wellbeing but is potentially counterproductive to promotion of breast feeding.

I suggest the following amendments to the author's key messages:

- First assess whether the heel prick is really necessary
- Minimise the discomfort of the procedure by asking the parent (or member of staff) to cuddle and soothe the baby
- If the mother is breastfeeding encourage her to put the baby to the breast before the procedure starts and allow the baby to suckle during the procedure

Lastly, before drug manufacturers seize a new opportunity to market prepacked phials of sterile sucrose solution, complete with dropper, could I urge the authors to consider mounting a study to answer their own query—namely, “whether simply cuddling a crying infant after heel prick is as effective in reducing crying as 50% sucrose.” It may be that going back to the basics is all that is needed.

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Are sugar pills unsuitable placebos?

EDITOR,—Now that a solution of 50% sucrose has been shown to have analgesic properties in babies,¹ I believe it is time to discard all those trials where lactose has been used as a placebo.

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- 1 Haouari N, Wood G, Griffiths G, Levene M. The analgesic effect of sucrose in full term infants: a randomised controlled trial. *BMJ* 1995;310:1498-500. (10 June.)

Adult survivors of child sex abuse

Group therapies are also effective

EDITOR,—In their paper on the pilot service, Breakfree, for adult survivors (both men and women) of childhood sexual abuse David Smith and colleagues leave some points unclear.¹ How many support workers were there, and how professionally trained were they? They were “initially supervised,” but by whom and for how long? The average duration of a counselling session was 1.8 hours (no range was given), sometimes twice weekly. This seems a lavish use of resources. The scheme was found to be successful in this study, but care would have to be taken in replication to ensure the quality of supervision and counselling.

In testing the differences between scores at the start and end of treatment the authors have emphasised hypothesis testing by quoting *z* and *P* values. It would have been helpful, however, if they had given summary statistics, such as the median scores and percentile ranges, and indicated the magnitude of the differences by calculating confidence intervals for the differences.² Finally, we are not told how the sum of £70 000 was arrived at as the cost of the year's pilot scheme.

In the psychological therapies service in Southampton we have been treating women

survivors of childhood sexual abuse in a weekly analytic group of one and a half hours' duration since January 1986. The learning from group therapy for these patients is particularly rapid, probably because they find that their experiences are not unique and they therefore feel less isolated. A clinical account of the first 94 patients admitted to the group from the 235 referred up until August 1990 has been published.³ Their depressive inventory score fell during their time in the group, and the fall was maintained for between two and seven years afterwards and was independent of treatment with antidepressants. Their use of psychiatric hospital and primary care services was also reduced over five years' follow up.⁴

It will be interesting to know if the improvement during the Breakfree programme is maintained at follow up and whether it depends on continued contact with the service. If so, the cost will increase with time.

We are now estimating the cost of our method of treating women survivors. It would be useful to be able to compare the cost and effectiveness of the two methods of dealing with this vast source of psychological distress.

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- 1 Smith D, Pearce L, Pringle M, Caplan R. Adults with a history of child sexual abuse: evaluation of a pilot therapy service. *BMJ* 1995;310:1175-8. (6 May.)
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Authors' reply

EDITOR,—Our study was an audit of a pilot scheme set up in response to identified needs of adult survivors requesting one to one “abuse focused” therapy in a community setting. Because of the diversity of long term effects of child sexual abuse, survivors will require and request therapy to suit their individual needs at a particular stage of their healing process. Our “imaginative” client led, community based, interagency pilot scheme reflects one sensitive and appropriate approach that clients found to be successful.

The pilot scheme had 12 sessional support workers, all of whom received training from specialists in treating adult survivors, such as Dr Liz Hall, a consultant clinical psychologist; training in issues concerning child protection and offenders' behaviour, provided by Lincoln social services' training department; and training in humanistic counselling. All staff initially received frequent debriefing by peers in addition to regular supervision (conforming to the guidelines of the British Association for Counselling) from fully qualified psychotherapists and psychologists.

Contracts for therapy were negotiated to meet individual need and ranged from half an hour a week to two two-hour sessions a week. Such flexibility of approach facilitated disclosure and allowed the clients to regain their composure before leaving the building.

The year's budget for the pilot scheme was £70 000, but this did not include any costs for the

infrastructure. The Breakfree Service for Adult Survivors is now operating as an independent service but still maintains a competitive costing structure. The pilot scheme was funded for only a year, and no provision was made for long term follow up. We now intend to continue evaluating the approach and to monitor long term outcome, perhaps with comparative studies.

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Protecting adolescent girls against tetanus

Targeting both sexes may avoid misunderstandings

EDITOR,—As a surgeon working in the developing world, but home on leave, I would like to comment on the editorial by Loretta Brabin and colleagues.¹ In our rural area in Cameroon we see at least as many teenage boys with tetanus as we see girls, possibly because of their hunting and outer outdoor pursuits. The incidence in men is certainly higher than in women, because of the number of women protected through antenatal care.

A few years ago a campaign to protect teenage girls went sadly wrong due to insufficient education of the community before the campaign. Because the campaign was aimed only at girls, a rumour started that these injections were of a long term contraceptive. The rumour was taken up by some religious leaders and believed by the girls and resulted in a sharp increase in pregnancies among school students.

For both these reasons it is preferable to target primary school leavers of both sexes. I know more toxoid would be needed, but the cold chain and staff could deal with both groups as many primary schools are coeducational. Those not attending school at all should also be targeted as they usually drop out after the infant course and do not come for the booster dose five years later. Since the cold chain is of variable efficiency some of the doses given may have been ineffective and an extra dose is therefore better than one dose too few.

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- 1 Brabin L, Kemp J, Maxwell S, Ikimalo J, Obunge O, Briggs N. Protecting adolescent girls against tetanus. *BMJ* 1995;311:73-4. (8 July.)

Induced abortion can predispose to tetanus

EDITOR,—As participants in the course for the diploma of reproductive health for developing countries at the Liverpool School of Tropical Medicine, we read with interest the article by Loretta Brabin and colleagues.¹ Four of the six participants on the course have had experience in managing a total of seven patients with post-abortion tetanus in three countries (table).

These seven women were admitted with tetanus following induced abortions, usually undertaken by a traditional abortionist. These cases illustrate that antenatal vaccination alone misses women