The majority of these young female patients came from broken homes or from families in which there was much conflict. Many of them had had unsuccessful marriages, and ignorance about sex was characteristic of the group. Most of them had started to work early, in poorly paid jobs, and their social life was limited to commercial recreation.

In this study there was no correlation between low economic status and the acquisition of a venereal infection; rather, promiscuous behaviour was prompted by a desire for male attention. This group of women were considered to be fairly representative of the young American working girl of the period, who was engaged in routine employment of an unskilled nature and receiving wages which were barely enough to cover the girl's basic physical needs.

The role of the social worker in providing skilled counselling based on an understanding of the needs of these girls, was described as helping them solve some of their social and economic problems. At the same time it was urged that more sex-education material suited to the

capacity and interest of these girls be provided.

Lumpkin Study (St. Louis) 1943

In this study, Miss Lumpkin reported on the characteristics of 50 white girls referred to the St. Louis Health Division by law enforcement authorities in 1943. On examination, only 30 percent were found to have an infection. The majority were under 21 years of age, and about one-third of them had higher than eighth grade education. Eighteen out of the group were chronic offenders and of that number, 12 were below average intelligence. Over 40 percent of the girls were unemployed and the others were working in service employment or in factories. There were 12 married women referred to the clinic, and all of them had a history of marital disharmony. Of the 19 single girls who were living with their families, 7 stated that their home life was characterized by severe family discord. Most of the girls lacked the opportunity of normal development and they turned to sexual experiences to give them the attention and excitement they craved. This study pointed out the need for more facilities to protect and shelter these girls when they came to the attention of the law. Mental testing for those who appeared to be mentally defective was recommended, since this kind of handicapped girl does not respond to the usual rehabilitative efforts. For those who were capable of gaining insight into the root causes of their difficulties, it was suggested that the social worker could be helpful to these patients in re-establishing themselves in the community.

Hironimus Study (Washington, D.C.) 1943

In this project, 100 May Act violators in a federal reformatory for women were studied. Most of these women were in their late teens or early twenties; their average I.Q. was 67; and only eight had reached high

school level. Thirty-one of the girls had had illegitimate children, and of the 53 who were married, 13 were either separated or divorced. Although 64 of the prisoners had been previously known to the authorities, their crimes were relatively minor and only a small proportion of the girls were described as chronic offenders. Most of these women came from rural families. Forty-three out of the 100 gave a history of disrupted family living, delinquent behaviour, alcoholism, neglect and cruelty in their experiences. Over 50 percent of the group drank to excess, and only 9 were abstainers. There was a correlation between alcoholism and sexual promiscuity which developed after the age of 30. The report indicated that these girls got into difficulties in urban settings because they were not equipped emotionally or otherwise to withstand the confusion of war-time living in the city with its excitement of soldiers, taverns, freedom from the life of drudgery from which they had come, and plentiful war jobs paying good money for easy work.

San Francisco Psychiatric Studies - 1943-1947

This material was published under the joint auspices of the San Francisco Department of Public Health, the California State Health Department, and the U.S. Public Health Service, and enquired into the causative factors of promiscuity. Promiscuity was defined as follows: For a married woman - extra-marital relations within six months preceding her referral to the clinic; for a single woman - relations with more than one man in the preceding six months, or relations with one man more than twice in the same period. A distinction was made between the habitually promiscuous, the potentially promiscuous, and those who were not promiscuous.

Patients were referred to the clinic from various sources, including social agencies, other community groups, and friends and relat-

ives of the patients. The examining team consisted of a psychiatrist, social workers and a psychologist. The first report describing these experiments in psychiatric treatment of promiscuous girls was published in 1945, and in 1948 a further report covering the entire four year period and including 235 male and 365 female patients was published under the title of A Psychiatric Approach to the Problem of Promiscuity.

In the total group, the predominant age was between 18 and 23, and white patients outnumbered negro and other racial groups about four to one. There were many more married women than there were married male patients, the proportion being about seven to two. Sixty percent of the patient-group came from broken homes or had a history of marital or familial conflict. About one-third of the men were living as part of a family group while only one-sixth of the female patients had this security. More women than men had been in difficulties with the authorities, although over half the total group had had some previous criminal record. In educational achievement, the group compared favourably with the national average of grade 10 schooling, and in intelligence, for white male patients the median I.Q. was 102, and for females 95, while for the negro group the comparable ratings were 84 for men and 86 for women. Most of the men were engaged in skilled or unskilled occupations while 60 percent of the women were either in war industry or in service employment. The other women were classified as unemployed.

With regard to sex experiences, two-thirds of the women and three-quarters of the men admitted that they had had sex experience before they were 18. With the women who had voluntary premarital intercourse, most of them stated that their experience was an unsatisfactory one. With many of these patients, their knowledge of sex was inadequate and

unscientific.

Seventy-six percent of the men and 57 percent of the women were so classified as being habitually promiscuous. Women tended to begin sex relations later than men; the men had twice as many sex partners as the women patients; and there was more homosexuality and sexual perversion among the men. For the men, their first experience was with pick-ups, prostitutes or casual acquaintances; the women gave friends as their early contacts. In terms of motivation of promiscuity, there were few differences between the male and female patients, the root cause for both sexes seeming to be personality difficulties and active conflicts. Among the men, an important factor was the separation of sex and love relationships.

Out of the total group, two-thirds of the women and one-half of the men took advantage of the psychiatric service available to them at the clinic; many of them gained real insight into their difficulties and no longer needed to behave in a promiscuous way. The studies pointed out that while no single factor or even group of factors determine whether or not a person will be promiscuous, but there appears to be a direct relationship between promiscuous behaviour and early unsatisfactory family and interpersonal relationships. Promiscuity was described as "symptomatic behaviour" arising out of neurotic conflict, with environmental factors a contributing rather than a "primary cause of any case of habitual promiscuity". It was pointed out that psychiatric referral could only be made of selected patients who were prepared to accept such service voluntarily. However, the necessity of having psychiatric help available for disturbed patients as part of a venereal disease control programme was emphasized.

In terms of the kind of people who acquire a venereal disease, the findings of these studies are fairly comparable to the repeater study.

The same psychological factors are present - emotional immaturity, poor family relationships, retarded personality development, social insecurity - and for most of these people, promiscuous behaviour is symptomatic of more basic disorders.

CHAPTER 5

SOCIAL TREATMENT - THE INDIVIDUAL APPROACH

Because the venereal diseases are spread through intimate contact with an infected person, it is the diseased individual who holds the key to control. On him depends the effectiveness of the control programme as far as case-finding is concerned, since the tracing of contacts is only as complete as the information that is given by the infected person. Similarly adequacy of treatment follow-up is dependent on the cooperation of the person receiving the treatment. Thus, case-finding and case-holding, which along with improved medical care are the chief weapons in the fight against venereal disease, are ineffective unless the patient is an ally. His cooperation cannot be legislated, it can only be enlisted, and the patient as a point of control has been too long ignored by those responsible for planning venereal disease campaigns.

At the Vancouver Clinic, beginning in 1949 the treatment procedure was extended to include an interview with a social worker for all patients coming to the clinic. This was begun as a study project when 150 consecutive newly diagnosed patients between 15 and 25 were interviewed by the Social Service Section, as a means of filling in some of the gaps in the clinic's knowledge about the kind of people who were being treated. In the course of this study, the socially oriented interview proved to be so effective in gaining the cooperation of the patients, that it was continued on a routine basis for all newly diagnosed patients. This 1949 project demonstrated how many of these patients had comcommitant non-medical problems that were hindering response to medical care. Some of these people were disabled by external pressures which could be relieved

by referral to other agency resources in the community; with some of them the pressures were internal resulting from the patient's confused feelings about himself and his infection, and these could often be released through the skilled counselling service of a medically trained social case worker.

Although the final results of this study have not yet been published, statistical information a bout recidivism in this group of patients was made available. Out of 97 men and 53 women included in the study, 37 men and 20 women had been previously infected, which gave a repeater rate of 38 percent with the male and female groups showing about the same proportion of r epeaters. This was slightly higher than the 1948 repeater rate but it was based not on total new admissions, but on a selected group, namely those between 15 and 25 years of age. The general picture to be seen from this 1949 study showed the same kind of personality disorganization that was indicated in the repeater patients of 1948 - broken homes, unhappy family relationships, poor marital adjustment, unsatisfactory work records - with sexual promiscuity just one of a number of anti-social activities.

In terms of reducing recidivism, what was significant was that in the year following the 1949 study, only 13 out of the 150 again repeated their infection. Of the four male repeaters who did repeat, one had been infected prior to the study, two had acquired new infections twice and one had been reinfected three times since the study. Of the nine female repeaters, six had been repeaters before 1949 and the other three had been reinfected once since then. In percentages, in the year since these 150 patients had passed through the Social Service screen, only 4.1 percent of the men and 16.9 percent of the women had acquired new infections. In view of the former rate of 38 percent, progress had been made.

For too long, treatment for a venereal disease had been an impersonal experience. From the time the patient was admitted to the clinic, he was a number on a piece of paper which he clutched in his hand. Originally the purpose of this was to protect the identity of the patient, but it made the clinic routine a mechanical procedure. Then as the volume of patients grew, the medical examination and epidemiological interview were conducted on an assembly-line basis, which made it possible for a patient to go through the whole experience without it having any personal effect on him. Ideally, the personal counselling that should accompany any kind of medical treatment would be given by the doctor making the diagnosis. However, in a busy public clinic this ideal is difficult to attain. The public health nurse might be expected to take over this function, but her interview with the patient has a specific purpose - to get accurate and adequate information from the patient about his sex partners so that these potential public health problems in the community can be located and examined, and to obtain particulars as to how the patient himself can be reached in the event that he lapses from treatment or surveillance. This interview is important from the public health point-of-view and the nurse cannot extend her discussion with the patient to deal with his personal troubles.

Because the main focus of the social worker in the clinic setting is the patient as a functioning social being, the job of getting to know the patient as a person is this worker's unique contribution to the treatment process. The purpose of the case work interview is to explore the personality pattern of the patient in order to determine his specific needs and to gauge his strengths. In the exploration process the patient is helped to see himself more clearly, first in relation to his venereal

disease and then in terms of his life pattern. In this way he is better able to sort out his problems and to mobilize his resources to meet them. This kind of social treatment then becomes a constructive part of the total treatment process and the whole experience takes on more meaning for the person who is a patient.

Because the aim of the case-worker is to establish a positive relationship with the patient, the interviews are conducted on a friendly informal basis. They are not stereotyped but start from the point where the patient is; throughout the discussion, the patient and his needs are kept in sharp focus. From the worker, the patient experiences warmth and understanding and acceptance of him as he is, with all his problems. For many of these people, this kind of acceptance is a new experience in personal relationships which in itself has therapeutic value. Because the case worker respects the patient as a person with certain rights and responsibilities for determining his own behaviour, she is able to help him clarify his thinking and feeling about his situation so that his energies can be redirected toward solving his problems instead of running away from them. The goal of this part of the total treatment for a venereal disease is to help the infected person find a new way of living that will be more satisfying to him and less likely to increase the problem of controlling venereal diseases.

By utilizing her diagnostic skills, the worker is able to shape the case work service to the needs and the capacity of the individual patient. For the person who is fairly well integrated, the interview with the social worker is primarily a frank discussion of the medical aspects of his infection. Diagramatic material showing the anatomical structure of males and females is used to help the patient formulate any questions

he may have about his condition or about the venereal diseases in general, and these questions are answered in simple terms that have meaning to him. For more specific medical information, the patient can be referred back to the medical consultant. In discussing the patient's infection, its public health significance is emphasized by the case worker and the patient is made aware of the important role he must play if the control programme is to be effective. The purpose of the contact history is stressed and the patient is reminded that since he is the only person who has full knowledge of his sex contacts, he is in a key position to help reduce the residue of undetected untreated venereal infection in the community. After these points have been covered, the interview is usually directed toward a general discussion of the patient's life to date and of his plans for the future and of how they can be jeapordized by the kind of irresponsible behaviour which has resulted in the acquisition of a venereal disease. In most cases this kind of specific counselling enables the patient to face up to his responsibilities and eventually to effect a real change in his pattern of behaviour. Such patients have the capacity to change and the will to do so. Insight comes quickly and for them the whole e xperience of coming to the clinic has been made a positive one.

For the patient who is emotionally disturbed about his infection but who is not seriously disorganized, the case work interview can again be helpful by serving to drain off some of the patient's anxieties. Sometimes with these people, the acquisition of a venereal disease has made them feel defiled; it has been a blow to their self-confidence, and the unreserved acceptance of them and their infection by the worker is reassuring to them. By means of a simple non-technical explanation of what has happened to the patient's body as a result of the disease, some of

groundless fears may be allayed. Having shared his burden, the patient can cope with it more effectively; having found support, he is more able to stand alone. With these emotionally involved patients, the case work service may have to be continued beyond the initial interview. Then the patient is seen each time he comes to the clinic, his progress is reviewed with him, and the worker's reassurances are repeated. As soon as the patient no longer needs this kind of moral support, the relationship is discontinued.

With patients whose venereal infection is symptomatic of a more serious personality disorder, the main purpose of the case work interview is to detect the problem for psychiatric referral. A full social history is prepared for the consultant psychiatrist before he examines the patient. Sometimes this part of the diagnostic process serves as a preliminary sorting out and is helpful to the patient. On a highly selective basis depending on the psychiatric diagnosis, short-term psychotherapy may be instituted for some of these patients as part of the medical treatment provided by the Division. Other patients may be carried on a case work basis by the Social Service Section, under the direction of the psychiatric consultant. With most of these patients the only kind of service which they can utilize is a supportive relationship with the worker until they are over the crisis of their venereal infection. Sometimes it is possible to refer patients to outside psychiatric services for a more continuing kind of help, but adequate community resources are woefully lacking. With these seriously disturbed patients, their venereal condition is a relatively minor part of a much bigger problem and treatment for the specific disease has little meaning for them. These are the chronic repeaters. They are incapable of learning from experience; they

have difficulty in establishing a meaningful relationship even on a supportive basis; and their prognosis from the point of view of venereal disease control is poor. However, with patience and persistence it is sometimes possible to gain the confidence of these people so that they will cooperate in treatment. This has been shown by the public health nurse who is in charge of the Examination Centre at the City Gaol. Over the years she has established herself as the trusted friend of that group of problem patients who are periodically caught in the police net. She has been able to communicate her professional concern to them in such a way that they feel they are important to her not only as patients but as people. She is firm with them in insisting that they cooperate in treatment and she is not afraid to use the legal authority provided in the Venereal Disease Act when necessary, but this does not affect her status with these people. Indeed it seems to give them a certain security to know that this worker always keeps her promises, for good or ill. In the three years that the Examination Centre has been in operation, there has been a steady growth of personal responsibility in this anti-social group, and more and more of them are coming to the Examination Centre on a voluntary basis and requesting an examination in order to be sure they have not become reinfected. This is the ultimate in effective venereal disease epidemiology, because these people are irresponsible in almost every other area of their lives.

In terms of the problem of controlling the infected individual, at the Vancouver Clinic it has been demonstrated that case work services can make the treatment process more meaningful to the patient by giving him some insight into the relationship between his difficulties and his behaviour. In this way each patient is helped to cooperate to the limit

of his capacity in the programme of control. This individualized approach can reduce recidivism among those who are capable of assuming responsibility for their behaviour and for those who cannot or do not want to change their pattern of living, it can improve their attitude to treatment. While recidivism among these chronic patients may not be materially reduced, they can become less of a public health problem when they will cooperate in treatment.

Case work services have been utilized in venereal disease programmes in various parts of the United States, notably in San Francisco, Baltimore, St. Louis, and Washington, D.C. However, the Vancouver Clinic set-up is the only one of its kind in Canada at the present time.

From all the studies that have been made of the kind of people who have become venereal disease patients, it is obvious that the infection is a relatively minor problem in a life situation that is fraught with difficulties. Their venereal condition is the one ailment for which there is a cure. However, treatment for this specific disorder will affect little real change in the lives of these people unless there are strengths within the personality structure of the individual which can be developed in the course of the treatment process. The venereal diseases could be eradicated by medical science,[21] and yet the life situation of most of these people would be improved very little. Their problems are bigger than the invasion of their bodies by the gonococcus or the spirchaete. Their difficulties stem from early deprivations which prevented the normal

[21]This a real medical possibility, according to Dr. John R. Stokes, world authority in venereology, in his address to the Vancouver Medical Society on May 10, 1949.

healthy development of the personality of these individuals. They are crippled people that cannot withstand the social, the economic, the emotional pressures of their everyday lives, because their fundamental needs - to be loved, to belong, to achieve, to have status in the community - have never been met. That is why they are problems to society. On a world-planning level, a Declaration of Human Rights has been proclaimed:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family including food, clothing, housing and medical care and necessary social services, and the right to security in the face of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."[22]

We could begin closer home if we considered how many of our venereal disease patients are being deprived of these human rights.

Unsavoury community conditions are allowed to exist in a city like Vancouver where the resources to deal with these reservoirs of social infection are infinite. Money can be raised to undertake any project that is backed by the will of the citizens. Why is the "Square-Mile of Vice", the "Skidroad", the Zone 1 in the 1948 Repeater Study permitted? Time and again the authorities have been made aware of this public menace, but nothing been done to eradicate it - because the citizens of Vancouver have not demanded action. The community should not be lulled into a false sense of security because the venereal disease rates are declining. This only means that improved medical care is reducing the infectiousness of these diseases, and better case-finding is locating new infections before they have had a chance to spread.

Problem children are bred by problem parents, and it is the

[22]Article 25-1, The Universal Declaration of Human Rights.

adults who need the help in comming to a better adjustment with the world in which they live. Until the needs of the parent group can be met, the children are going to suffer. Many of these adults need practice in positive human relationships, and this could come if the communities returned to the old "neighbourhood" type of organization where everyone worked and played together. This is belonging, this is how status can be achieved, this is how responsible behaviour can be developed.

Parents need to understand the growth processes of the children whose lives they are shaping, and this calls for an expansion of our mental hygiene facilities. The experts have a fund of knowledge that should be imparted to the people who are doing the job - namely the parents of young children - and this instruction could be integrated into the neighbourhood activities in such a way as to make the learning process a positive experience for the whole group. For those with special problems, the community resources should include a skilled counselling service.

How can children grow up into healthy, well-adjusted citizens when they have never known the security of a happy family relationship? Lip-service is given to the family as the basic unit in our society, and yet on every hand we see the evidence of family disintegration - ill-considered marriages, unhappy divorces, chronic disharmony - and in its wake a rising tide of juvenile delinquency. It is the social confusion of our era which needs treatment - not the venereal diseases. They are incidental to this much graver problem in human relationships that is not being faced today.

APPENDICES

APPENDIX A

TABULATION OF REPEATER AND NON-REPEATER GROUPS

VANCOUVER CLINIC

Factors	Male		Female	
	Repeaters (215 patients)	Non-Repeaters (50 patients)	Repeaters (130 patients)	Non-Repeaters (50 patients)
Age Group				
15 to 19	5	4	18	6
20 to 29	136	29	91	34
30 to 49	69	13	19	9
50 and over	5	4	2	1
Origin and Birth-Place				
Canadian-Born:				
British	101	29	54	24
European	22	9	21	9
Oriental	3	1		
Indian	15		24	2
Negro	6		3	
Other	7	2	2	
Foreign-Born:	24	9		5
Not Stated	37		26	10
Family Status				
Single (Unattached)	128	21	54	11
Single (Attached)	32	14	3	12
Separated	14	1	35	6
Divorced	5	2	8	1
Widowed			5	2
Married	30	12	19	17
Common-Law	6		6	1
Residence				
Zone 1	71	10	68	7
Zone 2	34	4	28	10
Zone 3	46	24	20	24
Zone 4	64	12	14	9

Factors	Male		Female	
	Repeaters (215 patients)	Non-Repeaters (50 patients)	Repeaters (130 patients)	Non-Repeaters (50 patients)
Occupation				
Unskilled	137	14	54	19
Skilled	27	15	2	2
Clerical	5	10	2	8
Seaman	26	6		
House-wives			54	18
Unemployed	20	5	18	3
Type of Contact				
Marital	12	1	18	12
Friend	15	1	20	9
Casual Friend	50	6	18	14
Pick-Up	117	23	74	7
Prostitute	21	3		
No Information		16		8
Other Problems				
Alcohol	117	19	81	10
Police Record	30		81	1
Drugs	1		5	
Homosexuality	3	1		
Illegitimacy	3		40	2
Prostitution			40	1

APPENDIX B

RESIDENCE ZONES - VANCOUVER

Zone	Boundaries
Zone 1	West from Dunlevy Avenue to Cambie Street South from Burrard Inlet to C.N.R. Station
Zone 2	West from Cambie Street to English Bay South from Burrard Inlet to Fraser River and East from Dunlevy Avenue to Commercial Drive
Zone 3	Residential Areas in Remainder of City
Zone 4	Outside City of Vancouver

APPENDIX C

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