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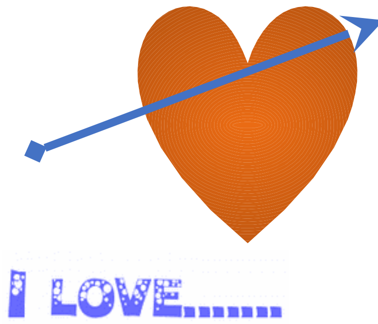

Supervising the Therapist who Works with Adolescent Clients

Jennifer Foran

This was another re-write after one of our days together, where the author moved from an academic piece to a simpler but more personal account of the particular needs of supervising those working with adolescents, focusing on the need to not defend against the strong feelings that can be evoked in both therapist and supervisor.

> Therapy is about making contact, and adolescent therapy requires a specific repertoire of contact skills, often looking and feeling very different than therapy with adult clients.
>
> (Starrs, 2009)

Adolescents like contact. I make this statement because as adults, a lot of the time we forget to meet this yearning. Most adolescents arrive at therapy because the contact with others and the contact with their self has been disrupted. Parents come in focussing on behaviours, perhaps forgetting that there is a young person looking to be seen, looking to be heard and, most importantly, looking to be unconditionally loved as they develop their unique sense of self. Imagine a plant shoot, poking its head above the ground. If the shoot is well situated and happy, it will bloom. The shoot can be equated to the young emerging adolescent's self – it's growing, and it's looking for nourishment. If the conditions are right, the adolescent thrives. If

the conditions are not favourable, or hostile, the fragile sense of self will not bloom, but instead, will wilt.

Adolescents thrive when adults make contact with them. Young people want adults to take them seriously, but a lot of the time adults disregard adolescents as being ‘too emotional’ and ‘too irrational’. The adolescent years are a time of ‘storm and stress’: how can it not be, when there are so many changes taking place? Picture this: you’re going along in your life and suddenly everything changes, the security of childhood gets ripped out from beneath you, and you are thrust into a different world – your body, your relationships, your thoughts all change, and your inner world begins to open up. It’s difficult to be rational and calm when the ground beneath your feet is shaky.

The period of adolescence is not new; every generation transitions this developmental period. However, what is unique to today’s generation, known as ‘Generation Z’, is that they have been immersed in cyberculture from the beginning of their lives. This immersion has resulted in adolescents developing a sense of self and capacity for contact which is very different from past generations.

Overlying this is that adolescents of today’s generation have been stifled by the safety culture that adults have imposed on them. Adolescents need to be kept safe, and as a supervisor I take safeguarding seriously. However, there is a dance between keeping an adolescent safe and smothering them. Smothering does not allow the adolescent to develop and grow, it does not facilitate the trust to help him or her move towards becoming the adult they would like to be.

Imagine, for a moment, that every time you went out, you were monitored and told that the world is not safe. Imagine that your whole life, from the breakfast you eat to the time you go to bed, is all documented on a social-media platform. Adolescents can feel that they are watched 24/7; they can feel that they are living their lives on a stage with every post and movement commented on. For some adolescents, this can be exciting; for others, it can be terrifying – the sense of feeling judged and having little wiggle room to make mistakes. Anxiety, depression, paranoia, self-harm and suicidal ideation are all symptoms that can arise. These symptoms trigger a parent, an adult or sometimes the adolescent to seek help.

The demand for adolescent therapy continues to grow. It is estimated that worldwide, between 10 and 20 per cent of adolescents experience mental health difficulties, with half of all mental health conditions starting by 14 years of age (Adolescent Mental Health, 2018). The high number of young people requiring therapeutic support suggests that supervisors who are familiar with working with this age group are in high demand (Neill, 2006).

In both my role as a supervisor and a therapist, I have encountered many adolescents who have been to countless professionals and have received several diagnoses. In fact, one in five adolescents aged between 9 and 17 years of age have been diagnosed with a mental health disorder (Adolescent Mental Health, 2018). One therapist spoke about a young person she was working with who had been diagnosed with seven different disorders. This is mind-blowing, but indicative of the way young people’s mental health is attended to in the present day.

I think back to when I was a teenager. The pranks I engaged in were hilarious, or so I thought at the time. In today’s culture, I imagine I would be a prime candidate for being diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), or be seen as too impulsive.

The reason for this context is that therapists and supervisors can forget what it is like to be an adolescent. Furthermore, a significant number of therapists with whom I’ve worked talk about the period of adolescence not being focussed on in their core training. The child and the adult were prominent in their process work, but their adolescence was a period that was only briefly glanced at. In a way, this makes sense, because adolescence is a messy, insecure and challenging time, and most adults don’t like encountering these feelings.

Therapists, when working with adolescents, can experience a wide array of difficult emotions.

Terms like challenging, complex, demanding, despairing, urgency, tiring and emotional are frequently used by therapists in the work. One of the biggest challenges that therapists bring to supervision is their capacity to build a trusting relationship with adolescents. Unlike adults, adolescents are generally referred by another adult, which can lead to resistance and lack of co-operation. Furthermore, therapists are tasked with building a relationship with adolescents whose cognitive development is evolving, whose environments may be volatile, and the adolescent's experience of adult relationships are wide-ranging.

First and foremost, the work with adolescents is not about fixing, or filling out worksheets, or focussing on their behaviour or symptoms. Instead, it is about building a relationship in which they can be seen, heard, validated and taken seriously. McConville (1995) writes 'that the real work with an adolescent client is getting the adolescent to become a client in the first place' (see also McConville & Wheeler, 2001). Therefore, the initial goal of supervision is to offer insight and clarity, and to reflect on how these relationships are progressing (Martin, 2002, p. 15). If a therapeutic relationship doesn't exist, then techniques and strategies fall by the wayside in a lot of instances, and supervisors need to be mindful of this.

Building a relationship is the foundation for all the other work in the therapy room to take place. As a supervisor I check this out regularly with the therapist, and through the exploration if we discover that the adolescent is just 'showing up', we explore this in the supervisory relationship, and sometimes with the adolescent.

Adolescents can a lot of time be disempowered for many reasons. As a supervisor, if we empower the therapists to empower the adolescents, then the work can be magical. 'Magical' is not a word that many therapists and supervisors use when working with adolescents. The complexity of working with adolescents means that the therapist must attend to a dizzying array of intricacies and, therefore, so does the supervisor (Koocher, 2003).

Leake et al. (2018) view the adolescent supervisor as having three functions – namely, that of a 'policeman, plumber and poet'. The 'policeman' metaphor equates to the supervisory function of protecting the adolescent client. The 'plumber' is the brass tacks of the supervisory relationship. It facilitates the reflection and discussion of individual sessions, bringing practical suggestions, educative advice and creative process to facilitate unconscious emotions and meaning-making to emerge. Finally, the supervisor is the 'poet' who, through the narrative, listens out for themes and patterns, but also explores the different layers of meaning.

I regularly work with therapists who find themselves predominately in the role of 'a policeman'. For example, a therapist recently spoke about her difficulty in making contact with a traumatised adolescent because she felt that she had to protect the client. Oaklander (2006) writes, 'Contact involves having the ability to be fully present in a particular situation with all of the aspects of the organism – senses, body, emotional expression, intellect – ready and available for use'. Taking on the role of 'a policemen' and collaborating with the legal, school and child welfare systems, managing parents' expectations, confidentiality resulted in the therapist feeling de-skilled, lost, unsupported and isolated in the work. These experiences impacted on her presence and her ability to make contact with the adolescent.

The adolescent, it seemed, shared some of these experiences too. In the face of trauma, adolescents can feel a profound sense of inadequacy, shame and isolation. Trauma can threaten an adolescent's sense of basic trust and secure attachment, and the environment can be perceived as threatening. When a therapist is not embodied or present in the work, then the adolescent can feel very unsafe and unsupported. In the supervision session, facilitating insight into the therapist's contact style with the adolescent and minimising unnecessary intrusion in the therapeutic work supported more fertile ground, trust and richer contact to emerge.

It is therefore vital that supervision does not become an arena for crisis management, and that the urgency and despair do not influence either the therapeutic relationship or the interventions. There

is no doubt that safety of the adolescent is paramount and that at times, outside agencies need to be informed. However, even when there is a threat to the adolescent's safety, we have to remember not to abandon the young person. Breaking confidentiality whilst maintaining a strong therapeutic alliance can be extremely difficult, and helping the therapist to support the adolescent will be an essential role in the supervision work.

Amongst novice therapists, urgency and despair are familiar feelings. Combine this with 'acting out' behaviours – for example, taking drugs, self-harming, school refusal, eating disorders – and this can create a general sense of responsibility and challenge in the therapeutic process. The therapist can feel a sense of urgency when working with these presenting issues and evoke a strong and primitive counter-transferential reaction.

Counter-transferential feelings of wanting to protect, rescue, be the mother, be the father can be evoked in the adolescent therapist more so than working with adult clients. It can sometimes be hard to stay with an adolescent's pain, and a consequence may be to protect, minimise and distract from the issues at hand (Leake et al., 2018). These specific issues often result in adolescent therapists feeling anxious and requesting more direction from supervisors.

Furthermore, working with adolescents can elicit a sense of hopelessness and incompetence. For example, when encountering silent or hostile adolescents, or when we meet adolescents whose behaviour is so risky, we become fearful. I remember supervising a therapist who felt continually challenged when she encountered hostile adolescents in her clinical work. For example, a 14-year-old boy was brought to therapy by his parents on the recommendation from the school. From the onset the therapist struggled to engage the adolescent and to build a therapeutic alliance. She experienced him as defiant, angry and defensive, and she continually experienced a power struggle between them in the sessions.

We explored the power struggle, and what emerged was the therapist's urgency of wanting to fix this adolescent's behaviour because, in her own words, he was 'out of control and a danger to himself and others'. Supervision provided a space for the therapist to explore the adolescent's life experience, facilitating her to walk in his shoes and to witness his pain. This process dissolved the despair and the urgency that the therapist was experiencing, and allowed a more empathic and supportive posture to emerge in the work.

This ability to move in close or pull out to get a broader perspective requires what Hawkins and Shohet (1989) call the 'helicopter ability'. This ability to move between these two positions can be challenging to accomplish for therapists working with adolescents because of the complexity and multi-faceted aspects of the work. While the therapist remains focused on the relationship with the client, the supervisor's distance from the adolescent client enables him or her to stand back and reflect on the intrapsychic and interpersonal aspects of the work, and support the therapist to do the same. This standing-back and reflective practice in the supervision process provides the adolescent therapist with a space in which to gain a superior knowledge of adolescent development, address the developmental challenges and validate the adolescent's experience.

If therapists and supervisors can put the relationship with adolescents at the heart of their work, they can provide a container and fertile ground for adolescents to gain the courage to grow up and become the person who they are. As McConville (1995) writes:

> When we look back over our own developmental journeys through adolescence and identify what we received from the adult world that helped us to get through (or what was missing that would have made a difference), we nearly always discover something simple and largely unintentional, but, by the same token, something profoundly human and reassuring. Some senior member of the tribe stopped and took us in, got interested in us, and thereby got us interested in ourselves, in ways we had not quite expected.

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About the contributor

Jennifer has extensive clinical experience as an Adolescent Psychotherapist and Supervisor working in her private practice in Ireland. She also works closely with adolescents' families and as well as with adult clients. Jennifer is also a tutor on the M.Sc. Adolescent Psychotherapy and M.Sc. Counselling & Psychotherapy Programmes in Dublin Counselling & Therapy Centre, in partnership with the University of Northampton. She is an accredited member of IAHIP and is a registered psychotherapist with the European Association of Psychotherapists (EAP).