Sanitized for Your Protection: Medical Discourse and the Denial of Incest in the United States, 1890–1940

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Medical Discourse and the Denial of Incest in the United States, 1890–1940

Lynn Sacco

This article examines medical discourses from 1890 to 1940, when physicians and reformers uncovered, and then dissembled, evidence that white, middle- and upper-class American men were sexually abusing their daughters. Doctors had long recognized that children could acquire gonorrhea, but they believed that infections were confined primarily to poor and working-class girls who had been sexually assaulted. In the 1890s, doctors began to incorporate new technologies into the diagnostic process and they were shocked to discover that gonorrhea infection was so common among girls that they feared it was epidemic. Doctors claimed that concurrent infections in fathers and daughters from “respectable” white families were particularly vexing. Although they could neither explain nor prove how else these girls became infected, doctors refused to consider the possibility of incest. Persistently ignoring the obvious, health care workers and reformers revised their views about the susceptibility of girls to infection, not incest. By 1940, medical textbooks relied on untested speculation to declare that most girls acquired gonorrhea from nonsexual contacts with other females or contaminated objects: their mothers, other girls, or toilet seats. “Scientific advances,” ironically, obscured rather than illuminated the source of girls’ infection.

In the fall of 1913, the Boston Dispensary and Massachusetts Society for Sex Education hired social worker Bertha C. Lovell to do case work with the dispensary’s female patients infected with a “venereal disease,” a term for sexually transmitted diseases that included gonorrhea and syphilis. The task of identifying the source of gonorrhea infections in girls, who comprised 10 percent of the gynecology clinic’s patients, quickly frustrated Lovell. Although she believed that adults acquired gonorrhea only from sexual contacts, Lovell considered girls susceptible to infection from innumerable mundane interactions: “Was it an accidental infection from a dirty toilet seat, or an infection, as accidentally incurred in the daily exigencies of life in a crowded household where the mother or father or perhaps an older sister had the disease? Or was it one of the rare cases of rape . . . ?” Lovell’s bewilderment was not unusual, but part of a dramatic shift in medical views about the etiology of gonorrhea infections in girls that occurred in the first half of the twentieth century. Nineteenth-century doc-
tors had expressed few doubts that gonorrhea was a sexually transmitted disease in children. Most of the children they diagnosed with the disease were poor and working-class girls who claimed to have been sexually assaulted, sometimes by their fathers. Gonorrhea was important evidence that corroborated both a girl’s accusation and the identity of her assailant, whom doctors also examined for infection. But in the 1890s, when new technologies significantly improved doctors’ ability to detect the disease, they were startled to discover that it was not limited to this relatively small pool of girls. Rather, so many girls from all classes—most of whom were between the ages of five and nine and who did not claim to have been assaulted—tested positive for gonorrhea that doctors feared it was epidemic.

Doctors realized that incest was the most likely source of infection, and tracing the source of infection by the traditional method of considering sexual contacts might have revealed the occurrence of incest throughout American society. But this is not what occurred. Using medical discourses from this period, this article argues that doctors, nurses, social workers, public health officials, and reformers mislabeled or even ignored the evidence of incest that they themselves had discovered. Physicians who believed that only “foreign,” “primitive,” or “ignorant” men abused their daughters assumed that incest was contained within African American, immigrant, poor, and working-class families. When the incidence of gonorrhea among the daughters of white middle- and upper-class men suggested otherwise, health care professionals revised their views on gonorrhea, not incest.

Nearly everyone who wrote about gonorrhea infections in girls between 1890 and 1940 rejected out of hand the possibility of incest, even though they could not agree—or prove—how else girls acquired the disease. One result was that incest was not documented except as a rare occurrence, confined to socially marginalized groups. Incest would not be “discovered” until the 1970s and 1980s, when mental health professionals who had been influenced by second-wave feminism suggested a different view.

In her groundbreaking 1981 book *Father-Daughter Incest*, feminist psychiatrist Judith Lewis Herman reconceptualized incest from a personal pathology to a mainstream gender issue: “Female children are regularly subjected to sexual assaults by adult males who are part of their intimate social world. . . . Any serious investigation of the emotional and sexual lives of women leads eventually to the discovery of the incest secret.” Herman was one of a growing number of mental health professionals who challenged the psychoanalytic orthodoxy that had narrowly construed Sigmund Freud’s theories and dismissed incest narratives as statements
of fantasy rather than fact. However, Herman’s assertion could only be accurate if incest permeated American society as a static facet of gender relations. Indeed, when, in the late 1980s and early 1990s, American women from all socioeconomic groups disclosed histories of father-daughter incest, their accusations raised questions about the racial and economic alterity of male sexuality that spun into a fiery debate over the incidence of incest in the United States. These debates became polarized within psychoanalytic discourses and the questions they raised remain unanswered.

In their books on domestic violence published in the late 1980s, historians Linda Gordon and Elizabeth Pleck identified incest as a gender issue and provided historical evidence of its occurrence over long chronological periods. But unlike other “personal problems” that second-wave feminists identified as gender issues, the topic of incest has received little attention from historians. This disinterest is surprising in light of the contentiousness of the recent debates, including among feminists. Moreover, some critics attempted to discredit incest accusations by arguing that they were inspired by feminism but unsupported by science, as though the two are mutually exclusive. They argued that “science” was an objective and therefore superior system of knowledge. Tracing shifts in the etiology of gonorrhea in girls suggests otherwise.

Definitions and Incidence

This article will be limited to father-daughter incest, defined here as any type of sexual contact between an adult male and his female child or stepchild. Although recent studies have estimated that as many as 54 percent of American women were sexually assaulted as children, little data exists with which to measure the incidence of incest. Yet when the U.S. Justice Department analyzed all reports of sexual assault made in the 1990s, it found that girls under the age of twelve comprised the single largest category of victims and that most had been assaulted in their own homes by an adult male who was a family member or acquaintance. No studies have shown that the incidence of incest differs by race or class, and data on ethnicity is inconclusive.

Incest is sometimes reported by doctors who have diagnosed a gonorrhea infection in a child. The Centers for Disease Control and Prevention define gonorrhea as a sexually transmitted disease (STD), and “the second most frequently reported communicable disease in the United States.” When parents and siblings of a girl infected with vaginal gonorrhea agree to be tested, the results are positive in half of the cases. However, like human immunodeficiency virus (HIV), Neisseria gonorrhoeae (N. gonorrhoeae), the bacteria that cause gonorrhea, dry too quickly for it to
spread by casual or nonsexual contact. A newborn may acquire gonorrhea from its mother but these infections affect the baby’s eyes or joints, and not its genitals. It was not until 1998 that the American Academy of Pediatrics emphasized that gonorrhea “in a child is diagnostic of abuse with very rare exception,” and it warned physicians that “a conclusion that the transmission was . . . nonsexual in nature is unacceptable.”

Contemporary physicians report more than 50,000 infections in children each year, and experts agree that, “Among all STDs diagnosed in children evaluated for suspected abuse, gonorrhea is the single most common diagnosis.” Child sexual abuse usually consists of rubbing, fondling, and oral contact, activities that may not leave any lasting genital marks or injuries. Because N. gonorrhoeae cause a local infection at the point “where they enter . . . the body,” gonorrhea may also be the only physical evidence of abuse. Boys and girls suffer from infections in the rectum or throat, but the vast majority of children diagnosed with an STD are prepubescent girls with vaginal gonorrhea, also called “vulvovaginitis” or “gonococcal vaginitis.” Its major symptom is a pus-like discharge.

Turn-of-the-Century Advances and Reappraisals

In the pre-bacterial era before the 1890s, a diagnosis of gonorrhea rested entirely on the physician’s clinical observations and his willingness to render an opinion that he could not verify and which entailed legal consequences. There was no laboratory test to assist doctors in determining whether a vaginal discharge was a symptom of gonorrhea or another type of disease, such as pinworms or “leucorrhea,” a catch-all phrase for vaginal infections. Recognizing that their diagnostic abilities were crude and imprecise, doctors weighed the heavy penalties for child rape—which included lengthy imprisonment and even execution—against their assumption that most accusations were false.

Late nineteenth-century scientific and technological advances dramatically improved doctors’ ability to diagnose gonorrhea in girls, but not their willingness to do so. After German dermatologist Albert Neisser identified N. gonorrhoeae in 1879, doctors could confirm a diagnosis by examining a culture or smear from a vaginal discharge under a microscope. If the slide revealed N. gonorrhoeae, the patient had gonorrhea. Doctors initially viewed bacteriological testing as a godsend that provided them with diagnostic certainty. However, as they incorporated testing into the diagnostic process, doctors also examined vaginal discharges from girls who did not claim to have been assaulted. These patients included girls from “respectable” white families, and doctors were shocked to realize that they were infected with gonorrhea. At the 1901 meeting of the American Medi-
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cal Association (AMA), Chicago physician J.C. Cook articulated the conundrum these cases presented to doctors. He declared that when it came to families of “educated and refined people,” “It is trying to our credulity to find a 4-year-old daughter and a 25-year old father having gonorrhea at the same time with no other source of infection to the daughter other than the father.”

Early-twentieth-century physicians were aware that incest occurred but they expected it only in homes they associated with primitivism and degeneracy. In 1886, Brooklyn physician Jerome Walker, who examined abused children for the Society for the Prevention of Cruelty to Children, admonished his colleagues that he had learned from experience that “certain motives, conditions, and statements” about child sexual abuse “are at variance with one’s ordinary conception of such things.” Among the factors that surprised Walker was that, “Apparently respectable men, as well as ordinary disreputable characters outrage children; that even fathers, step-fathers, and brothers will do it.” But doctors ignored Walker’s warnings and during a period of intense nativism focused exclusively on cases that occurred among the poor and working classes, especially immigrants and people of color.

For instance, in 1908, Dr. W. Travis Gibb, medical examiner for the New York Society for the Prevention of Cruelty to Children (NYSPCC), attributed incest to immigrants whom he claimed did not value children as highly as did “native-born” white Americans. Although he admitted that, “these crimes occur among the well-to-do,” he claimed that most men “among certain classes, especially ignorant Italians, Chinese, and Negroes,” assault their daughters because they supposedly believed “that, if a man afflicted with an obstinate venereal disease have intercourse with a virgin, the latter will develop the disease and he will be cured.” Nineteenth-century European physicians claimed to have encountered this “superstition cure” in Germany, Ireland, and Italy, and Richard von Krafft-Ebing mentioned it in *Psychopathia Sexualis*, his influential compendium of “psychosexual perversions.” In 1909, Dr. Flora Pollack, attending physician at the Johns Hopkins Gynecological Dispensary, cited Krafft-Ebing and reported that, “This superstition is so deeply rooted in the belief of men that were you to ask ten police officers, cab drivers, hucksters, etc. of the truth of it I think eight would affirm it as a ‘fact,’ and all would know of its existence.” Although Pollack left open the possibility that people from all classes believed in the superstition, most doctors did not, and references to the superstition and “foreign beliefs and practices” persisted in the medical literature as an explanation for child sexual assault and incest through the 1930s.

Doctors who viewed incest as a racially or culturally based behavior
considered it a measure of difference and a definable border between the “civilized” and the “savage,” the native-born, white American and the immigrant. Their unwillingness to acknowledge incest among the white middle and upper classes was so strong that they refused to consider the possibility even when an infected father admitted that he and his daughter slept in the same bed. For instance, in 1900, Dr. Herman B. Sheffield, who treated infected girls at New York City’s Metropolitan Hospital and Dispensary for Women and Children, and whose patients rarely exhibited obvious genital injuries, eagerly dismissed “indecent violence” as “very rare indeed.” He proposed that girls became infected “accidentally” from contacts with objects that “mediated” the transmission of bacteria from parent to child. “Little girls sleeping with their parents or elder brothers suffering from gonorrhea may contract the disease through coming in contact with the soiled bedclothes, cotton-pads, or rags which are being used for cleansing purposes.”

Sheffield drew from his experience in institutional settings. Nineteenth-century doctors had occasionally detected vaginal discharges among girls in orphanages and hospitals, which they had identified as leucorrhea and attributed to poor hygiene. When early-twentieth-century doctors began to examine these discharges bacteriologically, they discovered that entire wards of girls were infected with gonorrhea, not leucorrhea. But doctors continued to attribute the infections to uncleanliness. In an era when hospitals had little money to spend on supplies, nurses commonly used the same instruments, such as thermometers and wash rags, for each child, and any number of infections spread in this manner. To curtail “ward epidemics,” hospitals instituted new procedures, such as requiring that each girl receive her own supplies, including bedpans and catheters. When these measures failed, hospitals began to test every girl who sought admission, and by 1905, most refused to admit any girl found to be infected except for life-threatening emergencies.

However, as the number of infections acquired outside of institutional settings continued to rise, doctors became alarmed at both the extent and consequences of the disease. By 1903, Dr. Reuel B. Kimball, attending physician at the New York City Babies’ Hospital, called gonorrhea “one of the most dangerous microorganisms,” and doctors at the Johns Hopkins Hospital warned that its complications included death. Yet even as they grew to appreciate the seriousness of the disease, for which no effective cure had yet been discovered, doctors avoided discussing incest. In December 1905, New York physician W.D. Trenwith reported to the Section in Pediatrics of the New York Academy of Medicine that he did not believe that any of the girls he treated, most of whom were between the ages of four and six, had been assaulted, even though their fathers were also infected.
Trenwith claimed that after making inquiries of “the most searching character,” that “indirect infection by the father”—shared bed linen and wash rags—was responsible for 75 percent of the cases. He blamed other girls—their playmates and siblings—for the rest.43

Social Hygiene and “Innocent” Infection

As doctors muddied the etiology of gonorrhea in girls, “social hygiene,” a public health campaign developed to provide “reliable” medical information about sexually transmitted diseases became so successful that by the late 1930s, the U.S. Surgeon General had incorporated its tenets into national policy.44 Social hygiene was an ambitious social reform and medical program that early-twentieth-century physicians, health officials, and reformers believed would eradicate venereal disease from American society. A shared belief that venereal disease posed a serious threat to American society drew together a diverse coalition of prominent reformers and philanthropists, including John D. Rockefeller, Jr. and Jane Addams. They wanted to raise awareness that gonorrhea was a sexually transmitted disease and to encourage people to be tested and treated. To do so, social hygienists reframed venereal disease from a moral problem to a social and medical issue.45

Social hygienists challenged the assumption that adults acquired venereal disease only from “immoral” or extramarital sexual relations. The views of New York City physician Prince A. Morrow, a European-trained expert on venereal disease, deeply influenced the shape of twentieth-century social hygiene.46 In 1904, Morrow estimated that 75 percent of American men had been infected with gonorrhea, and he blamed them—not prostitutes—for the spread of infection.47 Morrow claimed that most of his female patients were respectable white women who were married to “men who have presented a fair exterior of regular and correct living—often the men of good business and social position,” and he blamed these men for bringing the disease into their homes.48

Yet even though he complained that “family epidemics” were frequent, Morrow did not believe that fathers infected their daughters in the same way that they infected their wives. Beginning in 1885, he declared that, “The existence of a purulent discharge from the vulva of children has often led to the unjust accusation and punishment of innocent persons for attempted violation.”49 After the turn of the twentieth century, bacteriological analysis minimized the chance that a man would be wrongly convicted because a physician had mistaken leucorrhea for gonorrhea. Still, when he published his influential Social Diseases and Marriage in 1904, Morrow repeated his pre-bacterial era warning, adding, “One knows the
facility with which children are disposed to accuse and lie.” He claimed instead that, “We now recognize that gonorrhoea in children is vastly more often due to accidental mediate transmission than to attempted intercourse.” However, the medical literature contained mostly anecdotal speculation and no research studies, and it did not support his unequivocal declaration. As Dr. J. Clifton Edgar, an NYSPCC medical examiner and the author of a chapter on child sexual assaults complained at an AMA session on vulvovaginitis that same year, “nothing of value had ever been published on the subject.”

An emphasis on “innocent” infection was a defining facet of twentieth-century social hygiene and an effective rhetorical maneuver that reduced the social stigma of venereal disease. As a result, significantly more men, women, and children were tested and treated. But no one expected so many of these patients to be girls. Dr. L. Emmett Holt, professor of diseases of children at Columbia University Medical School, author of an authoritative textbook on childhood diseases, and attending physician at the Babies’ Hospital, warned that physicians were not only detecting gonorrhea more frequently, but that its actual incidence among girls from all classes was increasing. He claimed that at least five or six of the 125 girls the hospital screened each month were infected, and that on a single summer day in 1904, five girls applying to the hospital for admission had tested positive for the disease. That same year, a Chicago pathologist declared gonorrhea among girls epidemic.

During the winter of 1911–1912, the children’s ward at the Cook County Hospital—which Jane Addams called the “most piteous . . . of all children’s wards”—placed girls three to a bed and turned away many more. In just one month, September 1926, the Vanderbilt Clinic on Manhattan’s Upper West Side, the city’s major provider of outpatient treatment for infected girls, saw 213 new cases. In 1927, the American Journal of Diseases of Children ranked gonorrhea as the second most common children’s contagious disease—“second to measles and outnumbering smallpox and scarlet fever.” By the early 1930s, the Massachusetts Department of Health announced that girls accounted for 10 percent of reported female gonorrhea infections, a figure that Washington D.C. matched for 1929. Yet, doctors and reformers did so little to investigate the cause of such widespread infection that in 1927, the New York City Department of Health called vulvovaginitis “the most neglected and poorly managed condition seen in medical practice.”

Doctors, public health officials, and reformers recognized that gonorrhea in girls was a costly problem, but their refusal to acknowledge incest sabotaged their efforts to effectively address prevention. Even Progressive-era women reformers, who were eager to demonstrate the evils of male sexual license and to protect girls from male predators, passed on
the opportunity to use the incidence of gonorrhea infection to expose male sexual misbehavior.\textsuperscript{60} Because they were committed to promoting the nuclear family as a corrective to social chaos, concerns about the viability of the family may have discouraged them from identifying its more sinister features.\textsuperscript{61}

Instead, many doctors believed that gonorrhea was endemic among African Americans, immigrants, and the working classes, and they simply added gonorrhea to the list of diseases they blamed domestic servants for carrying into “fashionable schools” and the “homes of luxury.”\textsuperscript{62} When the presence of a diseased servant could still not account for all of the cases, experienced practitioners simply lamented that, “one is occasionally utterly unable to trace the source of infection in a child surrounded by every protection and comfort money can procure.”\textsuperscript{63}

Sanitation activists filled in the gap. The early twentieth century was an era of heightened medical and public attention to cleanliness, including bathrooms and toilets, thought to be the source of a variety of diseases.\textsuperscript{64} Reformers who regarded improved sanitation as a remedy for many social problems readily included epidemics of gonorrhea in girls among the problems they could solve. Although sanitary reforms included coercive measures aimed at “Americanizing” poor and immigrant families, cleaning up cities and educating the public about germs had markedly reduced disease and mortality.\textsuperscript{65} Yet as applied to gonorrhea in girls, the focus on sanitation was tragically misguided.

“Mothers’ Hands and Dangerous Things”: Sanitation Reform

Sanitation reformers and public health activists, who wanted to improve social conditions by keeping America clean, had long held mothers responsible for keeping their families free of all kinds of disease.\textsuperscript{66} In her histories of sanitary reforms, Nancy Tomes has shown how late nineteenth-century reformers designated mothers responsible for protecting their family’s health by keeping their homes clean.\textsuperscript{67} Whereas an 1887 sanitary tract urged a woman who had “lost a child, a husband, or other relative to [disease]” to “consider whether the source of trouble may not be in the water-closet,” by the 1910s, home economists pressed mothers to become “active agents in the pursuit of the safe toilet.”\textsuperscript{68}

Therefore, in 1908, when Hull House resident and public health pioneer Dr. Alice Hamilton published an influential article on gonorrhea in girls that conceptualized it as a sanitary problem, she contextualized it within a well-known reform movement with a record of accomplishment (and in which she had established her reputation).\textsuperscript{69} Hamilton scoffed at the “popular” view that girls acquired gonorrhea only from sexual con-
tact, joining those who charged that such old-fashioned thinking had “con-
tributed to retard the clearing-up of this subject.” She argued that it was
wrong to assume that girls’ infections were necessarily “venereal”—sexu-
ally transmitted—and claimed that the disease spread because of the “close
contact” in “modern city life.” In a second paper read at the 1910 Na-
tional Conference on Charities and Corrections, Hamilton set out the “mod-
ern” view that, “The child victims of gonorrhea usually have been infected
by their mothers.” She argued that “dangerous things” transmit infection
when soiled with gonorrhea discharge, namely “nurses or mother’s fingers,
towels, wash-cloths, sponges, bath-tubs and the seats of closets,” by which
she meant toilet seats. Such contacts were so numerous that she con-
cluded, “other members of the family are responsible for a small number
of cases, and sexual violence for only an insignificant minority.”

Doctors knew that nonsexual transmission of N. gonorrhoeae was im-
probable because the bacteria die quickly in the open air. However, they
guessed that the genital lining of prepubertal girls was so thin that the
bacteria could penetrate it on casual contact. Therefore, doctors, social
hygienists, and sanitary reformers began to demand sanitary improve-
ments that would reduce opportunities for exposure to virulent bacteria.
In the 1910s, Dr. Clara Seippel was Chicago’s Assistant City Physician, attend-
ing physician at the Cook County Hospital children’s venereal disease ward,
and President of the Frances Juvenile Home Association, which operated
a residential facility for infected girls where Seippel was also attending
physician. As city physician, she had examined scores of girls for evidence
of assault, and the numbers of men who assaulted children, including their
own, troubled her. Still, she told a meeting of the Chicago Medical and
Social Hygiene societies that they had a civic duty to protect “hundreds of
children exposed to infection” by raising “standards of hygiene.”

Ignoring those cases that occurred in spacious and well-kept homes,
doctors and reformers insisted that “overcrowding and unhygienic sur-
rroundings predispose to its transference,” thereby shifting responsibility
for infection from fathers to mothers, and further widening the rift be-
tween sexual contact and infection. When a girl became ill with the dis-
ease, health care providers and social workers excoriated her mother for
poor housekeeping and did not waste time investigating the possibility of
incest. In the burgeoning literature on the topic, only Dr. Flora Pollack
dismissed sanitation theories as “a very useful shield for a guilty indi-
vidual” that “make it extremely difficult to protect children.” In 1909,
Pollack estimated that at least 1000 girls were infected in Baltimore each
year, and she visited police stations and met with community groups to
try to improve criminal prosecutions of men who assaulted girls. How-
ever, even Pollack conceded that it was difficult to believe that the inhab-
inhabitants of Baltimore included enough “perverts” to have caused so many infections.79

Doctors who treated infected girls insisted that few, if any, of their patients had been assaulted, even though they could not identify any other cause of infection. In 1913, Dr. Edith Rogers Spaulding, attending physician on the vulvovaginitis ward at the Children’s Hospital in Boston, admitted that she had been unable to determine the source of infection in thirty of her fifty-six cases.80 “Not discovered” was the largest category under “sources of infection”; twenty-six cases were classed as “history of discharge in one of parents,” by which she meant “accidental” infection from poor sanitation; sixteen patients had a history of a recent hospital stay; and three were ascribed to “history of contact,” meaning sex play with other children.81 Yet Spaulding refused to conclude that any of her patients (most of whom were under five years of age) had been raped. To prevent the spread of infection, Spaulding demanded that school nurses ensure that infected girls did not use the school toilet.

Since the mid-nineteenth century, doctors had occasionally speculated that chamber pots or toilet seats could be a source of girls’ infections.82 Now the sanitation and social hygiene movements seized upon the toilet as key. They claimed that toilets located in public places such as schools (where no family member could be implicated) were particularly dangerous. In 1912, Seippel warned that, “A drop of gonorrheal pus on the toilet seat in a public school can start [an] epidemic,” even though no “school epidemic” had been documented in the American medical literature, nor had any case of individual infection been traced to a school toilet.83 Nonetheless, the need to improve the rundown and dirty conditions of schools, particularly the lavatories, was an issue with which doctors and reformers were already familiar and engaged.84

From the 1910s to the 1940s, doctors endorsed the toilet seat as the primary source of girls’ infections, a theory that again displaced the source of danger to girls, this time to other girls. For instance, in 1914, Dr. Frederick J. Taussig, a nationally known gynecologist and member of the Executive Committee of the St. Louis Society for Social Hygiene, argued that “The most frequent source of infection is from child to child, and the most common manner of its transmission is through the school lavatory.”85 Taussig supported his supposition with imagination rather than research data: “Lavatories . . . are as a rule so high that the smaller children in using them are forced to have their genitals and clothing rub over a considerable portion of the seat. The greater the number of persons using the same lavatory, the less interval of time is apt to elapse between its use, and hence the greater likelihood of carrying infection. The lavatories in tenements, playgrounds, and public schools are consequently a source of considerable danger.”86
Taussig brushed aside the possibility that any of his patients had been raped because only a few were from “the ignorant, foreign-born population” where he assumed incest occurred. Nor could he imagine that the infection arose in the home environment, as his patients came from both squalid homes and the “fashionable parts of town.”

To prevent the spread of infection, Taussig recommended lowering toilets, U-shaped toilet seats, paper seat covers, and lavatory attendants who could detect discharges and ensure that girls used the seat covers.

However, early-twentieth-century school boards lacked the funds to keep lavatories clean, let alone remodel them. But in response to warnings that infected girls posed “a real menace” to other children, school boards and municipalities around the country—from New York City in 1916 to Los Angeles in 1937—enacted policies suspending them from school, even though the federal Children’s Bureau found such measures to be ineffectual. Dr. Nels A. Nelson, the Assistant Director of the Division of Communicable Diseases of the Massachusetts Department of Public Health, even included the topic in his Christmas Eve 1930 radio address. Nelson was against excluding girls and he assured parents that there was no proof that any girl had been infected at school. The issue was still unsettled in 1935, when Nelson had become the top public health official in Massachusetts in the area of venereal disease. Although he decried the “misunderstanding and resultant confusion, almost to the point of hysteria, over gonorrhea and syphilis in the public schools,” to allay parents’ fears, he recommended that girls be suspended until the discharge cleared up, about six to eight weeks.

“It Is Less Embarrassing To Accuse A Toilet Seat”

Parents may have become hysterical because the vague information provided by public health departments and social hygiene organizations confused them. For instance, a New York City Health Department pamphlet printed on pink paper and circulated in English and Italian in the 1930s entitled, “Important Information: Special Instructions for Vaginitis Cases,” warned mothers only that, “Your child is suffering from a contagious (catching) disease. You must be careful to prevent its spread to others. . . . Care in this cause means CLEANLINESS.” In a public education pamphlet that Nelson wrote for the Massachusetts Society for Social Hygiene in 1936, he conceded that “nobody knows” how children become infected from nonsexual contacts. Nor could he describe the process in a 1938 public health textbook: “How the gonococcus finds its way to the child’s vulva, if not by direct sexual contact, has never been determined.”

One reason that doctors had so little information was because they
asked few questions. Poorly funded and disorganized clinics in the 1920s and 1930s had neither the time nor the resources to investigate the sources of patients’ infections. Moreover, health care workers whose primary interest was to increase the number of people receiving treatment avoided questions that might have discouraged parents from permitting their daughters to be treated. However, doctors circumvented the issue in research studies as well. When a prestigious three-year clinical study at a specially constructed “vaginitis clinic” at New York City’s Bellevue-Yorkville Health Demonstration set out to identify the definitive source of girls’ infections, investigators pressured mothers to be tested but omitted fathers from their protocols. In 1933, the project’s investigators admitted in their lengthy final report that they could not determine whether either uncleanliness or rape had been the source of infection in any of the 322 cases studied. They concluded that, “the exact manner of transference of the infectious material from the ill to the well is unknown.”

Even so, practitioners continued to insist that nonsexual contacts caused infection, even though doing so had not improved their ability to trace contacts. By 1937, doctors Reuel A. Benson and Arthur Steer, attending physicians at the busy vaginitis ward at New York City’s Metropolitan Hospital, still could not identify the source of infection for one-half of their 195 patients. Yet, they dismissed rape as an “infrequent” cause of infection, even as they admitted that patient histories provided by a girl’s parents could not be verified when “things such as toilets seats, linen and bathing water were accused.” As Nelson commented in 1938, “It is less embarrassing to accuse a toilet seat than to seek for sexual sources or to request the examination of other members of the family.”

However much doctors relied upon the notion of nonsexual infection, no research study before 1940 attempted to test the possibility. The first do so was the New York Vaginitis Research Project of the Gonococcus Research Committee, which was organized by the New York City Department of Health, and funded by the U.S. Public Health Service and private foundations. By measuring factors such as the length of time N. gonorrhoeae remain virulent on a toilet seat, it was able to discredit the notion of casual infection. However, the committee did not explain how else girls acquired the disease from an infected parent. Although the study attributed infections transmitted between children to “sex play,” it only said of parent-child transmission that, “The relationship between the child and the infected adult has to be quite intimate.”

That same year the eleventh edition of Holt’s Diseases of Infancy and Childhood, the most prestigious pediatrics textbook of the twentieth century, repeated Alice Hamilton’s speculation as fact: “Gonococcus vaginitis in children is not to be regarded as a venereal disease. An insignificantly
small proportion of the cases are acquired by sex contact.” Holt’s instructed physicians that, “In schools and other public places [vulvovaginitis] may be spread by toilet seats . . . The young child may have slept in the same bed with an infected mother or sister; the infection may have occurred through baths, towels, clothing, toilets, etc.” To prevent the spread of infection, Holt’s suggested that doctors quarantine infected girls by isolating them within their homes where they would not be a “menace” to others. Fortunately for girls, shortly thereafter, penicillin became available as an “instant cure” for gonorrhea. Now that they no longer posed a risk of spreading a lingering infection to others, medical interest in girls’ infections evaporated and researchers and clinicians moved on to more pressing subjects.

Conclusion

Despite profound changes at the end of the twentieth century in talking about sex in general and about incest in particular, the incidence with which incest occurs remains in doubt. Contemporary women’s incest narratives arose amid events that were as disturbing as they were puzzling: the mass criminal prosecutions of daycare workers for sexual abuse; the imprisonment of fathers for incest and other crimes based on their daughters’ childhood memories; and the commercialization of a grassroots recovery movement that turned self-help into big business. The media and partisans in the debates often conflated these events and flattened the complicated issues they raised about memory, subjectivity, and power to an artificial contest between “irrational” feminism and “reliable” science. This paper demonstrates that evidence of the widespread occurrence of incest exists, but that professionals have used authoritative discourses to conceal it.

The discovery of seemingly rampant sexually transmitted disease among girls in the early twentieth century raised a compelling threat to the status quo, which health care professionals and reformers diffused by using their scientific authority to manipulate the evidence. Late nineteenth-century scientific advances substantially improved doctors’ ability to diagnose gonorrhea by detecting the presence of \( N. \) gonorrhoeae, a specific infectious agent. But the more attention professionals—from a strikingly diverse range of doctors, nurses, social workers, social hygienists, and reformers—paid to the disease, the more they obscured the source of infection. Scientific advances paradoxically fomented confusion rather than clarity. When the medical evidence before them conflicted with key ideologies about masculinity, class status, and citizenship, health care professionals and reformers did not hesitate to substitute speculation for
empirical data. They reframed infection from a medico-legal issue to a facet of sanitation reform, thereby placing the blame for infection first on bed linens, then on mothers, other girls, and, in desperation, even on toilet seats. This discursive move exonerated fathers from responsibility by rendering the issue of whether or not they had raped or sexually assaulted their daughters irrelevant.

The ways in which professionals revised the etiology of gonorrhea in girls supports the feminist argument that the production of knowledge is never value neutral, but always arises from historically specific social relations.108 “Scientific advances”—idealized as positivistic, objective, and reliable sources of knowledge—resulted in the discovery of widespread evidence of incest in the early twentieth century. But as Sandra Harding notes in her critique of scientific methods, “[A]ny body of systematic knowledge is always internally linked to a distinctive body of systematic ignorance.”109 Had the sexual misbehavior of fathers not been obvious all along, no concerted effort to disguise it would have been necessary. It was only after second-wave feminism—derided as a subjective, politicized, and ideological approach to knowledge—offered a new critical perspective from which to evaluate family relations and allegations of sexual assault that fathers’ sexual abuse of their daughters was finally recognized as incest.

NOTES

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2 Ibid., 505.


See, for example, Frederick Crews, “The Revenge of the Repressed,” Parts


17 Stewart, “Sexually Transmitted Disease,” 150.


20 Adimora, Sexually Transmitted Diseases, 354, 356, 378; and Laura T. Gutman, “Gonococcal Diseases in Infants and Children,” in Sexually Transmitted Diseases,


Ibid., 191.


43Ibid., 241.


45Ibid., 37–40; John C. Burnham, “The Progressive Era Revolution in American Attitudes Toward Sex,” *Journal of American History* 59 (March 1973): 885–908, esp. 890–92; and Roster of officers and directors, 1913–57 (ca. 1957), Box 18, folder 7, New York Social Hygiene Society, Inc., formerly the ASSMP, Box 125, folder 18, American Social Health Association Collection, Social Welfare History Archives, Walter Library, University of Minnesota, Minneapolis, MN (hereafter cited as ASHA). See also William Snow, “The American Social Hygiene Association: Some Notes on the Historical Background, Development and Future Opportunities of the National Voluntary Organization for Social Hygiene in the United States,” (New York: ASHA, June 1946); pamphlet, Box 1, folder 1; Minutes, American Vigilance Association, 17 February 1913; and pamphlet, Box 2, folder 6, in ASHA.


48Morrow, Social Diseases and Marriage, 23.
50Morrow, Social Diseases and Marriage, 117
51Ibid., 118.
60See, for example, Chicago Society of Social Hygiene, For the Protection of Wives and Children from Venereal Contamination (Chicago: Chicago Society of Social Hygiene, 1907); and Lavinia L. Dock, Hygiene and Morality: A Manual for Nurses and Others, Giving an Outline of the Medical, Social, and Legal Aspects of the Venereal Diseases (New York: G.P. Putnam’s Sons, 1910), 148–49.
63Seippel, “Venereal Diseases,” 52.


68Tomes, Gospel of Germs, 85; Tomes, “Spreading the Germ Theory,” 603.


73Ibid., 54.

74Ibid., 54–55; and J. Clifton Edgar, “Gonococcus Infection as a Cause of Blindness, Vulvovaginitis and Arthritis,” JAMA 49 (3 August 1907): 411–14, esp. 413–14.

75Seippel, “Venereal Diseases,” 51.


Ibid., 143.


Ibid., 483.

Ibid., 490.

Ibid., 483–84.


94Nelson and Crain, Public Health, 142–43.


101Nelson and Crain, Public Health, 144.

102Alfred Cohn, Arthur Steer, and Eleanor L. Adler, “Further Observations on Gonococcal Vulvovaginitis,” Transactions of the American Neisserian Medical Society, 6th annual session (New York, 10–11 June 1940), 24–41; and “Gonococcal

103 Cohn, “Further Observations,” 25.


105 Holt and McIntosh, eds., *Holt’s Diseases of Infancy and Childhood*, 821.


109 Harding, “Comment on Walby’s ‘Against Epistemological Chasms’” 516.