PSYCHIATRIC IMPLICATIONS OF VENEREAL DISEASE : AN AMERICAN SURVEY

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For the psychiatrist to deal with venereal infections may at first appear incongruous, because the field is contested mostly by bacteriologists, public health specialists, social hygienists, or even, with the introduction of sulpha drugs and penicillin, the biochemists. Most control methods have emanated from them or from the legal repression of vice or prostitution. So far little has been attempted to unravel the psychological motivations of sexual behaviour leading to venereal infection, while other factors responsible for the spread of venereal diseases have been studied and discussed for many years ; among these have been ignorance, poverty, family disorganization, economic or moral dislocations following wars or social crises, delinquency, and many others. Moralists or the religiously inclined have righteously considered venereal infection as the fitting retribution of God or Nature against those who wilfully transgress their "commands" outside of marriage.

The problem is not simple. It touches on problems of self-restraint and social responsibility in general, and therefore easily leads to considerations on personal freedom, the rights and the limits of the individual, or that of the State to control one of mankind's basic drives : that of sexual expression.

Psychopathological Implications of Venereal Disease

It is therefore essential to delineate the psychopathological implications of venereal diseases. The problem is caused, in our opinion, by the splitting of the physical aspects of sexuality from the emotional, affective life of the individual. As long as this dichotomy is not recognized no completely successful programme of venereal control can be carried out. Our basic premise, therefore, is that the venereal patient is not merely an individual suffering from a gonorrhœal discharge, a syphilitic chancre, or an inguinal bubo, but that he is someone representing the end product of a particular psycho-sexual development which leads him to use sexual intercourse for emotional reasons totally foreign, in the majority of cases, to adult, mature, genital union. It is only in this sense that the field of

venereal diseases can become part of a broader study which we shall call psychosomatic, in deference to current medical concepts and terminologies.

The difficulties encountered in such a study are many. Little psychiatric literature has been devoted to the subject, but questions of sex are apt to raise problems of morality, ethics, philosophy, religion, prejudice, and the place of woman in our culture.

The Layman's Attitude

Let us first consider the peculiar attitude of the layman to venereal diseases. Although, properly speaking, all infectious diseases are venereal, it occurs to few to think of syphilis or gonorrhœa in the same terms as measles or tuberculosis. The former belong to an odious class of their own, not because of the lesions they cause, perhaps not even because of the organs they affect, but because the mode of contamination implies "illicit" sexual activity, infraction of the moral code, and an insuperable social stigma.

Anthropological and Social Studies

Anthropological and social studies seem to indicate that the dread of venereal disease is a cultural acquisition, subject to variations in different socio-cultural settings. Although mention of venereal disease commonly elicits a feeling of horror or disgust, there are groups, such as the Mohave Indians (Devereux), who either view venereal diseases like any other disease, or even equate them with sexual maturity, without which the latter cannot be adequately established. Such views are, however, the exception, and the emphasis on avoidance and fear is shown in the widespread phobias encountered in psychiatric practice in connexion with either lues or gonorrhœa. Interpretation of these fears often reveals that they represent affective displacements of other origin. For Fenichel and others, syphilophobia constitutes a "rationalization of unreal dangers connected with sexual activity, which on a deep, unconscious level, may represent disguised sado-masochistic wishes, for it is equally possible to be infected by other persons and to infect

them." These peculiar psychological disturbances occur either singly or in combination with other anxiety equivalents. They deserve more than passing comment because they drive many of these patients to consult venereal disease clinics or private physicians continually for their non-existent venereal infection. Worse even, such people fall prey to quacks and charlatans, and waste, sometimes for years, their whole energy or income in a vain search for reassurance and relief. The psychodynamic forces at play in these distressing symptoms constitute the subject matter of a separate study.

These general attitudes explain the strongly coloured psychological reactions which accompany the acquisition of venereal diseases. Syphilis, of course, remains on the whole more dreaded than gonorrhœa, for it still carries for many the threat of incurability or life-long treatment, even with the newer modern therapies. In general, however, the patterns of emotion encountered in many patients at the time they contract their infection bear no relation to the type of the disease. One of the common patterns is an attitude of disbelief and incredulity, often rooted in very childish concepts of sexual physiology, hygiene, or venereal prophylaxis. In this respect it is of interest to find that in a group of two hundred venereally infected soldiers observed by Wittkower and Cowan (1944) only 9.5 per cent. had used adequate prophylaxis while 68.5 per cent. had not, for the following assortment of reasons: (1) condom regarded as unnecessary, 56 per cent. (she was my mistress; she looked respectable; she was well educated; she had a horror of venereal diseases; she said she was clean; other men in the unit had been with her and were all right; I have always been lucky; I had been with her before); (2) condom rejected because it impaired pleasure, 17 per cent.; (3) condom not available, 10 per cent.; (4) condom not used because of drunkenness, 13 per cent.; (5) condom regarded as contraceptive and not prophylactic, 2 per cent.

In a group of promiscuous girls studied in San Francisco (Lyon and others, 1945), no direct mention is made of the use of prophylactics. That contraceptive precautions were, to say the least, skimpy, is reflected by the large number of girls who had illegitimate pregnancies. Similarly Glueck and Glueck (1934), in a study of five hundred delinquent women, observed: "That our girls did not protect themselves from venereal diseases is obvious from the fact that at least 67.8 per cent. had contracted gonorrhœa or syphilis or both at one time or another before the age of 21, not counting the high proportion of illegitimate pregnancy before commitment to the reformatory." Even without indulging in psychoanalytic speculations, it is difficult to

read in these figures merely negligence, carelessness, or ignorance. A definite pattern emerges with immature beliefs in the magic of wishful thinking, "It cannot happen to me," by which reality situations are ignored and wilfully "wished away." Furthermore, improper application of prophylactic measures sheds considerable light on unconsciously motivated self-punitive tendencies, which we will find later and which are frequently revealed in the behaviour of venereal patients. We know that women who unconsciously want a child tend "accidentally" to become careless in their contraceptive technique, and a similar form of "negligence" is often encountered in venereal cases.

Because of ignorance, fear, and misinformation, and perhaps because venereal diseases affect those very organs whose over-evaluation has been pivotal in their life, many patients will learn of their misfortune and react to it by more or less severe, depressive episodes of variable duration, some of which may culminate in suicide, a far from infrequent issue. Others, after more or less serious periods of shame and guilt, will resort to extreme solutions such as voluntary castration, surgical sterilization, sometimes even self-mutilation and other methods of "atonement." Few objective studies have been available on this subject. In the only specific reference found in the San Francisco report on promiscuous girls it is stated that "Their reactions were similar to each patient's response to other situations involving loss of security and status. Those patients who habitually allocated responsibilities for their behaviour to others tended to be belligerent towards men who infected them and towards the clinic personnel. This group frequently lapsed in their treatment. The few patients who had been treated previously for venereal disease had less emotional reaction than those infected for the first time, and in a few instances they were indifferent to their infections. Most patients, however, expressed concern and frequently considered themselves 'unclean.' Concern that their parents or relatives would learn of the infection was great. Fear of being recognized in the clinic by acquaintances or of 'being found out' by employers, friends, or husbands was prevalent. A few expressed fear of becoming sterile. The feeling of having let themselves down and being punished for their promiscuous behaviour by becoming infected was also present with many patients."

Unconscious Masochistic Wishes

Even for the non-analytically-oriented psychiatrist, it is difficult to find a more fruitful territory for the exploration of unconscious masochistic wishes than in the exposure to venereal disease and the

psychological reactions to venereal infection. This is particularly true of those patients with whom every venereal clinic is familiar, who repeatedly contract venereal disease despite all indoctrination, previous experience, or pain, in a monotonously repetitive manner. No less interesting a field of study awaits those who would evaluate the psychological reaction of patients with advanced venereal disease. By this we mean those victims of chronic gonorrhoeal discharge with or without genito-urinary complications, such as chronic prostatitis or salpingitis, with or without sterility, urethral stricture, etc., or those late cases of syphilis when the disease does not affect mental functioning, but reveals itself in middle age abruptly by a spontaneous fracture or another unexpected manifestation of tabes or tertiary syphilis. Lymphogranuloma inguinale with rectal stenosis is another instance where deep psychological trauma is caused both by the abnormal sexual activity and its social stigmatization or the dreaded invalidism of colostomy. At the present time little is known in psychiatric terms of these late penalties which mar a life at its decline and certainly account, at least in part, for a good proportion of divorces, broken homes, and suicides after the age of 40. The peculiar psychological phenomenon of "denial of venereal disease" in advanced paretics has been studied by Hollos and Ferenczi (1932), but it could probably be found also in other stages of this disease. Similar considerations apply to those who do not deny their venereal disease, but boastfully acknowledge their infection to partners or acquaintances as if to convince themselves or others of their sexual prowess.

For practical purposes and because of their social implications the attitudes of revenge and "getting even" found in so many patients deserve critical attention. These hostile, aggressive tendencies are not caused by the disease itself, but may erupt under various forms at the time of the discovery of the infection. For some, retaliation will take the form of refusal to disclose the whereabouts of the infecting partner, who will then continue to evade treatment and therefore contaminate others, or suffer the ill effects of untreated infection. For others, homicidal assault on the partner will sometimes result from a pent-up resentment which, in paranoid cases, not infrequently victimizes innocent acquaintances. Still others will deliberately expose uninfected partners, applying the law of retaliation in its sadistic inhumanity or, as Vonderlehr and Heller (1946) point out, select young girls or virgins for intercourse, in the superstitious belief that this practice will cure them. "There are enough infections resulting from this vicious action to warrant recognition of the problem involved."

Young Victims

From a psychological standpoint, one of the most tragic effects is the one found in the young adolescent of either sex, not necessarily promiscuous, whose entire existence can be blighted emotionally by early exposure to venereal disease, particularly if contracted on the occasion of a first intercourse or even on a wedding trip. No one can ascertain how much personal unhappiness and anguish can result from such an experience, for, as Professor Clark of Harvard (1947) emphasizes,* "Venereal diseases are particularly youth ailments. More than half of the reported new cases, close to 60 per cent., occurred in age groups from 15 to 25." These figures deserve earnest thought since they reflect that it is precisely among the age groups who are not permitted sexual expression and whose instinctual life is socially most restricted in our culture that the majority of infections will occur.

Attitude toward Treatment

Attitudes concerning treatment are not without psychological import. Some patients will rather avoid any therapy at the risk of serious disability, or will seek help from non-professional sources, with all the possibilities of exploitation that this implies. Commonly patients consult one physician after another, never satisfied with the treatment that they receive, or otherwise interrupt it with or without provocation on the slightest pretext. This "will to fail" is astonishingly prevalent among all classes of society and often renders follow-up studies extremely difficult.

Factors Leading to Exposure

Thus far we have discussed the emotional impact with which the venereal patient meets his infection. We now propose to establish the various factors which lead him to acquire the disease. These may be grouped under the following headings: first, an analysis of the commonplace reasons usually advanced to explain exposure to venereal disease; secondly, a description and dynamic interpretation of the personality characteristics and family background of these patients; and finally, an evaluation of the unconscious motivations which lead to sexual promiscuity and its unwelcome consequences.

Promiscuity.—Among the main causes of the spread of venereal diseases, sexual promiscuity holds a major rank. In an excellent paper two British medical officers, Wittkower and Cowan (1944), designate sexual promiscuity as a "transient sexual relationship which ends after intercourse and includes, of course, relations on a commercial basis." They differentiate this from extra-marital inter-

* "About V.D.: We know too much that isn't so."

course, which includes all types of sexual commerce outside of marriage, from the semi-permanent liaison (the mistress or girl friend) to promiscuity in the strict sense. In line with our previous dichotomy, it would seem that their definition could be narrowed still further by emphasizing the purely physical aspects as well as the transiency.

The first question which comes to mind is therefore whether certain individuals are more prone to sexual excesses by virtue of temperament, race, biological needs, or other individual characteristics that differentiate them from the non-infected portion of the population. Without entering into a discussion as to what constitutes sexual normality in its physiological aspects, it seems proved that by and large there is no variability of sexual promiscuity along racial, anthropological, or social lines due to any of these factors *alone*. Frequency of sexual intercourse seems therefore to be culturally, not biologically, determined.

If we look for an explanation of sexual promiscuity in some obscure but overpowering search for pleasure of a sensuous nature we are equally disappointed. In one of the most complete studies of this kind undertaken anywhere, a group of San Francisco psychiatrists, psychologists, and social workers (Lyon and others, 1945) analyzed the usual reactions to intercourse of 254 female patients as follows: pleasant 39 per cent.; mixed feelings 35 per cent.; unpleasant 13 per cent.; indifferent 13 per cent.; making a gross average of about two only out of five women to experience sexual pleasure. Frigidity and promiscuity are therefore far from mutually exclusive and in fact are often related. Prostitutes, who form the largest reservoir of venereal diseases, are notoriously frigid. It is of course more difficult to evaluate the qualitative variations of masculine orgasm, but anyone familiar by professional experience with intemperate venery in men can attest to the validity of the old adage: "The flesh is sad after coitus." Many promiscuous males suffer from premature ejaculation and endlessly pursue their amorous affairs in a vain hope of finding full sexual pleasure. We may therefore conclude tentatively that sexual promiscuity and its infectious consequences have other sources besides some vaguely hormonal pressure or the erotic gratification it provides.

Is the venereal patient less intelligent than his "normal" counterpart in the population, and therefore more prone to expose himself to infection? Statistical studies do not bear out this point conclusively. In Wittkower's group of soldiers the intelligence distribution showed only a slight bias towards the lower grades, "insufficient to affect the general conclusions." Similarly only 20 per cent.

of Watts and Wilsons' (1945) Canadian soldiers venereally infected were found to be mentally dull. In the San Francisco group the median I.Q. of 283 promiscuous girls was 95 (although only 86 for 71 negro patients), in those studied by appropriate I.Q. tests.

Alcohol.—The relation between alcohol and sexual over-indulgence has been the object of caustic comment since the beginning of time on the part of poets, novelists, moralists, and other critics of human frailties. There is little doubt that alcoholism plays some part as a precipitating factor in exposure to venereal diseases, but it is difficult to say exactly to what extent, because alcoholism has psychiatric roots of its own.

In the San Francisco group alcohol is not listed as one of the contributing factors in female promiscuity, except that "The major recreational activities of the group as a whole were frequenting bars and public dances." Greater access to intoxicating beverages, lowering of social barriers to public drinking for women, competition with men in this, as in other spheres, undoubtedly play a part in female promiscuity and therefore in the spread of venereal disease. Previously held opinions (Abrahams) to the effect that a woman's psychological development drives her far less than man to turn to alcohol because it removes the effect of repression and therefore makes her less attractive, seem today outmoded. Statistical studies have shown a considerable increase in alcoholic consumption in both sexes from the high-school age upwards. Alcoholism and promiscuity are bound together only by the common denominator of individual or social neurosis, from which they may stem either singly or in combination. It is only in this light that sexual indulgence and drinking are relevant to the problem of psychiatric determinants of venereal disease.

Socio-Economic Factors

The socio-economic status of venereal patients has frequently been taken into account as a factor in the spread of the diseases, as well as in large-scale prophylactic measures to eradicate them as a social menace. This is not to say that the gonococcus or the spirochæte respect the upper classes. But a word of caution is in order, for the majority of statistics published by public health authorities emanate from venereal disease centres with a clientèle whose income (or lack of it) makes it liable to public care, while the economically better favoured patients seek private treatment, or, like some of the others, do not seek it at all. This, of course, is particularly true in those States where venereal diseases are not reportable. Any study on venereal disease control emphasizes the enormous reservoir of infected

individuals who, for various reasons including the social stigma involved, completely evade treatment or detection, and therefore represent a living culture medium perpetuating the disease and remaining beyond the reach of the public health officials, the venereologist, or the general practitioner.

In 304 female venereal patients, Rachlin (1944) found that less than 10 per cent. were unemployed, about 10 per cent. were housewives, and only three patients were prostitutes. Thus the great majority were gainfully employed; and even if we discount the considerable rise in female employment during the war years, when this study was made, the economic usefulness of the great majority of these infected women seems out of line with the old dictum that "idleness is mother of all vices." In the San Francisco group 40 per cent. approximately were unemployed, and because of the irregularity of employment the income of about 90 per cent. of the promiscuous patients was less than \$1,500.00 a year. The economic factor is, of negligible importance in promiscuity, however, because many promiscuous girls use their "employment" as situations in which to make the acquaintance of men easily and quickly. This was true especially of those who were "waitresses, usherettes, photo girls in concessions* or taxi dancers." Similarly Brody (1947) comments that the promiscuous man, because of "his libidinous ways" is readily solicited by these women, to whom he drifts spontaneously because of their ready access.

Personality.—This rapid survey indicates that the commonly blamed extrinsic factors affect sexual promiscuity only in a relatively minor way. From a psychological point of view we seem to approach the problem a little closer when we focus our attention on the personality of the infected individual himself instead of the society in which he circulates. By personality we designate, as Healy does, a system of habitual adjustments to the environment exhibited by attitudes, characteristics, and behaviour tendencies more or less specific for the individual. At once, however, it must be stated that no outstanding "promiscuous personality" exists which can cover the innumerable variations found in each patient.

In his group of 200 soldiers, Wittkower describes 59 per cent. as immature, 30 per cent. as borderline, and only 11 per cent. as mature types, and, for the sake of convenience, breaks his figures down to 28 per cent. unaggressive and dependent (immature), 30 per cent. as latent aggressive (borderline), and only 11 per cent. as controlled aggressives (mature) against 62 per cent. in the control series. These distinctions in terms of aggressive tendencies are of

major value in determining not only the motivations of sexual promiscuity, as we shall see, but also the individual psychological reactions of these patients to the acquisition of venereal disease, and their willingness to protect themselves from further exposure or to assume treatment responsibilities. The personality characteristics of the San Francisco group of promiscuous girls was assessed by psychiatric observation and in some cases by Rorschach studies as well. No homogeneous conclusions could be reached, but certain findings stood out prominently. Noteworthy among these were "the uneven development in the areas of physical, intellectual, emotional, and social maturity. For example, some patients had matured physically and intellectually, but were retarded in emotional and social areas. Assumption of self direction was usually in advance of emotional maturity. The patients tended to assume adult role during middle or late adolescence. As a group they separated themselves from their families during their adolescent years in terms of physical removal rather than emotional emancipation. Limited discrimination in selecting friends, in securing employment, and in making other choices was characteristic. Immaturity in development of character was prevalent and was expressed especially in the patients' inability and unwillingness to assume responsibility for their behaviour. Allocation of blame upon parents, husbands, and others to account for their shortcomings was common. A further disturbance in their interpersonal relationships was a marked ambivalence between dependency and independence. Fear of incurring obligations through dependency upon others often led the patients to assume an exaggerated degree of independence. However, for the most part they did not have the personality resources to maintain successfully the independence they coveted. Moreover, by means of the Rorschach test it was found that the group as a whole had more neurotic trends than the general population of women of the same age and intelligence. No one trait was common to all patients, but immaturity, impulsivity, and anxiety were frequently observed. Also commonly encountered were compulsive trends, paranoid tendencies, and masculinity-femininity conflicts. There was no indication, as has previously been shown, that this group of patients tended to have a higher degree of sensuality than would an unselected group. In fact some patients showed an under-development of sensuality. Oppositional and anti-social tendencies were infrequently demonstrated by the test."

From an entirely unanticipated source comes further information about the personality make-up and psychosomatic relationships in connexion with venereal infections and sexual promiscuity. In her

* Stands in amusement centres.

studies on the sexual adjustment in the personal background of various psychosomatic patients, Dunbar (1945) describes a high venereal disease rate accompanied by an emphasis on sexual problems in a large group of patients admitted for coronary, hypertensive cardiovascular disease and angina, while on the other hand the rates were low in diabetics. Patients with fractures were careful in general to avoid infection in their promiscuous relationships, but without exaggerated fear. Average venereal disease rates were reported for rheumatic fever and rheumatoid arthritis patients and those suffering from rheumatic heart lesions, accompanied, in the latter group, by a higher rate of both spontaneous and induced abortions. These findings are yet too scanty to permit definite conclusions, but point to fascinating new lines of approach in the psychosomatic study of venereal disease.

Some degree of correlation is similarly found between delinquency, crime and intemperate sexual indulgence. This is particularly true in groups studied in Army settings. In the San Francisco group of promiscuous girls, "One-eighth of the patients were known to have had juvenile court experiences because of either dependency or delinquency, and approximately one-seventh were known to have had adult court experiences. Several had been apprehended two or three times by the police. Approximately one-sixth were known to have had correctional school and jail sentences." From the figures offered by these various authors emerges a general impression of personality deviation manifesting itself in open rebelliousness against the established order and the rights of others' property or person, and in the acting out of hostile drives without consideration for the consequences, all of which point to a fundamental deficiency in social conscience and self-restraint.

A glance at the family background of many of these patients reveals the particular impact of early environmental dislocation on their later behaviour and attitudes in life. Anyone familiar with the developmental history of neurotics and psychotics alike will find many correlations with these figures, even if no degree of specificity can as yet be attributed to them. In 249 cases of Rachlin's study, half could recall separation, or divorce of parents, step-parents, foster homes, or illegitimacy in their childhood experiences. In the sixty-nine patients whose parents were living together, there was severe conflict because of alcoholism, incest, infidelity of one or both parents, mental disease, or excessive discipline at home. In the San Francisco group similar family disorganization was characteristic. "Divided loyalties between parents were common and emotional tie to one and rejection of the other, very frequent.

In some instances the situation was complicated by a lack of loyalty to the whole family as a group, or strong fixation on the father with rejection of the feminine role or rivalry with siblings and half-siblings. It was also noted that 80 per cent. of the patients had unresolved conflicts regarding their family, with strong feelings that their parents had been too strict and too repressive in regard to sex or companionships with boys. Much resentment was expressed towards authorities who were responsible for the girls' apprehension and detention, but were in part a transference of the hostility which the patients had carried over from their earlier experience with their parents, although they were due also to actual handling by the authorities. Court and jail experiences frequently led to attitudes of indifference and were used in some instances as an excuse for subsequent promiscuous behaviour."

Besides the indictment which these grim figures provide of the way in which the police handle early behaviour problems of an anti-social nature, it becomes clear from a psychological point of view that a chaotic family dislocation of this type can but lead to such deviations of character that many of these patients will escape intolerable memories, anxieties, and frustration of basic security needs in the most irresponsible manner, among which promiscuity plays a major role.

Unconscious Motivations.—Personality characteristics, social and cultural environment, family background, and other factors reviewed so far do not, however, explain all. We must still understand why the venereal patient uses sexuality as an instrument for the release of psychological conflicts. The analysis of largely unconscious motivations, revealed by psychiatric observation or deduction, illustrates perhaps most forcefully the basic dissociation of the physical and emotional aspects of sexual activity found in these patients. A study of these unconscious motivations in the "conflictual group" of promiscuous girls in the San Francisco clinic, representing 28 per cent. of the total, disclosed that "sexual behaviour was used frequently in an attempt to overcome frustrations, but this usually brought about extra concern. Patients with poor parental relationships sometimes used promiscuous behaviour as a means of defying authority. If as children they were unwanted they developed a pattern of anti-social behaviour in order to secure attention to punish the parents, some of the 'rejecting' mothers being themselves promiscuous. Neurotic disturbances were present from a mild to a marked degree with on occasion an outbreak of promiscuity representing a neurotic equivalent. A few had strong father attachments and to achieve emancipation

attached themselves to men, often with guilt feelings towards their mother. A certain amount of competition with women which often accompanied the promiscuity seemed to be an extension of the mother-daughter rivalry. Others on the other hand, showed definite masculine trends, but used promiscuity in order to prove to themselves their femininity, although the conflict in this sphere was severe and the experience unpleasant. Among the more extreme cases the patients were aggressive and very seductive towards men, but interested in them only as instruments. Their fears of accepting the feminine role which had implications of being raped was so great that, in anticipation of such attacks, these patients assume the role of aggressor in order to punish and control men. In the histories of some of these patients, there was strong hostility toward the father or step-father who were aggressive and frequently brutal men. Others, instead of punishing men, felt a need for self-punishment in the form of illegitimate pregnancy, exposure to venereal disease, or arrest. These gave them a temporary relief from guilt."

In contrast to this group the "maladapted" group comprised only 10 per cent. of the total and included individuals with long-standing personality disorders dating from childhood; they were impulsive, emotionally unstable, delinquent, often paranoid, asocial, and in general showing many of the characteristics of the psychopathic personality.

Emotional Immaturity.—Equally informative, although not as detailed, are the conclusions of Wittkower in his discussion on motives for behaviour in his venereally infected men. For him, too, "habitual promiscuity is related to an incapacity for deep attachment to any one woman or to a deficient amalgamation of feelings of love and sexuality. The individual who later becomes promiscuous carries in adult life an excessive load of self love and in addition, retains toward his mother an anxious and undue attachment together with a certain resentment. Towards his father he shows an ill-concealed and even outspoken hostility. Many reject the idea of marriage because, as they say, they prefer their mother's company to that of any other woman, and, if they marry, they often do so only after their mother's death. Habitually promiscuous individuals never reach full sexual maturity; each of their numerous sexual affairs have a playful character and resemble masturbatory gratifications more than a mature union. The multiplicity of their affairs points to a search for the unobtainable. In their phantasy life they feel themselves deprived of, or deceived about, what they regard as their due. Their promiscuity is a compulsive, repetitive expression of their demands. In relation to women they

may continue in adult life a child-like craving for love and affection (dependent type) or, if elements of vindictiveness predominate, they may despise women and display only a faint resemblance to, or even a complete absence of, true affection (aggressive types). This element of resentment is one of the driving forces behind the endless series of their unsatisfying sex affairs. Unconsciously they differentiate between the much coveted but unobtainable maternal figure and despise the easily accessible woman of loose virtue. This uneasy relationship to women drives them into male companionship, but latent repugnance for what is—for them—a homosexual relationship, strongly reinforces their drive to promiscuity. Similarly rebellion against stern and pleasure-denying fathers, whether real or imaginary, makes for a disproportionate reaction against disciplinary measures. Army life does revive on two separate counts their old conflicts, and sexual activity represents a flight from such maternal and paternal conflicts and a safety valve from pent-up tension, anxiety and hatred."

These illuminating comments on both female and male promiscuity, even if they appear at first glance to differ widely from each other, furnish us with the psychodynamic premise without which any study of venereal diseases and their control measures must necessarily remain one-sided and incomplete.

It is not our purpose to stray into a discussion of what a mature love experience is, in contrast to indiscriminate sexual contact. But it is not irrelevant, in the light of the above psychological formulation of promiscuity, to emphasize some of the following points. Promiscuous intercourse is a one-sided physical experience between human beings where one of the partners totally disregards the needs, integrity, and self esteem of the other as a person, doing so for purposes dictated by narcissistic self-love, reassurance against fears of rejection, or attraction to one's own sex, and anxiety as to one's competence and normality in matters sexual or otherwise. In many cases it also represents discharge of aggressive impulses, in what amounts to sexual assault, depreciation, and reviling of the partner, punishment for real or phantasied guilt, adherence to infantile forms of eroticism by means of a partner of the opposite sex, and crudely disguised, unsurmountable early attachments and identifications. Very often a strong latent homosexual drive or exhibitionistic impulses parade under the cloak of heterosexuality. In other words, instead of the free, genuine, spontaneous interplay and exchange of sensual and emotional currents between mature partners, sexual promiscuity is a monotonous and repetitive physical compulsion without real pleasure, lacking any permanency or constructive aspects, and

carrying its inherent punishment in the form of venereal infection.

The problem of emotional maturity thus confronts those who are concerned with an attack on the problem of venereal disease. Even though great strides have been made by the combined efforts of public health authorities, venereologists, epidemiologists, and social hygienists, some of the fundamental issues involved have so far escaped general notice. These deal basically with freedom or restriction of sexual activity in our culture and, by extension, with social responsibility and conscience, and the capacity for self-denial which is so heavily taxed in democratic, freedom-loving countries such as the United States. It is impossible to discuss the problem of venereal disease in psychological terms without at the same time finding oneself philosophizing "on the role and place of sexual expression in modern life." Along these lines it has been suggested that sexual expression should be permitted only in marriage; let adolescents marry early and there would be no venereal problem. This "solution" evades more problems than it solves, since early marriage is economically impossible in our society. It may even not be desirable. The issue is made even more delicate when we consider the relaxation of the religious bonds of marriage and, as Luehrs (1946) points out, the loss of its "sacramental" quality in conjunction with the liberalization of divorce laws, which can only promote further sexual freedom and, therefore, exposure to venereal infection. Others are in favour of enforced sexual abstinence outside marital bonds. This is the view of most churches. Its main fault lies in the fact that prohibition of sexual intercourse is prohibition of a basic human need and the question is, "Who will do the enforcing?" Would this mean mass recourse to masturbation to quiet the pangs of the flesh? In any case, there are many for whom the clandestine side of sexual intercourse is its major attraction. Oscar Wilde, fifty years ago, wrote ironically that "uncertainty is the essence of romance."

Need for Education

Still another school advocates sexual education and enlightenment of children, adolescents, and adults alike. That it permits sexual ignorance is among the worst indictments that can be levelled against a hypocritical society that still confuses the disgusting and immoral with sex. From a psychological point of view, however, we should beware of the great "American illusion" that education is the panacea for all ills and that we can "teach our way out" of nearly every difficulty which confronts our bewildered citizens. Let us suppose, however, that this education could be offered to all. What would

adults and adolescents alike do with their newly gained wisdom? Would not a certain amount of fear and ignorance serve as a restraint against exposure? This last question is sure to be asked by the "righteous."

Enforced prophylactic measures on a large scale have been possible only in time of war when large congregations of men can be policed, and prostitution to some degree "supervized." However, many slip through these "sanitary cordons" and carry the infection away to less restricted areas or more discreet partners. Moreover, as has been pointed out by Luehrs, effective and more easily available prophylaxis would make extramarital sex activities even freer from undesirable consequences.

Legal Responsibilities

Legal responsibility for those who spread venereal infections wilfully, but not for those who innocently contract it, was suggested by Havelock Ellis more than forty years ago. However, who will decide, even in detected cases, who is wilful and who is innocent? So far men have been more generally incriminated than women; but social changes in the status of woman have made her an economically self-sustaining member of our culture who, with the avowed or concealed goal of abolishing the much castigated standards of "double morality," wilfully limits her fertility while increasing her sexual activity.

Conclusions

The problems of sexual expression and of venereal disease are therefore closely connected with one another and with the obligations of an individual to his group. The absurd contradictions that beset the individual in our culture and time and that are spoken of by Karen Horney and many others, are a ruthless competitive spirit contrasting with our professed ideal of Christian tolerance and charity, the stimulation of the senses, and especially the sexual instincts, by the movies, the radio, the magazines and even beach fashions (in contrast to the frustrations encountered in their gratification), and finally our alleged freedom in contrast to the social restrictions hampering it on all sides.

It becomes, therefore, obvious that the psychiatrist's contribution to the problem of venereal disease must remain limited at the present time. This does not imply pessimism. On the contrary, it should stimulate his social conscience and encourage him to marshal all his resources in the fight for the prevention of venereal disease.

This task has hardly begun. The example of the San Francisco group gives us a programme which should be expanded and applied on a large scale.

Most attempts at controlling promiscuous behaviour by recreational or vocational training do not take into account the individual differences in motivation (Fenske and Rachlin, 1945). Educational measures are not the solution until the emotional problems are met. One of the most enlightening suggestions so far is the use of psychiatric services in every venereal disease clinic in the land. This would eliminate the need for reference elsewhere, to which many patients object. In this experiment several factors have yet to be evaluated: (1) the basis for reference of venereal patients to the psychiatric service (age, the patient's desire for help, indication of possible personality disorder, etc.); (2) methods of screening those whose prognosis and treatability are considered good and of selection for psychiatric treatment, either on a clinical basis or on a group Rorschach basis; (3) research and follow-up facilities by highly trained teams of social workers, psychologists, and psychiatrists in venereal disease centres.

It is not possible to summarize here the excellent work begun by the San Francisco group. To give an idea of their results, however, after a six-month follow-up period, of 40 per cent. of those patients who were given psychiatric treatment in some form, 90 per cent. had become markedly less promiscuous. Half had ceased sexual contacts altogether except within marriage. This is a remarkable success, especially as the psychiatric help was financially relatively cheap (hardly \$5.00 a visit).

In conclusion, as Stokes (1944) has indicated in speaking of the chemotherapy of venereal disease: "They will be less a device for the control of infection than an incentive to epidemicity through incitement to exposure. It is not the patient under treatment who spreads the disease, but the promiscuous individual before and after treatment. In other words we must move against promiscuity rather than, or in addition to, disease." Understanding of the psychological motives for sexual over-indulgence represents, therefore, potentially one of the most powerful weapons at our command in the fight against venereal disease, and one which has so far been the least developed. Sexual promiscuity is not an isolated fragment of behaviour pattern. The whole personality is involved, chiefly through failure of the individual's emotional growth to keep pace with his physical development. Whenever the individual is unable to achieve maturity, particularly in his personal relations, hypertrophy of his sexual life will mask his failures, frustrations, and anxieties.

The "Don Juans" of both sexes, who keep up their bravado of continual sexual conquests, are the product of this maladjustment. There is splitting of the emotional and physical life of the individual, together with an inability to establish mature love relationships which in turn reflect early psychological deviations. The responsibility for these lie in the home, the school, the church, and society, where the psychiatrist is not yet to be found. In so far as this is true, the problem becomes more clearly delineated, but also more complex since it involves all the measures, individual, psychological, and social, by which either mental health can be restored or, better yet, maladjustment prevented from childhood up. As Freud has said: "In the last resort, we must begin to love in order that we may not fall ill, and we must fall ill if, in consequence of frustration, we cannot love."

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