EDITORIAL

It is a pleasure for the Journal to publish in this number a collection of the papers presented to the 15th Anglo-American Symposium on Military Psychiatry held at the Royal Army Medical College 6-9 October 1980. As Colonel Abraham, who has edited the author's manuscripts, explains in the Introduction it has not been possible to include in the present issue more than a representative sample of the presentations made to the Symposium. None the less those that do appear serve to highlight the importance of a relatively neglected area of military medical planning. It is hoped that the dissemination to a wider audience of these important psychiatric deliberations and opinions will alert the military medical community to a new awareness of what has been hitherto all too often a disregarded aspect of the planning scenario.

THE 15th ANGLO-AMERICAN MILITARY PSYCHIATRY SYMPOSIUM

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Introduction

For some years British and American psychiatrists of all three Services had been meeting in Europe to exchange ideas and improve their clinical skills and military efficiency.

When the theme of the proposed Millbank conference, “Battle Casualties,” was announced at the 14th Symposium, and Gen Sir John Hackett’s “The Third World War” taken as the scenario, détente was already looking fragile under the influence of the infamous marxist Brezhnev Doctrine which could be interpreted as “What we have is ours, what you have is negotiable.” Within three months of the announcement, Russia had invaded Afghanistan, and within a year the birth of Solidarity in Poland gave added credibility to Gen Hackett’s sombre appraisal.

With this backdrop it seemed appropriate to invite, for the first time to these symposia, not only some representatives from other NATO allies, but also a number of combatant officers.

We were fortunate to be able to open the conference with consecutive contributions from Egypt and Israel. It was their recent experience of staggering numbers of psychiatric battle casualties, or, as we prefer to call them, battleshock cases, that had prompted us to re-examine our comfortable assumptions derived from the quite different circumstances of Korea, Vietnam and other counter-insurgency operations. One had to refer to the 1944 Battle for Normandy to be reminded that, in a battle of sufficient intensity, Saxons and Semites are both vulnerable to battleshock. The principal new and unequivocal lesson of the Middle East Wars is that in a high intensity conflict battleshock will occur, in numbers of the same order as the number of surgical cases, at the very outset. A more tentative one is that battle-shocked soldiers are unlikely to make a satisfactory recovery unless they get back to duty within a week, as most of them can and
should. It is thus clear that psychiatry is concerned with large scale reinforcement with fit men rather than merely attempting to mitigate the physical and mental suffering of those who have no further contribution to make to the battle.

Our third speaker described the whole new dimension which chemical agents add to the continuum between physical and mental incapacity on the one hand and the continuum between total incapacity and un-impaired efficiency on the other.

In recounting the Soviet View the fourth speaker showed that the Soviets were aware of the rapidity of onset of battlefield paralysis as they call it, and were organised with the intention of delivering stunning blows not only to individuals in forward trenches but also to the command and communication structure. The idea that an entire army could be afflicted with a collective paralysis was developed by a later speaker.

It was clear from subsequent papers that the existing provision for coping with battleshock once it has occurred was ramshackle or non-existent in most Services of most nations. Some scope for prevention was indicated by speakers like Professor Rachman, who underlined the role of training for British bomb disposal men, and others who emphasized group cohesion.

In informal discussion we learned that forward combat units in one army contain regimental medical officer assistants (RMOAs) specifically trained in the prevention and management of battleshock, with some apparent success.

Since training seems to play such an important part in the prevention and management of battleshock we were fortunate to have the Director General of
Army Training (Designate) to sum up on the first day. The only regret is that constraints of space and economy prevent the publication in this issue of more of the contributions and discussions.

Contents of Symposium

Traumatic War Neurosis
  by Brig El Sudany El Rayes.
Battleshock and its management described: experience gained from five wars in the last twenty-five years.

The Soviet Attitude to Stress in Battle
  by C Donnelly.
A realization of the value of exploiting the effects of stress on the enemy while diminishing them in one's own army.

The Concept of an Army as a Psychiatric Casualty
  by LTC William R Cline and LTC Frank H Rath.
A mighty enemy subdued by battleshock: can we prevent it happening again?

The Chemical Dimension of Battleshock
  by Col Francis C Cadigan, Jnr.

Disaster, Psychiatric Casualties and Implications for Future War
  by LTC Jacob M Romo and Maj Robert J Schneider.
The nuclear dimension: lessons from past disasters.

Fear and Courage: Some Military Aspects
  by S Rachman.
A discussion of some measures for preventing ineffectiveness with particular reference to bomb disposal operators.

Division-Based Psychiatry in Intensive War Situations: Suggestions for Improvement
  by Shabtai Noy.
An Israeli study describing the organization and training required to prevent battleshock.

REFERENCE