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medico friend circle bulletin

MAY 1976

RADICAL PSYCHIATRY : PRINCIPLES

CLAUDE STEINER

PSYCHIATRY is the art of soul healing. Anyone who practises the art is a psychiatrist. The practice of psychiatry, usurped by the medical profession, is in a sad state of disarray. Medicine has done nothing to improve it; as practised today, medical psychiatry is a step sideways, into pseudoscientism, from the state of the art in the Middle Ages when it was the province of elders and priests as well as physicians.

Psychiatry as it is predominantly practised today needs to be changed radically, that is ' at the root '.

Psychiatry is a political activity. Persons who avail themselves of psychiatric aid are invariably in the midst of power–structured relationships with one or more other human beings. The psychiatrist has an influence in the power arrangements of these relationships. Psychiatrists pride themselves on being ' neutral ' in their professional dealings. However, when one person dominates or oppresses another, a neutral participant, especially when he is seen as an authority, becomes an enforcer of the domination and his lack of activity becomes essentially political and oppressive.

The classic and prime example of this fact is found in psychiatry's usual role in relation to women where, at worst, psychiatrists promote oppressive sex roles and at best remain neutral, therefore supportive of them. The same is true of psychiatry's traditional role in relation to the young, black, and poor; in every case psychiatry represents tacit support of the oppressive status quo.

There are four types of psychiatrists. Alpha psychiatrists are conservative or liberal in their political consciousness and in their practice and methods of psychiatry; the largest majority of medical psychiatrists fall into this category. Beta psychiatrists are conservative or liberal in their politics and radical in their methods. Examples of this type are men like Fritz Perls and Eric Berne and the human potentialities psychiatrists, usually not physicians, who expand the boundaries of psychiatric practice, but tend to be unaware of the manner in which oppression is a factor in psychic suffering and ignore the political nature of their work. Gamma psychiatrists are radical in their politics but conservative in their practice. Examples of this are Laing and others (as a special case, Szasz, whose awareness of the politics of psychiatry is quite heightened) who practise old, outmoded methods of therapy based on Freudian or neo–Freudian theory with emphasis on individual psychotherapy, ' depth ', and ' insight '. The fourth kind of psychiatrist is the radical psychiatrist, who is radical both politically and in his psychiatric methods.

The first principle of radical psychiatry is that in the absence of oppression, human beings will, due to their basic nature or soul, which is preservative of themselves and their species, live in harmony with nature and each other. Oppression is the coercion of all human alienation.

The condition of the human soul which makes soul healing necessary is alienation. Alienation is a feeling within a person that he is not part of the human species, that she is dead or that everyone is dead, that he does not deserve to live, or that someone wishes her to die. It may be helpful, in this connection, to remember that psychiatrists were originally known as alienists, a fact that seems to validate the notion that our forefathers know more

about psychiatry than we. Alienation is the essence of all psychiatric conditions. This is the second principle of radical psychiatry. Everything diagnosed psychiatrically, unless clearly organic in origin, is a form of alienation.

The third principle of radical psychiatry is that all alienation is the result of oppression about which the oppressed has been mystified or deceived.

By deception is meant the mystification of the oppressed into believing that she is not oppressed or that there are good reasons for her oppression. The result is that the person instead of sensing his oppression and being angered by it decides that his ill feelings are his own fault and his own responsibility. The result of the acceptance of deception is that the person will feel alienated. A good example of this is the depressed youth who does not wish to participate in a war, but is forced to do so and told that he's doing it for the benefit of his country, the benefit of his brothers and sisters, or even for his own benefit. If he neglects to see that he is oppressed in this situation and comes to believe the mystifications about it, he will then turn from someone who is angry at his oppression to someone who is alienated and believes that he is a coward. Another example is the woman who, angered by her husband's domination, ceases to enjoy sex with him. Again, if she fails to recognize her oppression she will conclude that she is at fault; that she is ' frigid ', while if she becomes aware of the source of her anger she will recognize that her loving nature is intact.

Thus, the difference between alienation and anger about one's oppression is unawareness of deception. Psychiatry has a great deal to do with the deception of human beings about their oppression.

OPPRESSION + DECEPTION = ALIENATION
OPPRESSION + AWARENESS = ANGER

What, then, are the methods of radical psychiatry ? The radical psychiatrist sees anyone who presents himself with a psychiatric problem as being alienated, that is being oppressed and deceived about his oppression, for otherwise he would not seek psychiatric succour. All other theoretical considerations are secondary to this one.

The basic formula of radical psychiatry is :

LIBERATION = AWARENESS + CONTACT

The formula implies that for liberation two factors are necessary. On the one hand, awareness. That is, awareness of oppression and the sources of it. This type of awareness is amply illustrated by the writings of Laing and the writings by radical feminists and blacks, and so on. However, this formula also implies that pure awareness of oppression does not lead to liberation. Awareness of oppression leads to anger and a wish to do something about one's oppression so that a person who becomes so aware changes from one who is alienated to one who is angry in the manner in which some black people and women have become angry. Anger, therefore, is a healthy first step in the process of liberation rather than an ' irrationa ', ' neurotic ', or otherwise undesirable reaction. But liberation requires contact as well as awareness. That is to say, contact with other human beings who, united, will move against the oppression. This is why it is not possible to practise radical psychiatry in an individual psychotherapy context. An individual cannot move against his oppression as an individual; he can only do so with the support of a group of other human beings.

Thus it appears radical psychiatry is best practised in groups because contact is necessary. Because people seeking psychiatric help are alienated and therefore in need of awareness a radical psychiatry group seems to require a leader or leaders who will undertake to guide the liberation process. To avoid the leader's oppression of group members each individual member should propose a contract with the group that indicates his wish to work on a specific problem. Liberation from the leader's guidance is the ultimate goal of radical psychiatry and is indicated by the person's exit from the group.

Contact occurs between people in a number of different forms. Basically contact is human touch, or strokes, as defined by Berner. But contact includes also when people become aware of their oppression, permission, and protection. Permission is just what the word implies, a safe-conduct for a person to move against his oppressor and to take care of business '. This permission needs to come from a person or persons who at the moment feel stronger than the one who is oppressed, usually the leader. Along with the permission, the person who is to move against the oppression needs to know that he will be protected against the likely retaliation of the oppressor.

This, then, is the vital combination of elements in radical psychiatry : awareness to act against deception and contact to act against alienation. It should be reemphasized that neither awareness by itself nor contact by itself will produce liberation. As an example, it is very clear that contact without awareness is the essence of the therapeutic encounters of the ' human potentialities ' movement. The potency of human contact and its immediate production of well-being, as found at Esalen and the present RAP

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Is primary health care the new priority ? Yes, but....

—Charles Elliott

(Continued from last issue)

WE HAVE here, then, five areas of evidence that I suggest we need to ponder rather carefully. To recap briefly, these are :

1. Local communities tend to give health care low priority.
2. They tend to make the 'wrong' choices when given the opportunity to express their own preferences in terms of delivery systems : at an interpersonal level, they do not necessarily accept medical equality.
3. Community-based health strategies have proved extremely difficult to implement, partly (but only partly) because frontline workers are rapidly professionalized.
4. New health strategies may deliver health care to more people, but tend to deliver an extremely low quality of health care to the majority of those people.
5. We have probably overestimated the effects of disease on a community, and underestimated its cultural and possibly physical adaptability to a given burden of disease.

I have argued that each of these could provide evidence, (which I have deliberately not rehearsed in detail), that PHC strategy *alone* does not deliver us from the kind of professional domination we all associate with hospital-based curative services. This is *not,* not to say that PHC is a blind alley, or wrong or a mistake. Please let us be clear about that. It is to say that an overly naive espousal of PHC strategy, without a readiness to face deeper issues, is likely to result in bitter disappointment. For, to anticipate a moment, PHC strategy depends upon fallen man (both as healer and would-be-healed) and therefore upon fallen institutions. It, like everything else, is cast in an environment of original sin. This is a theme to which we must return. For the present let us limit the discussion to one central point.

The CMC and its many friends have been wholly justified in declaring war on the medical ideology of the middle sixties. The question I am asking is whether, in producing a substitute ideology, we are not in danger of doing the same violence to people and to communities, (though perhaps for higher motives), as did the people and institutions with which we have been struggling. Is there not a danger that the new set of ideas becomes as dominating, as dehumanized, as ultimately demonic as the old set of ideas ? If we really seek to respond to the situation as it is, to respect the *whole personality* of the community and individuals within it, might we not come out with a very different set of assumptions, strategies and tactics–and might not those assumptions, strategies and tactics have very little, at least overtly, to do with what we have traditionally regarded as health care ?

III. This takes me on to a new point, and a second hard question. The question can be put like this: *Is community health care as readily institutionalized as any other social service ?* Precisely because the PHC emphasis has already, become widely accepted (if not yet widely implemented), there is surly a danger that it will suffer from a hardening of the administrative arteries and a blunting of sensitivity that will change it from a potential asset to a certain liability.

If one looks at the literature on community services in general, (and person–directed community services in the United States and the United Kingdom in particular), one is impressed by the ease with which *an institution subverts the end for which it was created as a means into a means by which its own end can be justified.* Within the last six years, many studies have revealed how, in our own Western countries, services that were established to deal with 'the hard cases' have become extremely adept at developing administrative rules whereby the really hard cases are excluded, with the result that the service becomes available to the less hard, the more easily managed, the more administratively safe.

I see no reason to assume that this tendency is confined to one particular culture or one particular kind of organization. It seems to me to stem much more from the nature of fallen man and, when put together with the five bits of evidence I adduced for the first question, it does seem to me to suggest that even PHC stands in great danger of developing an institutionalized hierarchy of beneficiaries which will systematically exclude those who stand in the greatest need of health care – and in whose name the original moral impetus of PHC was originally generated.

This administrative distortion I see as an internal threat : it is parallelled and indeed aggravated by an external threat. That threat is the tendency for governments to see the provision of health care *as Part of the Process by which the government itself is legitimized.* To some extent, this is true of all social services; and to some extent, it is a proper and healthful

response of government of to popular pressure. The danger arises because different social groups are capable of threatening governments to different degrees. Different social groups can therefore demand different levels of tribute; and health care is one form that tribute can take. Put at its crudest, this tends to suggest that once PHC develops its own intitutional momentum and its own administrative rigidities, we may well find that it is subject to the same distributional biases as was the curative, hospital-based, 'undemocratic' structure of health care. Whenever and wherever there are resources to be distributed, they will be distributed in response to political pressures. The changing of the health package (in its widest sense) does not much affect that basic fact of political life.

Taken together, then, the internal and the external pressures on the community health care strategy will at the very least much moderate the effectiveness of that strategy in reaching the poorest and the most powerless.

IV. So far, I have asked questions about :

(a) the extent to which PHC has become a new form of professional domination, and

(b) the extent to which it has been, is being and will be institutionalized in a way that prevents it from effectively reaching those who need it most.

If these are valid questions, we have to ask : What then ? What can be done ? What, particularly, can be the reaction of the CMC or its successors ? Part of the answer is already clear. In discussing both of the basic questions I have tried to ask, I suggested that what one is up against is man as he is. Because one is up against man as he is, one is also up against institutions as they are, mirrors and magnifying glasses of man's moral and cultural ambiguities. Both as dispensers and recipients of health care, men-in-community are severely limited in their ability to give or receive health. *The fundamental problem that faces us, therefore, is to enlarge that ability.*

The process by which that is done can be ascribed a variety of different labels according to ideological or ethical positions. It can be called conscientization. It can be called liberation. It can be called cultural revolution. Or it can be called salvation. I'm not suggesting that these are either the same or even roughly equivalent: I am suggesting that *we are all looking for ways in which the delivery of health care does not become subverted into the protection of a profession; and for ways in which the receiving of health care does not become distorted into a process by which my neighbour is robbed.*

Here I think we glimpse something that the CMC has always emphasized, even if sometimes obliquely—namely, that health and salvation are mutually interdependent in every human society, irrespective of culture, political allegiance or level of gross national product (GNP). That interdependence is worked out, not only at the individual level, but also at the macro or social level. The personality of professional and patient is determined by what a passing generation of theologians called the state of grace, and the social milieu in which the personality is formed and lived. Thus, salvation does not, cannot and must never be allowed to have a purely personal reference. Salvation is a social process as well as an individual liberation.

The question remains : in operational terms, how can we make real this dawning perception that, in all our societies, rich quite as much as (perhaps even more than) poor, the processes of being healthy and making others healthy have to them a dimension completely ignored by traditional thinking, – a dimension that acknowledges that the people (both healer and healed) and the institutions are in continuous need of liberation, renewal and at-one-ment—a need that the biblical tradition call salvation, but which could often be equally well translated wholesomeness, or healthfulness ? In developed and underdeveloped countries, how do we bring healing and wholeness, not only to the sick. but to those who purport to cure the sick ? When we do that, what are the implications for the relationship between the practitioner and the patient, the curer and the cured ? This will doubtlessly need much further investigation, but one implication is clear. That relationship ceases to be a relationship between the sick and the healthy. It becomes rather a relationship between two people or groups *both* of which know that they are less than whole and *both* of which are seeking to find a greater degree of wholeness.

I know that some of what I have said is contentious and may spark challenge and even fundamental disagreement. So be it. But at the risk of seeming to confound confusion, let me make one final comment. If what I have said is even roughly right, there is clearly a limit to the extent to which the CMC, *the Christian Medical Commission,* can collaborate with agencies which deny to the concept of health the element of transcendental wholeness as expressed in the last paragraph. It is possible that some of these agencies will see that the physician is as much in need of healing as the sick. The real question will be : Where will the agencies look for the spiritual resources for

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HEALTH OR "HEALTH SERVICES"?

WE HAVE for review two books on the same subject—health—that supplement each other. *The Care of Health in Communities* (Macmillan, dollar 8.95) is by Nancy Milio, the registered nurse who spent a year or two working in a "mom and tots" center in the ghetto area of Detroit—getting it going, making it work—and then telling the story of this adventure in *9226 Kercheval (1970)*. The Detroit experience became the foundation for wide investigation. Miss Milio went back to school, did research, and wrote the present general report on health services throughout the United States. Quite evidently, *The Care of Health in Communities* is the result of a deeply felt need to understand why there are so many practical obstacles in the way of anyone who tries to work personally and effectively to help the poor and disadvantaged. *Access for Outcasts*, Miss Milio's subtitle, gives the motive and theme of this work.

The other book—not yet published in this country (U.S.A.) still; a draft circulated for comment and criticism—will be the American edition of Ivan Illich's *Medical Nemesis*, which has already appeared in England in briefer form. This book is the best example yet of Illich's extraordinary capacity for effective generalization. The impressive documentation supporting his judgments suggests that he and his colleagues have read every criticism in print of the modern practice of medicine. Illich's fundamental claim is that during the expansion of the social processes and structures of a civilization dominated by industrialism, a point is reached where activities originating as services begin to have a reverse effect. They begin to *harm* people instead of helping them. The damage is both subjective and objective. The reader is directed to proof of the damage in Illich's numerous footnotes. His text deals with psychological subversion, and the cutting edge of most of his generalizations is at this level. He contends that when individual responsibility is diminished by the requirements of technological systems, people tend to deny themselves the very possibility of healthful lives. Health, he suggests, is the spontaneous result when normal human beings cope resourcefully with a normal environment, matching their capacities with the natural limitations and obstacles in life.

Such statements have obvious metaphysical implications. They also have great intuitive appeal. *Medical Nemesis* represents Illich's effort to demonstrate that the facts of modern experience at every significant level support this analysis. Here we are able to give only a few of his generalizations:

Increasing and irreparable damage accompanies present industrial expansion in all sectors. In medicine this damage appears as iatrogenesis (physician-caused ills). Iatrogenesis is clinical when pain, sickness and death result from medical care; it is social when health policies reinforce an industrial organization which generates ill health; it is structural when medically sponsored behaviour and delusions restrict the vital autonomy of people by undermining their competence in growing up, caring for each other and aging, or when medical intervention disables personal responses to pain, disability, impairment, anguish and death.

Most of the remedies now proposed by the social engineers and economists to reduce iatrogenesis include a further increase of medical controls. These so-called remedies generate second-order iatrogenic ills on each of the three critical levels.

The most profound iatrogenic effects of the medical technostructure are a result of its non-technical functions, by which it supports the increasing institutionalization of values. The technical and non-technical consequences of instutional medicine coalesce and generate a new kind of suffering: anesthetized, impotent and solitary survival in a world turned into a hospital ward. Medical nemesis is the experience of people who are largely deprived of any autonomous ability to cope with nature, neighbours and dreams, and who are technically maintained within environmental, social and symbolic systems. Medical nemesis cannot be measured, but its experience can be shared. The intensity with which it is experienced will depend upon the independence, vitality and relatedness of each individual.

What is Illich's ideal? The following states it briefly:

The level of public health corresponds to the degree to which the means and responsibility for coping with illness are distributed among the total population. This ability to cope can be enhanced but never replaced by medical intervention or by the hygienic characteristics of the environment. That society which can reduce professional intervention to the minimum will provide the best conditions for health. The greater the potential for autonomous adaptation to self, to others and the

environment, the less management of adaptation will be needed or tolerated.

The weakness of *Medical Nemesis* is certainly not in Ivan Illich's diagnosis, but in his remedy—he wants to limit medical monopolies by law, and to give legislative encouragement to people to evolve their own forms of health service and care of the sick. Why should this be a weakness? Because Illich, despite the avalanche of facts he has assembled, is making a *Philosophic* criticism. At root he is recommending a changed attitude of mind—better ways for humans to think about themselves, their capacities, and their needs. You don't change minds with legislation. Changed minds may cause better legislation, but a vast number of minds have to change before the laws can be substantially improved. Only a dictator or an autocracy is able to change the laws in advance of a strong current of public opinion.

Illich may feel that his thought will remain utopian unless he proposes a political remedy for the ills he defines so well. But truly utopian programs are best initiated by numerous small-scale experiments, persistently repeated until they finally take root. Law-making is now in the hands of a collection of second-rate, secular grand inquisitors whose methods are all infected with their spiritual ancestor's assumptions. Entrusted to their hands, reforms aimed at self-reliance and increased individual responsibility will inevitably be turned around and made to have an opposite effect.

Illich's genius lies in showing what is wrong with the *Zeitgeist* of the industrial age. He reveals its self-defeating Faustian delusions and gives chapter and verse on where the defeats are taking place.

What is the *Zeitgeist?* It is spirit and mood, embodying both conscious and unconscious over-all value judgments about our lives and what is good. But men are more than any *Zeitgeist*. They are not entirely its creatures. They are not totally occupied by the generalization of their common weaknesses. In every doctor who submits to the imperatives of technological medicine there is still a human being who may be uneasy, who may sense that something is seriously wrong. The Prometheus who is subdued is not defeated. The *Zeitgeist* reflects the action, not the potentiality, of the age. Law-making, as a means, belongs to the past, not the future.

Nancy Milio, one could say, looks at world health care, and especially health care in the United States, from the point of view of what can be done in spite of *Zeitgeist*, of which she seems well aware. While Illich works at changing the polarity of human thinking, Nancy Milio considers what we may be able to do, in the meantime, out in the field. Mostly, of course, her book lists the limitations on health care—what is wrong. Inevitably, the *Zeitgeist* threatens her positive recommendations. In one place she says:

> Without public awareness of the very different consequences of numerous proposals all of which are labeled "national health insurance," there is likely to be little consumer response to Congressional moves. Without definitive public response, Congressional approaches are likely to follow familiar paths, with the result that changes will not alter current prerogatives very much, outcasts will gain little and the health of the American majority is not likely to improve.
>
> Creating such a truly democratic responsiveness would meet with many impediments, beyond finding sources for the funds that would be needed. Among them is the fact that health professionals—who are assumed to be experts on health—are often unaware, or narrowly aware as a result of their training and other reasons, of the big picture, of the context in which they work. In effect, they are more concerned about health services than health.
>
> Further, most health care providers are part of large groups and associations. Thus group decisions and organizational priorities are likely to take precedence over personal doubts, to stifle questions, to close options to new ways. And soon the newer—and sometimes more open—health personnel accept the same constraints and rewards as their mentors. Personal intention to do good and perform well takes or retains priority over the critical examination of the effects of collective actions. Were it otherwise, organized health professionals would probably have significant policy making influence toward support for the health-deriving social changes that would make personal health services more effective.

True to her purpose, Nancy Milio concludes by giving three examples of improved access that has already been achieved—programs in Orissa, India, in Amsterdam, Holland, and in Edinburgh, Scotland. The State of Orissa, "with all its difficulties, is doing what others have only talked about." Here paraprofessionals are reaching into outlying villages of Harijans ("untouchables," of whom there are four million in Orissa), and training local practical nurses and midwives. An extraordinary woman in Amsterdam is accomplishing similar effective contact with Surinam Blacks who have migrated to Holland, and

have been long neglected there. In Edinburgh the people of a low-income district have themselves organized a day nursery and health program and generated a community spirit which animates a variety of other activities—housing rehabilitation, and recreation for both young and old—with the result that " those who were to be organized have become the organizers, those who are outcast are together working to open and enter the decision-making that sets their options for living." A book entirely devoted to such initiative and achievements would make fine reading.

Courtesy, ' MANAS ' Feb. 11, 1976,

Dear Friend,

Is this a readers' bulletin ?

Inspite of the fact that I was very much involved in planning the various issues of the bulletin, when it comes in print, I can't help feeling that there should be more people participating in writing for it. The first two issuse have become a JNU affair which perhaps is not a very healthy sign. I suggest if we could in future invite members to contribute on certain specific problems (which we have selected).

In the second Bnlletin I am attracted by Shri Bapalal Vaidya's comment. " There is a need to liberate people from the grip of the doctors ". It appears that according to him Ayurveda has the answer but is being thwarted by the ICMR in its own interest. While I fully agree that indigenous medicine is not getting the kind of attention it deserves I also want to express my doubts about his hope that if funds were provided Aurvedic medicine will come to the rescue of the people. I suspect that the **same reasons** which obscure the preventive aspect of allopathic medicine will continue to operate on the teaching and practice of Aurvedic medicine and till we realise this, no amount of shifts from one system of medicine to other will make any sense.

—Imrana Qadeer, JNU, New Delhi.

Who is the culprit ?

It was interesting to go through ' The Myth of the Protein Gap '. Dr. JayaRao has accused vested interest of some countries having surplus protien resources for the myth. If it is true – and there are enough experiences in other fields to believe that it must be true – then it raises some serious and subtle question about our scientists and their so–called research activities. Are those scientists who perpetuated, supported and highlighted the so–called protein gap a party to vested interests ? Or were they fool enough to be misguided ? If so, it means that scientists may be trapped and used by vested interests. This is important because it is possible in a number of other fields also; these vested interests must be exploiting the scientists and ultimately the masses in the name of scientific truth. Not only masses are exploited individually but scarce national resources in terms of man and material are misspent. Wrong programmes are launched and authentic and false health education is imparted. Then people have to unlearn the compulsory miseducation imparted in order to accept new education. Not only that, any sensible person would hesitate to take the job of health educator, when there are many chances of miseducating the people. This unlearning requires tremendous effort and it means wastage of national resources. If this wastage is translated in crude language it is a question of bread or death for a common man in developing countries. Who is responsible for this ? Can scientists shun their responsibility in the name of science and research ? If it is due to an honest and sincere mistake in research itself then they may. But if it is planned by vested interest and scientists are being played with in their hands, it is not only unpardonable but scientists should be taken to task. They have a social responsibility to scrutinise the information put to them, either individually or collectively. Would anyone open the myths of pharmaceutical concepts ?

—A. B. Patel, Kheda.

The protein gap

The article ' The Myth of The Protein Gap ' appeared in last issue made a stimulating reading. I came across an exhaustive review article on ' The Protein Gap ' in ' Nature ' Vol. 258 November 13 1975 by Waterlow and Payne. I cannot resist myself to quote few passages from it, which may incite other readers to go through it.

" In 1968 the UN Advisory Committee on the Application of Science and Technology to Development presented a report to UNESCO with the title " International action to avert the impending protein crisis." Numerous recommendations were made about methods of increasing protein supplies, the production of high protein foods and the exploitation of unconventional sources of protein to fill the "protein gap". Seven years later there is a strong body of opinion that this is an incorrect statement of the problem : that what the world with its expanding population has to face is primarily a food gap or an energy gap and not a protein gap. McLaren, in his stimulating article " The great protein fiasco ", has summarised the history of this preoccupation with protein and in particular the reasoning by which the UN agencies came to identify protein as the weak point in the

world's nutritional defences. It all began with kwashiorkor.

" When Williams described kwashiorkor in young children in Ghana some forty years ago, she diagnosed it as a nutritional disease, adding cautiously "....in which some amino acid or protein deficiency cannot be excluded ". The children who developed the disease did so after weaning, when they were fed on starchy porridges rather low in protein, and they were cured by milk. It took some time for the diagnosis of protein deficiency to be generally accepted; in earlier accounts, particularly from Latin America, the presence of oedema and skin lesions in many cases led to the suggestion of a multiple vitamin deficiency. For the last 25 yrs, however, the view has been fairly generally held that the two extremes in the spectrum of childhood malnutrition – kwashiorkor and marasmus –represent conditions in which the main limiting factor is protein on the one hand, energy on the other. This satisfying hypothesis is epitomised in the title of a book published in 1968–*Calorie Deficiencies and protein Deficiencies.*

The chain of arguments which leads from these early clinical studies to the concept of the protein gap as a worldwide problem rest on three premises : that kwashiorkor is indeed a manifestation of protein deficiency; that it is very common in the developing world; and that wherever kwashiorkor occurs milder forms of protein deficiency must be widespread, affecting far more children than those who develop the severe disease. This is the ' tip of the iceberg ' theory. All three premises need to be examined.

" Is kwashiorkor a result of protein deficiency ? The evidence is to a large extent circumstantial. Retrospective dietary histories are of limited value because the illness itself causes a fall in appetite and thus a reduced intake of all nutrients. The most powerful evidence of cause and effect in nutritional work–the therapeutic test–is not practicable, because a sick child cannot be fed protein alone. In a prospective study of children in a poor community no quantitative or qualitative differences in the diet were found between children who developed kwashiorkor and those who became marasmic. Gopalan therefore suggested that it is not the diet which determines the clinical picture, but the way in which the subject adapts or fails to adapt.

" Is kwashiorkor common ? The WHO and FAO conducted a survey in Africa about childhood malnutrition in 1952. Their report concluded that : " Kwashiorkor is the most serious and widespread nutritional disorder known to medical and nutritional science ". McLaren has pointed out that this judgement, based largely on rural Africa, ignores large areas of the world where marasmaus is by far the commonest form of malnutrition.

" Is there evidence of widespread protein deficiency in the absence of clinical disease ? Estimates of WHO that in many countries 20–40% of childern are moderately or severely malnourished are in most cases based on a deficit in weight for age. This growth failure is, of course, a nonspecific effect of malnutrition. It is possible that more information may be obtained by analysing separately two component of growth failure : inadequate gain in weight and inadequate gain in length or height. The search for specific biochemical indicators of protein deficiency has been going on for many years. Whitehead has concluded that the most sensitive index of impending kwashiorkor is a decrease in serum albumin concentration. It remains to be proved, however, that this change is indeed a specific effect of protein deficiency. The third approach is by comparision of intakes with requirements. Before going on to this we have to consider the basis on which requirements have been estimated, since they are often considered not to be realistic, or little better than guesses.

—D. P. Shah, Bombay.

Radical Psychiatry.... *(Continued)*

Centre, is rightfully eyed with suspicion by therapists in the Movement because without awareness human contact has a capacity to pacify and reinforce the mystification of the oppressed. It is equally clear that pure awareness, whether it be psychoanalytic or political, does not aid the individual in overcoming oppression since the overcoming oppression requires the banding together of the oppressed.

Courtesy, **' The Radical Therapist '**

Is primary health Care.... *(Continued)*

the healing of the physician ? The Christian answer is (more or less) clear. Can we devise experiments which show those resources in action ? Or perhaps they are already at hand ? *[Concluded]*

Courtesy, **' Contact ', August '75.**

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