States of abjection in managed care[i].

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Introduction

In a recent meeting, a group of colleagues and I were discussing a young woman who had been referred to our National Health Service (NHS) primary care mental health service. This young woman was experiencing an episode of quite severe depression and had gone to her doctor seeking psychotherapeutic help. In the letter from the doctor, we learned that she had experienced a number of problems since early childhood: she had initially been raised in foster care; abused by a neighbour, she had left home at only 17, and subsequently engaged in a series of emotionally and sexually abusive relationships with men. The father of her baby had recently been jailed for drug-related crime, and now, at 24, she was raising her two-year-old by herself. She was currently unemployed, struggling to manage on government benefits, and appeared to have no family and few support networks available. The GP was clearly very concerned about her, and was putting the service under considerable pressure to treat her as a matter of priority.

During the discussion, a disagreement between various members of the group turned into a full-scale debate about the nature of the service, what it should be offering the community and the criteria for accepting patients into the service. Whilst one or two clinicians, including myself, felt that it was possible to offer this young woman some focused, brief work to address the current problem, the majority, including the clinical lead, felt that this patient's history meant that this was unlikely to be helpful. A number of anxieties were raised about the value of the brief psychotherapeutic work that would be available: suppose the patient regressed? How could the service manage and contain the probable risk issues? If ongoing support was needed pending any necessary referral to the community mental health team, how would this be reflected in targets and staff activity data, already under scrutiny by senior management? In the course of this lengthy debate, one of my colleagues, by now no doubt tired and exasperated, asked whether we thought the service was simply there to deal with '*shit life syndrome'*. This rather vivid rhetorical question resulted, unsurprisingly, in some further heated discussion which was eventually cut short by the clinical lead who agreed that, despite pressure from the doctor to accept this patient, the service could indeed not afford to take on everyone who suffered from 'shit life syndrome', and took the decision to reject the referral.

I have since become very curious about this expression '*shit life syndrome'*, not the least because of the implicit consensus by everyone in the meeting, including myself, as to what it meant. The phrase seemed to denote a level of long-standing poverty, family breakdown, lack of stability, unemployment and potential risk factors common to many of the predominantly young, working class patients referred to the service. There was no doubt that, quite apart from important debates about the inclusion and exclusion criteria for the service, these issues aroused a number of unspoken anxieties in all of us present at the meeting. But the particular choice of words used by my colleague I think tells us something about the unconscious nature of these anxieties. For shit, of course, is something that we generally prefer not to think about; something we continually reject, get rid of or hide. At the same time, it is something that we cannot completely repudiate; it is part of us, something we need, something that is ineluctably part of our status as human beings, as subjects. Those suffering from

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'*shit-life syndrome*', then, would seem to be those individuals whose problems are deemed to be so terrible, so untouchable, that they quite literally cannot be thought about, cannot be handled by the service. At the same time, the organisation is obliged to do so; it is confronted by continual pressure from the public and from referrers to provide psychological care and treatment for these same individuals who arouse such intense anxiety and from whom its staff wish to distance themselves.

In bringing a psychoanalytic sensibility to the study of organizations, Gabriel and Carr (2002) suggest that it '*opens valuable windows into the world of organisations and management, offering insights that are startlingly original, have extensive explanatory powers and can find ample practical implementations*' (p. 348). Whilst much psychoanalytic thinking about organizational dynamics traditionally draws on the object relations theories of Klein (1946) and Bion (1962), in this chapter I want to consider Kristeva's (1982) notion of the abject as a possible alternative lens through which to think about anxiety within mental health services. Kristeva suggests that anxiety indexes the perpetual attempt by the subject to expel something of the self that is deemed to be repulsive or untouchable, a dynamic that I will suggest has remained significant throughout society's long history of care for the mentally ill.

The arguments in this chapter are located in the context of contemporary UK public mental health services which have been identified by Thomas and Davies (2005), along with all public sector organizations, as 'sites of transformative change' (p. 684) since the 1980s, as a result of new public management (NPM) restructuring of health, education and social services. A particular emphasis in NPM is the introduction of new disciplinary technologies (Townley, 1994) aimed at instilling new organizational attitudes sponsoring workers' compliance with government target systems. These targets, and the technologies designed to generate them, actively construct the organizations in which they operate, shaping the behaviour and subjectivities of staff as well as the public perception of problems for which they are considered to be the solution (Power, 1997). In this chapter, I will attempt to link the unconscious dynamics of abjection with the organizational policies, structures and practices of contemporary UK mental health services subject to these technologies, specifically drawing on my work as a psychotherapist and supervisor within an Improving Access to Psychological Therapies (IAPT) service.

Using the above example as a starting point then, I start by offering a brief introduction to Lacanian and Kristevan views of anxiety before exploring the psychoanalytic notion of social defences in organisations. I then draw on work by Foucault (1964) and Shildrick (2002) to consider how individuals deemed to be psychologically distressed are cast as monstrous or 'other' by society. Exploring the way in which NPM preoccupations with regulation, surveillance and governance within mental health institutions may be characterised as a symbolic attempt to gain mastery over feelings unconsciously deemed to be abject reminders of the body, I offer an organisational case example to illuminate the way in which abjective dynamics are refracted within one particular IAPT service, impacting on both staff and patients.

Abjection: a theoretical outline.

There is no doubt that Kristeva's theories, drawing on psychoanalysis, linguistics, literary theory and philosophy, remain dauntingly abstruse to many clinical practitioners and researchers. Her concept of abjection is well-known to writers on intertextuality (Keenoy and Oswick, 2004; Riad, Vaara, & Zhang, 2012) , but is more frequently elaborated by feminist writers concerned with culture, gender

and sexuality (eg. Butler, 2004; Fotaki, 2011; Hopfl, 2008; Tietze, 2003). Her thinking derives from a Lacanian framework in which subjectivity is thought to be constituted by the interweaving of the three psychic realms of the Imaginary, the Symbolic and the Real.[ii] In Lacan's (1953) 'mirror stage', his template for the Imaginary order, the child's lack of physical coherence and motor co-ordination gives rise to a primal anxiety that is only allayed by identification with his or her mirror image. Identification thus confers a subjective feeling of wholeness, completeness and self-mastery, an anticipated sense of self-unity and control that the child does not yet possess. This forms the basis of an imaginary ego, a 'misrecognition' upon which an imaginary identity and thus a psychological dependence on the other is created and sustained. The specular re-constitution of the fragmented body at this stage covers over the ego's basic lack or insufficiency which is experienced as profound anxiety in the face of the Real.

Lacan claims that It is this fundamental loss of the (Imaginary) self that the individual attempts throughout life to recover via language and recognition by the (Symbolic) other. Kristeva (1982) however privileges the maternally-oriented, pre-symbolic, pre-linguistic order that she insists precedes, underpins and guarantees the subject of the symbolic order. She sees the mother's body as a receptacle, a place of semiotic drives and boundaryless plenitude. In a symbiotic state, akin to Lacan's Imaginary register, the infant experiences himself as one with and fulfilled by a mother guaranteeing wholeness and unity. In order to enter the Lacanian order of the Symbolic, to become a differentiated subject constituted by language and lack, the subject has to discard the unclean, improper or impure aspects of the maternal body while it is still within this symbiotic tie. The rejected parts of the self '*may be such things as faeces and sour milk, but they may also include symbolic representations of the child's relationship with its mother*' (Holmes et al, 2006, p. 307). Kristeva (1982) suggests that feelings of anxiety, disgust, repulsion and fear are ways in which each individual subsequently experiences and attempts to distance him or herself from what is felt to be improper or unclean in order to establish and strengthen his or her own subjectivity and retain a self that is '*propre*' or clean. In this struggle, the maternal body is abjected and becomes the site of primal repression whilst remaining the seat of maternally-oriented psychic energy beneath the symbolic order. Abjection is thus clearly linked to the construction of the speaking subject, where the marginalised or unrepresenatable aspects of language such as the rhythm, prosody and tone of text or speech are seen to underpin and continually threaten to destabilise the paternally-oriented symbolic order governing language, syntax and grammar.

Abjection is thus seen by Kristeva as a process through which the individual's sense of self and corporeal boundaries are established and positioned; where subject and object are distinguished, and where toxicity and waste are rejected and order installed. It is the measure by which the subject defines what is 'I' and what is 'not I'. In this struggle, whatever is not clearly demarcated in this way is connoted as abject: '*It is not lack of cleanliness or health that causes abjection*' writes Kristeva (1982), '*but what disturbs identity, system, order. What does not respect borders, positions, rules. The in-between, the ambiguous, the composite*' (p. 4).

Abjection and the social defence model: anxiety in organisations.

Discussions about the role of anxiety within organisations have traditionally been dominated by the so-called 'Tavistock model'. This work draws mainly on Kleinian psychoanalytic thinking to articulate how organizations structure themselves and the subjectivities of staff in order to defend against primitive anxieties. Isabel Menzies-Lyth's (1960) seminal study investigating the reasons for increasing numbers of student nurses leaving the profession found nurses experienced enormous emotional difficulties in handling, working with and caring for the sick, injured and dying patients in their care and argued that such work resurrected primitive anxieties. Her study identified a number of working practices such as strict routines, the division of labour and the identification of patients by number rather than by name that she understood as institutionally-embedded defences against death anxiety. Paradoxically, these same social defences reduced nurses' emotional investment in their work and satisfaction in their relationships with patients ultimately leading to a destabilising level of staff turnover at the hospital.

The Kleinian perspective offered by Menzies-Lyth (1959) and more recent theorists such as Obholzer (2003) also draws on Bion (1962) as a basis for assuming the significance of the institution as a container for the projected feelings and anxieties of society (eg Hinshelwood, 1994). However, the defensive position of abjection that Kristeva (1982) describes permits a rather different conceptualisation of some of the practices identified by Menzies-Lyth: not simply as institutional defences against a yet-to-be contained anxiety, but rather as part of the institution's enduring efforts to impose symbolic order on an anxiety that can never be completely managed, that is perpetually present and must continually to be opposed. The hospital's identification of patients by number rather than by name, the emphasis on ritual, protocol and guidelines and the denial of nurses' feelings and so forth may be seen as an ongoing unconscious attempt by the symbolic to overwrite the semiotic, to control and define the body's boundaries and to regulate the marginalised and unrepresentable aspects of experience in order to safeguard institutional system and order.

What, then, is the relevance of abjection in *psychological* care? In order to address this issue, it is important to remember that the care of the mentally ill has a long and dismaying history, in which their abjection within society has been a constant if tacit dynamic. Foucault (1964) points out that in the Middle Ages, it was the leper who occupied a place on the margins of communities, a space that seemed to open up after leprosy as an illness largely disappeared from the western world. Over the next three centuries, the poor, the criminals and the insane would come to take the place of the leper within society, occupying a liminal position where they were permitted to live in cities, yet were confined within institutions that were intended to control public spaces, clean the streets of 'problem people' and act as correctional establishments to address the economic and social problems emerging from within Europe.

Foucault draws attention to the way in which, from the 15th century on, the mentally ill individual was constructed as a *'bestial man…..the monster who is both man and beast'*, a construction that legitimated his or her exclusion from society. More recently, Shildrick's (2002) notion of 'monstrosity' drawing on the Lacanian 'mirror stage' in infant development, suggests that a sense of our own fragmentation and lack is what we encounter when we see any kind of deformity, disability or damage in others. The modernist ideal of the independent autonomous body and mind is threatened by the recognition that a fundamental lack of unity, an inescapable vulnerability, is the basis of our shared humanity. She goes on to argue that the predictable, 'normal' body is preserved and protected only by a process of normalization that ensures the 'monstrous' other is abjected, marginalised and

excluded. In line with Freud's (1919) notion of the 'uncanny', Shildrick (2002) also points to the way in which such a process is implicitly suffused with an anxiety sponsored by the threat of return, the reappearance of the abject:

'Monsters haunt us, not because they represent an external threat – and indeed some are benign – but because they stir recognition within, a sense of our openness and vulnerability that western discourse insists on covering over' (p. 81).

Abjection and contemporary mental health services.

The above discussion suggests that the mentally ill or psychologically distressed individual threatens us with the return of the abject, helping us to define our own normality and subjectivity by comparison with a radical or 'monstrous' other. This threat is, of course, particularly salient within mental health services where the professional role of staff in caring for the mentally ill may be at odds with personal feelings of unease and vulnerability when faced with those who, as Shildrick (2002) suggests, unconsciously remind them of their own fragmentation and lack.

It is here that I want to draw attention to the complex interplay between unconscious dynamics, organizational structure and government health policy. Recent UK government-backed initiatives such as the Improving Access to Psychological Therapies (IAPT) programme can be seen as both cause and consequence of NPM philosophies that result in organisational structures increasingly characterised by manageralism, surveillance and bureaucracy. I want to suggest that these 'rituals of verification', typical of the 'audit society' described by Power (1997) and its logic of coercive accountability, is constitutive of a mental health service's symbolic attempt to regulate and define the limits and borders of its own culture, defending the organization and its staff against the return of the abject.

In line with this view, Hopfl (2003) has argued that organizations have traditionally been constructed as patriarchal and masculine, and that such representations reduce the notion of organizations to abstract relationships, rational action and purposive behaviour. She contrasts this with a view of the maternally–oriented organization that questions and problematizes the ambivalence that is concealed and regulated by the patriarchal, symbolic order. Tiezte (2003) similarly points out that notions of loving, caring, protecting and suffering are intimately linked to notions of motherhood. '*This very essence of motherhood'* she writes, ' *is problematic in modern organisations, where the emotive is the abject, the pain of labour denied , the jouissance and horrors of intimacy rejected* (p. 65).

Tiezte's claim is particularly challenging in the context of the broader welfare system that Cooper and Lousada (2005) argue constitutes '*a socially-sanctioned system of concern'* (p.21). They question the way in which '*Little reference is made to intensity of feeling as lying at the heart of the work of welfare'* (p. 26) and point to the paradox that '*Day by day the welfare project continues to be about people, as it always has been and must be. Yet a parallel state of mind has been created and maintained through its adoption of a position that denies, ignores, and repudiates this experience* (p. 27).

The rise of NPM strategies of accountability and control within welfare services in general, and in public mental health services in particular, can thus be seen as part and parcel of the way in which mental illness and feelings of psychological distress, along with the vulnerability to which they give rise, are abjected within society and within these organizations. Insofar as the abject is violently

expelled from the body, so too I suggest that notions of psychological vulnerability may be violently expelled from the social body that is the organization, that expulsion effectively establishing such feelings as alien, as 'Other'. The ordered, regulated rationality of the Symbolic order expressed by the institution's attempt at regulation, surveillance and governance can be characterised as an attempt to gain 'mastery' over these abject reminders of the maternal body. In doing so, a defensive position is established within the organization in which the resurgence of abjected elements constantly threatens the prevailing order. I suggest this provides us with a provocative framework for understanding the government's current obsession with 'counting, control and calculation' (Power, 2004) within healthcare organizations where the symbolic requirements of the 'audit culture', or the Law, are given precedence over feelings or the unarticulated drives of the body.

The following retrospective case study, drawing on my work as a psychotherapist and clinical supervisor within an IAPT service attempts to illustrate some of the above dynamics. The material that I want to discuss is autoethnographical in nature, and is reflective of my position at the time as a female senior clinician within the service. In this sense, I am a 'participant-observer', with both '*one foot in and one foot out*' (Duncan and Diamond, 2011) of the organisation, a position that enables me, as Parry and Boyle (2009) suggest, to '*uncover and illuminate the tacit and subaltern aspects of organisation, such as how actions which lead to negative or positive organisational outcomes actually play out*' (p. 694).

Parry and Boyle (2009) also argue that a further advantage of organizational autoethnography is that it allows us to construct a richer, more informative understanding of organizational life, by '*connecting the micro and everyday and mundane aspects of organisational life with the broader political and strategic organisational agendas and practices*' (p 694)*.* My decision to focus here on a single illustrative vignette demonstrating the way abjective dynamics are refracted in one particular organization thus aims to consider the complex interplay between unconscious dynamics, staff behaviour and the particular regulatory procedures to which both I and my colleagues were subject. In this respect, I hope a focus on the 'particular' offers the potential for understanding something of the 'universal' (Warnock, 1987), shedding light on the wider significance, function and mechanisms of abjection in public sector organizations.

Case example: Improving Access to Psychological Therapies.

The 2008 launch of the UK government's Improving Access to Psychological Therapies (IAPT) programme sponsored an ambitious agenda of reform within primary care psychological services in the UK. Whilst other chapters in this book will detail the political and economic background and evolution of IAPT, here I think it sufficient merely to point out that IAPT undoubtedly constitutes the single most significant state investment in mental health services since the inception of the NHS.

The IAPT model can be contextualised within an overall NPM framework within mental health services privileging increasingly standardised and regulated forms of practice within public sector services. Both inexperienced 'Psychological Wellbeing Practitioners' (PWPs) and trained cognitive-behavioural and other psychotherapists are required to undertake a battery of standardised diagnostic, assessment and treatment protocols, including multiple clinical measures at every contact with a client. They receive frequent case management in order to review their caseload and clinical outcomes and are required to evidence increasingly high activity and clinical outcome targets. Managers and

service leads too are required to participate in similar regulatory mechanisms and to defend service activity and clinical outcomes to a centralised administration.

In the particular IAPT service in which I was employed, a large number of PWPs and cognitive-behavioural therapists were complemented by a small number of part-time psychotherapists offering short-term interventions and counselling for individuals referred for anxiety and depression. In line with their IAPT colleagues, I and my psychotherapist colleagues had recently been required to use the full IAPT dataset and software systems for recording clinical activity and outcome measures for each patient session. In addition, a decision was taken by senior management to expand psychotherapy provision to include several trainees who needed to gain clinical experience and practice hours for their professional accreditation. As their clinical supervisor, I was asked to ensure that these trainees complied with the IAPT data collection requirements, inputting their activity and clinical measures onto the same software system used by all practitioners in the service. The software system involved filling in each patient's demographic details, selecting a preliminary psychiatric diagnosis from a drop-down list, and completing several sets of on-line clinical measures to be undertaken each time the client was seen.

During a clinical supervision session which I was facilitating, it was clear to me that one member of my group of three trainees appeared upset and agitated and needed to be heard as a matter of priority. She told the group that she had seen a patient the previous week and had been very worried that this young woman she had been working with had walked out of the session after 20 minutes. This patient had been referred for help with what the referring doctor had termed 'severe depression' following a recent termination and was finding it difficult to talk about her feelings of guilt, self-loathing and shame. At the start of the session, my trainee said she had persuaded her to complete the various clinical measures required by the service as she had been concerned at the patient's obviously depressed mood. After sullenly filling in the forms, her patient thereafter spent the session mainly in silence, remaining hunched in her coat with her chin tucked into the collar, tears continuously pouring down her face and her nose running. My trainee said that she had found this frank and uninhibited display of continual misery very difficult to bear: '*She had snot all over her face*' she exclaimed, '*her collar was sodden; it was just…..revolting!*' The patient had largely ignored my trainee's efforts to engage her and seemed to be utterly sunk in a mood of rage alternating with apathy. Eventually, she had stood up and said that she couldn't put up with it anymore, and strode out of the room. My trainee said that she had felt '*completely paralysed*', unable to think and was left feeling very worried indeed about her client. It transpired that during the week, she had found herself becoming increasingly uncomfortable, guilty and concerned at this young woman's psychological plight, and it had become apparent to her that she was spending quite a lot of time thinking about this young woman, something, she said, she was not used to doing.

She then said that a few days after the session she had been discussing the case with a senior cognitive-behavioural therapist in the service. It seemed to me, hearing my trainee's story at this point, that this very experienced (male) colleague of mine clearly felt that my trainee's anxiety was not justified by her patient's presentation, and had tried to help her think more calmly about the case. He had asked to see the clinical measures that the trainee had taken from this young woman; and on finding that these were relatively low, said to her that there wasn't really any need to be too anxious, the patient was clearly showing sub-clinical scores, so she could not be held accountable were any risk issues to arise before the next session. In the group, my trainee said that she had felt partially

reassured by this and then spoke at length, and with some tears of her own, about her unaccustomed feelings of disgust and repulsion at her patient's uncontrollable distress.

In fact, this colleague had spoken to me during the week about the incident and it had been clear to me that he had become somewhat irritated with my trainee's request for help. Indeed, after a while he admitted that although he had initially been pleased to talk to her, he couldn't really manage what he called '*all this anxiety*'. He had work of his own to do, and said that he had been feeling under considerable pressure to complete all his own data collection requirements in order to achieve his weekly targets. He spoke about the '*real requirements*' of the service, and suggested to me, politely but impatiently, that postgraduate psychotherapy trainees ought to be able to contain themselves better. '*They don't just want spoon-feeding,*' he finally remarked, rather brusquely, '*they really want breast-feeding. It's not up to us to do that!*'. Somewhat taken aback at this rather vivid statement, I lamely tried to defend my trainee whilst struggling with a sudden mixture of anger, helplessness and what I later realised was a strong feeling of shame in myself; but it was to no avail. During the following week the clinical lead of the service asked me to ensure that my trainees did not request any further meetings with cognitive-behavioural therapists as this would reduce the time they needed to meet their increased activity targets.

Discussion

The conversation with my colleague had left me feeling confused, humiliated and angry, not just by the apparent relegation of my trainee to the status of demanding infant, but also, by extension, by my demotion to what I felt was some kind of nursemaid. Indeed, it is possible to understand my feelings of shame as a possible phenomenological index of the abjective dynamics at work here, arising in the face of a phallogocentric symbolic order dismissing the maternal, caring role as unnecessary to the '*real requirements*' of the service. I certainly felt an underlying unease – and subsequently, as I admitted in supervision, outright anger – about the overt privileging of targets and data-collection, which I felt were the only aspects of clinical work recognised and acknowledged within the service. In part, my anger rested on an awareness of an already-present, deeply-entrenched tension in the service between those whose training and theoretical orientation (cognitive-behavioural) favoured the IAPT culture and its emphasis on 'evidence-based clinical outcomes' (on which future funding depended), and those, like myself and my psychotherapist colleagues, whose theoretical interests (psychoanalytic) were more critical of such positivist epistemologies and praxes. In this sense, it can be seen that I had already positioned myself on one side of a fissure within the organization constituted along theoretical, clinical and, indeed, as the discussion with my colleague suggests, gendered lines; a split that my trainee and I were now struggling to manage.

Splitting, of course, is a familiar Kleinian term, pointing to the difficulty of integrating or reconciling ambivalent feelings. A traditional Kleinian reading of the above episode might also draw on Bion's (1962) notion of the 'container-contained', emphasising my trainee's difficulty in containing and managing her patient's feelings of anger and grief. Such an analysis might explore the way in which these feelings are subsequently split off and projected on to my colleague who then admits he cannot contain '*all this anxiety*'. But I think a Kristevan reading helps us to focus on something occurring within the organization that cannot and will not be contained. The notion of breastfeeding is not only maternal, feminine: it is abject, a messy, leaky business involving the exchange of body fluids. My colleague's reaction suggests that he feels it is not up to him, either as a man, or a clinician, to provide

such intimate care for my trainee: rather, the more ordered, symbolic activity of clinical and diagnostic measures is invoked as a means of understanding and managing both the client's and the trainee's distress. More, the intimacy and blurring of boundaries implied in the notion of breastfeeding as metaphor for maternal, emotional care is contrasted with the need for more legitimate, *'real requirements'* of 'data collection', something that is privileged within the organizational structure. *'A representative of the paternal function takes the place of the good maternal object that is wanting'*, writes Kristeva (1982). *'There is language instead of the good breast. Discourse is being substituted for maternal care…* (p. 45). I suggest this opposition creates a continual movement or dynamic in the organization between the revulsion entailed by engaging in messy emotional contact (*'breastfeeding'*) and the desire to undertake the more ordered, symbolic activities required of the organization. Indeed, the former could be said to mock the latter, threatening to subvert or sabotage the Law (*'it's not up to us to do that!).* It was this dynamic that seemed to be exemplified by my trainee's inability to manage the distress and vulnerability of her patient who, silent and tearful, faced her with an experience of vulnerability and utter abjection for which the symbolic discourse of the service – its clinical measures - appeared radically insufficient. Indeed, the patient's presenting problem – the termination of an unwanted baby – could be seen as paradigmatic of abjection itself: the violent expulsion of unwanted parts of the self, which are now threatening to return in her unspoken feelings of depression, rage and guilt.

In this case example, I suggest we can distinguish some of the ways in which a mental health service may confer abjection on staff and those they care for: first, by a process of psychiatric classification (*'depression'*) that interpellates [iii] the individual into a medical discourse which thereafter defines his or her problem and determines what is deemed to be the appropriate kind of treatment for the diagnostic categories it generates; second, by subjecting managers and clinicians to increasing surveillance via clinical governance systems that regulate, evaluate and legitimate clinical activity and outcomes (the *'real requirements'* of the service); and third, by the continual articulation, demarcation and extension of boundaries, rules and protocols within the service which define and proscribe 'the Law' – ie., what is or is not permitted to occur within the organisation, between staff and within psychological treatment (*'it's not up to us to do that!'*). All these processes are clearly located within the Symbolic order, where the materiality and the corporeality of mental illness and psychological distress is specified, tabulated, diagnosed and otherwise situated within a phallogocentric discourse that exiles the emotional, messy – and maternal - aspects of caregiving. This in turn defends the organization against the 'monstrous' psychological fragility of individuals referred to the service as well as the feelings of staff who provide care for them. Of course, where society constructs caregiving as *necessarily* maternally-oriented there is a peculiar paradox between the explicit aims of a service aiming to provide care for the mentally ill and the government-sponsored policies and protocols generating organizational dynamics, instrumental behaviour and clinical practice that serve to regulate, disavow and abject the very care such services are mandated by the public to provide. This in turn highlights a fundamental conflict between the explicit, rational aims of state-funded mental health provision and the unconscious, ambiguous and contradictory psychic mechanisms underpinning their implementation.

States of abjection

The above scenario offers us some insight into Fotaki's (2010) illuminating thoughts about 'why government policies fail so often'. Fotaki (2010) articulates the imaginary and fantasmatic basis of

many UK government health policies, including the pursuit of '*Choice For All*', suggesting that such policies offer '*a stark testimony of the impossibility of realizing the policy objectives it proclaims, despite or perhaps because of its universalistic (and omnipotent) aspirations…. The attempt to attain the fantasy of the impossible can also explain policy recycling and repetition of the same ideas, despite many documented failures.* (p.9).

A central tenet of the IAPT programme has been to '*improve not only the health and well-being of the population, but also to promote social inclusion and improve economic productivity*' (DoH, 2007, p.4). Certainly, the politically ambitious scale of the IAPT mental health programme currently being marketed to the public with its promise of equal access to therapy for all and the notion that this will sponsor social inclusion and improved economic prosperity at a time of unprecedented global austerity may be regarded as aspirational at best, since such an agenda appears to be founded on the omnipotent and imaginary illusion of total unity, satisfaction and social harmony. Indeed, Fotaki (2010) argues on this basis that some government policies are prone to 'capture' by certain political groups for their own ideological purposes. This is certainly a persuasive reading of the IAPT agenda which unequivocally recasts contemporary social and economic problems – the '*shit-life syndrome*' I identify at the start of this chapter - within the template of middle-class individualism.

 I suggest that as these state-governed aspirational policies are implemented across mental health services in the UK, social and organizational defences, including the dynamics of abjection, reinforce the impossibility of success, thus condemning such policies and the praxes they dictate to failure. Indeed, the problematic effects of recent government targets on healthcare, education and other public services have generated an entire literature (e.g. Bevan & Hood, 2006; Clapham, 2010; Hoggett, 2006, 2010; Shore, 2010; Shore & Wright, 1999). Notions of 'playing tick-box games' (McGivern & Ferlie, 2007) or 'gaming behaviour' (Bevan & Hood, 2006) suggest, along with the conclusions of the Francis Report (2013), that performance measurement systems similar to those currently being deployed within IAPT services may actually be 'fatal remedies' (Sieber, 1981) whose unintended consequences undermine the very activity they seek to assess and quantify. Perhaps it is not too much to suggest that these policies act to formalise a process of abjection within mental health services, giving rise to the unconscious dynamics illustrated above. If so, this offers a new way to understand the self-sabotaging nature of NPM reforms designed to improve transparency in public sector services (McGivern and Fischer 2011; Strathern 2000; Tsoukas, 1997) and brings a fresh perspective to how this is played out between staff and patients in a service. Perhaps what the above case study most vividly demonstrates is how mental health policy, unconscious organizational dynamics and clinical practice intersect to confer, sustain and enact abjection in ways that undermine and destabilize an organization's primary caring role.

Conclusion

In this chapter I propose Kristeva's concept of abjection as a useful alternative lens through which to examine unconscious dynamics and processes within mental health services in general and IAPT services in particular. I argue that the presence of the abject serves as a perpetual if unconscious reminder of the existence of the 'monstrous' other within the self, and offers a view of the divided

individual as perpetually engaged in the struggle to demarcate his or her subjectivity. Clinical work within mental health services thus entails a continual effort by the organization and its staff to work with and empathically respond to patients who evoke unrecognised feelings of disgust and fear, and from whom they simultaneously seek to distance themselves.

I also suggest that the continual abjection of reminders of the 'messy' maternal body and semiotic drives within mental health services paradoxically undermines and subverts the very care these services set out to provide. This supports the view that the rationalist agenda of many public health policies ignores the unconscious, irrational motivations that underlie clinicians' behaviour and fails to recognise how these may both be influenced by and contribute to the defensive practices of the organisation. This links to the wider perspective discussed by Fotaki (2010) who points out that the rationalist and realist epistemology of contemporary socio-economics fails to take account of the unrecognised, imaginary or fantasmatic basis of much public health policy-making, and is one reason why such policies fail so often.

Finally, I suggest that Kristeva's (1982) notion of abjection sheds new light on the nature of the 'rituals of verification' (Power, 1997) characteristic of NPM's growing demand for transparency, accountability and governance within public sector services. In the context of an IAPT mental health service, I have argued that an understanding of abjection contributes to our theoretical understanding of contemporary social practices of quality assurance, audit and evaluation, which can now be recast as the organizational attempt to defend and uphold the Symbolic order, and the struggle to define and maintain an institutional frontier against the semiotic drives of the body. This in turn potentially illuminates and deepens our understanding of the 'tyranny of transparency' (Strathern, 2000) common in public sector services as well as the related problems associated with clinical practitioners' 'reactivity' to regulatory mechanisms, for example in medicine and psychotherapy (McGivern and Fischer, 2011).

Just as we cannot get rid of shit, so I suggest we cannot free ourselves from psychological distress and mental ill-health. As Shildrick (2002) suggests, these issues arouse huge anxiety in us at both individual and organizational levels because they bring us into unwilling contact with our own abjected vulnerability, our own 'monstrous' need, our own ineluctable lack or fragmentation within. Indeed, the development and evolution of the IAPT programme as a whole can be understood as one way in which those involved in planning, commissioning and managing public sector mental health services have perhaps unconsciously colluded to control, overwrite or subdue the abject in the interests of managing public anxiety arising at a time of unprecedented economic austerity. In this chapter I have attempted to outline some of the ways in which an understanding of such processes may offer a fertile, if provocative, area for future debate and research.

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[ii] The Lacanian 'Real' is not synonymous with reality. Rather, it denotes a primordial state of nature from which we are forever separated by our entry into language. The Real is opposed to the Imaginary and lies outside the Symbolic order. Indeed, its resistance to symbolization is what lends the Real its traumatic and anxiety-provoking quality.

[iii] Interpellation is a concept associated with Louis Althusser (1971), who uses the term to describe how individual identity is constituted through pre-existing ideologies, institutions and discourses which 'hail' the subject into being via social interactions.