and demand will bring down medical fees. I wonder. It appears that most young doctors wish to specialise and avoid general practice. Surgeons' fees varied a bit some ten years ago when there was a glut of general surgeons, but no one lowered his fees to attract the customers; more usually they charged what they could (or what they needed to stay in business). Some three years ago the Australian Medical Association emerged as the fee-setting organisation for the whole profession, and the various specialist groups' fees were brought together in one book. The Government chose a lower scale of fees on which to base the patients' rebates. Since then the passing years have added to the fees but not as much as inflation has eroded their value. On each occasion this has happened the Government congratulated the Australian Medical Association for its self-sacrificing nobility, which hardly makes up for the fact that my standard of living is slowly going down. But I must not grumble as I am still much better off than my opposite numbers in the UK.

The overseas doctors on the registers of some states are there because Australia has no overall general medical council. Each state has its own medical register, with different conditions. South Australia has hundreds of doctors who live and work in the countries to the north of Australia. There is fear that the state might be swamped by overseas doctors if things go wrong abroad. NSW has much wider registration possibilities than does Victoria. This was publicised recently when a small country town was unable to obtain the services of an Indian doctor who was willing to move from NSW, where he was registered, to Victoria. This was not to be, as his qualifications, acceptable in NSW, were not acceptable in Victoria. It is said that last year the NSW Medical Board registered more foreign than Australian graduates. Perhaps NSW is oversupplied in some specialties as a result of an influx of foreigners.

References

[1] McEwin, R, *Medical Journal of Australia*, 1977, **2**, 288.
[2] Howells, G, *Medical Journal of Australia*, 1977, **2**, 341.
[3] Knight, J, *British Medical Journal*, 1978, **1**, 93.

Dynamic Approach to Adolescence

Treatment

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British Medical Journal, 1978, **1**, 563-566

The dynamic approach to adolescent disturbances, taking account of the patient's total personality and total situation, can be based on outpatient or residential treatment.

Outpatient treatment

Two frequently used methods for treating disturbed adolescents as outpatients are individual psychotherapy and family therapy.

INDIVIDUAL PSYCHOTHERAPY

Adolescents generally long for a one-to-one relationship. They have secrets that confuse and worry them, they have many questions for which they want answers, and they often feel misunderstood, lonely, and unloved. They are ripe and ready to relate to an adult whom they can trust.

Nevertheless, they are also wary of adults and angry with them and usually begin by displacing these feelings on to the therapist. They are also ashamed of their need and wish for a dependent relationship with the therapist and want to deny it. If the therapist is aware of the adolescent's confusion, his ambivalence, and his underlying wish to make a relationship, and approaches him sensitively and with empathy, a good relationship can be easily established. Within such a context many different techniques can be used to help the adolescent with his difficulties.

FAMILY THERAPY

Simply getting all the family together for discussions can solve many an adolescent problem. Often parents do not realise that their teenage son or daughter is having some serious worries. Parents tend to believe that their little children have all they need—a good home, food and clothing, and opportunities to study and make friends—and that any worries they have must be very minor ones. Anxieties and worries that children attempt to convey to their parents, sometimes directly and clearly and at others indirectly and in disguised form, are often minimised and dismissed. For the adolescent to see his whole family getting together—perhaps at great personal sacrifice of time, money, and leisure—for his sake, thinking and discussing what he feels to be his personal difficulties, and to hear his parents' anxieties and concerns about him is often a unique experience. He realises for the first time that he is indeed cared for and is a member of a caring family and, in fact, not alone. He feels better about himself and better able to cope and to deal with his problems and feelings constructively. The actual sharing of his feelings with the family lightens his burden.

Parents often attend these family interviews with reluctance because they feel considerable guilt about being the cause of their children's problems. They are sensitive to such suggestions, defend themselves, over-react, never relax, and finally stop coming if their guilt is not handled with sensitivity. Many potentially useful family discussions are destroyed by the therapist's attempts to make "clever" and facile interpretations that seem to be aimed at displaying his competence rather than

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aiding useful family interaction. Similarly, over-identification with either the parents or the child can blind the therapist and lead to his joining in and perpetuating a family conflict.

The therapist must tune into the particular culture of the family and create an enabling family atmosphere during the sessions. It is only then that useful therapeutic interventions can be made. The techniques used in these interventions, however, will vary according to the therapist's training, expertise, and personality.

Residential treatment

Residential treatment of the disturbed adolescent must cater for two aspects—not only the treatment of his illness but also his ordinary developmental adolescent needs.

HELPING THE ADOLESCENT PROCESS

For the adolescent to develop adequately he needs a flexible yet containing environment in which he can test himself out, experiment with his emerging new capacities, find out about himself by experiencing the honest reactions of the adults and peers around him, and experience his bad impulses without getting a reaction that is too frightening for him but also tells him something true about himself. He must be able to experience his intensely loving impulses without getting into an inextricable mess, and he must be able to get close to and feel and test out authority. He can do this only in an environment in which he is surrounded by sensitive, stable, loving, and caring adults who together can provide the right balance between authority and permissiveness. This can be accomplished only if the staff are working together and feel free to react to the adolescents on the assumption that they are relatively normal and healthy people. This in itself is a difficult task in view of the number of adolescents they are concerned with and the different personalities, temperaments, training, and background of each of the staff.

In a good treatment unit it is not enough to accomplish this difficult task alone because the adolescents in the unit are not normal—they are sick but do not look ill like the inpatients of a psychiatric hospital. They have usually been found to be uncontainable or have not been helped elsewhere—in special schools, for example, boarding schools for the maladjusted, psychiatric hospitals, or community homes. They need a specialised unit and specialised treatment for their individual and distinctive psychopathology. The psychopathology of each adolescent and the adolescent process act one on the other, distorting the normal adolescent process and disguising much of his pathology.

Approaches to treatment

The approach of an adolescent unit must conflict with classic psychoanalytical technique. In the service of the adolescent process the adults must express themselves, interact with the adolescent, and show him some of their real selves. One must exert authority, express opinions, make value judgments, and set examples for the youngster to emulate.

In dynamic treatment based on the phenomenon of transference none of these things should happen. The therapist must remain something of an enigma, permitting the patient to experience him in terms of preconceptions and fantasies, and work interpretively and therapeutically with these fantasies and stereotypes. A therapist will try to avoid moral judgments or having any directive authority over the patient and will resist being drawn into ordinary social interactions. Clearly these two opposing roles cannot be taken by the same staff working in the same unit. When a centre uses the same staff for treatment and for work in the residential community one can have at best a modified form of treatment using psychoanalytical principles.

While behaviour therapy, Rogerian psychotherapy, and even ordinary discussion by untrained, well-balanced, sensitive adults can be of great benefit to disturbed adolescents, I think most people who have made an in-depth study of psychodynamics will agree that the most effective treatment can be done with techniques using transference interpretations.[1–3] Because of the special problems within an inpatient setting, however, methods of treatment must be evolved that are practical but as deeply effective as possible. A useful model that takes into account the difference in the aims and techniques of treatment and interactions within the residential community (on-the-floor work), and also capitalises on the difference, is what can be conveniently called "the pressure-cooker model." This is a term that I first heard used in a discussion between Dr A H Williams, chairman of the adolescent department of the Tavistock Clinic, and Dr Brian A O'Connell, director of the Northgate Clinic, to describe a similar model at the Northgate Clinic.

Pressure-cooker model

Work on the floor consists essentially of the approach described above. What this effectively does with the adolescent is to prevent him acting out his impulses as freely as he would wish. Ideally this happens by a joint effort on the part of the patient and staff. Behaviour is thereby encouraged to be converted into feelings.[4] The patient takes these feelings into individual psychotherapy or small-group psychotherapy, where they are examined, elaborated on, discussed, and interpreted, which may result in the uncovering of deeper feelings. This results in a tendency for these uncovered feelings to be acted out on the floor, which in turn are encouraged to be converted into feelings that are taken into treatment, and so on, a pressure-cooker like effect being created within the patient. This model has an advantage over the usual outpatient psychotherapy because outpatients usually have the opportunity to act out without getting into trouble. They do not have a group of staff who are interacting with them constantly with the aim of working with their disturbed feelings and their behaviour in a helpful way.

On the floor

Apart from providing the environment for the developmental needs of adolescents and acting as one part of the pressure cooker in the pressure-cooker model, on-the-floor work provides the opportunity to deal with the pathology of the patients. In the process of interactions in the residential community patients constantly attempt to reproduce and recreate situations and patterns of behaviour from their own home environments. These are the only sorts of relationships they are familiar with and even though they have been essentially unhappy they are the only ones they know and can feel safe in, and there is a natural desire to replace the unfamiliar with the familiar.

Some staff on the floor, particularly those who can become relatively distanced from the patients, will be the objects of strong transference feelings and do valuable work with the pathology that emerges in this way. Sometimes patients act out their pathology constantly on the floor. With good and frequent discussions and greater understanding by the staff of the unconscious meaning of the patients' behaviour both as a total group and as individuals the staff can respond to the pathological behaviour of the patients rather than simply react in the invited manner. A whole group of adults responding in both their attitudes and their behaviour at a deep level can have the most powerful therapeutic effect on the pathology of the patients.

For example, a highly intelligent but aggressive and loud-mouthed girl, who had been charged with causing grievous bodily harm and carrying offensive weapons, had suffered from early parental discord and separation and had strong feelings of guilt about her part in causing the parental conflict. She also had intense sibling rivalry and made constant attention-seeking demands on staff. After a few months

at Brookside all the staff observed that she became violently angry and abusive whenever she was confronted by something that she had done that she felt to be bad. More often she created situations where she could have angry arguments with the staff about something completely trivial, such as whether they had woken her three or four times that morning or her rights in the unit, which were obvious. After such vigorous and angry arguments she would subside and become calm and quite amenable for some time. It was clear that she could not stand the feelings of guilt within her. She dealt with this problem in two ways—by becoming angry and abusive whenever staff said something that touched her guilt and by inviting vigorous, useless arguments that she would invariably lose, after which she felt calm, as if she had been punished and had expiated her guilt. After staff discussions about this behaviour there was total agreement that they would avoid getting into any useless arguments by simply saying something like "You know that is a useless argument—we don't want to quarrel with you about that" and not refrain from pointing out to her the bad things she did in spite of the aggressive abuse with which she reacted. After a few weeks of this united staff approach the girl changed. She became more and more depressed and thoughtful about her feelings, her guilt, and her relationship with her parents. She finally left the unit a changed person.

In a residential treatment unit for adolescents it is on-the-floor work, done essentially by the nursing staff, that is of the greatest importance. This is particularly true and is clearly evident in a unit such as Brookside where no individual psychotherapy for inpatients is undertaken. In such conditions, where there is no powerful bond between one patient and a single member of staff, the patients become acutely sensitive to total staff attitudes, and the slightest staff conflicts and changes in attitudes are clearly reflected in the behaviour and the feelings of the patients.

Problems and dangers of on-the-floor work

HONESTY

One of the commonest problems staff face in on-the-floor work is how to be honest and sincere with the adolescents and come over to them as real people, for at staff discussions and clinical meetings in which the pathology of the patients and the dynamics of the staff are discussed the underlying implication is that if they behave like ordinary human beings they will be damaging the patients. There is no easy answer to this dilemma. Certainly behaving like ordinary human beings and simply reacting "honestly" with the young people is inadequate and can be damaging. Some of the questions that must be considered are: What is honesty? If a particular patient creates a feeling of disgust in a member of staff is it honest to convey that feeling to the patient or is it honest to suppress it and examine why he disgusts one? If a patient is extraordinarily charming and seductive and continually invites staff to join in some collusive destructive behaviour and the adult is naturally inclined to go along with this, is it honest to give in to this feeling and behave, as it were, "honestly," or to question the meaning of the patient's behaviour and why one feels seduced and drawn in by the patient?

EQUALITY

There is a strong drive on the part of both staff and adolescents in a community to blur differences and practise equality. The broad-minded liberal concept of all human beings being equal is attractive. Staff who enter this type of work are usually broad-minded and liberal and, moreover, like to regard themselves as such. They want to be honest, forthright, and sophisticated in their thinking. Besides such attractive philosophical influences, at a more personal level staff want to be themselves, to relax, and to interact freely with the adolescents in their care. They do not want to watch themselves constantly, remind themselves of their roles and responsibilities, and, as it were, behave artificially. Here again staff may use "honesty" as a way out of facing realities and difficulties. It is not easy to grasp the value of recognising and maintaining the real differences between staff and patients.

Staff on the floor are sometimes placed in great difficulty by the adolescents. Patients often say, "I tell you my secrets and problems, why don't you tell me yours?" or "I'm honest with you, why don't you be honest with me, why do you pretend you have no problems?" A patient may pour out his problems and his intense trouble and sadness, and the staff at the receiving end often feel helpless and guilty because they do not know how to help. In such a state of mind the staff are easy victims to invitations to share their problems. They may do this in the belief that sharing a problem and letting the youngster know that they also have difficulties will make him feel better, and they will feel better for a short time. This, however, is likely to result in a patient's being burdened by the adult's problems and having to carry these as well as his own. Moreover, the adolescent who is confused, immature, and emotionally ill, and who does not have the capacity to discriminate, will project on to the member of staff all his own fantasies of illness, depression, and perhaps madness related to his inner feelings and be unable to respect and use beneficially that adult again. The patient may pick on the adult's problems and attack him or, if those problems link with his own, they may get into an ever-escalating collusive relationship that is likely to end in disaster. When a patient pours out his problems and difficulties staff on the floor must accept —however difficult this is—that they can give little real help except by showing empathy, perhaps discussing and clarifying any confusing issues, and permitting him to carry his own sadness and depression.[5]

The patient's wish to deny the differences between himself and staff is related to the discomfort, sadness, depression, and envy about feeling little, incompetent, and underprivileged. He would rather ignore the real differences and make himself falsely feel better by putting himself on a level with the staff or triumphing over them. A striking example of this occurred at one of the good community meetings at Brookside recently.

The question of staff holidays and staff privileges was brought up by one of the patients. He asked why staff were allowed to go on holidays when they, the patients, were not permitted to do so. This question was asked immediately after there had been a reasonably good discussion on the need for both patients and staff to be on time for all meetings, which had been agreed by everyone. The patient's question was thrown in rapidly just after this and taken up by several other patients. Separate staff meetings excluding patients, secrets kept by staff, and several other staff/patient differences and staff privileges were also brought up. The meeting quickly deteriorated into the patients' mocking, attacking, and jubilantly laughing at the staff. A girl patient said, "We thought the director was a very high-up person but actually he is not." Comments of the same nature were made about many of the other staff. Attempts to start a serious discussion about staff/patient differences failed until a member of staff made an interpretation suggesting that the differences between patients and staff were similar to the differences between themselves and their parents, when quietness and order were resumed. The envious attack on the staff that was triggered off by the realistic decision to equalise staff and patients in one small area was brought to a halt by reminding the patients of realities that were very painful, distressing, and close to them. Presumably they felt the same kind of envy and wish to attack and triumph over their parents as they had shown at the meeting.

SPLITTING

An almost universal experience of disturbed adolescents is parental conflict. They have a fantasy that they have helped to create the conflicts between their parents. This gives them feelings of great insecurity and fear as well as feelings of power about their ability to create conflicts in adults. When they feel depressed, small, and alone they often like to overcome these feelings by getting in touch with the fantasy power they have. They may recreate this parental conflict in an inpatient com-

munity, partly to keep in touch with their power and partly to test out themselves and the adults around them. They select one member or a group of the staff and create in them a feeling that they are either better or worse than some other member of staff, slightly distorting what one of them has said. If staff are not wary they will find themselves victims of this kind of "splitting" manoeuvre (see part IV of this series), collude with it, and become angry with each other. They must therefore be open, discuss their feelings honestly with each other, and be seen by the adolescents to be getting on well with each other. The adolescents must know that everything that happens is known and shared by all the staff—and also that staff can have differing views and disagreements that do not create conflicts such as to make working together impossible. They must, moreover, know that their own interests are the common concern of all the staff.

The pressure-cooker phenomenon and the role of staff on the floor minimising acting out create other problems and dangers. Containing acting-out behaviour can be done in various ways. Staff who have the task of containing acting-out behaviour and, as it were, pushing it back into the patient may well be inclined to use this as a legitimate opportunity of unleashing their own aggressive and sadistic feelings on the patient. Patients who are experiencing severe persecutory anxiety may be pushed into psychotic behaviour if their verbal and behavioural acting out is not handled sensitively and with sympathy. There is the danger that staff will become the victims of projective identification and unknowingly persecute the patients.

Staff on the floor must be constantly aware that they have a responsibility and role. They must attempt a sympathetic and realistic interaction with the patients and at the same time constantly examine their own feelings and behaviour. Genuine concern, non-possessive warmth, and empathy, the staff attitudes advocated by Carl Roger, are essential for this type of work.

The fifth of six weekly articles.

References

1 Strachey, J, *International Journal of Psycho-Analysis*, 1934, **15**, 127.
2 Ezriel, H, *British Journal for the Philosophy of Science*, 1956-7, **7**, 29.
3 Ezriel, H, *British Journal for the Philosophy of Science*, 1956-7, **7**, 342.
4 Freud, S, *Complete Psychological Works*, vol XXIII, p 177. London, Hogarth Press, 1964.
5 Bion, W K, *Learning from Experience*. London, Heinemann, 1962.
6 Klein, M, in *Contributions to Psycho-Analysis 1921-45*, p 282. London, Hogarth Press, 1948.
7 Klein, M, *et al*, in *Developments in Psycho-Analysis*, p 198. London, Hogarth Press, 1952.

Is the vertebrobasilar syndrome a common cause of a "drop fall" in the middle-aged? How can the diagnosis be established, and is there any treatment? Is there an association with Menière's disease?

Almost all middle-aged sufferers from drop attacks are women. The victim falls forward on to her hands and knees but remains conscious. In the absence of injury she recovers immediately. Some patients say they are not aware of falling, but all can feel the impact on striking the ground. Such attacks are quite common, and 12 out of 200 consecutive women attending a gynaecological clinic gave a history of such a fall.[1] In most patients no cause is apparent, and the tendency to drop attacks may disappear after a year or two. They have been called cryptogenic drop attacks.[1]

Drop attacks associated with vertebrobasilar insufficiency may occur in middle age but are much commoner in the elderly. They are associated with other features of brain stem dysfunction—transient or permanent. Vertigo, ataxia, or weakness may precede or follow the attack, and there may be precipitating factors such as rising from a chair, turning the head, or extending the neck. Such attacks are often attributed to compression of the vertebral artery by osteophytes in the neck. Since most of the attacks have no obvious cause investigation is largely a process of careful history taking and the elimination of other possibilities. These include weakness of the muscles around the hips; spastic weakness of the legs associated with cervical spondylosis; Parkinsonism; and, very rarely, akinetic epilepsy, which is usually associated with petit mal and myoclonus. Falls caused by postural hypotension or Stokes-Adams attacks are usually associated with faintness rather than simple falling. To undertake vertebral angiography to establish a diagnosis of vertebrobasilar insufficiency would be like using a dangerous sledge hammer to crack a nut.

In cryptogenic cases there is no treatment. In others the underlying cause is treated. In drop attacks associated with cervical spondylosis and vertebrobasilar insufficiency it is always worth trying a collar. There is no association with Menière's disease, as in this condition there is deafness, tinnitus, and severe attacks of vertigo, which is quite another story.

1 Stevens, D L, and Matthews, W B, *British Medical Journal*, 1973, **1**, 439.

What is the treatment for persistent tennis elbow?

Tennis elbow is a musculotendinous enthesiopathy of the lateral epicondylic attachment of the extensor muscles of the forearm. It is usually an "over use" injury but may arise spontaneously. It is characterised by (*a*) pain in the elbow on resisted extension of wrist or forearm muscles (this may be limited to the extension of only one finger); (*b*) pain on lifting heavy objects; and (*c*) a sharply localised, severe tenderness strictly limited to the lateral epicondyle but occasionally producing a radiated pain down the forearm or up to the mid-arm. Tennis elbow may be associated with cervical spondylosis and carpal tunnel syndrome, which may be the cause when treatment is not immediately effective.

The most effective and quickest method of treating tennis elbow is an accurately placed 50-mg dose of hydrocortisone acetate injected with a wide-bore needle, accompanied by 1 ml of 2% lignocaine, into the point of maximum tenderness; the injection should preferably be as deep as possible. This will relieve pain in most patients within a few days. A firm bandage applied immediately after the injection is often also effective and worth while. In cervical spondylosis the pain is sometimes referred to the outside of the forearm from structures in the neck, but if the above physical signs are present this should not cause confusion in diagnosis. If the diagnosis is certain, and there is only a temporary response to local steroid infiltration, avoiding activities that exacerbate the pain, such as tennis, squash, badminton, or clothes wringing, for a month or so is often effective. The patient should also be reassured that the condition is essentially self-limiting and if untreated generally resolves spontaneously in one or two years. Surgical release of the attachment is effective but rarely needed or advised. Other local forms of treatment that have their proponents are deep transverse frictions, as advised by Cyriax,[1] and the local application of ultrasonics, which may sometimes help. Manipulative treatment (either of the elbow or of the cervical spine) is also used at times but requires knowledge of specialised techniques.

1 Cyriax, J, *Text Book of Orthopaedic Medicine*, vol 1, 6th edn, 1975; vol 2, 9th edn, 1977. London, Baillière and Tindall.

Do antiperspirants cause lumps in the breasts?

The most widely used topical antiperspirants contain aluminium salts, in particular, chlorides, sulphates, and phenyl sulphonates; the most effective, however, is aluminium chloride hexahydrate, 20% in ethyl alcohol. Practically no absorption of aluminium occurs even after swallowing these soluble salts. Although milk is apocrine sweat, topically applied antiperspirants have never been shown to affect its secretion, nor have they been shown to cause lumps of any type in the breasts.

RAWP and the Oxford Region

We regret that the third part of Mr Michael Jeffries's article, "Closures, economies, and cuts," must be held over until next week.