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HOW MUCH TIME DO WE NEED? TIME AND PSYCHOANALYTIC PSYCHOTHERAPY IN CAMHS

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The author considers what seem to be norms and values concerning session frequency and length of treatment in 'traditional' and current child and adolescent psychotherapy practice, and the impact of training expectations and models of training on identity and status as a child and adolescent psychotherapist. In the National Health Service (the publicly funded healthcare system in the United Kingdom), there is pressure to do more in less time: the norm is once-weekly work. Such an expectation does not sit comfortably with psychoanalytic theory and training, which remains rooted in higher frequency, longer-term cases. For trainees, this can lead to feelings of fraudulence and questioning whether less frequent therapies imply that the work is not psychoanalysis. The author explores, through a literature review, a case study and research material, how one might acknowledge the tension between these conflicting values about time; how psychoanalytic work in all its forms might be valued and be valuable for patients; and urges the need to feedback clinical experience into training structures and ongoing learning.

KEYWORDS: SESSION FREQUENCY, TIME, CHILD PSYCHOTHERAPY, ADOLESCENCE, PSYCHOANALYTIC FRAME, RELATIONAL PSYCHOTHERAPY

INTRODUCTION

I work within the UK National Health Service (NHS) in Child and Adolescent Mental Health Services (CAMHS) with children, young people, and their families and networks. I was inspired by reading Jane Polden's (2018) article 'A question of sessions: How many times?' to contribute my thoughts on time, therapeutic effectiveness and the experience of working in publically provided mental healthcare.

As a recently qualified child psychotherapist, I have experienced a change of gear from intensive psychoanalytic work (three times per week) when in training, to once-weekly or fortnightly sessions as standard practice within CAMHS. Polden (2018) questioned whether psychoanalysis, conducted four or five times a week, is essentially different from lower frequency psychoanalytic psychotherapy and, if so,

how. She described a rift between how psychoanalytic work is theorized and how it is practiced and asks the important question: 'What are the conditions that make deep psychoanalytic work possible and how can these conditions best be protected?'

My research question while in training was about how UK child and adolescent psychotherapists talk about time and psychotherapy within an NHS context.[1] My experience in training is of a certain amount of anxiety about keeping hold of the training patient, particularly the adolescents, for the officially prescribed amount of time (three times a week for either one or two years) and a concern about prioritizing my training needs above the patient's therapeutic needs. I started intensive work with two adolescent cases which, for differing reasons, did not last beyond six months and a third case which just made it to one year, but with many missed sessions during the final months. I needed this young man to continue coming to sessions in order to complete my training. My training did also have an emphasis on once-weekly work and on the fairly new manualized short-term psychoanalytic psychotherapy (STPP) model of treatment. This combination stood me in good stead for the reality of work as a qualified psychotherapist within the NHS.

As a qualified psychotherapist, the pressure in CAMHS is to spread time out 'fairly' between one's caseload and keep in mind the children on the waiting list. With the exception of psychotherapists in training, offering more than once-weekly psychotherapy sessions is unusual. My doctorate research interviews confirmed my lived experience that once-weekly planned sessions were the norm and that over one-year duration was considered 'long term'. Analysis of my interviews with child and adolescent psychotherapists in CAMHS settings showed that these clinicians experienced autonomy in practicing psychoanalytic psychotherapy; however, the factor of treatment time was not often explicitly talked about. In other words, these clinicians were not told 'you must ration sessions to x number per patient' but did have high caseloads, which internalized the pressure to spread oneself thinly. Thus offering two or three sessions per week to one child feels like taking those treatment hours away from another.

In this paper I will consider:

- the norms and status of time as a frame for psychoanalytic work with children and adolescents;
- the difficulty of what we mean by 'time', given that it is a messy, multi-layered concept. I found Mander's description of the therapeutic hour as 'a slice of vertical time … as opposed to the horizontal flow of time' a helpful metaphor of how therapeutic time feels different (Mander, 1995);
- the multiple layers of human perception of time, including archetypal personifications of time expressed in Greek mythology;
- clinical material from a weekly case in which time and timing was a critical factor in the effectiveness of therapeutic work; and
- the tension between holding the values that the psychoanalytic psychotherapy profession appears to hold in relation to time (e.g. the importance of waiting for

unconscious processes to unfold) and the values of mental health treatment within CAMHS (e.g. time as a predictable unit of measurement and the pressure of waiting lists).

CHILD PSYCHOANALYSIS AND PSYCHOTHERAPY

During my research, I looked for descriptions of what early child analysis meant in terms of length and frequency. In Melanie Klein's (1932) accounts of early analysis with small children, she wrote notes about the number of hours she treated many of her young analysands, for example, Inge whose treatment was 375 hours in all, Kenneth 225 hours. As she described meeting her 10-year-old patient, Richard, five times a week in *Narrative of a Child Analysis* (Klein, 1961), we can infer that Klein and her patients had sessions five times weekly over one or two years.

Five times a week seemed to be the expected frequency at the Tavistock Clinic and Anna Freud Centre in London. However, in practice, this did not fit with family time structures, as Anna Freud reflected on when describing the evolution of child psychoanalysis: 'Child patients were difficult to obtain … their commitments to school, homework, etc, made their regular, five times weekly attendance impracticable' (Freud, 1972, p. 152).

In contrast, Donald Winnicott, a paediatrician as well as a psychoanalyst, saw thousands of children and families for single or extended consultations in his paediatric work in Paddington Green Hospital, several hundred for what he called 'psychotherapy' and just a few for 'analysis'. He developed an 'on demand' method with no fixed time patterns, which he described in *The Piggle, an Account of the Psychoanalytic Treatment of a Little Girl*:

> 'Analysis for analysis' sake has no meaning for me. I do analysis because that is what the patient needs to have done and to have done with. If the patient does not need analysis then I do something else. In analysis one asks: how much can one be allowed to do? And, by contrast, in my clinic the motto is: how little need be done? (Winnicott, 1965, p. 166).

In this paragraph, Winnicott very neatly captures how differently he conceives of time with his psychoanalytic 'hat' on compared with working psychotherapeutically in a publicly funded clinic setting. It also illustrates the differing and sometimes competing time needs and limitations of the patient, family, clinician and clinic, and the power balance within those relationships. Anna Freud talked of 'obtaining' child patients for training cases, which suggests a focus on the trainee's need for the right patient. As I mentioned, this tension was familiar to me while training: the need for suitable patients to stay in treatment for the prescribed amount of time.

Ruth Schmidt-Neven (2016), in her book on time-limited psychodynamic psychotherapy with children, argues that in the UK over the past two decades, a biomedical model of focusing on psychopathology in the child has taken precedence over seeing the child as a part of a family system. This has coincided with an increase in cognitive behavioural therapies available, which are always short term

and time limited. Schmidt also argues that traditional child psychotherapy gives primacy to long-term treatment, and therefore the nature of what is psychoanalytic psychotherapy has become associated with length rather than method or outcome. She stresses the importance of widening the conceptual frame to include the internal and external world of the child; that is, making time for the network around the child within a time-limited frame. An obvious point is that time given to each child is not just within the session; there is the vital but time-consuming scaffolding of assessing, preparing and working with the child's family and network (e.g. schools, social workers), as well as the time for child and analyst to process thoughts and feelings between sessions. However, the identifying marker of what kind of psychotherapy is being practiced is bound up with length of treatment and session frequency. This links with our professional identity as psychoanalytic psychotherapists, who exist alongside and sometimes in competition with psychologists, family therapists and other mental health clinicians.

While this paper is not an in-depth study of the patient's experience of time, I would like to mention the ideas of two psychoanalysts. It is commonly observed that young children experience 'endless time', possibly because they are still developing connections between past memories and future expectations. Becoming orientated to chronological time is a developmental achievement and vital for greater independence in the child or adolescent. Hamish Canham (1999) wrote about how often adopted or fostered children have distorted perceptions of time due to the impact of early neglect, abuse and not being held in mind. When in the care system, children in care 'end up with two experiences of time; either that it passes excruciatingly slowly, or bewilderingly quickly' and a common psychic defence is to 'obliterate time'. Otto Kernberg (2008) writes about a 'shrinkage of time', particularly when working with adults with narcissistic personality disorder. He argues that the subjective experience of chronological time passing is intertwined with 'meaningful and gratifying relationships and activities'. Without that, patients can wake up 'at age 40, 50 or 60 with a desperate sense of years lost' (p. 301).

FREQUENCY OF SESSIONS AND PROFESSIONAL IDENTITY

Polden makes the point that high-frequency psychoanalysis equates to high status. This stems from an interpretation of Freud's 1918 speech to the Budapest Congress (Freud, 1919) where he spoke of the 'pure gold of analysis' and the 'copper of direct suggestion'. Polden argues that Freud may have been raising the issue of 'what works best for whom' as the practice of psychoanalysis spread wider and to greater numbers of patients. For only a very few, mostly wealthy people, were patients of the original pioneers of psychoanalysis, for example, Freud and Jung.

What is considered a necessary frequency for deep psychoanalytic work has been reducing from Freud's method of meeting patients six times a week (Freud, 1913) to the current training requirement of three or four times a week for patients and personal analysis. While many qualified psychotherapists predominantly see patients

weekly, the theoretical basis and training underpinning psychoanalytic work remains rooted in high-frequency, long-term cases.

Aron and Starr (2012), in their book *A Psychotherapy for the People*, argue that in the 'golden' times of post WW2 American mental health arena, psychoanalysis was defined in contrast to other psychoanalytically informed therapies by the frequency of session. A great deal of effort went into maintaining the dichotomy of psychoanalysis being about exploring meaning and psychotherapy being about the search for feeling better. This was in the context of many other psychological therapies (including cognitive behavioural therapies) under the banner of psychotherapy emerging. Competition made it more important to define what could be considered psychoanalysis. George Frank (2011) wrote about how a five-year study group of psychoanalysts in the US in the 1950s could not arrive at a consensus at what session frequency was optimal for analysis. The issue remained undefined until 2005 when New York licensing laws, which were driven by insurance companies, wanted certainty about what would be paid for.

I found it interesting to discover more about how norms of psychological treatment duration were established. A meta-analysis study of adult US outpatients having psychotherapy (Howard *et al*., 1986) helped shape ideas about how many psychotherapy sessions were effective. This started 'dose response' research, a concept borrowed from biological sciences, in which each psychotherapy session was seen as a 'dose' and the 'response' was whether the patient showed any meaningful change in symptoms, as measured by standardized outcome forms. The study noted that 53% of patients showed improvement (not recovery) at session 8 and 74% of patients showed improvement after 26 sessions (Howard *et al*., 1986).

My reason for mentioning this is twofold. Firstly, that measuring the session as the dose means not counting (and therefore not valuing) the scaffolding, networking and thinking work going on between sessions. Secondly, that the lower number of sessions has emerged as a standardized time frame for many psychotherapy treatments, which then increases expectations of rapid, predictable improvements. Jonathon Shelder, in his paper 'Where is the evidence base for "evidence-based therapy"?', argues that research can become weaponized to support or oppose differing professional identities. He argues that long-term psychodynamic psychotherapy is effectively being excluded from the powerful term 'evidence-based' because it does not 'fit the master narrative' (Shelder, 2017).

Returning to the point about high-frequency sessions denoting high status, I am unsure whether this is true in CAMHS. Certainly, intensive psychotherapy is seen as 'high cost' in terms of time commitments from the service, the child and the family or network. (Of course, within CAMHS, the issue of monetary cost is absent because the NHS is free at the point of use.) Children and adolescents often have to be brought to their therapy sessions. Time has to be carved out of not only their routines, but also the routine of an entire family, with parents, carers and sometimes siblings waiting for the child having psychotherapy. A defined time frame (rather than open-ended work) is sometimes essential in order to allow the child to access

therapy, but this makes for a very different relationship than a classic analysis in which the ending is, ideally, a mutual decision between analyst and analysand.

TIME AND PSYCHOTHERAPY

Time is both a fixed and measurable concept – 50 minutes will tick past whatever happens within the session – and an extremely messy, elusive concept, which has been studied by philosophers, theologians, scientists and artists since time immemorial (or certainly since St Augustine questioned the meaning of time in the fifth century).

The sociologist, Barbara Adam, commented that 'time forms such an integral part of our lives that it is rarely thought about' (Adam, 2013, p. 177). Adam's central point was that, while time is often divided into two concepts, for example, the two words in the Greek language for time: chronos and kairos: objective and subjective time (Jacques, 1982), there are actually multiple layers to human perceptions and conceptions of time. What we take for granted about ordering activities across time is culturally determined in many layers, for instance, at a national level, such as the NHS culture, and at a local level, within families and workplaces. In order to function, we have to build routines for how we use time to free up thinking space for other matters. These routines can quickly become ritualized and therefore not thought about. I was surprised when I read that Freud saw patients six times a week and Anna Freud saw child patients five times a week because my 'normal' was the three times a week expected in training.

TIME: KNOWING AND NOT KNOWING

Reflecting on my experience of working in CAMHS, there are competing concepts of time within the culture of CAMHS and the culture of my professional identity, but we lack a shared language to describe it.

Drawing on the Jungian concepts of archetypes, an American philosopher, Segall (2015), notes that there are *three* ancient Greek gods who personify archetypal meanings of time: Chronos, Kairos and Aion.

- *Chronos* represents the regular, quantifiable passing of minutes and hours, continuing to tick on, oblivious to events and emotions. Chronos is usually portrayed as an old, wise man with a long, grey beard, similar to 'Father Time'.
- *Kairos* (or Caerus), the god of opportunity, the opportune moment, or time that is significant and meaningful. Usually portrayed as a young, swift man.
- *Aion* (or aeon) represents time as an eternal circle, as geological, cyclical, unbounded time. Aion is connected to the unconscious, to dreams and spiritual ideas.

It is easier to understand time as represented by 'Chronos': we have a commonly used word for Chronos in the English language (chronic: meaning ongoing) and chronological 'clock-time' dominates modern-day thinking and behaviour. In my

view, the culture of CAMHS is embedded within chronological time; while psychoanalytic thinking prizes the kind of time represented by Kairos and Aion.

The reason I feel the need to draw on Greek mythology is because in my doctorate research, I found it frustratingly hard to grasp the contradictions and tension of opposites inherent in the concept of time as a factor in psychotherapy. On analysing the interview texts, my main interest was in the way my interviewees spoke of being simultaneously defined by time and not defined by time – one participant captured this by saying 'we live by the clock' and then a few moments later 'there is no internal clock for recovery'. We have to be very mindful of Chronos to establish and hold the therapeutic frame and yet allow the door to open for Kairos (the right time to say something) and allow awareness of Aion (e.g. the unconscious or body processes of the analysand).

Chronological 'clock time' correlates with certainty, eternal 'aionic' time with processes beyond human certainty. We build defences through time structures to defend against the 'bewildering uncertainties inherent in psychoanalytic work (Polden, 2018). These are very necessary defences. In the work I am familiar with in CAMHS, time and space for a child and clinician (and sometimes family members) to be together *not knowing* is precious and hard fought for through many exercises in framing and explaining the problem and the solution. Bion, borrowing from the English Romantic poet John Keats, used the term 'negative capability' to describe practice of allowing space and time for new thoughts and experiences to arise: 'In every session the psycho-analyst should be able (to) … relate to what is unknown both to him and to the analysand' (Bion, 1970, p. 124).

I find this necessary state of not knowing, but trusting what may come from the unconscious, hard to embody and to communicate to the child, young person and family. There is a tension with the expectation within my workplace, couched in the language of certainty, that there is a diagnosis and agreed, measureable, treatment plan.

It comes as no surprise that psychotherapists in CAMHS are busy and wish for more thinking time for each patient. It did surprise me that my research participants, when they stopped to think about it, were self-critical about how they used time. Sessions sometimes felt like a 'waste of time' and that feeling was deeply uncomfortable within a value system of needing to justify time spent, rather than valuing (linked with Bion's eschewing of 'memory and desire') time created for the unknown.

Several studies in the social sciences field have looked at conflicts linked with time in caring professions. For example, Hirvonen and Husso (2012, p. 366) 'Living on a knife's edge: Temporal conflicts in welfare service work' concludes that 'the demands of efficiency … undermine the relational nature of care work and hurt both the care workers and the cared for'. Polden (2018) argues that the rift between theory, training and practice can generate feelings of fraudulence in clinicians. It is certainly easy to be self-critical and expect as much insight and depth in a weekly case with a young person, as with an intensive case.

CLINICAL MATERIAL

I would like to describe in brief a short-term case from my time as a child psychotherapist in training. A depressed and suicidal 17-year-old girl, who I will call Amy, left me with a feeling of floating timelessness. She wanted to talk and was intelligent and reflective. She was also highly vulnerable, living in a refuge away from family and having recently disclosed sexual abuse in her early childhood by an extended family member. The question of timing, of how much or how little to offer, was an important issue. She was referred for intensive psychotherapy (three times a week), but it soon became clear this was too much for her and she stopped attending part way into the assessment. I tried offering weekly sessions stretched six weeks into the future. She came; then she didn't. Several times she didn't come because of severe 'time of the month' pains but asked for another day that week. I was able to offer an alternative time in the week on two occasions. I was more flexible with my time for her than for my other patients and, interestingly, I was not annoyed when she cancelled, even though I was holding anxiety that we would end before we could begin. As with many young people, she needed me according to her own rhythm, which rarely coincided with my patterns of working and resting. There was understandable avoidance of thinking about her traumatic past and her uncertain future.

Six months into our therapeutic relationship, she recalled her mother bringing her hot drinks when she was having period pains. At the same time, as she was turning 18 in a few months, I had to set an end date for her therapy with me at CAMHS. She began to attend her sessions with me more regularly and was more grounded in daily life, for example, reconnected with a school friend and enrolled in a college. She cautiously reconnected with her parents. As we worked towards an ending, she seemed to have developed very quickly and yet still be only on the cusp of working through severe and cumulative early trauma. I referred her to adult services, but heard later that she did not engage.

After she was discharged from CAMHS, I worked out that I had seen her 26 times over the course of one year. This was a similar number to a short-term psychoanalytic psychotherapy (STPP) case I was doing simultaneously, but time and timing were very different, in that with STPP, our session dates were known from the beginning. With Amy, I felt it was important that we did not look too far ahead and that she had some control in the timing of her contact with me. Given the sexual abuse she had experienced, a sense of control was needed even more. The bodily rhythm of her menstrual cycle was also an important grounding factor. A shared awareness of the cyclical body time (personified by Aion) allowed for memories of being cared for, which led to an improved ability to cope with the demands of Chronos, including getting to her psychotherapy sessions. I am uncertain how much the flexible, yet anchoring rhythm of our sessions and how much the prospect of ending and the significance of turning 18 played a part in the changes that happened for Amy.

PSYCHOANALYTIC WORK

I like the way Polden uses the phrase 'psychoanalytic work' because it transcends the need for distinctions between psychotherapy and psychoanalysis. I have no way

of knowing where Amy would have taken our psychoanalytic work together had she been in the position to attend three times a week or had we been able to continue the work beyond her 18th birthday. Our irregular and short therapeutic relationship was powerful. I felt that she began to reconnect with her past and with a sense of her future, which allowed her to live within the societal demands of chronological time, such as attending college. At the same time, there was so much trauma left untouched and unprocessed; I felt she had not had enough time. As Monica Lanyado notes, in 'Holding and letting go', it is normal to doubt that the ending of psychoanalytic work is the right time and that we 'can only accompany our patients on a small section of their journey through life' (Lanyado, 2004, p. 376).

Returning to the question about what conditions make deep psychoanalytic work possible, I think deep psychoanalytic encounters can take place in brief work as well as intensive, long-term work. Yet the ordinary impingements of a 'clock time' dominated CAMHS pulls us back to the 'safer, less turbulent shallows', as Polden puts it (Polden, 2018). There is a reality to the fear that psychoanalytic psychotherapy may cease to exist within NHS settings in the future. I have experienced the cost-cutting reorganization of one CAMHS, which explicitly excluded any long-term treatment and meant that all the psychoanalytic psychotherapists were made redundant or left. There is also the danger that, in adapting to the norm of once-weekly, time-limited work, more intense psychotherapy becomes an alien, impossible concept within publicly funded institutions. This is not helped if psychoanalytic psychotherapy is seen as serving the analyst, rather than the patient. As Polden states, 'the habit of pressurizing patients to come at higher frequencies than they themselves yet feel the need for' links to the public perception of psychoanalytic work as 'coercive, authoritarian and self-serving' (Polden, 2018, p. 595).

STUDYING SHORT-TERM PSYCHOANALYTIC WORK

During my research, I looked at a sample of articles from the *Journal of Child Psychotherapy* (those published in 2014). More than two-thirds of the case study articles were from treatments over one year, and within those, approximately half were intensive cases.

It is understandable why more is written about long-term and intensive cases. The greater amount of time spent with the child allows for greater depth of insight and thinking to happen. In training, I was more deeply immersed and invested in a small number of relationships with children, young people, their families and networks, than I am now as a qualified child and adolescent psychotherapist. There was, for the most part, security of tenure and relationship which allowed me greater freedom *not* to know.

With my intensive training cases, I wrote and filed detailed process notes because this was required for weekly case supervision and for a potential qualifying paper. With the clinical material above, I wrote brief notes on CAMHS computer systems,

which I can no longer access as I do not work there anymore. So, what I have written about Amy is based on my memory of the sessions.

From my perspective, there has been a shift since I started training (in 2012) to studying and practicing short-term, time-limited psychotherapy. Within many CAMHS, short-term treatment 'packages' are recognized and routinely offered to children and young people. Much credit for this goes to the large-scale, randomized controlled trials comparing the treatment of depression in adolescents (Trowell *et al*., 2007) and, more recently, the IMPACT study (Goodyer *et al*., 2017).

On a personal level, I really appreciate the follow-up research from the IMPACT study, which was the largest evaluation of short-term psychoanalytic psychotherapy to have ever taken place (465 young people participated within CAMHS). The recorded audio material is a gold mine for further research. This means a great deal more being written about short-term, time-limited work (e.g. Grossfeld *et al*., 2019) and continued learning about what works for whom. Within my CAMHS work, being able to offer a time-limited psychoanalytic treatment 'package' is helpful, firstly because it means protected time. I can book in the dates (for STPP it is 28 child sessions and seven parent sessions) and allow work to happen with less pressure to review and measure, until the allotted time is up. Secondly, having the option of STPP helped me to argue for long-term psychoanalytic work with one young person, who I felt would need more than 28 sessions to get anywhere near deep psychoanalytic work.

TRAINING AND SESSION FREQUENCY

The requirement for my four-year training was to build a portfolio of patients. The portfolio was categorized by age ranges (i.e. under 5, latency, adolescent) and by session frequency: 'intensive' (three times a week) and 'non-intensive' cases (once a week). Most of the time, effort and resources went into the intensive cases, including a specialist supervisor for each case. My intensive cases allowed rich, deep learning and I greatly appreciated the support of my supervisors. It is vital for trainees to experience intensive, long-term work. However, thinking back to Amy and my adolescent intensive cases, in particular, I wish I had used more of the clinical thinking space available to consider the young people who did not fit the expected time boundaries of therapeutic models and to value the work we did manage to achieve.

I wonder whether a training portfolio categorized by age range and presenting difficulties might be more in keeping with how psychoanalysts practice and how patients search for analysts. Families and young people usually search for psychotherapy to help with a specific problem. CAMHS want psychotherapists who have expertise with particular patient groups (e.g. depression, neuro-developmental difficulties, looked-after children).

There is, as I mentioned above, a fear that there would be a downward pressure within the NHS to do more in less time; that is, only once weekly. In my view, that speaks to building up our ability, as a profession, to convince colleagues and

managers that intensive psychoanalytic psychotherapy should be a valued treatment option within the service that can be offered *both* by trainees *and* qualified psychotherapists.

CONCLUSION

My title question 'How much time do we need?' is something that a parent asked me at the beginning of her child's therapeutic work. It is a question about expectations, hopes and fears for the future, and the exploration of an answer is unique to each therapeutic relationship. Often, as with Amy, the question has to be 'How much time do we have?' because of institutional boundaries, such as age limits.

Since qualifying, I have offered only weekly psychotherapy. It takes relational time between psychotherapist, child and the child's network for a mutual recognition of the need to increase session frequency. When and if this happens in my current workplace, it will take persistence, confidence and supportive colleagues to successfully argue for more intensive work and to make time for it.

I would welcome a greater emphasis while training on studying the nuance and skill it takes to find a rhythm of working that suits the patient's therapeutic needs and how best to communicate that within the predominantly 'clock time' narrative of CAMHS and patients' networks.

To keep hold of my professional identity while working in CAMHS, I find it helpful to keep in mind the three 'gods' of time; exercising some control through the boundaries of chronological time, in order to allow opportune moments to arise and for communication with the timeless unconscious. My training has come from two institutions with very different conceptions of time. My training in psychoanalytic and Jungian thinking through the British Psychotherapy Foundation helps me to value time spent not knowing. Working with children and young people in CAMHS presents me with the urgency of immediate need. Nurturing conditions for deep psychoanalytic work within CAMHS takes the ongoing work of embodying how shared time for thinking, reflecting, supervision and learning from each other and our patients is vital for all clinicians aiming to support children and young people suffering mental distress.

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During my training as a child and adolescent psychotherapist, I started qualitative research with Birkbeck University's Psychosocial Studies Department into 'How do child and adolescent psychotherapists working in NHS settings talk about time as a factor in their clinical work?' I decided to withdraw from this doctorate in 2018; the materials and ideas I make reference to in this article are based on the literature review I did and three pilot interviews with child and adolescent psychotherapists working in the London area.

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NOTE

1. See Acknowledgements, for the context of this research

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