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PSYCHOANALYTIC CLINIC AS RESISTANCE IN THE CULTURE OF "MANAGED CARE" IN MENTAL HEALTH: *ANNA FITZGERALD, A JOURNEY IN BRITISH PSYCHOANALYSIS*

CLÍNICA PSICANALÍTICA COMO RESISTÊNCIA NA CULTURA DO "CUIDADO GERENCIADO" EM SAÚDE MENTAL: *ENTREVISTA COM ANNA FITZGERALD, UM PERCURSO NA PSICANÁLISE BRITÂNICA*

CLÍNICA PSICOANALÍTICA COMO RESISTENCIA EN LA CULTURA DE LA "ATENCIÓN GESTIONADA" EN SALUD MENTAL: *ANNA FITZGERALD, UN CAMINO EN EL PSICOANÁLISIS BRITÁNICO*

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INTRODUCTION (GENERAL PRESENTATION ABOUT THE INTERVIEWEE AND THE PUBLIC MENTAL HEALTH SYSTEM IN ENGLAND)

Established in 1948, the National Health Service (NHS) is the primary public health system for primary, hospital, and specialized care for residents of England, Scotland, Wales, and Northern Ireland. It is often considered one of the world's pioneering systems of socialized medicine, and although it was not the first, it was a trailblazer in its national scale and comprehensiveness. Like the Sistema Unico de Saude (SUS) in Brazil, the NHS also shares the commitment to providing universal access to healthcare for the inhabitants of the United Kingdom.

In terms of mental health provision, the NHS offers: Primary Care Services through the general practitioners (GPs) who play a role in diagnosing and treating common mental health conditions; Specialized Mental Health Services provided by psychiatrists, psychologists, psychotherapists, nurses, and social workers. They offer assessment, diagnosis, and treatment for more complex mental health issues, including severe depression, bipolar disorder, schizophrenia, and personality disorders; Community Mental Health Teams (CMHTs) which provide support and treatment for individuals with severe and enduring mental health problems that require ongoing care in the community, with interventions including medication management, psychological therapies, and social support; Crisis Resolution and Home Treatment Teams (CRHTs), which provide rapid assessment and intensive short-term support for individuals experiencing crisis episodes. Their goal is to prevent unnecessary hospital admissions by offering emergency intervention and support in the individual's home or community environment; finally, for individuals who require more intensive support and treatment, the NHS offers inpatient care in psychiatric hospitals and hospital units. These facilities provide 24-hour care and support for individuals facing severe mental health crises or those who need stabilization and intensive treatment.

In general, the NHS's provision of mental health care aims to promote well-being and provide timely and effective support and treatment. However, beginning in 2010, the UK entered the period of the most significant government austerity since the 1970s, with widespread public spending reductions and budget cuts as part of measures to address the national budget deficit.

The impact of austerity on the NHS was significant and multifaceted, affecting various crucial aspects of its functioning, as the new budget was significantly reduced and did not keep pace with growing demand and costs. Austerity measures also contributed to a hiring-freeze for professionals, resulting in a shortage of specialized personnel. Investment in infrastructure, such as hospital buildings and equipment, was also restricted, leading to a backlog of delayed maintenance and delays in updating facilities.

The reduced funding increased pressure on services: hospitals, clinics, and surgeries faced much heavier workloads, significantly longer waiting times for patients, and reduced capacity to meet the demand for support, especially for the most vulnerable populations. The

government's response to the budget deficit had severe political implications, not only in the clinical sphere but also culturally, as the impact of austerity was not distributed uniformly. Disadvantaged communities and regions suffered the most from the negative effects of inequality.

In the field of mental health and clinical care, there was a general paradigm shift post-2010 with a covert imposition of a "managed care" culture. This culture favoured cognitive-behavioural therapy as the only effective modality of psychotherapeutic treatment, under the disguised rhetoric of efficiency and high volume of care through the simplification of services provided – to the detriment of the quality of offerings.

For community mental health centres serving peripheral urban populations, the emphasis of treatment is currently placed on the implementation of standardized, low-cost techniques, stagnating in a rather mechanized pace of reinforcement and behavioural change. It can be said that the result of the austerity faced by NHS mental health policies over the past nearly fifteen years is the contemporary treatment of the human psyche as an organ suffering from malfunction and therefore in need of re-education.

At the opposite end of the spectrum, the psychoanalytic method in public-community care, by offering an ethical model that is not utilitarian, has faced setbacks and ended up isolated in specialized—and scattered—centres across the constituent countries of the United Kingdom. Instead of adapting, psychoanalysis addresses and confronts the subject with reality in all its raw manifestations, as education does not transform the unconscious.

Rather than teaching the patient to normalize their symptoms, psychoanalysis makes the symptoms productive, allowing for the discovery of subjective meanings.

When patients recognize that their subjectivity has been expressed through symptoms, it often leads to a productive moment of emergence; the birth of a singular truth that triggers a new sense of personal responsibility that takes time and does not bow to budgetary laws or behaviour manuals.

The psychoanalytic method offers a voice of resistance to utilitarianism, and today's interviewee is one of its spokespersons. Anna Fitzgerald, a psychotherapist of a psychoanalytic orientation and nearly three decades of clinical experience in both private practice and public service with the NHS in the UK, has spent much of her extensive career providing specialized psychoanalytic care to parents-infant/child and intensive and non-intensive individual work with children who have experienced deprivation and early, often intergenerational, trauma in family life.

Her career began at the Tavistock Clinic in London in the early 1990s, which established the clinical foundation for her lifelong interest in the impact of early trauma and neurodevelopmental difficulties on self-development, and an interest in the psychoanalytic understanding of the interaction between adverse socio-political experiences of power and oppression in the external world on the development of the early internal world and sense of identity.

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Below are some of her considerations on public policies, psychoanalytic care, and the unconscious.

PLURAL INTERVIEW

1. Anna, we would like you to give us a summary of your professional life, and how you ended up working with children as a psychoanalytic psychotherapist in the NHS as well as in private practice.

I first trained as a teacher and worked with adolescents at an inner London comprehensive school in a deprived urban area. I quickly saw that emotional and behavioural problems interfered with learning, creating a cycle of failure, low self-esteem, aggression, depression, and disengagement in education. I worked for six years as a teacher in a therapeutic multi-disciplinary special school for adolescents unable to cope in mainstream education. Working in a team with psychoanalytic child and adolescent counsellors and psychotherapists inspired me to train and to work as a psychodynamic counsellor. I was appointed to the head of an adolescent counselling service funded by the education department for adolescents with emotional and behavioural difficulties, (1990-1999). While in this post, I completed the Tavistock pre-clinical foundation course part-time, and then entered the four year full-time clinical training in psychoanalytic psychotherapy with children, adolescents and parents., (2000-2004.

On completing the training, I was appointed to a combined clinical and teaching post at the Tavistock Clinic, 2004 -2012. I left this post to set up in private practice and contribute to a two- year UK government funded research project on the impact of work with parents to alleviate symptoms in children with mental health I have continued to supervise and to teach on clinical courses at Birkbeck College, University of London, the British Psychotherapy Foundation and for the past ten years I have contributed to the Sino -British psychoanalytic training in Beijing for clinical psychologists, psychiatrists and other mental health professionals, who have an interest in British Psychoanalytic approaches.

I first came across psychoanalysis as a teenager, dipping into Freud's writings on dreams and sexuality. I had first been interested in psychoanalysis as a teenager, dipping into Freud's writings on dreams and sexuality. I learned about the Kleinian approach at the Tavistock clinic through a publication by Tavistock trained psychotherapists, '*The Emotional Experience of Learning and Teaching*', first published in 1983, and re-printed throughout the 1990's. This and other Tavistock publications introduced public sector workers to Klein's thinking about complex mental mechanisms in the emotional development of children and young people: unconscious processes, anxieties and defences the interplay between the internal and external world, and between early experience and emotional development across the life cycle.

The NHS was established as part of the wider welfare state in 1948, in response to the need to rebuild a society torn apart by the first world war, deep economic depression and the continuing impact of the trauma of the second world war. Psychoanalytic psychotherapy was included in the specified interventions to be provided by the new NHS Mental Health service nationwide clinics, alongside psychiatry, clinical psychology and social work, largely through the influence of the work undertaken by the Tavistock clinic as a charitable clinic established to offer outpatient psychoanalytic treatment for servicemen, children and families traumatised by war.

Training and public sector outpatient provision has ebbed and flowed, in response to changes in the wider socio-political landscape in which mental health training and service delivery has been embedded. Therapeutic out-patient therapeutic mental health services flourished in the 60's and 70's when I was at school and university, as part of a more liberal cultural shift in society away from an institutionalised, medicalised response to mental health needs. This period gave birth to wider movements in favour of social change; the advent of the contraceptive pill, the Women's Movement, the Gay Liberation movement, to name a few.

The election of the Conservative Party in the UK, 1979-1997, brought about a policy shift that aimed to reduce dependence on state provision, through incremental cuts to NHS and public sector funding over an eighteen-year period. At the same time there was a shift towards University Academic accreditation of clinical trainings in psychoanalytic psychotherapy, in order to be competitive in bidding for ever-reducing state financial support and resources, and a culture of competitive internal market policies.

Despite draconian restrictions to funding in the NHS, in 1995 the Tavistock Clinic and the wider professional Association for Child Psychotherapy, (ACP), successfully lobbied to secure core NHS funding for the intensive 4-year child psychoanalytic psychotherapy training for a limited number of candidates each year, in each of the different training schools, (Kleinian, Freudian Jungian and Independent. This enabled a significant expansion in access to child psychotherapy across the country, and greater diversity in access to training, spanning the years when I was training and practicing psychoanalytic psychotherapy in the NHS.

2. How was your training in the UK at the time of your qualification, what did it entail and has it changed over time? If so, how?

I was fortunate to undertake the clinical training at the Tavistock Clinic in a full-time NHS funded training post, 20O0-2004. My training was very intensive; the foundation level two-year part- time course included psychoanalytic theory; Freud, Klein and Winnicott, the child development research literature, including findings emerging from neuroscience. Infant observation has been at the heart of child and adult psychoanalytic training in Britain, since its inception as a core component of the psychoanalytic child psychotherapy training at the Tavistoc Clinic in 1948.

This experiential pre-clinical component required trainees to observe a mother and baby for one hour each week, in the home, from shortly after birth until the second birthday. Infant observation as a required component is now well established at the heart of psychoanalytic training in all British schools, (Kleinian, Freudian, and Independent), at the Institute of Psychoanalyis and the British Psychotherapy Foundation.

In the four -year clinical training, core theoretical texts were revisited, extending to an in-depth study of the work of Wilfred Bion; *this has had the most significant and influential impact in the evolution of psychoanalytic theory in the 21st century, particularly in the Kleinian tradition in which I trained, but also in contemporary psychoanalytic practice in all schools and traditions*. Intensive personal psychoanalytic psychotherapy was required for a minimum of four days weekly, starting a year prior to the clinical training and in most cases continuing for a year or more after qualification.

In the clinical component of the child training, the minimum requirement was to have 3 longer term, intensive training patients; one under five, a latency age child, and an adolescent. Each training patient attended 3-4 days weekly, one patient for a minimum of two years and the others for a minimum of one year each. Each training patient was supervised by a consultant psychotherapist once weekly throughout the training. In addition, trainees were required to see children/adolescents on the community clinic waiting list once or twice weekly, to work with individual parents, one for a minimum of one year, and in the final year of training, individual assessments of children and families. In the final three years of training, specialist options were required. I completed specialist options in infant-parent-toddler psychotherapy, autism and infant/young child mental health, fostering and adoption and work with parents.

After qualifying, I worked in one of the Tavistock based clinic teams and a community 'Child and Family Mental Health Service ', (CAMHS). I taught on the foundation level pre-clinical trainings offered by the Tavistock, by then academically accredited at MSc level. I had anticipated at the start of my training that I would continue to work with adolescents after qualification, however my experience of infant observation and intensive psychotherapy with a developmentally delayed 4-year-old training patient, were very powerful. This led to my specialising in parent-infant psychotherapy, psychotherapy with children under five and work with parents, as well as the usual clinic waiting list work across the age range.

I was in the last cohort of trainees to be awarded a clinical qualification; the new training was a university accredited clinical doctoral programme. In part, this change to academic accreditation was in response to new requirement that was introduced in 1999 for NHS services to provide Evidence Based Research to standards required by the development of National Institute for Clinical Excellence (NICE). The rationale was to ensure taxpayer's money be spent on interventions proven to be effective, to ensure value for money in NHS provision. There has been a view that this requirement was a way of rationing mental health interventions in the NHS. Providing a research evidence base is much easier to do for short

term interventions that have a rapid turnover of larger numbers in patient cohorts, and are based on objective measures, such as CBT and pharmacological interventions.

Psychoanalytic psychotherapy is longer term, labour intensive, expensive to do, measurements are complex. Not withstanding these obstacles, there has been success in some psychoanalytic research studies in meeting NICE guidelines for inclusion as a recommended NHS treatment. Reductions in NHS funding however has meant that while some pharmacological and therapeutic interventions have been approved by NICE, they may not be offered in the NHS due to cost.

In the years following qualification in 2004, political drivers and external socio -political events have continued to impact on child psychoanalytic psychotherapy in the public sector and in private practice. My in-depth training is what had enabled me to continue to work effectively in less intensive, once weekly work and in shorter term work, ranging from 5 appointment brief parent- baby/toddler interventions, brief once weekly interventions for 30 weeks, with children who met the clinical range for anxiety and depression. It may seem counter-intuitive, however in my experience, in -depth training is a necessary pre-requisite to enable clinicians to work effectively in brief and non-intensive work.

3. The psychoanalytic thinking in America has developed over time based on a model which privileges Medical Sciences and the Academia/University – in Brazil, it is true that there are some reputable psychoanalytic institutions and societies across the country, but it is also fair to say that it is vastly through the Clinical Psychology curricula at the Universities that future trainees have Psychoanalysis introduced to them – a model which mirrors, in so many ways, the US.

I agree that with a proliferation of less in-depth training options and treatment interventions, the requirement for academic accreditation has increased. I was in the last cohort of trainees in the child psychoanalytic psychotherapy training at the Tavistock clinic to qualify with a clinical rather than academic qualification. This shift has meant a greater emphasis on teaching theory that can be cognitively learned relatively quickly, an emphasis on assessment of theoretical learning, rather than assessment of development of clinical capacities: analytic attitudes, and clinical skills. Jonathan Shedler has spoken about this development in America, resulting in a proliferation of the availability of therapy interventions, by academic psychologists, and a massive reduction in the availability of what Shedler has called ‘meaningful therapy’. He makes the point that many academically qualified practitioners have never themselves experienced ‘meaningful therapy’, so sadly do not even know what that might look like or feel like.

At the time I qualified the assessment process required a 12,000- word clinical case study of a patient seen for a minimum of three times weekly for a minimum of one year. The requirement was to describe the therapy as it evolved; beginning, middle, and end. The focus was the integration and application of theory in clinical practice, work with the unconscious,

latent communication, inter and intrapsychic processes, non-verbal play and communication, the positive and negative transference, working through the past in the present therapeutic relationship, conveyed to the reader through granular in description of the fluctuations in the interaction and relationship, over time.

Trainees currently on the child psychoanalytic psychotherapy training at the Tavistock do submit some theoretical and clinical writing at different points throughout the training. The main emphasis for qualification however is a research dissertation, typically a qualitative analysis of themes in a single case study, rather than a granular description of the interaction in the unfolding clinical relationship.

4. Please can you tell us more about how, to you, the British Psychoanalytic tradition radically differs from this model?

I am not sure that we can speak today about the 'British Psychoanalytic Tradition' in training, as this has been variously influenced by academic requirements filtering into different analytic training institutions. Perhaps what comes closest to the core psychoanalytic tradition is the training at the British Institute of Psychoanalysis, a private institution, which has therefore been relatively immune to pressures to conform to the requirements of a medical or academic model of learning and assessment of learning.

Similarly, the British Psychotherapy Foundation as a private, charitable institution has managed to withstand the pressures towards academic theory and research in the delivery and assessment of clinical trainings. Birkbeck College too has managed to uphold the psychoanalytic training in many respects and resist the encroachment of academic rather than clinical teaching and learning. This has been and continues to be a long struggle, maintained by the model of clinician- lecturers on the Birkbeck MSc Psychodynamic Psychotherapy, in a wider academic faculty.

My teaching on the Sino -British programme in China is a pleasure in being under no pressure from academia. The trainee cohort already have an academic qualification to practice as doctors, clinical psychologists etc. This training programme came about due to a psychiatrist recognising the lack of clinical skills and understanding in mental health services in China generally, and a lack of psychoanalytic training in particular. The clinical training was established in Beijing as additional clinical training at post-qualification level, under the auspices of a medical mental health hospital and university joint venture. Theory teaching is offered intensively three time a year in 5-7 all day teaching events, followed up by a rolling programme of small weekly infant observation seminar groups and clinical supervision groups.

5. Please can you tell us more about your personal choice to train, study, and practice psychoanalysis outside of Academia (as a position of resistance to the University/Academia model, which unfortunately we see spreading nowadays also in the UK; a resistance aimed at perhaps keeping the psychoanalytic principles to its core)?

As described above, at the time I trained only a clinical training recognised by the NHS was an option, an academic route for psychoanalytic psychotherapy training did not exist in my time. Pre-clinical training requirements included a relevant degree and a professional qualification, in for example, teaching, social work, psychology, nursing. I have opted to contribute to psychoanalytic teaching and training organisations that have been able to maintain a clinical model of teaching and assessment, very much in the minority of training options in the UK today.

I decided to leave the NHS, to work in private practice, as a consequence of the way in which clinical service delivery and training were being driven by political agendas, to the point where it seemed that what was required was to plaster over the cracks, rather than to undertake meaningful clinical assessment and treatment. The bureaucracy required to provide paper evidence of what had been done and measurement goals even in single appointments had mushroomed to the point that clinicians were increasingly spending more time doing paperwork than seeing patients.

6. Could you tell us more about public mental health provision in the UK for children, how this has changed over time, and what do you think of psychoanalytic modalities losing space in favor of CBT in the public sector?

I think I have commented on this above, it is true that shortly after I left the NHS, child psychotherapy colleagues felt under pressure to train in, and to offer CBT interventions, rather than child psychotherapy. This was in response to reductions in resources to undertake meaningful treatment interventions and an increase in short-term behavioural interventions, creating a revolving door of access to short-term interventions.

7. In Brazil we see a disconcerting exponential growth of the use of CBT combined with medication as the preferred choices of treatment for children in the healthcare sector – what are the risks in your opinion, of a clinical practice which focuses on medicalizing life?

This is also a trend in the UK where the NHS is already on its knees due to years of underfunding, particularly in mental health generally and child mental health in particular. There is a significant escalation of clinical disturbances in children and in the adult and prison population. Waiting list in Child clinics are now one year-eighteen months, with only minimal treatment intervention possible when seen. This increase in demand is partly a consequence of public policy that for the last 14 years has increased precariousness in meeting basic needs for stable housing, employment, education, healthcare. This has created additional stress in family life and breakdown of cohesion in family and community support structures, alongside massive reductions in every aspect of health, education, and social care provision.

8. Is it fair to say this combination above could be considered, when not rigorously monitored, a true reductionism of the complexity of the unconscious?

Yes, indeed.

9. Could you tell us more about your work with children, both in public health settings such as the NHS, at the Tavistock Clinic as well as in private practice – has anything changed in your relationship with these patients; was there any adjustment to your stance as a practitioner over time, considering so many changes in our society in the last 20 to 30 years?

I have been practicing through a time when there were some interesting and valuable developments in the profession. Child psychotherapy within the NHS initially greatly extended the provision of psychoanalytic psychotherapy to children from diverse backgrounds. Significantly, the early development of a theory and technique for child psychoanalytic psychotherapy by Melanie Klein was based on a narrow range of mainly young children under 5, from middle-class families with an interest in psychoanalysis, seen privately. Their eternal circumstances were considered by Klein to be favourable socio-economically and most likely to be within the 'good enough' range in terms of family life. (Freud did uncover instances of abuse and emotional harm in the same socio-economic group of patients, who came to him for help as adults).

The difficulties in the child patients seen by Klein, informed the development of her theoretical innovations to Freud's theory and technique. Although often serious, their difficulties were mainly internal in origin, so amenable to a classical psychoanalytic approach to neurotic symptoms; anxiety, depression, aggression, obsessive compulsive disorders, technically adapted to facilitate unconscious communication; free association through play and work with the transference to explore the internal world and phantasy life of the child, and a better integration between internal and external reality.

At the time I started training at the Tavistock in 2000, seeing child patients in the NHS, I saw children with difficulties similar to the patients seen by Klein. I was astounded to see the unfolding of the internal world and unconscious mental mechanisms of young children as described in Klein's writing, in my clinical sessions, and the relief that followed interpretation of the positive and negative transference and working through of the child's phantasy life in symbolic communication through play.

I became aware over time, that saw children who did not fit Klein's description, children who could not play or relate, children who had suffered external deprivation, abuse and trauma in family life. With increasing reductions to funding in the wider Welfare state in the UK, to social work, nursery provision, and education, the NHS rapidly saw the case load of children referred suffering from mainly external adverse circumstances being the main cause of emotional and mental health problems, and exacerbating internal difficulties in others.

Soon writing began to appear in the child psychotherapy literature that helped me to adapt my technique. Authors noted for example, the distinction between externally deprived, neglected, abused children who make use of defence mechanisms to help them to survive physically and emotionally, when there is no-one to depend on, rather than using defences for internal reasons of being unable to tolerate being small, helpless and dependent in object relations; a deliberate turning away from, rather than an absence of, the hand that feeds.

I and many of my colleagues were increasingly seeing children in the former group, the latter being largely excluded from NHS treatment by the deluge of referrals, of children with complex external difficulties. Anne Alvarez and others addressed this clinical difference and the need for adaptations in technique, see for example her chapter, 'Borderline Conditions: Differentiating Disturbance and Deficit'. in: Rustin, M., and Quagliata, E. (eds,) *Assessment in Child Psychotherapy,* 1997, London, Routledge.

10. Are there any innovations in contemporary psychoanalytic thinking that you have incorporated into your practice with children? Can you tell us a bit more if any of these are your own thoughts and interpretations based on your years of experience, and how they differ – if at all - from a more classical approach?

On reflection, it is striking that the innovations introduced by Alvarez and others were not foregrounded much more in my NHS funded training, which focussed on classical Kleinian theory and technique. Differences had arisen about theory and technique developed by Anna Freud and Klein, leading to the 'controversial discussions' in the British Institute. Anna Freud's theory and technique were informed by her work with deprived and traumatised children in the Hampstead War nurseries. It seems to me that the differences in theory and technique are needed for different patient groups and this was more at the heart of differences, rather than the specific schools of thought. This is much more recognised today, with more cross-fertilisation of thinking about theory and technique that evolves from different schools of thought, according to the needs of different kinds of patients, more consideration of what works for whom, when and why an adaptation to classical technique might be needed.

11. With regard to your work with children, specifically in the public sector: has this population changed since you qualified? Who are these children nowadays and what is the degree of social vulnerability we are looking at?

The threshold for referral of children to community public sector provision in the NHS has risen exponentially, so that over time it has become the case that only the most seriously disturbed children and adolescents meet the threshold for referral, and the root cause of many difficulties in the children seen are external. Erosion to NHS funding, reduction or closure of more expensive higher- level specialist therapeutic, and combined therapeutic/ social care services, has meant that only community front line NHS services are available to referrers, with

long waiting times and capacity to offer only brief interventions. The range of socio- political crises and policies, the reduction of economic resources and restrictions on how this is spent has meant that mental health support for children and adults has been at a critical point for many years.

This is reflected in the UK in what is recognised as an epidemic of increasing mental health difficulty of greater complexity; multiple, complex, physical, mental health and learning needs, and/or needs arising from neurodiversity, the risks posed by new technology, the impact of coronavirus and so on. More and more children and families fall through the holes in the net of service provision in a Britain that is increasingly failing to provide adequately for many of its citizens, facing many of the problems more typical of a developing country.

12. Finally, about mental suffering and public policies – Brazil is a developing country and there are common external factors related to the mental suffering patients bring to psychotherapy, and such external factors tend to be heightened amongst marginalized populations (we are looking here at racism, xenophobia, poverty).

If we were to think about certain populations of children you see, is there a common, recurrent external theme you witness with a certain frequency, and if so, how does your psychoanalytic practice consider these external factors? Are there any differences between private practice and public healthcare?

Sadly, public healthcare, social care and education have long been in decline in the UK, a key theme increasingly is that of poverty, deprivation, acute stress and trauma in family life. Inevitably, this stirs up anxiety about survival, provoking primitive defences within and between different groups and communities. Children and young people experience increased exposed to hatred and aggression, and as you say, an intensification of racism, sexism, homophobia, misogyny, intolerance. The rise in drug misuse, knife crime, and criminality is concerning.

13. What advice would you give to enthusiasts of the British School of Psychoanalysis and its work with children, who are still at the beginning of their practice – trainees or recent qualified professionals? Something you perhaps wish you knew when you were at the beginning of your career?

When living and working through cycles that include periods of challenging difficulties, it is tempting to close down, to lose the capacity for curiosity and conviction. I would encourage hopefulness and thinking about what might be possible to learn from even adverse experiences. The capacity to work with the unconscious and to think about an process experience is powerful, and a great ally in surviving and continuing to make transformational change possible, at a time when the very notion of working with the unconscious is being undervalued and even under attack.

NOTES

* In the United Kingdom, there is a clear distinction between those working in psychotherapeutic services with a psychoanalytic orientation. Each of these professional titles is exclusive and legally protected, requiring professionals to meet specific criteria before they can officially use them. Typically, these criteria include, but are not limited to, the duration and intensity of personal analysis, the qualifications obtained from the institution where the professional received training, and the specific area of clinical practice in which they specialized. These requirements align with the regulations set forth by the various professional councils overseeing clinical practice in the United Kingdom. Broadly speaking, and for illustrative purposes, a simplified (though not simplistic) division can be outlined as follows: a) *Psychodynamic Counselor*: a short postgraduate course (approximately one year), combined with face-to-face individual psychotherapy once a week; b) *Psychodynamic Psychotherapist*: a two to three-year postgraduate course, combined with face-to-face individual psychotherapy once or twice a week; c) *Psychoanalytic Psychotherapist*: a four-year training program, combined with individual psychotherapy/analysis on a couch two to three times a week; d) *Psychoanalyst*: a training program of at least five years at a psychoanalytic training institute, combined with individual psychotherapy/analysis on a couch four to five times a week.

** Jonathan Shedler is a psychologist known for his work in promoting and advocating psychodynamic psychotherapy. He outlined several key principles that characterize this therapeutic approach, emphasizing the importance of understanding underlying psychological processes and emotional dynamics to foster profound and lasting changes in patients' lives.

*** NICE: The National Institute for Health and Care Excellence (NICE) is a public executive body funded by the Department of Health and Social Care. NICE is responsible for supporting and monitoring continuous improvement efforts in public health across the United Kingdom.

**** Psychoanalysts were employed by the public clinic as full-time staff members with exclusive dedication.

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