In his article, Dr Bridges fails to mention the fate of hospitals or training schemes receiving 'U' status; perhaps they sink slowly into oblivion or does the College still believe that their decisions will stimulate drastic changes in regional planning and finance policy?

I feel that the award of a 'U' category puts a hospital in a 'Catch 22' situation; without Approval they lose the training posts and the standard of junior staff falls, but without a training scheme they cannot regain Approval from the College.

Finally, while criticism of schemes is often directed at consultant and teaching staff, let us remember that those most affected by the decision are the junior staff, whose careers are suddenly jeopardized through no fault of their own, and the patients, who are perhaps most likely to suffer in the long run. Surely, it must be better for all if the College makes constructive criticism taking into account local difficulties and offers to help hospitals to fulfil the College's requirements and to get back to the important task of training future psychiatrists.

S. EDWARDS

All Saints Hospital,
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Falklands aftermath: psychological casualties

DEAR SIRS

During routine clinical work in the University Department of Psychiatry at the Western General Hospital in Edinburgh we observed that during the Falklands Crisis the presentation of several patients with psychiatric disorders was influenced to varying extents by this distant conflict.

Two of our patients were depressed; one having made a suicide attempt because of worry about the loss of so many young lives in the Falklands and another became so concerned about this war, that it dominated her depressive thoughts. Yet a third had been referred because of a head tremor present for 30 years since the Korean War. This patient told us that the Falklands Crisis brought back memories of his own traumatic war experiences and that the present loss of life was now particularly abhorrent because war had never formally been declared. It seemed possible that the additional anxiety that had caused this referral was related to his worry about the Falklands conflict itself. A further patient suffered from an anxiety neurosis associated with a belief that an intense catastrophe was imminent (catastrophobia); his most recent preoccupation being the conflict in the Falkland Islands. A fifth patient had a more lengthy psychiatric history than the others and had the belief that Britain was now ruled by Argentina.

Initially it surprised us that this limited and distant conflict should nevertheless have had this influence on our patients. We thought this might be explained by the remoteness of the conflict itself and the consequent helplessness of many in influencing its course. It also seemed likely that for some it reawakened painful memories of previous wars and some unresolved grief. We wondered whether our experience in Edinburgh was unusual or was shared by other psychiatrists working elsewhere, and more especially by psychiatrists with longer memories of earlier wars?

LINDA MACPHERSON
JOHN L. COX

Western General Hospital and
Royal Edinburgh Hospital, Edinburgh

Psychology of nuclear disarmament

DEAR SIRS

I believe there is a considerable number of College members who are concerned about psychiatric problems related to nuclear war.

These would include aspects related to the effects of nuclear war, i.e. psychiatric casualties, the planning of services to deal with them, and issues related to the psychological stress of living under the threat of nuclear war. Also included is the question of whether psychiatrists have any expertise to contribute (or any responsibility to do so) to the difficult area of prevention.

Can I suggest that the College sets up a working party to study and report on this most important topic. It could benefit by being a joint one with the British Psychological Society as many of the issues are intricately linked with broader psychological ones.

I hope that any members who are interested will write to me so that I can use their support when raising the matter with the College.

JOHN GLEISNER
Secretary
Medical Campaign Against Nuclear Weapons
37 Alan Road,
Manchester

DEAR SIRS

The distinction between healthy fear of nuclear war and the marked preoccupation of doom in mental illness was well made by Jeremy Holmes (*Bulletin,* August 1982, **6,** 136–38). The fact that fear is appropriate and can provide a motivation for seeking safety is the psychological basis of the strategy of defence-by-threat that is called deterrence. Because people habituate to fear, the strategists have progressively increased the threat by increasing the risks. Assuming that the population of Britain is not intended as the principal victims of this fear, the psychology seems as naive as the belief of an addict that increasing his dose can perpetually postpone withdrawal symptoms.

Whatever the intention, a defence policy based on nuclear

weapons produces a variety of unpleasant emotions in many healthy Britons: fear, anger and despair are prominent. The intensity of emotion rises at first with knowledge of the subject and it is sometimes claimed that informing the public about the health risks is harmful and unethical. The BBC postponed the documentary 'A Guide to Armageddon' because it was deemed too alarming to show during the Falklands War.

We should be aware that the public pressure generated by non-morbid emotion is the mainspring of politics. If we are persuaded that our function is to reassure patients by encouraging delusions of safety then there are political consequences. We should not be complacent that psychiatric treatment of political heterodoxy cannot happen in Britain.

I would be grateful if colleagues would notify me of any examples of official encouragement to treat non-morbid fear of nuclear war.

NEILL SIMPSON
Press Officer
Medical Campaign Against Nuclear Weapons
5 Lorne Street,
Mossley

DEAR SIRS

I was interested in Dr Holmes' 'case study' of 'The Psychology of Nuclear Disarmament' (*Bulletin*, August 1982, **6**, 136–38). Like him, I also believed that it would be irrelevant or arrogant for psychiatrists to apply their individual expertise to sociological and international matters. Yet (as he demonstrates) the nuclear arms issue seems remarkably open to psychological analysis. The leading speakers in the present debate for nuclear disarmament (e.g. Dr Helen Caldicott) also liberally use the language of personal and interpersonal affairs to describe the international dynamics of nuclear arms. Although other factors are important—notably the economic empire built on the armament business—personal concepts allow the ordinary citizen (including the psychiatrist) more chance to understand and grapple with a problem which ultimately has to do with the personal matter of individual annihilation.

Dr Holmes emphasized the point that military and psychodynamic terminology have a lot in common. In an article on how Freudian terminology changed its use and meaning in the translation from Freud's ordinary German language to the specialized (and often reified) English vocabulary, Lewis Brandt (1961) demonstrated how Freud used well-known military analogies and terms which have different and more dynamic implications than have their translations—e.g. 'defence', 'cathexis', 'repression'.

So using psychodynamic terminology to understand military problems brings the wheel full circle.

NICK CHILD

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Wishaw

REFERENCE

BRANDT, L. W. (1961) Some notes on English Freudian terminology. *The Journal of the American Psychoanalytic Association*, **9**, 331–39.

Videotapes on psychiatric subjects

DEAR SIRS

Sheffield University Television Service has produced a number of videotapes on psychiatric subjects made in conjunction with the Department of Psychiatry. These are available for purchase (£50 + VAT) on either U-matic or VHS formats. Information may be obtained from Mrs Roslyn Hancock, Television Service, The University of Sheffield, Sheffield S10 2TN; telephone (0742) 78555, extn. 6063.

The following tapes are available:

I've Sprained My Knee Doctor (Colour, 22 mins): Two versions of a patient visiting her family doctor because of a sprained knee. A calm relaxed friendly doctor proves just as efficient and more acceptable than a brusque irritable one. The attitude of the doctor spreads to his receptionist.

Psychiatric Interview (Colour, 26 mins): The format of the psychiatric interview is demonstrated, emphasizing the need for a relaxed, empathic approach offering emotional support.

Parasuicide (Colour, 26 mins): An interview with a patient who has taken a small dose of tranquillizers and alcohol in response to a row with her boyfriend. After exclusion of a specific psychiatric disorder, alternative help is offered.

Giving ECT (Colour, 13 mins): A demonstration of the whole process of giving ECT including pre-treatment assessment, putting the patient at ease and allowing ample time for recovery.

Compulsive Gambling (Colour, 23 mins): An account of the way the wife of a compulsive gambler learns of the extent of his problems and the opportunities open for help.

Violence in Hospital (Colour, 26 mins): A case study—a patient in a surgical ward develops post-operative paranoid psychosis and attacks one of the nursing staff. The management of such problems in a general surgical ward is discussed by the nurses and doctor.

Accompanying notes are available with some of these tapes.

C. P. SEAGER

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DEAR SIRS

The survey on the use of electroconvulsive therapy by Pippard and Ellam has shown that there is a great need for a training videotape which would enable young psychiatrists responsible for giving ECT to learn how the treatment is given. The Department of Psychiatry at the University of