the hopelessness of our efforts, that God has forsaken us, that there is no health in us. While it may not always be possible, or even desirable, that we should have only pleasant Pollyanna emotions, we should at least know the risks we run and our patients run if they habitually indulge in unharmonious emotions.

How to modify them? Perhaps not easy. Children imitate their parents' emotional reactions, so that might be a starting point, to impress on parents the need of emotional tranquillity if they want their children to be emotionally stable. The child should be taught that life will always have its difficulties but there are mature and immature ways of reacting to them. Children can be emotionally inoculated by learning how to react to the minor difficulties of childhood so they will not collapse emotionally when faced with the more serious stresses of adulthood.

We speak also of controlling emotions. I doubt if we can really control them except by good habit training on the one hand and by controlling the physical expression of emotions. The individual who leads with his chin every time he is offended gets angrier (and incidentally more battered) than if he had kept his muscles relaxed instead of tense and aggressive. We feel more courageous if we literally keep our chins up. Conversely we feel more depressed and hopeless if we allow ourselves to physically collapse.

10. The tenth and last principle I should like to emphasize is the importance of environment. Each type of plant, of bird and animal, including the human animal, has its own environmental preference in which it can best thrive. In some other type of environment it cannot do well and may die. For our physical health public health has done much to remove unfavourable environmental influences, such as the malaria organism and anopheles, yellow fever, plague, syphilis; we have removed children from the stultifying influence of sweatshops and mines. We have improved housing. We have not done so well in the field of mental health. In our lifetime we have gone through two world wars and a terrific economic depression. There has been little personal or national security. We have poverty, vice, crime and disease about us.

Too many and too severe stresses overwhelm many of us. While difficulties are needed to develop mental strength and vigour these environmental difficulties should not be excessive. In the provision of a healthy international and economic environment our statesmen and business executives have a great responsibility for intelligent leadership so that all of us, even the frailest of us, may have a fair chance to develop our personalities, to gain satisfactions and to contribute to the world's work and to the progress of civilization so far as our capacity and training permit.

It is not suggested that these ten mental health principles are all that could be enumerated or that they are presented in anything but the briefest outline. Nevertheless a review of them will indicate that good mental health depends on attention to a variety of influences; eugenics; obstetrics, gynæcology and pædiatrics; physical health; the home, the school and the church; good habit formation; certain psychological mechanisms; economics and social integration and a healthful environment broadly conceived.

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A STUDY OF PERSONALITY FACTORS AMONG VENEREAL DISEASE PATIENTS

By Major G. O. Watts, R.C.A.M.C.
Psychiatrist
and
Major R. A. Wilson, R.C.A.M.C.
Venereal Disease Control Officer

THIS paper considers some of the factors contributing to the acquisition of venereal infection among Canadian Army personnel.

MATERIAL

A recent survey was made in one military district in Canada of 292 consecutive cases of V.D. occurring among male soldiers. Records of psychiatric reports were used for information about the personality of the men. Wherever necessary, social service reports were obtained. Information regarding the military efficiency of

the patients was secured from training records and Army Examiner's reports.

A control group was secured by making comparative personality studies of 158 soldiers selected at random from a group of 1,000 consecutive files in the Depot personnel selection office. The age distribution, the marital status, and education of the control group were found to be within 2% of the figures taken from the 1,000 files.

RESULTS OF ANALYSIS

AGE AND MARITAL STATUS AS FACTORS

Percentage Age Distribution of Patients Studied

Age group	*V.D. patients*	*Control group*
	%	%
Under 22	28	43
Between 22 and 30	43	37
Between 31 and 40	18	18
Over 40	3	2
Not stated	8	0
Total	100%	100%

Percentage Marital Status of Patients Studied

Status	*V.D. patients*	*Control group*
	%	%
Single	28	31
Married	59	67
Not stated	13	2
Total	100%	100%

The percentage of men under 22 in the control group is 15% higher than in the V.D. group, which would suggest that V.D. is less likely to occur in the recruit under 22 than in the 22 to 30 age group. The percentage of married and single men in both groups was approximately the same.

PSYCHIATRIC ABNORMALITY IN VENEREAL DISEASE SPREAD

CERTAIN PSYCHIATRIC FACTORS AMONG V.D. PATIENTS SHOWING PERCENTAGE OF TOTAL GROUP WITH THESE FACTORS

Psychiatric factor	*V.D. patients*	*Control group*
	%	%
Abnormal childhood environment	36	18
Marital incompatibility	32	10
Excessive alcoholic habits	19	less than 1
Psychiatric referrals	43	5

The term "abnormal childhood environment" is intended to include cases where at least one of the parents was dead or was markedly unstable emotionally, or where there was separation or divorce. The percentage of soldiers in the V.D. group with abnormal childhood environment was twice as high as in the control group.

The percentage of marital incompatability (divorce, separation or frequent quarrelling) was three times as high as in the control group.

A record of drunkenness obtained from conduct sheets and from V.D. records, occurred 19 times more frequently among the V.D. patients than among the control group.

Records of psychiatric consultation among V.D. patients were examined. A sharp contrast is noted in the percentage of psychiatric referrals in the V.D. group as compared with the control group. It is important to note that none of the V.D. cases was referred to the psychiatrist because of V.D. All had been referred, independently, because of unsatisfactory adjustment or lack of progress in training. Yet 43% of the V.D. group had been referred to the psychiatrist as compared with 5% of the control group. Ninety-five per cent of the men in the V.D. group who had been psychiatrically examined were found to have emotional or intelligence handicaps existing in a chronic state. This handicap was sufficient to lower their categories and seriously impair their usefulness to the Army. Approximately one-half of those referred for psychiatric examination were discharged from the Army with a diagnosis of psychopathic personality — an unstable individual who has excesses in many aspects of his life.

To check this further, in the military district which was the locale for this study, all cases discharged from the Army with a diagnosis of psychopathic personality over a six-month period were studied and compared with 100 consecutive neurotic patients who also had been discharged. Among those discharged with a diagnosis of psychopathic personality, 25% had a proved history of V.D., while in the neurotic group only 3% had had V.D.

It was observed further that approximately 20% of all men who received psychiatric examination were found to be mentally retarded. By this is meant a mental dullness (as opposed to a mental defect) which is sufficient to limit a man's capacity to absorb training at the normal rate. Only 5% of referrals were found to be emotionally stable and to have average intelligence. It was noted that during psychiatric routine questioning of a soldier about V.D., the soldier frequently denied having been infected, although records concerning his infection were present in the office of the V.D. Control Officer.

FACTORS IN MILITARY ENVIRONMENT CONCERNED IN V.D. SPREAD

CERTAIN MILITARY FACTORS AMONG V.D. PATIENTS SHOWING PERCENTAGE OF TOTAL GROUP WITH THESE FACTORS

Military factors	*V.D. patients*	*Control group*
	%	%
Efficiency poor	40	19
Detention	17	5
Military conduct poor	28	7
Dissatisfied with army routine	24	8
Grade VII education	54	71

The percentage of men with poor military efficiency was twice as high in the V.D. group as in the control group. The amount of poor conduct, as measured by the number and frequency of entries on the conduct sheet, and periods of detention were four times as high.

Compared with the control group, there were three times as many men in the V.D. group who stated they did not like their allocation.

Grade VII education was taken as a yardstick. Seventeen per cent less men had passed Grade VII in the V.D. group than in the control group. This is also reflected by the results of the M test in the two groups—the control group scoring 10% better marks than the V.D. group.

Multiple infections comprised about 12% of the total number of infections. Of all the cases that had at least two separate infections, 80% were discharged independently of V.D. with a diagnosis of psychopathic personality, unfit for any service.

To summarize, the main predisposing personality traits among the V.D. patients were found to be related to the following:

1. Unstable men who do not control themselves in any aspect of their lives (psychopathic personalities).

2. Habits of heavy drinking which are related to instability.

3. Promiscuous men who are immature in their attitude and behaviour.

4. Men who are too dull to be good soldiers and to avoid V.D.

The common precipitating factors were found to be the following:

1. Assigned to work that the man does not like.

2. Punished for a crime similar to that committed by others fortunate enough to escape punishment.

3. Quarrel with his wife or girl friend. Some of the cases of V.D. were acquired under severe provocation. One man received anonymous letters stating that "his wife was running around. She was spending all of their money, and the children were being neglected." This man became intoxicated. He met a sympathetic girl, was exposed, and developed V.D.

THE EVALUATION OF THE V.D. PATIENT

We have considered here a large body of physically fit men recruited from civilian life and placed in a military environment entirely new to them. Physical and environmental factors related to both civilian and military life have their part to play in the acquisition of V.D. It is important to determine, if possible, if the V.D. is the result of an episode due to some temporary emotional upset or the result of a pattern of irresponsible behaviour.

It is not fair to conclude that because a man contracts V.D. he is necessarily a poor soldier. Every case must be considered individually. Anybody can make a mistake. A good soldier may get V.D. However, if a man gets V.D. twice, or more often, it indicates a weak personality because he does not learn by experience. Such patients should be thoroughly investigated.

The spectacular success of penicillin in the treatment of gonorrhœa and early syphilis has led some medical men to conclude that the V.D. problem has been practically solved by the use of this powerful therapeutic weapon. However, curing an urethral discharge or penile sore does not influence immature habits of behaviour which contribute to the acquisition of venereal disease. The personality will still have to be treated on a social basis to prevent, for instance, the unhappy marital adjustment associated with promiscuity.

Some men annoy their medical officer with the belief that they have a venereal disease. Careful history and examination may disclose no evidence of disease. Often the history indicates that they were not even exposed to infection. This false belief, which is very hard to overcome, is a symptom of a much more serious disease than urethritis. Behind this belief may be a strong feeling of guilt. It is usually unwise to try to shake such an individual from this belief. The best course of action is to refer such a man to a psychiatrist.

SUMMARY

A personality study was carried out on 292 male cases of V.D. occurring in soldiers from one military district in Canada. A control series of 158 men was similarly studied. From the results obtained, it was found that a significantly large proportion of soldiers who developed V.D. have personality defects. In the evaluation of the V.D. patient, consideration should be given to the factors in the military and civilian environment of the patient that have been partly responsible for the acquisition of his infection.

CHRONIC RIGHT-SIDED PAIN IN WOMEN*

By H. B. Atlee, M.D., F.R.C.S.[Edin. and C.]

Halifax

THERE was an epoch in medical history when the operating surgeon was a most necessary agent in opening the Pandora box of living pathology, and for fifty years he pushed back the frontiers of our ignorance in an amazing fashion. As a result we yielded him the glamour of a conquistador—and the golden rewards. I wonder if we should continue much longer to do so, for with surgery as with geography the last frontiers have been opened up, the last body cavities explored, and further surgical advances will probably be mainly along the lines of improved technique. Even technique has been so standardized that any fresh medical graduate possessed of a modicum of courage, a nearby hospital and a textbook on operative surgery, can set himself up as a surgical glamour-boy. As a result a great deal of unwise and unnecessary operating is being done, too much of it in the bellies of unfortunate women suffering from chronic low abdominal pain, and in particular chronic right-iliac pain. I use the term "unfortunate", because so large a percentage of women so operated upon receive no benefit from the surgical procedure, and a fair number of them are actually made worse.

Let me outline briefly what often happens to the unhappy woman with this symptom. First, her appendix is removed. Then, being still in possession of her pain, she becomes a candidate for the gynæcologist—if it wasn't her appendix it must be her ovary or her retroverted uterus. So she undergoes a partial or complete resection of her ovary, or a suspension of her uterus. But she still has her pain. The diagnosis is now "adhesions", and she undergoes another laparotomy, or perhaps a subtotal hysterectomy, or some plastic work on a slight cystocele. By this time even the most abandoned operator has begun to doubt the efficacy of the Bard-Parker, and sends the poor woman to an internist. Perhaps the internist treats her for constipation or an irritated cæcum, or perhaps, recognizing the neurotic element in what the patient herself is beginning to describe as increasing "nervousness", he throws in his hand scientifically and prescribes the artful bromide or barbiturate. But the woman still has her pain.

If the story just unfolded sounds exaggerated or fictional to you, it is very real to me, since I am constantly seeing women who have run some such surgical gamut. As a gynæcologist attached to a general hospital I am called into consultation more often for chronic right-sided pain than for any other single condition: a great many of these women have had surgical operations without relief. In my private practice in 1944 I saw 42 women with this symptom, of whom 12 had had one operation, 5 two operations and 3 three operations without relief. Only the other day I saw one who had had five operations without relief!

Because the symptom has been so common in my practice and because there seems to be so much ignorance concerning its causes, I have tried to learn something about it. I am sorry to have to admit that I have learned very little; like Aristotle, all that I know about it is that I know nothing. Perhaps that is a very poor reason for coming all this distance to discuss it, nevertheless I felt that it might be useful to share my perplexity with you.

I shall approach the subject from the standpoint of the various diagnoses involved. (1) Chronic appendicitis. (2) "Adhesions". (3) Painful right ovary and/or Fallopian tube. (4) "Cysts of the ovary". (5) Painful right

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