function of culture, religion, social class, socialisation at menarche, and current life events.

Because the aetiology of this phenomenon is unknown, all treatments are experimental. No treatment is risk free. We urge caution and consideration of risks and benefits on the part of both health care professionals and people seeking treatment. We are concerned about the commercialisation of treatments based upon limited and inconclusive evidence.

To correct the widespread misunderstanding of menstrual cycle-related experience, education should be a top priority. We recommend creative education programmes directed toward the general public, including both children and adults. In addition, special attention should be paid to the training and continuing education of members of the biomedical community. Because of their perspective, women's groups should be centrally involved in these programmes.

The *Biomedical Subgroup* reported:

Many women report a variety of physical and behavioural changes that occur in temporal relation to the menses, but there is, at present, no universally accepted definition of PMS. Although a number of symptoms such as irritability, abdominal bloating, mood lability, breast tenderness, hostility, and tension are frequently reported in relation to the premenstruum, diagnosis of PMS cannot be made solely on the basis of symptomatology. Most experts agree that a precise definition of PMS must incorporate information about severity and timing of symptoms. The importance of obtaining this information prospectively cannot be overemphasised. Prospective records have, in fact, revealed the existence of a group of women in whom symptoms cyclically reappear in the premenstrual phase of the cycle, with relief following the onset of menstruation. At times, premenstrual symptoms are sufficiently distressing to result in reports of significant impairment of function. However, it is not yet known if PMS is an extreme form of formal premenstrual symptoms, or if it is a distinctive clinical entity.

The current uncertainty arises in part from the differences that can be expected when separate disciplines examine a subject and from the inherent difficulty in comparing work that uses widely disparate constructs. It is even questionable whether various investigators have been examining the same basic phenomenon. Much of the confusion may result from the tendency to generalise findings from restricted samples of women.

Many modalities have been reported to be effective in the treatment of PMS. However, evidence at present does not support any currently aetiological model, nor does it support the therapeutic superiority of any prescribed treatment. The cornerstone of the treatment of PMS at present should be careful, comprehensive, longitudinal evaluation with attention paid to the severity and pattern of appearance of symptoms, as well as to medical, social, and psychological factors that may affect symptom appearance. Treatment may include such modalities as social support, education, counselling, life-style changes, and pharmacotherapy tailored to a patient's individual needs.

Much of the present difficulty in assessing treatments results from methodology that omits necessary control and placebo conditions, as well as the failure to select patients/subjects on the basis of multiple prospective ratings throughout the menstrual cycle and over the course of several cycles. Further conclusions concerning the efficacy of treatment modalities must await the results of rigorously designed studies that include the following: utilisation of clear and consistent definitions of PMS; prospective diagnostic confirmation; double-blind placebo control trials; utilisation of treatment cells that are long enough to avoid the obfuscating effects of intercycle symptomatic variation; and consideration of socio-cultural variables. In addition, collateral objective assessment of symptoms is recommended to evaluate the reliability of subjective ratings.

It appears that the least ambiguous results will be obtained by studies of women who are severely affected premenstrually yet have no clinical evidence of emotional or behavioural disturbance at other phases of their menstrual cycle. If PMS could be defined in these women and the data used to construct operationally-defined criteria and specific symptom-rating tools, it should be possible to compare more reliably future studies of the aetiology and treatment of this disabling condition.

Currently available data do not permit reliable estimates of the prevalence and impact of this disorder, highlighting the importance of the need for well-designed, prospective, epidemiological studies.

Correspondence

The adolescent services

DEAR SIRS

Dr Perinpanayagam's letter (*Bulletin*, November 1985, **9**, 226–227) makes reference to those of us working in Child Guidance settings as not having opportunities to develop expertise in working with adolescents. May I assure him that this is not the case in all Child Guidance Clinics. Here in Macclesfield, although the title has been retained for historical reasons, over a third of our Child Guidance referrals are aged 12 and over and include a number of youngsters deemed 'unsuitable' for treatment by adolescent in-patient services.

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The Membership List 1985

DEAR SIRS

It is interesting to note in the College's *Membership List, 1985* that there are many non-consultant and non-training grades who have got their memberships in the recent years—about 35 associate specialists and an equal number of clinical assistants. In this context, I recall the article 'The Short Report and its implications' by Fiona Caldicott (*Bulletin*, September 1982, **6**, 155–157), the then Chairman of the College's Manpower Committee. She stated: '... many Associate Specialists in Psychiatry have completed appropriate training and moved to Consultant Posts. This possibility should persist as the recommendation suggests'.

I feel the College should encourage the non-training grades to do their membership examination, provided they have completed their general professional training in

psychiatry. I also feel that the College should consider ways and means of those non-training grades with their memberships being able to get further appropriate training (higher training), if necessary, without losing their seniority to be eligible to apply for consultant posts.

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Stigma: A common sense view

DEAR SIRS

Dr Turner's admirable attempt (*Bulletin*, January, 1986, **10,** 8–9) to identify the reasons for persistent or even increasing stigma towards psychiatry and psychiatric patients misses a fundamental point. Psychiatric illness to the layman is not necessarily equated with violence or fear but is either 'not real illness' (i.e. malingering) or 'weird' irrationality. I think the point is one of unpredictability. If someone has once lost his reason in a psychotic breakdown, to what extent can his friends or colleagues really ever be completely sure of him again? Even if well on lithium or depot neuroleptics will he always take his medication? Will the drugs always be effective? Can such patients be entirely trusted in responsible jobs—in the police or armed forces, as airline pilots, as doctors or nurses?

Like epilepsy it is not necessarily lack of compassion that leads to stigma: more the question of uncertainty. I doubt if attempts to change attitudes can ever alter the reality of the disorders we psychiatrists try to treat.

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The need for communication

DEAR SIRS

I write in acclamation of the two articles 'The Psychopathology of Nuclear War' and 'Whatever Happened to Stigma' (*Bulletin*, January 1986, **10,** 2–5 and 8–9). The first because it is the least politically biased statement of its kind I have ever read, and the second as a reminder that the battle against deep-rooted prejudice in the minds of the public and their media mentors is one which must be understood and accepted as inevitably never ending.

That said, two points seem worthy of mention. While unreservedly endorsing the final paragraph and concluding quotation in the first article, there still remains an inescapable reality to be accepted: that for the total 'release of healthy emotion in the service of survival', to succeed, one obstacle must be tackled by both superpowers: the communication barrier.

The recent Summit Meeting provided a ray of hope. But while the population of the USSR are bound to remember the 20 million killed in the Great Patriotic War, they are equally conditioned to forget not only the Nazi Soviet Non-Aggression Pact in 1939, which released the final assault upon Europe and later themselves, but also to remain passive about the reality, if not actually unaware of the fact, that their own psychiatrists are still likely to be imprisoned as dissidents if they ally themselves openly with the eminently sane and reasonable conclusions of Dr Jim Dyer.

The second point arises from the Stigma article, and comes in two parts; I cannot agree that responsible psychiatrists in teaching hospitals are 'camouflaging themselves as humdrum hospital doctors'. The verb and adjective in that phrase are in my personal opinion not only inaccurate but negatively provocative. We must set the right example if we expect to earn and deserve the respect and confidence of our colleagues and fellow teachers in other fields of medicine and surgery. On the 'clients/patients' issue, I am certain that medical terminology is not only right but *essential*. A patient is a person who needs medical help: a client, a person whose health is unimpaired but who seeks professional social advice: whether it be legal, financial, domestic, or architectural, for example.

Thank you Drs Dyer and Turner for two admirable expressions of lucid and vital opinion: and please regard these comments as constructive rather than contentious.

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Psychiatry and the peace movement

DEAR SIRS

It will be fairly common knowledge that International Physicians for Prevention of Nuclear War (IPPNW) are shortly to receive the Nobel Peace Prize, and this is no small encouragement. The outcome of the recent discussions between President Reagan and Mr Gorbachev likewise are not without genuine promise. Human nature being what it is, we are tempted to believe that we can now address our minds more fully to the often pressing matters at work and at home. Indeed the dangers are decreased only by a mere fraction and the risk is that armaments may stealthily increase behind a screen of wishful thinking on the public's part and that the world will awake one day to discover that it is already well past the eleventh hour.

Can psychiatrists help in the follow-up to this? Manifestly we need a change of ideas, a reversal of some of our feelings. Consider the following:

(1) Ever since 1914—which is as far back as I can go in any memory of warring nations—we have harboured the illusion that whoever the 'enemy' is (Germany and Austria then, Russia now) is evil and unworthy; and that the way to ward off disaster is a show of military strength. But are those people different from ourselves or are their governments more greedy and grasping than our own?

(2) We have shelved much of our responsibility for poverty in the Third World and this includes (as the recent IPPNW conference in Hungary made clear) our duty in respect of preventive medicine among children. Professor Velasco-Suarez, Mexico, said, 'We shall never have peace and justice till we have a different economic order etc in the world. A fraction of what is