

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 investi-

gators 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