Long life or old age? (Working with the elderly)*

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Held just a short distance from the Freud museum, this conference addressed an issue only considered by Freud in relation to himself – psychoanalytical work with the elderly. I suspect psychoanalysis is far from the minds of many old age psychiatrists labouring away in busy clinics. This is perhaps a shame. A consideration of analytical ideas could enhance the breadth and depth of old age psychiatry.

Two examples of psychoanalytical psychotherapy with the elderly were presented. Professor Peter Hildebrand from the Tavistock described individual therapy and Brian Martindale and Mark Ardern from St Charles Hospital in London described group analysis. A recurrent theme was that the flavour but not the substance of psychodynamic work with the elderly differs from that with the young. The elderly face many losses and need to renegotiate family relationships. The process of psychotherapy itself may have a different emphasis – transference and countertransference issues between a young therapist and an older patient are likely to be different. Much good sense was spoken throughout; shorter sessions may be needed and the rigidity of the analytic consulting room may need to be softened. An elderly woman with arthritis who cannot rise from her chair needs a helping hand before an interpretation. Not all psychotherapy is analysis, however, and Jane Garner, a Consultant in Old Age Psychiatry, described the family and couple therapy that is increasingly part of the service at Chase Farm, and indeed many other services.

In an erudite paper, the psychoanalyst Michael Conran struggled with death in general and the death instinct in particular. Using a psychosomatic allegory he argued that the death instinct, so contrary to our views on the perpetuity of life, is an anti-inflammatory process. Inflammation is the rejection of that which is foreign, the boundary between self and other. With the approach of death, ideas about the life beyond grow stronger and the boundary between self and other becomes blurred. The circle, which started when baby and mother were one, nears closure. It is against this instinct that doctors struggle, not always to the benefit of their patient. It is against this too that Dylan Thomas urges his father to "rage, rage against the dying of the light."

This was a stimulating meeting that moved deftly between the realms of ideas and practice. A dialogue was established between the practitioners of psychoanalytical psychotherapy and old age psychiatry. This is surely of benefit to both – the inner world, the unconscious, does not disappear with old age.

**Conference held in London by The Association for Psychoanalytic Psychotherapy in the NHS (APP) on 4 and 5 October 1991.*

Military psychiatry training day: Operation Granby*

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The purpose of this training day was to examine the psychiatric support of British Forces during the Gulf War (Operation Granby) and to consider how this would affect future planning. The majority of those deployed with psychiatric units to the Gulf attended, along with service mental health workers in the United Kingdom (UK) and the British Army of the Rhine (BAOR) who had been involved in Operation Granby.

The first morning session was dedicated to psychological debriefing. Members of the individual teams were encouraged to review their impressions and reactions in small groups facilitated by service personnel experienced in such work.

The remainder of the morning was chaired by Professor Watson, Honorary Civilian Consultant in Psychiatry to the Army, and dedicated to three research reports presented by Army Psychiatrists present in the Gulf.

Lieutenant Colonel Coogan, Senior Military Psychiatrist in the Gulf, presented a paper discussing the principles of management of the psychiatric casualties of war, tying this in with the Gulf experience. In summary, early forward intervention was used successfully in both World Wars , but seemed to have

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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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