

**Perverting the course of therapy:  
the fetishization of governance in public sector mental health services.**

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**Abstract**

In this paper, I draw on Freudian and Lacanian psychoanalytic theory to consider the notion of perversion and fetishisation within the context of contemporary UK public mental health services which have been subject to New Public Management (NPM) restructuring. Offering an organizational case example based on clinical experience within an expanded NHS mental health service, I explore how services that are subject to neo-liberal regulatory and performance management systems sponsor a perverse organizational solution to the anxieties and difficulties of dealing with psychologically distressed patients. I conclude that theorizing the unconscious dynamics of perversion and fetishism may provide an opportunity to rethink governmentality, offering a potentially fruitful means of addressing recent political concerns about the negative impact of a 'target culture' on public sector health services.

**Keywords**

Fetishization, IAPT, Lacan, mental health, NHS, NPM, organizational dynamics, perversion, psychoanalysis.

**Introduction**

A middle-aged woman came to see me for psychotherapy in an NHS mental health service a few months ago. When she arrived, she was asked by the receptionist at the front desk to complete a number of routine questionnaires that were now required by the service before the start of our appointment. These questionnaires included brief, standardised self-report measures of her mood over the last week; her employment status; and a rating scale of how her difficulties were impacting on her ability to manage at home and in her close relationships. My patient duly completed the various forms and handed them to me when I came to collect her for our appointment. When we arrived at my consulting room, she not unreasonably asked why she had to answer all these questions. I replied that the service was required to demonstrate weekly outcomes to the government in order to continue being funded. After a pause, my patient said, somewhat dryly, that she didn't really think that the 'outcomes' on the form were the outcomes she was interested in - and would I mind if she didn't fill in the forms? *'Not at all'* I replied, putting them down on the table. *'Actually'* she said after a pause, now looking at me sideways with a smile, rather like a naughty child, *'I don't want to make trouble. Let's have them there - but not really. I'll fill in my name and the date, but I won't fill in the rest. I'll give you blank forms to keep on file –and at least that'll keep the government happy'*. We both laughed heartily at this, and thereafter each week she solemnly

handed me a blank form, index of her unwillingness to comply with service governance requirements.

When I raised the matter at a subsequent clinical supervision group, there was some disagreement about the best way to deal with this rather delightful piece of what is often referred to, in the psychoanalytic field, as 'acting out'. One colleague thought that if my patient wasn't willing to complete the questionnaires then she shouldn't be offered psychotherapy. Another thought I was secretly colluding with the patient's lack of co-operation. A third argued heatedly that, as we all 'knew' the scores were irrelevant to understanding our patients, it was perfectly reasonable for my patient to refuse to comply. Indeed, after a while, the discussion turned into a more general debate about the nature of the service and the recent imposition by management of what many felt were therapeutically intrusive and clinically inappropriate outcome measures on those referred to the service. Finally, perhaps in response to what was fast becoming a rather fractious mood in the group, the supervisor intervened to suggest that, as the funding of the service was now unfortunately dependent on receiving data from our patients, perhaps I should consider completing the scores myself on the basis of how I felt my patient was progressing.

I later found myself rather thoughtful about this notion of things being '*there...but not really*'. For it seemed to me that our group, my patient and the supervisor were all part of a system that had recruited us into a very particular position in relation to reality: one in which we were being asked to subscribe to something whilst at the same time undermining it. This mental feat clearly involved everyone in an act of disavowal which in this case entailed the acceptance of something – in this case, the requirement for clinical outcome measures - being '*there....but not really*': we had been conscripted, it seemed, into what might be termed a lying relationship to reality. Indeed, the outburst of wry laughter in the group following our supervisor's suggestion was, I think, testament to our recognition of precisely this perverse position we found ourselves adopting as clinicians.

The psychoanalytic term perversion has been used in many different ways. It was originally identified by Freud (1927) in the rather narrow context of the sexual perversions or fetishism, but in subsequent literature has been regarded either as a solution to developmental conflict (eg. Stoller, 1986; Khan, 1987) or as a disavowal of castration and lack (Lacan and Granoff, 1956). It has since been accorded a wider significance in the psychosocial and organizational literature, which has attempted to illuminate how systemic failures within institutions (Long, 2009) and perverse social defences (Hoggett, 2010; Rizq, 2012a) disavow and undermine the work of an organization. Building on the rich tradition of psychoanalytic theorizing about organizations (Jaques, 1952; Menzies-Lyth, 1960; Trist and Bamforth, 1951; Miller 1976), and following recent papers theorising unconscious organizational dynamics (Rizq, 2011; 2012a,b; Rizq 2013a,b), I want to consider notions of perversion and fetishization within the context of contemporary UK public mental health services which have been subject to New Public Management (NPM) restructuring since the 1980s. Indeed, deployment of NPM strategies in the work of teachers, police officers, doctors and social workers has been evident for some time where rationalist philosophies of transparency, effectiveness and accountability prevail, resulting in an audit culture pervading all levels of the organization.

Recent scandals, however, suggest that a 'tick-box culture' characteristic of these NPM strategies lies at the heart of serious problems within the NHS, including failings at the Mid-Staffordshire NHS Foundation Trust, abuse at Winterbourne View Hospital and the deaths of 'Baby P' and Victoria

Climbie to mention only a few recent high-profile examples. These were all cases where attention to government targets, clinical outcomes and paperwork took precedence over what Ballatt and Campling (2011) call 'intelligent kindness', resulting in perverse organizational dynamics that ultimately led to terrible suffering and unnecessary deaths.

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). In this paper, then, I want to use a psychoanalytic lens to illuminate how mental health services that are subject to neo-liberal regulatory and performance management systems sponsor a perverse organizational solution to the anxieties and difficulties of dealing with psychologically distressed patients. I will first offer a brief theoretical outline of psychoanalytic views of perversion and fetishism, drawing on Freud and Lacan, before suggesting that the current marketization of the NHS and the pressure on staff and managers to conform to ever-increasing clinical governance requirements both result from and defend against anxieties aroused by contact with those in psychological distress. Drawing on my clinical and supervisory work in an NHS mental health service, I then offer a case vignette to illustrate how perverse dynamics percolate throughout an organization in ways that undermine the very care these services set out to provide.

### **Psychoanalytic views of perversion and fetishism.**

In his early essay 'Fetishism', Freud (1927) argues that the little boy is unable to accept the fact that a woman has no penis. Using the term 'Verleugnung', he proposes that an unconscious process of disavowal takes place whereby the child is able both to know and to not-know about this absence at one and the same time:

*'It is not true that, after the child has made his observation of the woman, he has preserved unaltered his belief that woman have a phallus. He has retained that belief, but he has also given it up' (p.154).*

Freud's early example points to the significance of the individual's relationship to absence - a loss that is disavowed with consequent implications for the possibility of its symbolic representation. Thus for Freud, the disavowal of loss is seen as a central obstacle to the construction of inner psychic reality. Indeed, the trauma of the loss is what can trigger fetishism, where the fetish object - the shoe, the silk dress - becomes the symbolic substitute for the mother's missing penis. It masks a gap or an absence that cannot be symbolised.

Whilst Freud sees perversion and fetishism largely as a process of sexual substitution that results in aberrant sexual behaviour, Lacan weaves the notion of disavowal into a more complex theoretical account of personality structure in which a constitutive lack or fragmentation at the heart of subjectivity is perceived as fundamental. In Lacan's (1949) 'mirror stage', his template for the Imaginary order, the child's primordial anxiety is seen as a response to its lack of physical coherence and motor co-ordination. Identification with his or her mirror image thus confers a subjective feeling of wholeness, completeness and self-mastery, allowing the child triumphantly to assume a narcissistic ideal, an anticipated sense of self-unity and control that it does not yet possess. By contrast, the Symbolic order is represented by the Law of the Father, a symbolic Father and symbolic phallus that fulfil a function independent of the existence or behaviour of the actual flesh and blood

father and his penis. The symbolic Father imposes the Law and regulates desire in the Oedipal configuration of mother and child. It is acceptance of the Law of the Father - ie. acceding to castration or lack - that separates the child from an Imaginary identification with the desire of the mother and precipitates him or her into the Symbolic order where the child comes to understand his relation to others within the larger socio-symbolic system of language, rules, gender differences and cultural ideals. However, whilst repression and foreclosure are the fundamental operations by which the neurotic and the psychotic respectively manage their knowledge of lack, Lacan sees disavowal as the main mechanism by which the pervert relates to his or her knowledge of castration: by simultaneously denying and recognizing it.

What is disavowed here, according to Lacan (1962), is the notion that lack causes desire. The perverse individual constitutes himself as the subject that plugs up the desire in the (m)Other so that there can be no lack and no castration. However, this process of disavowal paradoxically engenders intense anxiety:

*'What provokes anxiety? Contrary to what people say, it is neither the rhythm nor the alternation of the mothers' presence-absence. What proves this is that the child indulges in repeating presence-absence games: security of presence is found in the possibility of absence. What is most anxiety-producing for the child is when the relationship through which he comes to be – on the basis of lack which makes him desire – is most perturbed: when there is no possibility of lack, when his mother is constantly on his back' (Seminar X, 1962).*

Lacan and Granoff's (1956) reworking of Freud's (1927) original paper suggests that fetishism occurs when these anxieties are transferred to the social images and ideals of the Symbolic order, in particular, the Name of the Father or his representatives such as the state, the government, the police, or the law. For this reason perversion – or fetishism - always involves an attempt to buttress the paternal function, to bring the Law into being so that the anxiety-relieving separation from the (m)Other can occur. Indeed, Lacan writes perversion as *'pere-version'*, to emphasise the way in which the pervert appeals to the father, trying to make the symbolic Other exist via the perverse act:

*[T]he perversion (that is, the fetish) serves to multiply the force of the father's symbolic action (putting the mOther's lack into words), to supplement or prop up the paternal function. The name given by the father is a start, a first step, but does not go far enough. It needs support, it needs amplification (Fink, 1997, p. 183).*

In perversion then, there is a staging of the Law; an attempt to bring the Law into being. However, Lacan argues that the fetish object can never be fully functioning: the subject can never entirely 'be' the longed-for symbolic phallus. This is because the order of the Real, the realm of that which cannot be symbolized, ensures there is always a lack which escapes the subject and therefore the symbolic Other. It is this lack that engenders the subject's ceaseless search for the lost jouissance of unity with the (m)Other and ensures the perpetuation of desire.

### **Perversion and anxiety.**

Understanding the organizational dynamics operating in the context of care for the mentally ill involves recognising how Western society has historically viewed, defined and treated those deemed to be 'mad'. Foucault's (1972) notion of mental disorder as a social construction in the service of

exclusion and social control is often conveniently forgotten in the contemporary drive to label, treat and cure the mentally ill. Indeed, the transformation of what was once a space of exclusion into a medical space is what, according to Foucault, enabled mental illness to become the object of scientific observation and experimentation. Currently, the so-called scientific basis of psychological treatment takes for granted the object that it has, in fact, itself constructed. The uncritical acceptance of this assumption is central to current mental health policies whose implementation depends on psychiatric diagnoses that are presumed to index preferred forms of government-approved therapeutic and pharmacological treatments. Foucault reminds us that:

*'The positivist psychiatry of the nineteenth century, like our own.....secretly inherited the relationship that classical culture as a whole had set up with unreason. They were modified and displaced, and it was thought that madness was being studied from the point of view of an objective pathology; but despite those good intentions, madness was still haunted by an ethical view of unreason, and the scandal of its animal nature'* (1972/2006, p. 159).

I want to suggest that public sector organizations offering psychological care are still subject to this 'secret inheritance'; still haunted by the fear of 'unreason' and the mentally ill's 'animal nature'. Indeed, the psychosocial literature, drawing on Kleinian psychoanalytic theory and Menzies-Lyth's (1960) view of social defences against anxiety is one that draws on precisely this view by suggesting that institutions develop strategies and defences designed to protect staff from the emotional difficulties aroused by contact with vulnerability, illness and death. The difficulties, stresses and strains of working with those deemed to be mentally ill have also been documented in an extensive clinical literature, usually incorporating psychoanalytic concepts such as splitting, projection, and projective identification to understand the often paradoxical ways in which organizations aiming to help those in distress fail to help those most in need of their care (eg Cooper and Lousada, 2005; Main, 1957; Obholzer, 2003; Scanlon and Adlam, 2011).

From a Lacanian perspective, however, anxiety is not simply an affect subject to repression: anxiety is rather something that arises when subject is confronted with the ineluctable fragmentation and instability of the self (Lacan, 1962). The Imaginary nature of the self's sense of unity and identity is disrupted by any reminder of its constitutive lack of cohesion, which would result in a confrontation with the traumatic Real. It is this that sponsors an anxiety that can never be contained or dissipated, although the gap between the illusory ego and the alienated subject may be temporarily filled with language, forming the basis of social projects unconsciously designed to recapture a lost fantasy of unity and wholeness. The mentally ill, then, whose vulnerability and dependence confront us with a fragmentation that is the basis of a shared humanity, may be said to arouse particular anxieties in society which governments and welfare institutions are tasked with managing. In line with Foucault, MacCallum (2002) and Peternelj-Taylor (2004) have referred to a process of 'othering' by which means we establish clear boundaries between those who are 'normal' and those who are deemed to be different, damaged or deformed (Shildrick, 2002). In this way, I suggest, mental health services unconsciously operate to organize and sustain an Imaginary sense of unity and 'normality' within society, keeping painful subjective reminders of lack and division at bay.

Following Long (2009) and Hoggett (2010), I now want to suggest that the current marketization of the NHS, the fragmentation and privatization of its services and the pressure on staff and managers to conform to ever-increasing clinical governance requirements both result from and are the

consequence of anxieties aroused by contact with those in psychological distress. I propose the emergence of a perverse organizational solution, where these anxieties are concealed and disavowed beneath a fetishized 'target culture' which offers an idealized picture of the work of a mental health service whilst simultaneously undermining and subverting the very care that it is mandated by government to provide. In order to develop my thesis, I want to draw on recent developments in public sector mental health services where the UK government's Improving Access to Psychological Therapies (IAPT) programme has resulted in extensive changes to the way in which mental health services are now commissioned, organized, implemented and evaluated. Initiated by the Layard (2006) Depression Report which made a robust economic case for the improved provision of psychological therapies, the IAPT programme promised savings for the Department of Work and Pensions by reducing the cost of incapacity benefit for those unable to work because of depression and anxiety. Following an initial investment of £3.7 million funding to launch the programme, the Department of Health Spending Review 2010 subsequently included around £433million for psychological therapies over the period to April 2015. The current UK Coalition Government has signalled continued support for the IAPT programme, with planned expansion of services to include children and young people, those with physical health long-term conditions, medically unexplained symptoms and those with severe mental illness.

A key feature of IAPT and one which defines it clearly as a mental health programme exemplifying the NPM ideals of transparency, accountability and governance is the requirement for clinical staff to record multiple clinical outcome measures on a computer software system. Staff are closely monitored to ensure they record every contact with patients and evaluate clinical progress according to the full IAPT dataset. This is used to inform local and national reporting, to demonstrate adherence to 'best practice' guidelines and to justify the use of what are deemed to be 'evidence-based' approaches to psychological therapy recommended by the National Institute for Health and Clinical Excellence (NICE).

The following case example, based on a period of work as a senior psychologist and clinical supervisor within a Primary Care IAPT service, is intended to be illustrative of the complex intersection between unconscious perverse dynamics, staff behaviour and the specific regulatory procedures to which both I and my colleagues were subject.

### **Organizational case example.**

The IAPT programme, incorporating the 'stepped care' approach advocated by the NICE guidelines, has introduced large numbers of newly trained junior mental health workers into the NHS (Psychological Wellbeing advisors, or PWPAs) offering both 'low-intensity' guided self-help, computerised cognitive-behavioural therapy (CBT), psycho-education and signposting to voluntary sector services alongside 'high-intensity' face-to-face therapeutic work, based mainly on cognitive-behavioural principles.

This particular Primary Care service went through a long period of upheaval and change. For over two years, due to the planned restructuring of all services within the NHS, including the abolition of Strategic Health Authorities and Primary Care Trusts, it was decided that the service and its staff should be re-employed by a local NHS Mental Health Trust. During this period, managers of the service were under increasing pressure to demonstrate compliance with activity targets and recovery rates in the service in order to establish the viability and legitimacy of the service to its

prospective employers. As part of the validation process, the most junior staff in the service, the PWPs, came under renewed pressure to increase their caseloads to meet the expected number of 5000 referrals a year. However, during this time, a number of these junior staff made a decision to leave after only a very short time in the service and it became apparent to managers in the service that these young and in many cases very inexperienced staff were finding the demands of high volume, high turnover clinical work very challenging. There was concern that the planned handover to the Mental Health Trust would be placed in jeopardy due to the loss of staff and the resulting reduced activity levels in the service.

For some years previously, a system of monthly support groups or 'reflective practice' groups had been in place, facilitated by senior counsellors and psychotherapists in the service. They had been set up in order to provide a space where PWPs could reflect on and discuss salient professional and personal issues arising from their clinical work. The groups had been set up and ran on a voluntary basis with staff attending by agreement unless they had unavoidable clinical commitments. Over time, they had become a regular part of the service. As a senior psychologist and psychotherapist in the service, I was asked to offer individual supervision to the counsellors who facilitated these groups. Over a period of two or three years, it had become clear to me that the counsellors felt these groups served an important function in the service. They seemed to enable the PWPs to share difficulties, particularly those arising from some of the more complex cases in which they frequently found themselves involved. It was also clear that the groups served as a safety valve for the venting of complaints and grumbles usually relating to the increasing demands on their caseloads, the lack of time permitted for joint clinical discussion, the problems associated with individual caseload management, and the reluctance on the part of management to consider their training and development needs.

During one supervision session recently, a counsellor told me that a letter of complaint about a PWP had recently been received by the Head of the service. This young PWP had been shown the letter which she had brought and read out to the group. It was clear, my supervisee said, that the client who had made the complaint was very angry and upset. She had been seeking counselling from the service to help support her with a profoundly disabled child, and, following her referral, had received the offer of a telephone consultation to discuss the problem. However, in her letter, the patient had complained about the way this PWP had handled the discussion: by telephoning her when she had expected a 'proper' face-to-face' appointment; by asking her to complete a number of what she felt were irrelevant questionnaires over the telephone; by telling her that, if she was unwilling to complete these questionnaires, she would be unable to access the service at all; and finally, by offering to refer her on to a voluntary sector service when she had specifically asked for NHS counselling. In the letter, the patient wrote: *'I felt utterly uncared for, I was treated like a number'*, and went on to say that she was shocked that an NHS service could dismiss her legitimate needs in such a way.

My supervisee went on to explain that the PWP, for her part, had clearly felt guilty and defensive. In explaining the case to the group, she made it clear that she had treated this very depressed and anxious client with great care and courtesy, and that she had carefully followed all the relevant protocols for a telephone assessment. What else was she supposed to do? She felt that she had done everything she could – including the onward referral of the patient to a service that could offer her respite care for her disabled child. *'I didn't come here to be complained about'*, she said rather

tearfully to the group, *'I can't care for everybody!'* At this point, group members who had initially tried to help their colleague think about how else she might have dealt with the situation all rallied round, agreeing that she had certainly done everything she could reasonably do in the circumstances; indeed, they reasoned, given the numbers of people on their caseloads, of course she wasn't able to care for everybody. There seemed to be, my supervisee said, a growing anxiety and indignation in the group about this accusation from a patient of being *'utterly uncared for'*, as if group members felt that following the correct procedure, doing everything *'right'*, should be sufficient. It was as if, he said rather worriedly, *'there's no need actually to care; the policies and protocols will do the work instead'*. When my supervisee invited the group to think more closely about what this undoubtedly very angry patient had wanted from their colleague, he was met with much protest about the impossibility of managing the intense emotional demands of such *'fragile'* patients, about the lack of training provided for coping with *'difficult'* members of the public and about the many other patients that remained on caseloads awaiting attention. It was clear that the complaint had created enormous anxieties for the group and that their ability to think about the feelings generated by such an event was limited.

Two weeks later, the Head of the service sent an email round to all staff announcing that the reflective practice groups were to become compulsory. No explanation was given for this blanket directive and no link was made with the previous complaint. As supervisor, I was summoned by the clinical lead and asked to ensure that each facilitator kept a group attendance register and notes on what was discussed each session. I too would be required to keep a supervision register and notes on what was discussed with each of my supervisees. When I queried the necessity to undertake the additional work and administration involved, I was rather briskly told that the service needed to ensure it was *'covered in case of complaints'* and so, along with all other aspects of the service, what took place within the reflective practice groups should be recorded and kept on file. This would demonstrate *'good practice'* and *'transparency'* in line with what the service's prospective employers expected. In subsequently discussing these procedural changes with the counsellors, it was clear that we all uncomfortable and worried about the change from what had hitherto been a fairly relaxed and informal setting, a space that was free of impingement by management, to yet another bureaucratized space, one that was being watched and reported on.

Over the next few months, the few PWP's who had not so far shown an interest in attending the groups were now required by their managers to participate. Some of these individuals were initially unwilling to come and several counsellors noticed that this changed the atmosphere of the groups from one of enthusiasm, goodwill and interest into one that was, for a time at least, characterised by a degree of covert resistance. I now started to hear from my supervisee how he struggled to manage some of the PWP's who expressed impatience with having to make time to attend when they had so many assessments to undertake. Over time, however, these difficulties seemed to recede and I became increasingly aware of a more subtle shift in the work he reported. For example, I heard less about the PWP's difficulties, mistakes and problems and more about examples of clinical work that group members felt had been particularly innovative or successful. Others in turn started to discuss administrative matters and to provide detailed examples of how they had managed to find short-cuts on the computer system that enabled them to input activity data and clinical outcomes more efficiently. My supervisee, relieved to find these discussions reviving what he had felt had been the group's flagging interest, recounted with satisfaction several occasions where, spurred on by their colleagues, group members appeared to *'compete'* with each other in offering accounts of



how they had successfully managed 'tricky' patients or manoeuvred the system to their advantage in different ways. Grumbles and complaints in the group seemed to reduce, and I now heard how the group was rather ambitiously extolling the virtues of 'best practice' and their successful use of an 'evidence-base' in their work. Members were keen to talk about how well the service was faring relative to other services in the locality, and were excited at the planned recruitment of new staff to replace those who had left. Over time, my supervisee started to joke that the group didn't really seem to need him anymore, and that it could perhaps *'run by itself now'*.

It was during this period of time that I found myself uncharacteristically seized with a sudden sleepiness during our supervision sessions. My supervisee and I met in the afternoons, and for several weeks I told myself it was a post-lunch dip in my metabolism. Much as I tried to rationalise it, it quickly became clear to me that I was not able to pay proper attention to what he was saying. I felt tired, muzzy and overpoweringly drowsy and on several occasions I even had to ask him to repeat what he had said. I became increasingly concerned – and ashamed - about what I felt was my lack of interest in the supervision and redoubled my attempts to demonstrate attention and interest. However, it was not until he unprecedentedly failed to attend a session, ostensibly because he had forgotten to put the date in his diary, that matters came to a head. On finding him absent at the usual time, I sent a text asking where he was: I received a profuse apology and we arranged to meet a week or so later. When I asked my colleague about what had happened, I found, to my surprise, that he was unwilling to discuss our missed session, reiterating that it was simply a timetabling mistake and 'wasn't important'. At the end of the session, however, he asked, in an offhand sort of way, whether I intended to record his absence on my own supervision record: it was obvious to me that he didn't want management to know about his 'timetabling mistake'. Anxious to reassure him about something that clearly was important now, I said that of course I would simply be recording the current date as the one originally agreed. *'Thanks for covering for me'* he said, clearly relieved, and left the room.

### **The fetishization of bureaucracy.**

The above organizational case illustrates how a letter of complaint pointing to a lack within the service – a perceived lack of caring – is experienced as a devastating attack by the individual concerned, the group and the organization. The PWP's initial feelings of doubt and shame quickly give way to comforting reminders of how service policies and protocols should be sufficient to demonstrate care and the group moves to reassure their colleague that, by following these directives, she has done all that can be expected in the circumstances. Indeed, the fact that she *'can't care for everyone'* – that there are limits to what such young and inexperienced mental health workers can be expected to manage, given their extremely high caseloads and the nature of the short, protocol-based IAPT training they undertake – is not something that appears to be considered at an organizational level. The perceived lack of emotional care raised by the complaint is not discussed by management at all, but instead appears to be addressed by recourse to increased bureaucracy and surveillance. By pursuing imaginary objectives such as demonstrating 'transparency' and 'accountability', by insisting on compulsory attendance at the group as well as access to registers and process notes, management aims to 'cover' itself: there is a 'staging' of the Law as it were, which is invoked as a means of disavowing the lack of care brought to light by the patient's complaint.

The use of the term 'cover' is important in this context, and it is here that the notion of the fetish becomes relevant. Lacan (1994) uses metaphors such as the 'veil' or 'curtain' to refer to the masked or disguised qualities of the fetish. Indeed, its 'fig-leaf' qualities draw attention to its unconscious function in misrepresenting reality. This is taken up by Chasseguet-Smirgel (1971) in her discussion of Hans Andersen's 'The Nightingale and the Emperor of China', a story about how the Emperor prefers the mechanical tinkling of an artificial bird over the song of the real nightingale. Chasseguet-Smirgel draws a parallel between the artificial bird in the story and a fetish, noting that in both cases admirers are enthralled by what is false. She contrasts the mechanical bird, which is covered with glittering jewels, with the more 'modest' plumes of the real, living nightingale, pointing out that:

*...the true one does not need to hoodwink anybody or make any display to the world, because it has nothing to conceal. At the same time the mechanical nightingale by its radiance will have to try to make people forget that it is 'fabricated' and only an assemblage of mechanics' (p. 201).*

I have previously (Rizq, 2012a) taken Hans Andersen's fairy-tale as rich metaphor for the IAPT programme's fascination with NPM strategies of governance and proceduralism. Like the admirers of the mechanical nightingale, managers in the service appeared to be gripped not only by the glittering 'virtual reality' displayed in the activity data required by the service but more generally by the possibility of measuring, labelling, quantifying and calculating its activities and outcomes. These 'technologies of representation' (Power, 2004, p. 778) are of course part and parcel of a wider discourse generated recently by the requirements of what has been called 'evidence-based practice' in the psychotherapeutic field. As such, it is services that demonstrate models of therapeutic practice and systems of care that conform to the demand for comprehensive performance monitoring systems demonstrating efficiency and effectiveness that attract continued funding and investment by the government. For this reason, I suggest, such systems generate a level of excitement and energy that undoubtedly constitutes a fetish, an attractive fabrication serving to conceal what is felt to be an unbearable lack within the organization.

In the case example above, it can be seen that management's insistence on the marshalling of evidence - the directive to make the groups mandatory, to keep attendance registers and to open the group's process to scrutiny by management - was not only an extension of the performance-monitoring system characteristic of the service, but in fact sponsored further perverse dynamics. In response to the increased surveillance following the letter of complaint, the group reacted by idealising their work. Difficulties, problems and complexity were increasingly glossed over, as were the feelings of shame, guilt and inadequacy that had initially been expressed. Instead, a 'glittering' version of the work started to emerge, one in which the very real difficulties in providing sufficient care and concern were ignored and replaced with a discourse of excellence, ready-made rules, regulations and 'short-cuts' all of which seemed to absolve members from any responsibility for thinking about what had happened. My supervisee too seemed to become swept up in the fabrication that was being constructed, led astray by the perverse dynamics being played out in the group in which his own role and function - in fact, *to provide care and concern to staff* - was increasingly diminished and marginalised.

It was with my own clinical supervisor that I had the opportunity to examine my relationship with my supervisee in a little more detail. Somewhat reluctantly, I noticed how I too had been increasingly marginalised in the supervision sessions. Just as my supervisee felt redundant in the face of the

group's increasingly self-celebratory language (leading him to feel the group could '*run by itself now*'), so too I had felt redundant, emotionally removing myself through boredom and sleepiness. I realised that I had been losing interest for some time in our work; indeed, in a perverse dynamic akin to the one with which I started this paper, perhaps I had been '*there.....but not really*', unconsciously allowing my supervisee to '*run by himself*': in this sense, it was not surprising that he had 'forgotten' to come to the session. Indeed, at a wider level, it seems that an unconscious perverse organizational dynamic had been percolating through the service, culminating in the missed supervision session that indexed and enacted the very lack (of care) within the service that had been noticed by the complaining patient. It seemed to me that my colleague had himself disavowed the lack of care I had been showing, as well as, perhaps, his own unconscious anger, by refusing to discuss his absence in any detail. Instead, he had recruited me as willing accomplice (Long, 2009) into 'covering' the absence (thereby ensuring that he too was '*there.....but not really*'), using the service's 'rituals of verification' (Power, 1999) to conceal something felt to be shameful, something that could not be spoken or thought about.

## **Discussion**

What is it that the fetishization of bureaucracy within mental health services disavows? Obholzer (1993) argues that a national health service is used as an unconscious receptacle for the nation's anxieties about frailty, illness and death, suggesting that, quite apart from its acknowledged, normative healthcare aims, the NHS has always performed a symbolic or existential role in society. Hinshelwood (1994), too, argues that: '*Our institutions are set up with the prime purpose of dealing with unwanted anxiety*' (p. 42). He goes on to propose that mental health staff are tasked by society to carry out 'anxiety work' demanding an exceptionally high degree of emotional resilience in those who have to cope with the psychological stress of managing 'madness', vulnerability and mental illness.

The continuing – and escalating - demand for the care of the mentally ill was, of course, something the IAPT programme was explicitly designed to address. As a flagship mental health initiative, it has received the highest level of investment by any UK government since the inception of the NHS, resulting in a doubling of the annual budget spent on mental health services from 0.3% to 0.6%. At the same time, however, Layton (2009) points out the prevalence of neoliberal philosophies that over the last thirty years have sponsored a form of subjectivity within free market cultures characterized by omnipotent fantasies of invulnerability and security alongside a repudiation of weakness, dependency and a reduced capacity for empathy. She points to the lack of secure containing governmental authorities and the failure of governments to offer adequate social provision, resulting in a traumatic decline in people's sense of safety, security and trust. These reactions speak vividly to the UK experience, where there is increasing disavowal of the need for social and institutional containers, obvious examples of which include the recent abolition of universal child support, the instigation of 'parent-led' schools, the demise of final salary pension schemes and swingeing cuts to welfare services and benefits. Within public healthcare services too, the Coalition Government's Health and Social Care Bill, introduced into parliament in January 2011, points to a political decision to absolve government from the responsibility for service provision in favour of service commissioning.

How might this decline in symbolic authority together with its repudiation of citizens' dependency needs intersect with healthcare policy, organizational structure and the emergence of the above perverse dynamics in mental health services? Fotaki (2010) argues that one of the difficulties in understanding the impact of public policy-making is that contemporary theorizing is generally based on assumptions of rational reflexivity. She goes on to suggest, from a Lacanian perspective, that policy-making expresses not only rational objectives, but also '*societal fantasies originating in the imaginary strivings of the subject*' (p.704). Applying Fotaki's arguments to the hugely ambitious scale of the IAPT mental health programme, we can view its overtly optimistic agenda to '*improve not only the health and well-being of the population but also promote social inclusion and improve economic productivity*' (DoH, 2007, p.4) as more aspirational than achievable. Indeed, Fotaki (2006) goes on to argue that policies based on '*semi-utopian*' ideas must ultimately fail: in reality, of course, we '*can't care for everybody*'. I want to propose that the government's response to this unwelcome piece of reality is the emergence of what might be termed a perverse solution: one in which it is not only implementing a large-scale mental health policy based on improving financial productivity in a time of unprecedented global austerity, (thereby 'turning a blind eye' to contemporary global socio-economic realities) but one in which the dependency and psychological suffering of patients, as well as the anxieties and limitations of those tasked with caring for them are simultaneously disavowed and concealed beneath overwhelming bureaucratic and governance systems.

I suggest that the construction of this 'virtual' system of psychological care constitutes a fetish, a fabricated Symbolic father, where attention to targets, activity data, risk assessments and measurable clinical outcomes and so on 'covers' or substitutes for the failure of government to install thoughtful, containing institutions and services. Like the song of the mechanical nightingale, the signifiers of care thus become more important, more real - and more attractive - than the actual care they signify. In this way, as Hoggett (2010) suggests, '*welfare governance takes on the form of a virtual reality*' (p. 5), perverting the course of therapy and leaving patients feeling '*utterly uncared for*' whilst the organization remains duped by its own illusory competence.

Indeed, I suspect it was no coincidence that the patient who made the complaint was herself struggling to cope with a profoundly disabled child, whose total dependence on her maternal care and support was clearly overwhelming, exhausting and draining. As exemplar of the disavowed suffering and dependency of patients (recall that this patient was in fact refused counselling and referred to another service), I suggest the letter of complaint, which may be seen as part of a Symbolic order structured by loss and lack, acted to blow the service's Imaginary 'cover', exposing, articulating and driving home the unwelcome reality of the service's limitations in caring for such mentally distressed patients. The fetishization of governance within the organization thus provides a managerially-sanctioned route to the disavowal of limitations intrinsic to the care of the mentally ill (Cooper and Lousada, 2005) via the staging of 'evidence' intended to demonstrate an idealised view of the organization's work.

## **Conclusion**

*'Finally', writes Power (2000), 'the 'audit society' can be understood as a label for a loss of confidence in the central steering institutions of society, particularly politics. So it may be that a loss of faith in intellectual, political and economic leadership has led to the creation of industries of checking which satisfy a demand for signals of order. In the UK auditing and inspection will be set to*

*work in the name of 'best value' and 'joined-up' government, but we may be forced to understand auditing as part of a general language of decline which attempts to bridge the widening gulf between plans and achievements' (p. 118).*

Power's comments above speak to the way in which systems of governance act to 'prop up' or support failing trust in the Symbolic role of government. In this paper I have argued that the organizational dynamics of perversion demonstrate a complex intersection of health policy, neo-liberal governmentality and individual subjectivity. Using the example of the UK government's IAPT programme, I have suggested that an emphasis on performance measurement systems in mental health services can be used unconsciously to buttress the paternal function of a government that is deemed by the public to be increasingly weak and uninterested in welfare provision whilst at the same time undermining and subverting the very care these systems are mandated to ensure. Theorizing the paradoxical effects of the audit culture in this way expands our understanding beyond the more traditional psychoanalytic Kleinian literature on unconscious social defences within organizations (Jaques, 1955; Hinshelwood, 1994; Hoggett, 2006; Menzies-Lyth, 1960) by recasting NPM strategies of audit, evaluation and performance as fetishistic constructions unconsciously designed to mask or conceal a subjective sense of lack and fragmentation sponsored by contact with psychological pain and suffering.

This paper has also attempted to illuminate the 'tyranny of transparency' (Strathern, 2000) endemic in public sector institutions and points to the detrimental impact of governance, regulation and surveillance on clinical practice and supervision in mental health services. Indeed, the Francis Report (2010), commissioned by the government to investigate the hundreds of deaths at the Mid-Staffordshire NHS Foundation Trust Hospital during the period 2005-2009, is outspoken about the way in which hospital staff reacted to the pressure to meet targets, trenchantly concluding that:

*'People must always come before numbers. Individual patients and their treatment are what really matters. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all those who design and implement policy for the NHS' (p. 4).*

Francis's words are increasingly apposite in the current context of widespread changes to the structure of the NHS which now includes, amongst other things, mandatory tendering of services to private sector companies, 'payment by results' according to national and locally-set mental health tariffs and Clinical Commissioning Groups that ensure General Practitioners (GPs) take responsibility for the commissioning and purchasing of services in their locality. I would like to suggest that a psychoanalytic understanding of the unconscious dynamics of perversion and fetishism may enable clinical practitioners, managers, politicians and academics alike to address the practical issues identified by the Francis Report more effectively and creatively, thereby permitting greater understanding of the likely psychic – and clinical - consequences of operational and strategic decision-making within public sector healthcare organizations. As we now move through some of the biggest reforms ever seen in the NHS's history, such understanding is likely to be crucial to sustaining effective and empathic work within our mental health care services.

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