been largely ignored in military planning after World War II. It is only in the last decade that the importance of having psychiatric teams close to the front line has been appreciated once more. Since 1984 "Field Psychiatric Teams" (FPTs) and simulated psychiatric casualties have been used regularly in military training. The Gulf War was the first time FPTs had ever been formally deployed in a real conflict situation.

Major Gillham described his FPT's experiences with three case presentations supporting the widely held philosophy that immediacy, proximity and expectancy are all vital ingredients in successfully treating and returning soldiers to the front line.

Major O'Brien discussed the treatment of 25 soldiers presenting with anxiety as a result of not only the threat of exposure to chemical warfare but also the wearing of protective clothing and respirators. His team found that the majority suffering problems were unable to transfer skills learned in training to the real threat situation. Treatment along behavioural lines enabled 23 of the casualties to overcome their fears and return to their original units.

The first afternoon session consisted of seven presentations from members of the psychiatric teams involved in Operation Granby. Contributions were made by the team who debriefed the British prisoners of war, the psychiatric teams which had served in the Gulf and those providing care in the UK and BAOR to the families and casualties who were evacuated. The latter presentations included one from members of the "Combat Fitness Retraining Unit". This establishment was formed to provide a military milieu in which to rehabilitate those battleshock casualties who required evacuation back from the forward psychiatric units. In the event it was not necessary to mobilise the unit, as the service hospitals dealt with all the psychiatric casualties who returned to the UK and BAOR during the conflict. However, it could have accommodated all unrecovered battleshock cases.

A plenary session concluded the day and considered the clinical training value and operational lessons learnt. It was agreed that the Gulf War had been a milestone in military psychiatry. Fortunately there were few British psychiatric casualties. However, the planning and provision of units should add to military psychiatry's ability to provide an effective service to this country's servicemen in the future, should the need arise, as well as to any casualties who present in the aftermath of this war.

37th International Psychoanalytical Congress*

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The two major questions tentatively answered throughout the Congress were:
does psychic change occur as a result of insight?
does psychic change occur through the relationship with the analyst?

Mrs Manfredi referred to psychic change in the context of reparations of damaged internal objects, while also acknowledging that spontaneous psychic change can occur without psychoanalytical psychotherapy or psychoanalysis. She focused on the fears of the analyst changing the patient into a person unrecognisable to himself or to others. A difference between psychoanalytical psychotherapy and psychoanalysis was described, which would require further understanding and discussion. It was proposed that psychoanalytical psychotherapy is capable of producing persisting changes, but that only psychoanalysis can produce changes of basic psychic structures, and that this transformation (or change) of perturbing unconscious structures produces "insight". This is an interesting viewpoint which differs from the traditional model of insight as the principal agent preceding change.

Dr Garcia-Badaracco described some "insights" as "penetrating" but of no value, i.e. they produce no change. Change occurs when a trusting bond with the analyst is achieved, from where interpretations can take place. Only through that trusting bond can the identifying restructuring of the mind, required for the change, take place. Psychic change therefore is change for the better, which allows revisiting stages of personal development that were never accomplished. The potential ego of the patient, linked through the analytic process to the analyst's ego resources which he/she offers to the patient, allows these 'de-identifications', and the development of new inner representations.

There was evidence of a dichotomy between the more traditional schools, where the analyst remains as a blank screen and works within the transference, and that which Dr Garcia-Badaracco reflected upon, where "the link with the *other*, (the patient) the mutual process of sharing the *maddening* experiences of the patient", has not just an effect in the patient but also implies a change in the analyst's psyche. This, in time, would leave the analyst open to the "analytic surprise", that capability of the analyst of simultaneously knowing and not knowing.

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Mrs Joyce McDougall referred to psychic change being intimately involved with the patient's ability to regress, in which each step allows for a new "surprise", a new discovery. She also emphasised that there are pre-verbal gestures and body expressions that affect both patient and analyst. "All analysts are also psychological survivors; the patients help to promote psychic changes in the analyst too, which in turn promotes psychoanalysis itself."

Of the many workshops, the one about training concerned a topic that affects us all. How much evaluation of standards takes place? How much are trainees allowed to participate in their educational systems? Why not allow different theories to be taught if the students required it? Fear of chaos if pluralism was to be permitted might stifle creativity in the trainees. A new model of training more tolerant of change and variety, without infantilising the trainees, is required. There was a feeling that there should be more sharing of educational and scientific activities between a training analysis and candidates. An increase in research and an academic university-type atmosphere is also to be encouraged in analytic institutions.

Dr Etchegoyen, in his closing address, gave a thorough historical perspective of thought and psychic change. He also expressed his preference for clinical presentations at conferences, rather than high level academic discussions. He emphasised that the *fundamental* issue is to get in touch with the patient's feelings.

Psychiatric Bulletin (1992), **16**, 170–179

Correspondence

Are your case-notes perfect?

Dear Sirs

Dr Cunningham has stated that the "perfect case-notes" should serve four main functions – informative, legal, communicative and storage of information. (*Psychiatric Bulletin*, 1991, **15**, 672–674.)

As part of our regular medical audit we looked at the accuracy of documenting important symptoms of depression in the notes of 20 patients admitted to our hospital with an ICD diagnosis of manic depression – depressed type (296.1). We identified 13 symptoms commonly used to make such a diagnosis. The figures in brackets indicate the percentage of notes in which the symptom is clearly stated as being present or absent. These symptoms included: depressed mood (100%), anhedonia (64%), appetite disturbance (75%), weight change (55%), sleep disturbance (84%), lack of energy (30%), psychomotor agitation/retardation (40%), suicidal ideation (75%), poor concentration (75%), ideas of guilt (40%), diurnal variation in mood (50%), hallucinations (90%) and delusions (85%).

Also, previous episodes of hypomania/mania were documented only in 15% of the notes. Level of nursing observation on admission was clearly stated in only 65% of the notes and severity of depression was stated in only 26%. Our small study has important implications. Firstly, from a medico-legal point it is important that the notes clearly state the admitting doctors' initial assessment of suicide risk and also the level of nursing observation appropriate.

The draft copy of ICD-10 (WHO, 1990) requires for a diagnosis of a depressive episode there has to be the presence of three cardinal symptoms – depressed mood, anhedonia and lack of energy. In the 20 notes we were unable to give them ICD-10 diagnoses as basic information in the notes was lacking. We are sure that the junior doctors elicit this information but it appears that this is not always put into writing.

During our meeting we discussed the feasibility of the admitting doctors filling in a depression checklist. We concluded that this would impede the clinical interview. The results of the audit have been circulated to the junior doctors and we will do a follow-up audit in due course.

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Reference

World Health Organization (1990) ICD-10 1990 draft of Chapter V, *Mental and Behavioural Disorders*. F00-F99. Geneva: WHO.

Dear Sirs

Dr Cunningham's article on the audit of case-notes identified several areas which necessitate improvement and suggested a strategy to reinforce the findings. The use of Care Plans (Holman, 1989) would provide an objective focus and means of updating the notes and recording management decisions. The recent change in the law which provides patients, at their request, with access to records written manually

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