Dynamic Approach to Adolescence

Dynamic psychiatry

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The world of adolescent psychiatry is something of a jungle. The different disciplines and workers often find themselves in conflict and confusion. Opinions about the most appropriate way of dealing with a disturbed adolescent differ and are held with conviction. Objectivity often becomes elusive, and feelings run high. The self-defeating intense emotional involvement of well-meaning but inexperienced workers is common in adolescent psychiatry, and even the most intelligent and skilled professionals can become irrational and de-skilled when they become involved with a disturbed adolescent. At the other extreme some psychiatrists refuse even to see such patients. These phenomena rarely occur with psychiatrically ill children or adults.

Difficulties of adolescent psychiatry

Adolescents are confusing young people. Chronologically they are between children and adults; in truth they are both child and adult. They may feel and behave like children at one time and quickly switch to becoming adult. They deftly throw out a bit of pathology amidst a variety of normal developmental feelings and behaviour. They are highly adept at sensing the weak points of adults and using this knowledge to embarrass, attack, seduce, and manipulate adults. Even with the greatest objectivity it is difficult and confusing for those working with disturbed adolescents. It is even more so for the youngster, for he is often not aware of what he is doing.

The difficulties that occur because of the very nature of adolescence are only one aspect of the problem. A more important factor, and the one that causes the greatest problems in dealing with disturbed adolescents, is that the intense feelings experienced by him are similar to one's own more hidden ones. It is difficult for the adult helper to separate himself from the youngster and regard him clinically and objectively. Most disturbed adolescents do not look ill and cannot be placed in a diagnostic category with a recognised treatment. It is relatively easy to place a psychiatrically ill adult in a diagnostic category and to keep aloof, calling him ill and oneself well, and to look at him clinically. Equally, to separate oneself from a disturbed child is relatively easy; after all, he is only a child and the helper is an adult. But the disturbed adolescent is neither a child nor an ill adult: he is a youngster who suffers intensely from feelings of depression, anger, fear, guilt, and confusion—feelings common to all normal adults. His feelings are so similar to one's own that the boundaries between him and the adult helper are blurred.

It is a myth that adults grow out of adolescence into a state of sexual and emotional maturity, confidence, and independence with a well-crystallised identity. Many aspects of adolescence remain with normal adults in varying degrees of intensity throughout adult life, and when one is confronted by youngsters with problems one's own adolescent aspects are touched—often exacerbating any unresolved pathological aspects of the personality. It is this that creates the greatest difficulty and confusion in dealing with the disturbed youngster. Inability to recognise this confusion results in an "acting out" and consequently an attempt to get rid of the adolescent, or a confused involvement with him that perpetuates one or more aspects of the problem. To be able to treat most adolescent disturbances the psychiatric worker must experience and deal with the feelings aroused in him by contact with the disturbed youngster. If he attempts to avoid this painful and difficult contact or allows himself to succumb to the feelings engendered he will not give adequate help.

Nature of dynamic psychiatry

The term dynamic psychiatry is ill understood and often misused. Many believe it to be some impractical, ineffective, and esoteric exercise indulged in by people who have time on their hands and who play around in a casual fashion with people and ideas. In fact, the dynamic approach is the only valid and practical treatment for most disturbed adolescents, though techniques such as behaviour modification, discipline and retraining, and chemotherapy may also be useful.

The basis of dynamic psychiatry is the fact that relationships with "significant" people have an effect on development and current behaviour and that behaviour can be altered by examining and understanding relationships and feelings. If the unconscious mind is acknowledged, then, in undertaking this examination, you must observe and take into account more than what appears on the surface in others as well as within yourself. Techniques used in this type of work vary from psychoanalysis—the most complex, deep, and subtle of them—at one extreme to less ambitious and more practicable techniques, such as psychodrama and role-playing, at the other. Other techniques, such as behaviour modification and chemotherapy, could be used to complement dynamic psychiatry provided that such combinations are carefully undertaken, well understood, and designed to meet the requirements of the individual case; otherwise they could work against each other and defeat the primary object of helping the patient.

Dynamic psychiatry is a form of thinking and an attitude that is unusual in the ordinary course of life. Whatever the form of society, everyone has been brought up to behave well, to be pleasant and nice, and to make himself and others comfortable and happy. Society's aim has been to curb "bad" feelings and impulses to create people who are acceptable to others. One has learnt, with varying degrees of success, to push away into forgotten corners of the mind one's "badness" and nasty

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feelings, not only through social conditioning but also because these feelings are unpleasant. In some cases these "bad" feelings have been inadequately dealt with and cause trouble. Dynamic psychiatry brings out the long-forgotten impulses and experiences underlying a patient's disturbance and makes them available for examination. It might then be possible to resolve the unconscious conflicts and problems, or at least put them away more effectively.

Dynamic psychiatry is difficult for both the patient and the worker. For the patient, at first, it seems as if life is being made even more difficult; he is being forced into owning unpleasant—perhaps frightening—feelings, the very thing he has been trying to avoid and hopes to escape from by coming for treatment.

For the worker, to grasp and hold on to the value of the concepts used in dynamic work—something that goes so much against his natural tendency—is not easy. To be touched emotionally by the disturbance of the patient makes him anxious and insecure. It is most difficult for the doctor. Doctors have had a specialised training in treatment based on antidynamic principles in which they have developed confidence over the years. They have also developed a feeling of security and an uncomfortable yet satisfying feeling of near omnipotence as a

result of projections on to them from lay people. It is with the greatest difficulty that they abandon the security of these attitudes in the face of all the internal and external forces that work towards their retaining them.

Ever since mental illnesses began to be regarded as amenable to treatment attempts have been made to classify them on some rational basis so that treatment could be administered in a simple, logical manner in accordance with such classifications. While efforts at classification continue, I believe that the human mind is increasingly recognised to be too complex and subject to too many variables to permit a simple medical model of mental illness. This is true of adolescent psychiatry more than any other branch of psychiatry.¹

Any rational and serious attempt to treat adolescent problems must take the causative factors into account. Usually these result from the adolescents' relationships with significant people in their lives. Treatment must take these factors into account and therefore must be on dynamic lines.

References

- ¹ World Health Organisation, *Glossary of Mental Disorders and Guide to their Classification*. Geneva, WHO, 1974.

Clinical Topics

Value of a testicular biopsy rating for prognosis in oligozoospermia

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Summary and conclusions

Testicular biopsies of 142 oligozoospermic men were used to obtain a testicular biopsy score count. These scores were clearly related to the chance of fertility, in contradistinction to data on hormone concentrations and from analysis of semen. In 36 patients with a score of 9-10 there were 15 pregnancies; in 59 patients with a score of 8-9, 12; and in 47 patients with scores below 8 there was only one successful pregnancy, though this last group also contained an additional three patients whose wives' pregnancies ended in miscarriages.

Rating of testicular biopsies is more useful for proper

evaluation of oligozoospermic patients than are data on hormone concentrations and from semen analysis. Proper evaluation of new treatments should be based on trials where experimental and control groups are matched on these ratings.

Introduction

Spermatogenesis is a complicated process that makes description of the tissue obtained at testicular biopsy difficult. As a result opinions about the value of such biopsy specimens have widely differed. In 1970, however, Johnsen¹ published an elegant and simple scoring method for characterising spermatogenesis. Having used a modification of this method² to study the relation of mean biopsy rating scores with fertility, we report our results in a larger group of patients for whom data on the occurrence of pregnancy are also available.

Patients and methods

During 1971-6 609 men were investigated for infertility. They were referred to the department of clinical endocrinology because semen abnormalities had been suspected as the cause of their infertility. We included 142 of these patients who underwent testicular biopsy in

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