In theory, controlled trials are justified for any unvalidated practice, no matter how widely it is adopted, and since we have shown that an appreciable minority of obstetricians withhold almost all the treatments discussed there can be no ethical bar to prospective investigations.

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Dynamic Approach to Adolescence

Support of the staff

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From all that has been said it must be clear that attempting any useful treatment with residential psychologically ill adolescents is an extremely complex task. It makes the greatest demands on staff working in the unit. There are the relatively ordinary problems of rivalry between each other, conflicts about authority, individuality, philosophical issues, and the rightness or wrongness of what is done with and to patients, and many other such problems that arise in almost any institutional set-up in varying degrees and arise here most acutely. But the staff's difficulties are complicated by two more specific factors: one is the very complexity of what goes on in the unit and the other is the deep and powerful way in which staff are affected by the pathology of the adolescents.

Like everyone else, staff working in a difficult set-up feel comfortable if the policy of the unit is simple, clear, and well-defined, if they can identify their roles clearly, and think that they are doing something useful that is valued by the patients and by their colleagues, and if they can see for themselves that their own efforts bring quick and obvious beneficial results. These things do not happen in dynamic work in such a setting. Patients do not appreciate the efforts of staff. The staff are often abused and mistreated by the adolescents. The correct approach to the patient's disturbance often leads not to an immediate improvement but rather to an apparent worsening of his behaviour. Sympathy and understanding and sharing of confusions and frustrations by colleagues is not readily forthcoming because of the intra-staff dynamics, and from time to time staff feel frustrated, angry, and hopeless about working in such a place. Specially chosen staff are necessary for this work—people who are emotionally tough, who have a high capacity to tolerate frustration, who have relatively open minds, and who are genuinely interested in the work. It takes an average person about a year of working intensely in the unit to grasp fully the meanings, aims, and complexities of the work.

Clearly, both their normal development and the treatment of their disturbances demand that the young people in the unit are treated as whole individuals. The total approach must therefore be designed to bring out their individuality, which includes their most worrying, frightening, and sickest aspects. Staff on their part must also be able to interact with them as individuals.

In this design, which is calculated to bring out the individuality of all concerned, attention must be given to matters such as the structure and layout of the building at one extreme and to frequent discussions by the staff about their roles and attitudes to the patients and themselves at the other. For instance, dormitories, arranged like army barracks with bedhead ticket numbers for each patient, and staff in uniforms have a dramatic effect in helping the patients lose their identity as individuals and move comfortably into a feeling of simply being a member of a group of unfortunates. They become far more containable, actually feel safer and less anxious, and create less anxiety in staff. But this will diminish the possibility of effective work with their pathology. Likewise various devices and manoeuvres designed to diminish the anxiety of staff and the effect of the patients' projections on to staff, such as splitting up staff/patient relationships, ritual task performances by staff, depersonalisation of both patients and staff, and many more such devices that are used in conventional hospitals to minimise the difficulties and anxieties of the staff, cannot be used in a good residential treatment unit.¹ Any attempt at truly treating the adolescent necessarily means a philosophy in which the adolescent is not suppressed but is rather encouraged to experience and to relate to staff with his total personality—which includes his confusion, his disturbance, his anger, and all his nastiness. The staff absorb the full impact of the patients' disturbances, and they must be given understanding, support, and training to enable them to deal not only with disturbed adolescents but also with their own feelings.

In such an organisation it is essential that anxiety and responsibility are passed upwards so that finally the nursing officer and the director carry the greatest amount of anxiety and responsibility. Authority must be passed downwards so that the lowest paid staff will feel that they are carrying within them the authority of the total staff.

Within an inpatient adolescent unit the results of bad judgment, mismanagement, or serious staff conflicts can have the

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most disastrous consequences. All adolescents have angry, rebellious, and destructive feelings very near the surface; it only requires a catalyst or a combination of the right ingredients for the most destructive and devastating behaviour to ensue.

The world outside

The treatment and management of disturbed adolescents is indeed a complex and difficult task for those who undertake it seriously. The pressures that arise from within the unit are great. Every moment in a good treatment unit the staff have to think, make quick judgments and decisions, and at the same time contain their own and the patient's anxiety.

The reactions, attitudes, and projections into the unit of the world outside make this task even more difficult for the staff. Basically there are two opposing attitudes. One is that an adolescent unit must take into it and contain all the adolescent problems and difficulties and all the anxieties that adolescents create, and produce complete cures. If it does not do this then it must be attacked for not doing its job. The other is that all the worst things that go on in the world—the nature of which relates to each person's imagination and fantasies—must happen in an adolescent unit, and therefore it must be attacked and even destroyed as being evil and wicked.

Parents often become angry with those who have helped a disturbed adolescent. What they expect from treatment is for

their disturbed, angry, and rebellious child to be "cured" of his wish for independence and become a compliant and dependent little child all over again—instead of which, having been helped with his difficulty, he acquires more confidence and a greater wish for independence and expresses this to the great disappointment of the parents, who blame the adolescent unit for what has happened. The unit also serves as the most convenient focus for the projection of the guilt that parents have about possibly having been to blame for their child's difficulties.

The greatest allies of those treating the adolescent are the nature of adolescence and the patient's own motivation. Adolescents are in a period of rapid change, and those who start treatment are motivated towards helping themselves. Despite all the trouble, anxiety, and confusion they cause they change rapidly for the better if a helpful environment can be created for them.

I thank Dr Kabir Padamsee, senior registrar at Brookside, for the many hours he spent in analysing the referrals and for the many thoughtful discussions and suggestions he offered me, and Dr P L G Gallwey of the Portman Clinic for a critical review of these papers.

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(The last of a series of articles, accepted on 21 December 1977)

What is the treatment for recurrent herpes simplex on the cheek or lips? Can it be prevented?

The most effective local application for primary as well as recurrent herpes simplex skin lesions is 5% idoxuridine in dimethyl sulphoxide, which may be applied with a small paintbrush or with lint 3-4 times daily. Healing usually occurs within 2-3 days; without dimethyl sulphoxide idoxuridine is ineffective on skin. Some clinicians have disputed the claim¹ that in more severe cases and particularly in herpes zoster a 40% solution of idoxuridine is necessary. Earlier fears that idoxuridine might induce cataracts after repeated use are fortunately unfounded. They were based on inappropriate animal experiments carried out mostly in the USA. This treatment has been used widely for over eight years with safety and much benefit.

Iodoxuridine applied in excess, however, to corneal erosions may cause further epithelial damage. Recently Betadine paint (povidone-iodine 10% w/v in alcohol) has been advocated as a safe and effective local treatment for herpes simplex of the cheek or lips.²

Grenz rays and soft x-rays (50-100 Roentgen units given once only at 50 kV) have been used, particularly in Continental countries and the USA, to induce rapid healing of acute and chronic herpes simplex lesions. They usually prevent recurrences for 4-12 months, sometimes even longer. Grenz rays have been used at a dose of 4×200 R at daily intervals. A double-blind controlled trial showed the efficacy of Grenz rays as a prophylactic measure in this troublesome condition.³ Even if such small doses of radiotherapy are given several times they are virtually free from the risk inherent in the doses used for treating neoplastic conditions.

¹ Juel-Jensen, B E, and McCallum, F O, *Herpes Simplex, Varicella and Zoster*. London, Heinemann, 1972.

² Woodbridge, P, *Journal of International Medical Research*, 1977, **5**, 378.

³ Knight, A G, *British Journal of Dermatology*, 1972, **86**, 172.

I use a preparation made by Minipak Aerosols Ltd, called Arcton, which contains 15% dichlorodifluoromethane and 85% dichlorotetrafluoroethane, as a skin anaesthetic and freezing agent for dermabrasion of tattoos. I understand that this is a vapour after leaving the container and not a droplet aerosol. I have used it for the past seven years without ill effect, but I have been asked whether there is any possibility of ill effect from inhaling it in a closed room, such as a theatre (although I always wear a mask).

Chlorofluorocarbons (CFC) are widely used as aerosol propellants. The main toxic effects of these compounds is on the heart: they depress the myocardium and can cause dysrhythmias. Sudden death

is not unusual in people who "sniff" such propellants, and is probably due to dysrhythmia. Palpitations and abnormal electrocardiograms were also found among pathologists using a CFC as a spray-on freezer for preparing frozen sections during an investigation after some unexplained sudden deaths. But toxic concentrations of CFC in the myocardium are probably reached only after inhaling large amounts of aerosol in a short time, perhaps 10-20 consecutive breaths. The use of CFCs as a local anaesthetic in a closed room resembles their use in preparing frozen sections, though the amounts may be less. It is advisable to use CFCs only in a well-ventilated room, and in modest amounts. A mask gives no protection.

McClean, A E M, *British Journal of Clinical Pharmacology*, 1977, **4**, 663.

A patient has returned from the psychiatrist with a prescription for propranolol and tranlycypromine (Parstelin). Propranolol blocks the uptake of adrenalin and tranlycypromine contains a monoamine oxidase inhibitor. The patient's clinical response shows that there are no ill effects from this combination but what is the rationale?

The prescription suggests that the patient's clinical condition included anxiety symptoms and possibly atypical depressive features. Propranolol acts by blocking beta-adrenergic receptors peripherally, thereby reducing symptoms and signs of anxiety such as tachycardia and tremor. In the usual therapeutic doses it appears to have little or no effect on the brain.¹ Tranlycypromine, however, causes a build-up of biogenic amines within the brain and other parts of the body. From the psychiatric point of view it acts centrally and is effective in many anxiety states, anxiety symptoms in depression, and atypical depressive states. No doubt the prescriber intends to produce both a central therapeutic effect and a concurrent peripheral reduction in symptoms to prevent feedback.

¹ Goodman, L S, and Gilman, A, *The Pharmacological Basis of Therapeutics*, 5th edn. New York, Macmillan, 1975.

Why is hay fever a bar to employment as aircrew both in the Royal Air Force and in civil airlines?

It costs about £70 000 to train aircrew to first officer stage. It is not, therefore, commercially sound to start training someone who may have to retire part of the way through his career because of ill health. Sufferers from hay fever are banned because upper respiratory congestion precludes flying, antihistamines are prohibited in aircrew, and late asthma is a possibility.