Child sex abuse

DEAR SIRS

I read the article 'The Diagnosis of Child Sexual Abuse' by Arnon Bentovim (*Bulletin*, September 1987, **11**, 295–299) with great concern. There is much discussion at present about child sex abuse among doctors as a whole and also among psychiatrists. It seems we all believe in the existence of a disease like child sex abuse. I am writing this to request my colleagues to pause for a while to think about child abuse before we go any further.

As far as I know, child sexual abuse is not a disease included in the international classification of diseases. It is not an illness that is described in any major textbook of medicine, surgery, psychiatry or paediatrics. There are no uniformly agreed diagnostic criteria to make this diagnosis. The methods of investigation of a suspected case are also not clear. There is no real proof that any of the proposed suggestions of management of the case is any better than the ones that exist at present.

The whole question of child sexual abuse needs to be discussed thoroughly by doctors as a whole so that we can find answers to these issues. Only after acceptance of this as an illness, with agreed diagnostic criteria, should one talk about child sexual abuse as a disease. If the profession cannot do this and different people talk about child sexual abuse as if they are authorities in the subject, that can only confuse the issue. This is simply because the so-called experts in this field at present are self-educated enthusiasts and no wonder some of them get into trouble. There is no training for doctors in child sexual abuse at present and if we have to accept someone as an expert we should make sure that there are training centres and such experts go through a complete training programme.

M. S. ALEXANDER

St James's University Hospital
Leeds

Dr Bentovim replies

DEAR SIRS

I read Dr Alexander's letter in response to my article with some concern. I certainly appreciate his concern about the issue of sexual abuse as a disease and how it stands within the spectrum of conditions. I would certainly agree that there could be some helpful wide ranging discussions between colleagues to try and conceptualise the issues in a more satisfactory fashion. Having now had referred something in the region of 800 families to our team at Great Ormond Street and the Tavistock Clinic, I think that it would be reasonable to say that we have had a reasonable experience of the phenomenon. In our experience we can say with some confidence that we see the sexual abuse of children as a phenomenon very closely allied to the physical abuse of children. The Battered Child Syndrome as described by Kempe is also not a disease in the formal sense of the word, although fractures, bruises and subdural haematoma etc. are diseases in their own right resulting from abusive acts which may arise from individuals who have disordered personalities or on a family level may function in ways that appear to require a victim to direct abuse at. Similarly, in sexual abuse the post-traumatic stress disorder is a clearly described DSM III diagnosis as are conduct problems, emotional disorders, personality disordered individuals, those addicted to alcohol, those with a variety of perversions who enact the abuse of children. We do have a real problem of describing family based phenomena in ways which are acceptable in a nosological sense.

There are currently attempts to develop a typology of family disorder which may bear fruit and help to categorise problems such as the sexual abuse of children in a satisfactory fashion. Meanwhile, in ICD-9 we have to think of sexual abuse as occurring on the psycho-social axis.

The problem is that the urgent question of children who have been abused, families who are inevitably caught up with child care and the legal context cannot wait for a satisfactory classification scheme before we attempt to devise appropriate ways of providing help. Psychiatrists have not always been in the forefront of the management of serious physical abuse of children. It is important that we define our role in relationship to sexual abuse and help other professionals think about the complex issues associated with it. Inevitably we have to use principles derived from other fields to gain experience to develop appropriate ways of dealing with the problems. Obviously no one can be trained in a field which does not exist until practice is defined. I hope we are now developing our practice and that the whole issue of how we conceptualise sexual abuse can be addressed.

ARNON BENTOVIM

The Hospitals for Sick Children
Great Ormond Street
London WC1

Canadian qualifications for British psychiatrists

DEAR SIRS

Our Centre has been active in the recruitment of British psychiatrists for a number of years (*Bulletin*, April 1985, **4**, 77–78) and we have now achieved some significant experience in the problems entailed in British psychiatrists achieving Canadian qualifications and licences to practise. It was thus with interest that we read Professor Munro's recent article (*Bulletin*, September 1987, **11**, 305–306). Professor Munro's article implies caution in respect of prospects of immigration to Canada and upon this point we would like to amplify.

In order to obtain the Canadian qualification of LMCC, which is the licence to practise accepted by the Canadian provinces, one must pass the Canadian Qualifying Examination of the Medical Council of Canada. In order to take the Canadian Qualifying Examination it is generally necessary to pass the Canadian Evaluating Examination, unless one is already practising in Canada in which case the Evaluating

Examination may sometimes be bypassed. Once the Canadian Qualifying Examination is passed, one must obtain from a provincial College of Physicians and Surgeons a certificate of appropriate training. This certificate of appropriate training is generally only given to those who have undergone a North American type of rotational internship, covering obstetrics and gynaecology, paediatrics, etc. Some provinces will make the exception of granting this certificate, without evidence of a rotating internship, if the physician has first achieved a Canadian Royal College higher qualification, such as the FRCP(Psych). The Qualifying Examination and the certificate of appropriate training are the two prerequisites to achieve the LMCC.

As Professor Munro indicates, Canada does not accept the British MRC(Psych) as the equivalent of their own FRCP(Psych). In order to take the FRCP(Psych) Canada one must first pass a screening examination. These screening examinations include the Canadian Qualifying or Evaluating examinations and also the FLEX or FMGEMS examinations of the USA. Probably even more crucial than success at a screening examination is the need to have one's training assessed by the Royal College of Physicians and Surgeons in Ottawa. Although British psychiatric training may be passed by the Royal College as being satisfactory, it is not uncommon for the Royal College to decide a further period of residency training is necessary, which can range from six months to two years or longer. This then places the candidate in a position of having to gain entry into a Canadian residency programme, with, of course, having to suffer the financial consequences, in order to complete his eligibility for the FRCP(Psych) examination. This can result in a very traumatic state of affairs for the British trained psychiatrist and we recommend that anyone taking up a permanent position in Canada would be wise to have this formal assessment of their training completed before they leave British shores.

Professor Munro states that "aiding immigration for suitably training psychiatrists ... has become all but impossible". Although we concur that the immigration of British psychiatrists to Canada is becoming progressively more difficult, it is still possible for British psychiatrists to obtain a 'special licence' (limited licence to practise), in certain Canadian provinces such as Saskatchewan and Manitoba, based entirely on their British qualifications. Individuals taking up such appointments, however, still have the steps spelt out above to contend with if they hope to achieve a general licence to practise and wish eventually to obtain their Canadian general medical and psychiatric qualifications.

Finally, with the intricacies outlined above, it would be interesting to hear the position of the British Royal College of Psychiatrists in respect of physicians who hold Canadian qualifications and wish to practise in the United Kingdom.

C. GREEN
S. MANOHAR

Regional Psychiatric Centre (Prairies)
Saskatoon, Saskatchewan, Canada

Abuse and neglect of the elderly mentally infirm

DEAR SIRS

I and colleagues from other disciplines have recently been involved in cases where there has been physical abuse and/or neglect of an elderly mentally infirm person and we are trying to formulate a policy or procedure to deal with these cases, which unfortunately seem to be on the increase.

I would be very grateful for any help or advice from members who have tried to deal with similar problems in their own practice, especially if they know of or have devised a workable procedure in their own districts.

DELYTH ALLDRICK

Whitchurch Hospital
Cardiff

Children allegedly killed or injured by nannies

DEAR SIRS

I have seen two cases where nannies have allegedly killed or injured children in their care, and a colleague has seen a similar case. I should like to hear from other colleagues who have seen cases of this kind.

O. V. BRISCOE

The Maudsley Hospital
Denmark Hill, London SE5 8AZ

Gilles de la Tourette's Syndrome

DEAR SIRS

I write in the hope that you can assist me in tracing the address of a support society in Britain for sufferers from Gilles de la Tourette's Syndrome and their relatives.

Thank you for your assistance.

R. V. SCHNEIDER

Lindsay Miller Clinic
Launceston General Hospital
Launceston, Tasmania 7250

Layout of 'Bulletin'

DEAR SIRS

I do feel that much could be done to increase the attractiveness and readability of the *Bulletin*. The present layout and type-face is most off-putting and I feel hardly inspires the reader to keep up to date with College news and views.

We live in an age of computer desk top publishing and by comparison the *Bulletin* looks as though it were laboriously assembled by one of Caxton's assistants.

ANDREW R. JOHNS

Drug Dependence Clinical Research
and Treatment Unit
The Maudsley Hospital, London SE5

Editorial Note: This matter is under active consideration.