years ago by an ill-fated Medical Research Council trial.¹⁸ This attitude contrasts sharply with that of modern behaviour therapists, who not only challenge the theoretical basis of psychoanalytical "therapy"¹⁹ but can point to some evidence favouring their own activities.²⁰

In the 1980s the medical profession can no longer afford to adopt a laissez-faire attitude to the unsupported claims of the psychotherapists or be overimpressed by what D H Lawrence once called "the deep damnation of self-righteousness that sticks to every creed." A further psychotherapist, it has been calculated, could be required for every 100 000 members of the population²¹; and some general practitioners, social workers, family therapists, and counsellors of all persuasions continue to press the case for psychotherapeutic services at a less specialised level. The matter is rendered still more important by two major points emphasised in Sir John Foster's report: firstly, that "those who feel they need psychotherapy tend to be the very people who are most easily exploited: the weak, the insecure, the nervous, the lonely, the inadequate, and the depressed, whose desperation so often is such that they are willing to do and pay anything for some improvement of their condition"; and, secondly, that "the possibilities of harm to the patient from the abuse, or the unskilled use, of these techniques are at least as great as the possibilities of good in the right hands."

If the undoubtedly large numbers of the "most easily exploited" are to be offered more than support, humanitarian assistance, and professional friendship, a rigorous examination of the scientific as well as the organisational basis of psychotherapy is needed. This task is not easy and will surely call for a more objective appraisal than can be expected of practitioners with a heavily vested interest in the debate. Perhaps a new decade will usher in a new sense of urgency.

References

- ¹ Mowrer, O H, *Journal of Nervous and Mental Disease*, 1959, **129**, 222.
- ² *Time*, p 74. 2 April 1979.
- ³ Ostow, M, *Bulletin of the New York Academy of Medicine*, 1979, **55**, 477.
- ⁴ Lewis, A, in *The Later Papers of Sir Aubrey Lewis*, p 59. Oxford, Oxford University Press, 1979.
- ⁵ Ellenberger, H F, *The Discovery of the Unconscious*. London, Allen Lane, 1970.
- ⁶ Trilling, L, in *The Liberal Imagination*, p 47. Harmondsworth, Penguin, 1970.
- ⁷ Janet, P, *Psychological Healing*, vol I, p 589. London, George Allen and Unwin, 1925.
- ⁸ Gifford, S, in *Psychoanalysis, Psychotherapy and the New England Medical Scene*, ed G E Gifford Jun, p 325. New York, Science History Publications, 1978.
- ⁹ Appelbaum, S A, *Out in Inner Space: a Psychoanalyst Explores the New Therapies*. New York, Anchor Press/Doubleday, 1979.
- ¹⁰ Shepherd, M, *American Journal of Psychiatry*, 1957, **114**, 417.
- ¹¹ Guze, S B, *Comprehensive Psychiatry*, 1978, **19**, 295.
- ¹² Bassin, F V, in *Neurosis*, ed O Janota and E Wolf. Prague, Státní zdravotnické nakladatelství, 1961.
- ¹³ Turkle, S, *Psychoanalytic Politics*. Thetford, Burnett Books, 1979.
- ¹⁴ Foster, J G, *Enquiry into the Practice and Effects of Scientology*. London, HMSO, 1971.
- ¹⁵ Profession's Joint Working Party on Statutory Registration of Psychotherapists, *Statutory Registration of Psychotherapists: a Report*. London, Tavistock Centre, 1978.
- ¹⁶ WHO Working Group, *Cost/Benefit Analysis in Mental Health Services*. Copenhagen, WHO, 1976.
- ¹⁷ Parloff, M B, *American Psychologist*, 1979, **34**, 296.
- ¹⁸ Candy, J, et al, *Psychological Medicine*, 1972, **2**, 345.
- ¹⁹ Marks, I, *Psychological Medicine*, 1979, **9**, 629.
- ²⁰ Sloane, R B, et al, *Short-term Analytically Oriented Psychotherapy vs Behaviour Therapy*. Cambridge, Mass, Harvard University Press, 1975.
- ²¹ Wing, J K, and Wing, L, *British Journal of Psychiatry*, 1970, **116**, 51.

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My Student Elective

Babies and bananas: on foot in Rwanda

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There are few international airports smaller than Kigali, whose embracing hills force an airliner to descend in a series of alarming turns before hitting the almost-too-short runway with a jolt. On the ground, the profusion of immigration papers supplies in formality what the terminal buildings lack, and beyond the gate the country's only tarmac road leads between the fields and banana patches into Kigali itself. The town is a haphazard, dusty place with shanty-town fringes encroaching on the countryside, and this is the capital of Rwanda.

Rwanda lies in the central highlands of Africa where the equator crosses the Nile-Congo divide. It is a land of beauty and

squalor crowded with four or five million people; it is also inaccessible but welcoming, politically stable (by African standards), and desperately poor. As a former Belgian protectorate it is little known in Britain except among those with an interest in its mountain gorillas, tribal anthropology, or the signal part it has played in the growth and revival of the African church. An elective in 1976 took me there and proved an experience so vivid that two house jobs have not blunted its impact or eclipsed its importance in my outlook on medicine.

Two student colleagues met me in Nairobi and, all of us full of first impressions of Africa, we flew on to Kigali before driving the final dusty leg through the hills to Gahini hospital. The hospital was our base and home for the next 10 weeks, while we did some of the groundwork for starting an under-5s clinic. The aim of our trip was to study the nutrition and health of the local toddlers in order to fit the running of the clinic to their special problems, and to provide a "before" portrait of this unmeasured population against which the benefits of the new work could be assessed. Our part was to organise a survey of all the under-5s in a defined area and to provide the hands and feet to carry out

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the work in the time available. In the end, with the help of two local interpreters, we had interviewed some 600 families and examined as many children: an intensely memorable experience. Working out how to do this in an area of undulating bush irregularly dotted with near-identical mud huts was an absorbing problem, but a pattern of work soon evolved.

First of all, an open meeting, which attracted a curious and colourful crowd, was held on each hill. An explanation of the purpose of the survey was given, the examination of a "volunteer" child demonstrated, and questions invited. Although only a minority of the total population attended the meetings, these ensured good relations with local officials, accustomed the people to our strange pink faces, and stimulated rapid spread of news about this novel type of safari.

Toddlers and tape-measures

Each afternoon our guide would visit the scattered homes to be included the next day in the survey and would have a preliminary talk with the family, ensuring that they would be in when the team came. On arrival we could then—after the essential exchange of greetings—proceed to interview the parents about the family diet and history of illness, while one of us weighed, measured, and examined all the under-5s. Discovering the children's ages taxed our ingenuity and knowledge of developmental norms: "Was he born after the last coup? (1973) . . . Was it during the bean harvest or the maize planting? . . ." Without exception the people were hospitable and co-operative, although some of the toddlers were less keen and at least one bolted into the shelter of the family banana patch at our approach. In our turn, we had to swallow our own self-consciousness in front of inquisitive African faces and learn the gracious Kinyarwanda greetings. Fortunately, laughter is international, and with the daily sight of squirming toddlers dangling from a spring balance we had plenty of that.

Hospital staff, missionaries, and the children themselves helped us overcome the language barrier, our cultural awkwardness, and the inexperience of our early clinical examinations. Friendship grew with our two guides, who soon became adept at measuring a nervous infant, and our days settled into a pattern of a drive into the bush in the soft light of early morning and then a long walk between the scattered homes before the sun became too hot. We slowly came to appreciate the fabric of a Rwandan home, from the mud walls without to the complex and supportive family within; and the sight of the ubiquitous beans and bananas ripening became as familiar to us as their taste. Several times our survey was interrupted by a crisis, usually the discovery of someone desperately ill but too weak to walk to the hospital, which might be 10 miles away, and we became an ambulance or travelling clinic. There was no alternative except to let them die.

What we learned

This is not a technical paper and so a few basic figures only will suffice to indicate the outcome of the work, which eventually encompassed a sample of 2800 people. The bleakness of the statistics will not surprise anyone familiar with the Third World.

The crude birth rate in rural Rwanda is a staggering 59 per 1000. Among our under-5s some 30% had a weight under the third centile for European children, and in some areas some 70% of the weaned children received no animal protein whatsoever. A plot of the children's mean weight against age falters tellingly at two critical periods: the first is at six months, when breast milk alone becomes an inadequate diet; the second is at around two years, when the second child is born. The arrival of a new baby makes the elder child very vulnerable, and an African word for it has come into our language: kwashiorkor. Finally, the population pyramid we constructed from an age analysis of our families has an alarmingly broad base. Fully half of Rwanda's people are under 15 years old, and will, of course, be the parents in 10 years' time of the next and bigger generation of under-5s—at least, that is, those who survive to the age of parenthood.

The benefits of this work to the local people will be slow to appear but were immediate to us as students. Firstly, we learned the hard way about the pitfalls of this kind of research: the practical and theoretical difficulties of anthropometry in an unstudied racial group; the long hours that go into the collection of statistically meaningful samples; and the truism that answers are only as valuable as the initial questions are specific. Poring over figures at night by the light of a paraffin lamp rubbed in the inadequacy of our grasp of statistics and sharpened our appreciation of the statistical help we eventually received. As the survey results accumulated and turned us into amateur sociologists, we began to value, regret, or laugh at some aspects of our own culture when measured against what is normal in Africa.

Father nursing child with kwashiorkor.

Secondly, we inevitably saw a new range of diseases arising more from poverty than from the arthropod vectors of the tropical textbooks. Tuberculosis, syphilis, and typhoid were not uncommon and lent substance to the dry accounts read at home. To see a child pass a prize *Ascaris* during a ward round, the fear in an adolescent girl dying of rabies, and the stormy postoperative course of a woman with a ruptured uterus make a deep impression on the mind and prevent one ever again taking for granted the good health and hospital services we enjoy in this country.

Thirdly, and most humbling of all, was to see people coping cheerfully with conditions that would appal and defeat many of

us: illiterate farming families of simple faith who gave us such hospitality despite their poverty; or missionary doctors who would see in a day the number of outpatients seen here in a week, then sit down and do the hospital accounts, before being interrupted by the need for emergency surgery, an instrumental delivery, or the repair of the generator.

The "BTAF" (been to Africa) degree once mentioned in this journal is a degree in awareness as much as capability. One's reflections on the narrow and privileged world of Western medicine are given cogency, and a glimpse of the realities behind the Oxfam posters gives the necessary perspective to any plans for a future career. For me, 10 weeks in Rwanda gave more than

some practical research lessons, a linguistic challenge, and an opportunity for lasting friendships. That short period proved a springboard for my own thinking on medical priorities; it has left an abiding interest in appropriate health care for the world's rural poor—the majority of mankind—and implanted a deep sense of gratitude for all that we in Britain have inherited.

We were kept going from day to day by the enthusiasm of Dr Richard Rowland of Gahini Hospital, whose idea the survey was. We were given valuable advice by the University of London's Tropical Child Health Unit, and financial support by Oxfam, the Medical Research Council, and Edinburgh Medical Missionary Society.

Clinical Topics

Thrombocytosis, circulating platelet aggregates, and neurological dysfunction

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Summary and conclusions

In 12 patients whose neurological dysfunction was associated with thrombocytosis or evidence of abnormal platelet activation, or both, correction of the platelet disorder corresponded with reversal of the neurological symptoms. This suggests that platelet abnormalities may, in certain cases, produce several syndromes of neurological dysfunction, presumably as a result of obstruction of the cerebral microcirculation.

Introduction

There is increasing awareness of the importance of platelets in the pathogenesis of arterial thromboembolic disorders. In cerebrovascular disease the importance of platelets is usually considered in relation to their role in atherogenesis, and few reports have attempted to show that clinical syndromes of neurological dysfunction may relate to specific abnormalities of circulating platelets. Each of the 12 patients in this study had neurological signs and symptoms associated with various abnormalities of platelets and platelet function. Correction of the platelet defect coincided with reversal of the clinical symptoms.

Patients and methods

Twelve patients (seven male and five female aged 8-72 years) were studied. Nine patients had had transient ischaemic attacks, two had developed neurological signs and symptoms after splenectomy, and one had experienced neurological symptoms after splenic infarction.

The platelet abnormalities included thrombocytosis detected on at least three separate occasions, spontaneous platelet aggregation, and circulating platelet aggregates. Nine patients had raised platelet counts; of these, five had essential thrombocythaemia and four had secondary thrombocytosis. Three patients had circulating platelet aggregates, which in two cases were associated with spontaneous platelet aggregation. This was also detected in blood samples from three of the patients with thrombocytosis (see table).

LABORATORY TESTS

Platelet aggregation responses, including the detection of spontaneous platelet aggregation, were performed by means of a Payton platelet aggregometer.¹ Reversible platelet aggregates were detected by a modification² of the method originally described by Wu and Hoak.³ Low platelet aggregate ratios indicate reversible platelet aggregates. The presence of circulating platelet aggregates, as indicated by this method, was confirmed by inspecting a peripheral blood film. Platelet survival, measured in three patients before and after treatment, was measured by an isotope method using ⁵¹Cr.⁴

Results of treatment

Patients with essential thrombocythaemia were treated with both platelet and myelosuppressive drugs. Platelet-suppressive treatment consisted of enteric-coated aspirin, 325 mg, and Persantin (dipyridamole), 100 mg, both thrice daily. All patients improved considerably within a few days of starting treatment. This initial response can almost certainly be attributed to the antiplatelet drugs, since the myelosuppressive agents (radioactive phosphorus, busulphan) require a few weeks to produce an appreciable effect on the platelet count. After correction of the thrombocytosis the patients became symptom-free.

We present details of three patients with secondary thrombocytosis and one with circulating platelet aggregates. Each of the remaining patients received enteric-coated aspirin and Persantin. Within 24

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