Communicating with adolescents

Communicating with adolescents can be very demanding.

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Few health professionals have not, at some stage in their daily work, had the experience of being rendered confused and frustrated, if not downright impotent, by an adolescent slouching uncooperatively in the patient chair.

General practitioners are often the first port of call for parents who are having difficulties with their teenagers. Desperate parents hope that the good family doctor who used to have such sway with their youngsters can still reach them as before. But the bright-eyed, spontaneously friendly primary school pupil has suddenly morphed into the recalcitrant 14-year-old boy with a knife wound, the mutely defiant 15-year-old pregnant girl/woman/mother, the bright anaemic 13-year-old who self-righteously denounces meat, the hopeless 17-year-old kidney patient who suddenly refuses medication, or perhaps just the average irritating kid who inexplicably makes you feel like an idiot while you're good-naturedly trying to fix his flu.

This article is a brief and by no means comprehensive attempt to address the issue of communicating more confidently and purposefully with adolescent patients in general practice. To this end, the article emphasises the theoretical understanding of particular adolescent psychodynamics that can inform intergenerational communication. Thereafter some practical implications are discussed. This is largely motivated by the author's ideological conviction that techniques alone can never successfully equip one for the complex task of effective communication with another human being. At the least a genuine curiosity and non-judgemental acceptance of their particular state of mind and experience is crucial. A nurturing understanding or capacity figuratively to hold what is being communicated, and an unsentimental valuing of the essence of the other is preferable. And this is especially true of communication with adolescents for, as will be described in more detail below, adolescence is a time of intense seeking for *authenticity* – both for authentic identity and authentic authority or power.[1]

Adolescence

It is common knowledge and most mainstream psychological theories concur that adolescence is a distinct developmental period characterised by enormous physical, emotional and psychological shifts that can and often do manifest in quite dramatic changes in behaviour. Chronologically, adolescence is heralded by the onset of puberty at approximately 12 years of age and progresses in different phases until the early twenties when, theoretically, the young adult should have reached a somewhat more integrated identity, and the tentative capacity to commit to an intimate relationship, to work and to a responsible place in society.[2] Of course the actual timing of these stages depends largely on each individual's temperament and the way in which his or her environment has had an impact on the resolution of previous developmental milestones. Thus, unresolved psychological or emotional trauma, chronic illness, educational or cultural deficits, unhealthy parenting, and so on, can all lead to developmental arrest during this time.

The distinction between chronological adolescence and adolescence as a 'state of mind' is important.[2] Adolescence epitomises transitional spaces, what the Jungians refer to as Mercurial energy, the trickster energy that characterises any time of huge change, regardless of age. Mercury is a trickster god of the borders. He brings messages from other places and potentialities and as such can bring the blessing of renewal, but can equally laughingly lead you astray. Knowing this helps us as adults better to identify with our youth when we think of how we felt at the precarious brink of something new in our lives, that exhilarating, terrifying, empowering, paralysing place we reach when we've cut ties with the old and have not yet completely found the new. It happens, for example, at significant career changes, decisions to emigrate, decisions to marry or divorce, to have children, and at menopause and retirement.

Returning to our teenaged patient: A hallmark of adolescence is the physical and emotional enactment of a dramatic tension of opposites in the psyche. And it is this tension that has direct implications for how adults (whether health professionals, parents or teachers) communicate with them. Psychoanalysts such as Klein, Bion and Winnicott, among others, have contributed much to a better understanding of this polar tension.[2] Simply, the adolescent finds him/herself caught between two enormously strong pulls on his/her being: the developmental urge forward to separation and individual identity, juxtaposed with an equally formidable draw back to the fusion and safety in the bosom of childhood. This tension creates overwhelming psychic conflict – between love and hate, desire and shame, hope and despair, gain and loss. Now that in itself need not necessarily pose such a problem, except that humans seem innately defended against the conscious experience of psychic conflict because of the anxiety, pain and guilt it creates. So in order not to consciously feel or think about these uncomfortable things the psyche uses defences to keep things unconscious. And this is where so-called 'typical adolescent behaviour' comes in (at any age).

Two pertinent defences are 'acting out' (expressing through behaviour what one cannot contain psychically) and 'projection' (putting onto others what one cannot yet own in oneself). 'Acting out' includes extremely erratic behaviour, now rude and defensive, now loving and needy; obsessive studying; not studying; school refusal; withdrawal and isolation; delinquent behaviour; risk-taking behaviour, and so on. 'Projection' is used by the developing

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psyche when it starts to seek identity. To defend against the anxiety of this seeking, the young adolescent projects the different parts that are auditioning to become part of him/her, onto others in the environment. Thus parents and teachers may carry the prohibitive parts of him/her which he/she vehemently spurns; sport stars, American rappers, Hollywood heroes may carry the transcendent parts he/she would like to claim; the different members of the peer group may carry the brave or timid or cowardly or sexy or clever or delinquent parts he/she is evaluating and experimenting with through them. Thus the initial self-righteous black-and-white thinking of early adolescence; the heightened emotion around clothing and hairstyles; the complete dependence on peer group and the intense dramas, rivalries and loves within that group, at the expense of all other activities like school, sport and family.[3]

These defences are not necessarily pathological. While the body and the unconscious' capacity for growth move relentlessly forward, the ego defences regulate the pace. The alternating periods of regression and progression witnessed over the teenage years are crucial for the psyche to adapt and integrate at a manageable speed.[1] Another benefit is that they are sometimes used to attract help from adults when the adolescent cannot ask for it directly – e.g. when adolescents steal or lie or break rules in ways that suggest they want to be caught out. It is only when these behaviours become prolonged or extreme that psychological or psychiatric help should be sought. Often the parents' intuition is a valuable diagnostic aide. Attuned parents may have a 'feel' whether their daughter temporarily needs to hole herself up in her dirty room listening to music all the time, or whether she's becoming developmentally stuck there; whether their son is just experimenting with a little alcohol and a little anarchy, or becoming drug-addicted and delinquent.

In normal development, as the adolescent matures he/she gradually learns to allow him/herself to feel and think through psychic conflict and emotional discomfort, rather than acting it out, and to take the parts of his/her identity that have been projected onto others back into an integrated sense of self and identity. This makes him/her less dependent on parents or peers and he/she is able to make increasingly authentic choices regarding his/her life and to experiment more seriously with commitment and intimacy in an exclusive sexual partnership.[2] Of course, this does not happen as neatly as theorised and can continue late into chronological adulthood.

Adult response to adolescence

Holding the tension of the opposites

Understanding the dynamic of the tension of opposites in adolescence is crucial to effective communication with adolescent patients. The crisis of adolescence is the struggle to hold this tension in healthy ways and what they most need of the adults in their lives is an example of how to hold it. The psychiatrist Carl Jung wrote extensively about archetypes. Simply stated, the growing psyche contains archetypes/universal psychic organisations[4]/genetic imprints that predispose it to actively seek out in its environment those experiences or people that will facilitate its optimal growth. Previously parents and close family members had the responsibility for helping the child to contain psychic tension. Now the adolescent must reject these figures but most often still needs help and containment. Often the parents were not able to fulfil this role in the past and the adolescent needs even more help at a time when he/she must also become more independent. So unconsciously the healthy adolescent psyche is actively seeking such adult help, as long as it is truly authentic.

Where there is more deficit or pathology an adolescent may need long-term therapy from a trained professional. But for a generally healthy psyche, half an hour with a genuinely containing adult can make a substantial difference. Of course the majority of especially young adolescents will not or cannot acknowledge this. Our job as adults is to try and understand what they need and to control how we respond without expecting to control how they respond.

So how does one hold this tension of opposites? Perhaps it lies in the delicate and precarious balance between love and structure, between a combination of 'feminine' holding or allowing and 'masculine' containment or limitation.

Holding

Both the adolescent and his/her parents are often completely caught up in the confusion of the moment. A professional who understands something of adolescent dynamics can in a few words and limited time, in fact simply by example, help to contain some of the rampant anxieties on both sides. And often that means not prying and rushing in to fix and change, but trusting the adolescent's process. Winnicott describes the need during adolescence for concealment, incubation in order to emerge later, that cannot be hurried but can be destroyed by invasive clumsy handling.[5]

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The felt sense of lack of firm identity and internal stability causes shame and lack of self-esteem in many adolescents. This is often masked by arrogance and narcissism. Parents often defend against helplessness and guilt through blame and criticism. A 'holding' professional can help both parties to *re-imagine* adolescence. Looking at him/herself and his/her behaviours differently through your eyes can increase a 'stuck' adolescent's self-esteem and openness to life.

Limiting

As important as it is to be able to re-imagine adolescence and to see the immense potential and transformation that lurks secretively behind the upheaval and confusion, equally important is the clear-sighted and unsentimental capacity to acknowledge and limit its very destructive potential. The urge toward transcendence can make an adolescent unrealistically idealistic and experimentally fearless, like the mythological Greek teenager, Icarus, who used his beautiful new wings to fly too near the sun – and came crashing down. The imperative search for identity can make them narcissistic and remorseless. The pull back to childhood

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can cause smothering developmental arrest. Adolescents need wise and responsible adults who, while appreciating the transcendent functionality of their various behaviours, are not afraid to curb these same behaviours. As with children, when adolescents go out of control, they need adults to adjust the responsibility and freedoms given and to set firm limits.[6] Again the adolescent will not necessarily consciously thank you for it, but a healthy psyche seeks to internalise authentic inhibition, integrity and compassion.[1]

Adult limitations to effective communication

The unspoken assumption throughout this writing is that a large and important part of human communication takes place unconsciously. And especially so with adolescents where so much of their identity formation is taking place behind the smokescreens of their diverse actions and personas. Fig. 1 illustrates this assumption.

Doctor and adolescent bring both conscious and unconscious material to their interaction in the consulting room and there is communication between conscious and unconscious both within and between the two parties. Knowledge of this can provide us with direction and a little confidence when we work with teenagers. But it can also help us to be more aware of the powerful ways in which we can negatively affect the interaction. One example is our unconscious issues with our own lost adolescence and our own developmental 'state of mind'. Sometimes adults are secretly resentful of teenagers because we feel we never really had an adolescence; sometimes we are so sad about the disappointments of our own lives that we cannot tolerate youths' freedom to dream; sometimes the freshness and promise of an adolescent's young body confronts us with our own ageing; often we are ourselves uncomfortable with the 'darker' human capacities for aggression, hatred, perversion.[1] These feelings are all perfectly normal and acceptable. But if we want to relate authentically to teenagers we must become aware of our own cut-off attitudes toward them, lest they sabotage our communications on an unconscious level.

Practical do's and don'ts

Holding the tension of opposites

- Spend time with both the parent/s and adolescent together and with the adolescent individually. This acknowledges that he/she is both still a minor in the family and that he/she is growing up and needing privacy and responsibility.
- Be clear about confidentiality and its limits and keep to it.
- Make sure you are up to date with the laws regarding privacy and age of consent in different situations.
- Do not be tempted to polarise, either by siding with the adolescent against a parent or teacher, or by rushing in with reprimands to tales of rebellion.
- Do not try to explain the adolescent to him/herself. Your understanding is to help *you* communicate better. 'Holding' is often just a gesture, a heartfelt comment or the ability to carry a projection mindfully for a while.

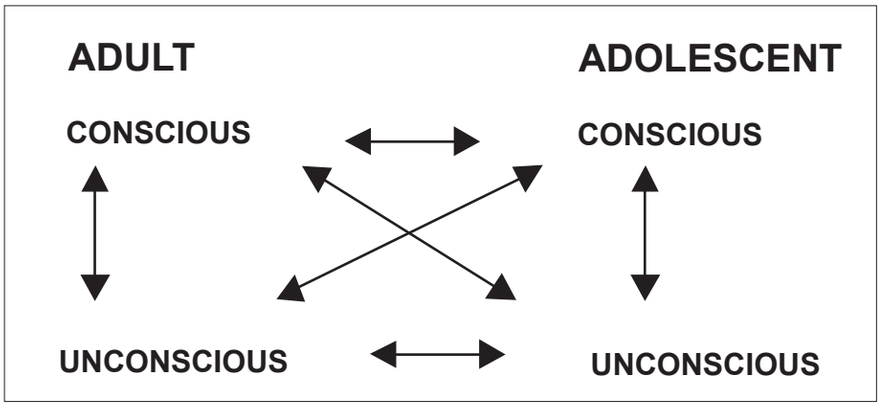

Fig. 1. Levels of communication.

Creating space for communication

- You may need to take the initiative in the beginning, especially with younger adolescents, e.g. ask them how they feel to be there, but don't take all the responsibility for communication. Give them some space and time to reach out to you.
- Although you have an agenda to investigate symptoms, diagnose and treat, spend a little initial time discovering what's on the adolescent's mind. An uncooperative teenager often becomes a lot less resistant once he/she feels you're interested in his/her side of things.
- Listen to what they think before saying what you think and be willing to negotiate where appropriate.
- Do not offer unsolicited 'life wisdom' and do not succumb to lecturing.
- When medical advice/treatment is not negotiable, appreciate their need to resist but remain firm, and clearly request their co-operation.

Our job as adults is to try and understand what they need and to control how we respond without expecting to control how they respond.

Containing your own anxiety

- Evasion and secrecy often make adults anxious, but do not pry unnecessarily. A respectful yet interested distance is preferable.
- Remember that if you're feeling confused or helpless during the consultation, it's probably because that's what the adolescent is feeling.

Maintaining authenticity

- Remember the role of the unconscious and try to become increasingly aware of your prejudices and attitudes toward what adolescents bring to your consulting room.
- Do not try to be 'on their level' or try to impress them. They need you to be a worthy professional adult, not a peer. For instance, if you do not understand the slang expressions they use or have not followed their explanations, do not pretend that you do, rather ask for clarification.

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- Maintain your personal and professional boundaries. You can say when you feel uncomfortable answering personal questions or complying with questionable demands. Do not allow aggressive or destructive behaviour.
- Be clear about what you want from them and why, but do not manipulate them by making them responsible for your feelings.[6] Instead of saying 'I'm disappointed that you forgot to take your tablets', you can say something like: 'I hear you forgot to take your tablets. I want you to take them because you will become seriously ill if you don't. Let's talk about ways to help you remember in future.'

Conclusion

Despite teenagers' overt preference for secrecy and annoyance at adult prying, the forward-looking and healthy part of developing adolescent psyches seeks genuine relationships with adults who can help them find themselves.

Such adults need an appreciation of adolescence, and to be genuinely interested in all the disparate and sometimes frightening or discomforting sides of the adolescent. Such respectful 'allowing' into the consulting space may enable a mutual and cooperative exploration of the problem at hand with less need for the adolescent either to hide, throw out confusing red herrings or act out unthinkingly. However, this is not a naive allowing. It is an important task of the service provider to struggle to integrate a positive non-pathologising approach to adolescence that is simultaneously practically relevant in a context where the destructive potential of adolescents is also clearly demonstrated in current South African society.

Psychodynamic theory of adolescence leads to a number of practical applications. Good techniques, however, do not guarantee that adolescents will immediately respond as we desire. We apply these strategies primarily to control our behaviour as responsible and caring adults.

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In a nutshell

- A non-pathologising psychodynamic understanding of adolescence can assist health professionals to communicate more effectively with teenage patients.
- Adolescence is a distinct developmental period characterised by enormous physical, emotional and psychological shifts that can manifest in dramatic behavioural changes.
- A hallmark of adolescence is an extreme tension of opposites in the psyche that tugs and pulls the adolescent between the safety of childhood and the developmental urges toward separation and individuality.
- This tension causes psychic conflict and concomitant anxiety that the psyche deals with through defence mechanisms.
- Two pertinent defence mechanisms that explain many of the overt behaviours typically seen in adolescence are 'acting out' and 'projection'.
- These defences are normal and functional except when, taken to the extreme, they can cause developmental arrest.
- In aid of normal human development, healthy psyches are unconsciously predisposed toward recognising authentic adults who can both 'hold' their anxieties and limit their destructive potential.
- Communication always occurs on both conscious and unconscious levels simultaneously, thus health professionals need to become aware of unconscious prejudices and attitudes toward adolescents that can severely hinder effective communication.

single suture

Tetracyclines, teeth and children

Tetracyclines are contraindicated in children because of the fear that they will stain the children's teeth. But, an Israeli team noticed that routine use of doxycycline in a paediatric asthma unit did not seem to cause any dental changes. They went on to conduct a small randomised controlled trial of 61 children. The treatment group was given at least 2 courses of doxycycline. Apparently no teeth staining was detected by a dentist in any of the children in the study.

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