IAPT, ANXIETY AND ENVY: A PSYCHOANALYTIC VIEW OF NHS PRIMARY CARE MENTAL HEALTH SERVICES TODAY

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Abstract

The Labour government’s response to the Layard (2004) report was to implement the ‘Improving Access to Psychological Therapies’ (IAPT) programme within Primary Care Trusts in the NHS. In this paper, I argue that the IAPT programme’s explicit commitment to ‘well-being work’ risks distorting the unconscious anxiety-containing function that society traditionally allocates to mental health practitioners. Drawing on the social defence paradigm of Menzies Lyth (1959) and later work by Stein (2000), I use an organizational case example to explore some of the unconscious dynamics within an IAPT service and explore how mechanisms such as defensive splitting and projective identification within the multidisciplinary team result in psychotherapists coming to represent an unwanted, vulnerable and expendable aspect of the service. I contend that psychotherapists may serve an important function as unconscious ambassadors of a split-off affective aspect of IAPT primary care mental health services, and that as such they will urgently need to ensure they do not succumb to burnout or unhelpful ways of working and relating within the team.

Key words: anxiety, IAPT, counselling, envy, primary care, psychotherapy, social defence, well-being

Introduction

It is no secret that we are living through a time of unprecedented change in the field of the psychological therapies. The Labour government’s response to the Layard (2004) report on ‘Mental health: Britain’s biggest social problem’ was to fund and implement the ‘Improving Access to Psychological Therapies’ (IAPT) programme.1 This incorporates the stepped care model proposed within the National Institute for Clinical Excellence (NICE) guidelines and advocates the introduction of large numbers of mental health practitioners in the NHS delivering ‘low-intensity’ guided self-help interventions, computerised CBT and signposting to voluntary sector services alongside ‘high intensity’ therapeutic work, at present based mainly on cognitive–behavioural principles.

This programme, aimed at people referred for common mental health problems, including mild to moderate depression and anxiety, is currently being rolled out across the UK. In the face of the high-volume, high turnover patient targets set by IAPT, commissioners of primary care services and mental health teams are under considerable pressure to reorganize services to ensure the provision, delivery and evaluation of these new psychological services to a large proportion of the population. Whilst there has been much recent debate about the theoretical commitments of IAPT services (e.g. Samuels & Veale, 2009) and

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the impact of IAPT on the structure, implementation and delivery of primary care mental health services, there has been very little interest in or understanding of the unconscious dynamics experienced by staff working within IAPT teams. In this paper, I draw on the Kleinian developmental view of anxiety and Isabel Menzies Lyth’s (1959) work on social defence systems to argue that the IAPT programme is explicitly identified and tasked with what might be termed ‘well-being work’ and is underpinned by organizational structures that defend against and minimize notions of vulnerability and dependence. This can be contrasted with what Hinshelwood (1994) has characterised as the more traditional ‘anxiety work’ unconsciously allocated by society to mental health services. Through an organizational case example, I will explore how this distinction may unconsciously be enacted with an IAPT service, resulting in defensive splitting and envious attack within the mental health teams. I then explore how psychotherapists working alongside IAPT-trained staff may unconsciously come to represent an unwanted, vulnerable and expendable aspect of the service and may, via splitting and projection, themselves be drawn into unhelpful ways of working and relating.

IAPT and Anxiety: A Psychoanalytic Framework

McGivern et al. (2009) have recently remarked on an ‘emerging assemblage’ of regulatory procedures in the field of psychotherapy and counselling. Certainly, the government’s IAPT programme needs to be contextualized within an overall framework that includes the government’s plans for the statutory regulation in the field, the development by Skills for Health (SfH) of ‘competency frameworks’ leading to National Occupational Standards for differing models of therapy, and the development and implementation of the NICE guidelines within the NHS. This rapid pace of change can itself be placed within the broader context of new public management (NPM) restructuring of health, education and social services that has been taking place in the UK since the 1980s. This restructuring has been introduced and maintained by successive governments with a view to making public services more efficient, accountable and responsive to ‘customer’ need. Ferlie et al. (1996) have argued that NPM has also aimed to make professional practice more transparent and controllable. Private sector notions of market forces, assessment and management have underpinned the rise of managerialism (Loewenthal, 2002), audit culture (Power, 1997) and ‘neo-bureaucracy’ (Harrison & Smith, 2003) in public sector services, where economic rationalism and technicism, efficiency, accountability and performativity are privileged over basic trust in public sector professionals (O’Neill, 2002).

IAPT may perhaps be regarded as the psychological child of the above NPM reforms; and indeed the birth of this rapidly-developing youngster within the context of the NHS marketplace has provoked not a little turmoil – some might say a crisis – within the family of psychotherapeutic professions. Whilst organizational change undoubtedly brings with it the possibility of creativity in the form of developing new ideas and innovative services, it is also likely to sponsor anxiety in the face of risk, uncertainty and the loss of familiar ways of
working. The sheer volume of current public discussion about mental health services matched by, at times, an exceptionally rancorous professional debate about the role, funding and effectiveness of IAPT services and their perceived ability to manage what appears to be a rising tide of mental health problems in the UK is, I think, testament to the levels of anxiety generated by the introduction and proliferation of the IAPT programme throughout the NHS. At an organizational level, the requirements for service redesign, the deployment and management of large numbers of trainees or newly-trained staff, the decision about how – or whether – to integrate existing psychotherapeutic professionals within these services as well as managing ever-increasing numbers of patients (many of whom now self-refer to IAPT services they hear about through the media) all serve to heighten anxiety within primary care mental health teams about the capacity to adequately meet elevated public and governmental expectations. At a clinical level, too, there are anxieties about IAPT workers’ capacity to carry out and sustain clinical work with psychologically distressed individuals. Indeed, a recent piece of qualitative research I undertook (Rizq et al., 2010) within an IAPT service showed how some low-intensity workers were struggling to cope with patients becoming tearful, angry or demanding and how they found the emotional impact of clinical work unexpectedly challenging and draining.

**Anxiety: A Kleinian Framework**

Whilst it is clear that many of the above anxieties arise from the competing political interests of differing stakeholders within the mental health professions, I would like to suggest that the clinical and theoretical understanding emerging from psychoanalytic psychotherapy can provide us with a possible language and framework within which to conceptualize some of the more unconscious anxieties underlying IAPT’s existence and structure. Contemporary psychoanalytic formulations of group and organizational problems have focused on the notion of management and containment of anxiety as a central issue. Much theorising in the area has centred on Klein’s contribution to understanding the specific constellations of anxieties and defences characteristic of the early paranoid-schizoid and depressive positions (Klein, 1935, 1940, 1946; Segal, 1973). There has been particular interest paid to the concept of projective identification which Klein (1946) views as one of the earliest defence mechanisms used by the developing infant to protect him or herself against internal persecutory anxieties deriving from the death instinct. Projective identification refers to an unconscious phantasy whereby the infant, unable to reconcile ambivalent feelings of love and hate, locates unwanted or intolerable feelings in the object which is then identified with the split-off aspects of the self. The splitting of good and bad experiences, which includes the use of primitive defences such as fragmentation, idealization and devaluation, can be contrasted with more mature ‘depressive’ level functioning in which the infant begins to grasp that his feelings of love and hate are directed at a single object. This move towards psychic integration subsequently sponsors feelings of concern for the object, giving rise to feelings of loss, guilt and the desire for reparative activity. Klein
(1946) suggested that individuals continue to fluctuate between these two mental positions in adulthood, reworking the difficulties of depressive integration at each major developmental stage in life.

Steiner (1993) has pointed out that, in the normal course of projective identification, we are able both to project into and subsequently withdraw projections from others so that we can understand their point of view whilst retaining our own perspective: the ability to empathize can be seen to depend on this process. However, under conditions of emotional pressure or psychological distress this reversibility may be blocked: the individual is now unable to withdraw the projection and so remains out of touch with that aspect of the self which remains unconsciously located inside the object with which it is identified. This not only results in depletion of the projector’s ego but also in the distortion of the object, which may now unconsciously experience, embody and enact the split-off and denied aspects of the projector. Segal points out that the unconscious motivation behind such projection varies:

Bad parts of the self may be projected in order to get rid of them as well as to attack and destroy the object, good parts may be projected to avoid separation or keep them safe from bad things inside or to improve the external object through a kind of primitive projective reparation. (Segal, 1973, pp. 27–8)

Bion (1961), in developing Klein’s ideas, has pointed out that the use of primitive projective processes is also characteristic of how groups manage unconscious anxiety. Making a distinction between the ‘work group’ and the ‘basic assumption’ group, he argues that in uncertain or complex environments, where anxiety levels are high, ‘basic assumptions’ and phantasies may come to predominate, and the mental state of the group may come to be characterised by a more primitive constellation of defences, affects and phantasies underpinned and driven by the need for emotional security. The resulting defensive splitting and projective mechanisms outlined by Klein (1946) and Steiner (1993) above are thought to ensure that individual members now take up roles and emotional relationships within the group’s phantasy, thus undermining the real work or task of the institution. Bion went on to identify a number of mechanisms such as fight/flight, dependency and pairing which groups will resort to under intense strain or psychological pressure. The ‘basic assumption’ group mentality is thus seen by Bion as a defence against the anxiety of uncertainty, chaos and ‘not knowing’.

**Social Defences against Anxiety**

Menzies Lyth (1959) argues that such primitive anxieties lead organizations to construct particular routines and procedures that operate as social defence systems that ultimately sabotage the very tasks they are required to carry out. In her seminal study examining the unconscious reasons why nurses in the health service became increasingly reluctant to care for the sick and vulnerable people in hospitals, she found that nurses experienced enormous emotional difficulties in working with and handling sick, dying and injured patients. The study identified a number of working practices such as strict routines and
division of labour; the idealization of the professional, ‘detached’ nurse untouched by the death of a patient; the identification of patients by number rather than by name; the reduction in responsibility via delegation to superiors; and the avoidance of change. These practices, whilst serving as institutionally embedded defences against anxiety, paradoxically reduced nurses’ emotional investment and satisfaction in relationships with their patients. Inhibition of the nurses’ capacities and creative energies led to high levels of doubt and job dissatisfaction which in turn led to a rapid and destabilizing staff turnover at the hospital. This then further undermined the development of close and effective working relationships which could have gone some way to offset the level of anxiety within the institution. Both Menzies Lyth (1959) and Jaques (1955) point out that it is extremely difficult to instigate change in organizations which are in the grip of such primitive defence systems. These are the very organizations that are least willing to appreciate the magnitude of their institutional problems and are consequently least able to undertake meaningful social change.

Many studies since Menzies Lyth’s, including those, for example, by Nightingale and Scott (1994), Hinshelwood and Skogstad (2000, 2002) and Morante (2005) have used a psychoanalytic perspective to observe, understand and enhance the functioning of mental health professionals within the NHS. Obholzer (2003) has pointed out the significance of the institution as a container for anxiety, suggesting that the NHS can be considered as:

[a] receptacle for the nation’s projections of death and as a collective unconscious system to shield us from an awareness of illness and mortality. To lose sight of the ‘anxiety-containing’ function of the service means an increase in turmoil, and neither its conscious nor its unconscious functions are served adequately. Consider, for example, the outrage in developed countries when advanced medical technologies cannot be made available to all; or the unfounded hopes in experimental treatments; or the tendency to feel duped when interventions fail. In all these situations, both individuals and society at large are quick to blame, as if good enough medical care should prevent illness and death. Patients and doctors collude in this to prevent the former from facing their fear of death and the latter from facing their fallibility. (p. 283)

Just as medical services in the NHS may be unconsciously experienced as a defence against the overwhelming realities of illness and death – and doctors and other medical staff recruited into the fantasy of protecting us from our own mortality – so mental health services in the NHS may be experienced as a collective unconscious system to defend us from overwhelming anxieties relating to psychological vulnerability, dependence, fragility and deeper fears of madness and loss of control. Indeed Hinshelwood (1994), in discussing psychiatric services, points out that: ‘Our institutions are set up with the prime purpose of dealing with unwanted anxiety’ (p. 42) and suggests that mental health institutions and organizations have to cope with individuals whose psychological demands have exhausted the goodwill and emotional capacity of friends, family and colleagues. This means, he argues, that mental health staff are implicitly tasked with carrying out ‘anxiety work’ on behalf of society, work that
demands a high level of emotional robustness in coping with psychological tension resulting from intolerable states of mind. Similarly, Hoggett (2006) has argued that public institutions, in addition to their explicit goals, are often required to contain what is disowned by the rest of society: in this way, they become an arena for the contestability of public concerns and purposes via the projection of unconscious desires and conflicts in society.

IAPT Services and ‘Well-being Work’

At first blush, it might appear that the IAPT programme is a major step forward in addressing anxiety and psychological distress in society. After all, the Labour government invested £173 million of public money in establishing the training, employment and career structure of a huge number of IAPT staff within primary care trusts: a programme of change and reorganization that attempts radically to address the traditional under-investment in mental health services within the NHS. Of note are the recent IAPT targets for 2010/11 which include: 900,000 people treated for common mental health problems, with 50 per cent of these ‘moving towards recovery’; recruitment of a total of 3,600 trained IAPT therapists; and ensuring that 25,000 fewer patients are on sick pay and benefits. Overall, the aim is to establish an IAPT site in every PCT in the UK by 2011, providing access to psychological treatment for at least half the UK population (DoH, 2010).

It can be seen that IAPT’s focus is explicitly on the recovery, productivity and well-being of individuals, notions that have formed the central plank of the government’s think-tank, Foresight, for some time. The Foresight Project on Mental Capital and Wellbeing (2008) claims:

> The trend in recent years has been towards a model of public services based on greater levels of personal choice, active citizenship, personal responsibility, and ‘coproduction’. This is set to continue. To work most effectively, these models of service/client relationship require the greatest number of the public to be equipped with the mental capital and disposition to participate. This calls for a policy mindset that aims to foster mental capital and wellbeing across the whole population. (p. 5)

This emphasis on choice, personal responsibility and financial productivity, earlier outlined in the Department of Health document, Creating a Patient-led NHS: Delivering the NHS Improvement Plan (DoH, 2005), was subsequently adopted in Layard’s (2006) Depression Report. This argued the case for brief, straightforward remedies for feelings of depression and anxiety:

> Crippling depression and chronic anxiety are the biggest causes of misery in Britain today. They are the great submerged problem, which shame keeps out of sight...The good news is that we now have evidence-based psychological therapies that can lift at least half of those affected out of their depression or chronic fear. These new therapies are not endless nor backward-looking. They are short, forward-looking treatments that enable people to challenge their negative thinking and build on the positive side of their personalities and situations. (p. 1)

An overtly optimistic agenda has since translated into mental health policy that now aims 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). I would like to suggest that such a policy emphasis on what might be termed ‘well-being work’, underpinned by a financial agenda aimed at substantially reducing the £7.2 billion invalidity benefit budget, ensures that IAPT mental health services are explicitly conceived, constructed and tasked, not with the job of managing and containing anxiety and psychological distress as is suggested by Hinshelwood’s (1994) notion of ‘anxiety work’, but rather with promoting well-being, happiness and, most importantly, financial productivity in those referred to them.

Layton (2009) has recently argued that social and political changes over the last 30 years have sponsored a form of ‘neo-liberal subjectivity’ within free market cultures which she sees as characterised by omnipotent fantasies of invulnerability and security alongside a repudiation of weakness, dependency and a reduced capacity for empathy. In this scenario, there may be a reluctance to fully recognize suffering or to relate meaningfully to those who depend on us. In the context of an IAPT service, this form of subjectivity emerges with clarity, particularly when we examine the current training curriculum for ‘low-intensity’ workers:

Low-intensity workers assess and support patients with common mental health problems (principally anxiety and depression) in the self-management of their recovery. Treatment programmes are designed to aid clinical improvement and social inclusion – including return to work or other meaningful activity. Low-intensity workers do this through the providing of information and support for evidence-based low-intensity psychological treatments, mainly involving cognitive-behavioural therapy (CBT). Low-intensity psychological treatments place a greater emphasis on patient self-management and are less burdensome than traditional psychological treatments. Examples include guided self-help and computerized CBT. Support specifically designed to enable patients to optimize their use of self-management recovery information and may be delivered through face-to-face, telephone, email or other contact methods. (DoH, 2008, p. 3)

The explicit emphasis here on ‘self-management’, on ‘less burdensome’ CBT-based psychological treatments, on returning patients to work or ‘meaningful activity’ and on the use of self-help information may of course be seen as another example of the above patient choice agenda in the emerging ‘market for care’ (Hoggett, 2006) which in turn is conceived as ‘empowering’ patients. From the psychoanalytic perspective I am exploring here, however, I would like to suggest that the above discourse powerfully embodies Layton’s notion of ‘neoliberal subjectivity’ and what Hoggett (2006) similarly terms the ‘dis-owned subjectivity’ of society, by dispensing with any reference to notions of dependence and vulnerability and distress; notions that evoke primitive anxieties deemed antithetical to IAPT’s explicit aim to achieve – and to be seen to achieve – optimal service outcomes privileging well-being and productivity. But, as argued above, a health system’s role as a specialized institution is precisely to contain and manage the split-off, unwanted and anxiety-provoking aspects of human existence that society unconsciously hands over to it, a function upon which society depends at a symbolic level. I contend, then, that one
of the more troubling features of the new IAPT programme is characterised by its unequivocal dis-identification with or rejection of the unconscious anxiety-containing role traditionally allocated to mental health services.

**IAPT Defences against ‘Anxiety Work’**

This dis-identification has been buttressed at the organizational level by a massive reorganization of services within primary care and the implementation of a tightly regulated and highly standardized culture within IAPT designed to permit an unprecedented level of public and government scrutiny. I think it is fair to say that IAPT practitioners are arguably amongst the most closely monitored of any psychological practitioner within the NHS today: they are expected to train in and carry out highly standardized assessment and treatment protocols; to take and record multiple clinical outcome measures for each client contact; to receive frequent case management rather than clinical supervision; and to achieve increasingly high activity and clinical outcome targets. As an example, the first IAPT demonstration site in Doncaster received 4000 referrals in its first year (Richards & Suckling, 2008) and this referral target has now increased to 5000 referrals per year for IAPT sites throughout the UK. Fifty per cent of these referrals are currently expected to have ‘moved towards recovery’, that is, to demonstrate a significant improvement in clinical scores by the end of treatment (DoH, 2009).

Managers and service leads are equally required to participate in a variety of quality assurance and regulatory mechanisms, to account in minute detail for their service activity and to justify their clinical outcomes to a central IAPT administration. Indeed, these and other overly rationalistic, bureaucratized structures and practices adopted by IAPT services may not only be regarded as the apogee of what Power (1997) calls the ‘audit culture’, but should also alert us to the possible unconscious irrational fantasies and anxieties underpinning their implementation. Many of the strict routines and structures that IAPT services put in place – particularly the stringent requirements for high-volume ‘case activity’ of up to 45 active cases at any one time (DoH, 2008), the strict protocols for assessment and the regular use of brief telephone contact in preference to face-to-face client contact all seem designed to reduce to a minimum the possibilities for emotional engagement between patient and therapist, and seem remarkably similar to the defensive routines and procedures identified by Menzies Lyth (1959) in her study. And just as Menzies Lyth found that these routines themselves constituted a source of anxiety for nurses, so too within IAPT services, I think it is likely that IAPT practitioners, carrying out what I have termed ‘well-being work’, may similarly experience feelings of guilt and anxiety about the systematic lack of opportunity for meaningful emotional involvement with clients. In turn, I think this is likely to contribute to feelings of guilt, resentment and dissatisfaction, and result in what has already been identified as a staff retention issue within IAPT services.

I would like to suggest that the above routines, alongside the tightly controlled, monitored and bureaucratized processes specific to IAPT services, have
been established and maintained both to ward off any identification with the more traditional anxiety-containing role of mental health services, and to defend staff from the unconscious anxiety that dealing with psychologically-distressed patients evokes. Paradoxically, however, it is precisely such routines and organizational structures that create anxieties of their own, in part due to their role in creating what Hirschorn (1997) calls ‘a more primitive psychology’. He suggests that, in the face of new organizational structures, a sense of ‘market risk’ has emerged, creating a sense of vulnerability in individuals who ‘question their own competence and their ability to act autonomously. In consequence, just when they need to build a more sophisticated psychological culture, they inadvertently create a more primitive one’ (Hirschorn, 1997, p. 27).

**Well-being Work versus Anxiety Work: Social Systems as Envious Attack**

What impact does the emergence of this more primitive culture have on a primary care service? From the Kleinian perspective I am discussing, it could be suggested that uncontained feelings of anxiety, anger and envy are likely to come to the fore and to be defended against by splitting and projection within and between services and teams. Envy is likely to be a particularly salient emotion here. There are, of course, complex political, financial and professional reasons why the IAPT programme has evoked particularly high levels of competitiveness, aggression and greed between psychotherapeutic disciplines in the mental health field. Within organizations, however, Stein (2000) has argued that the social defence paradigm, influential for the past four decades, now needs to be supplemented by a model that incorporates the notion of social systems as envious attack rather than simply as defence against anxiety. Drawing on earlier work by Kernberg (1985), Main (1985), Obholzer (1994) and Schlapobersky (1994), he points out that some organizations may be characterised by a quality of enviously attacking and destroying elements of the system felt to be good, and on which the system as a whole depends. He highlights three areas where envious attacks are most likely to be directed within an organization. Firstly, positive and creative relationships with others may be experienced as threatening or even toxic, resulting in meaningful relationships within the organization being undermined and devalued. Secondly, insofar as learning evokes painful feelings of inadequacy and dependence, those possessing knowledge or experience within the system may be denigrated and marginalized. Thirdly, those occupying positions of leadership and authority – and on whom the success of the organisation depends – may be challenged, resented and undermined where they evoke strong feelings of dependency and inferiority within the system.

In a primary care mental health service, envious attack can occur at many different levels but is perhaps most likely to occur along pre-existing fissures or divides, the most visible of which are located at the point where patients are referred on to other services, such as those at secondary or tertiary care level. ‘Referral on’ to other services, and the professional discussions, disagreements and rivalries entailed in passing on patients with significant risk issues, or those
with multiple social and psychological problems, indicate that substantial ‘anxiety work’ is being negotiated at the boundary between one type of service and another. Indeed, the government’s determination to reduce admissions to secondary care services, and the increasingly tight criteria required for such referrals – as well as the professional cachet associated with successfully placing a referral further up the service hierarchy – testifies to the possible unconscious demand for – and envy of – those whose emotional capacities are deemed capable of managing particularly anxiety-provoking patients.

Within an IAPT service, however, referral to different members of the multidisciplinary team similarly evokes feelings of rivalry and envy. Quick and appropriate referral by low-intensity staff to other members of the team is deemed an important part of working within the ‘stepped-care’ model advocated by the National Institute of Clinical Excellence’s (NICE) guidelines, where those assessed as unsuitable for interventions such as guided self-help, signposting to community and voluntary sector services or computerised CBT may be ‘stepped up’ to more traditional face-to-face psychological interventions. I suggest this creates a clear demarcation between those within an IAPT service deemed to be carrying out ‘well-being work’, and those who, as Hinshelwood (1994) suggests, are unconsciously allocated ‘anxiety work’; that is, those who are, by virtue of training or tradition, identified with the more complex realities, difficulties and frustrations of therapeutic work with those in psychological distress and are deemed suitable to work in more depth with clients. This is likely to provoke enormous feelings of competition and envy, particularly as many of those entering a low-intensity IAPT training wish to undertake further professional training and to undertake more in-depth clinical work themselves (O’Connor, 2006). In many NHS mental health services, the staff likely to be most closely identified with ‘anxiety work’ are those working in teams alongside their IAPT-trained colleagues, but whose clinical training and practice are very different, such as psychotherapists working from person-centred, integrative or psychoanalytic perspectives. This means that the actual referral process may be underpinned not only by rational decision-making, but also by an unconscious distribution of ‘emotional labour’ (Hoschild, 1983) indexing a potent phantasy circulating within the team about some team members’ capacity for emotional contact, and about their willingness and ability to engage in depth with their clients’ vulnerability and dependence. I suggest such a phantasy represents a ‘shadow side’ of IAPT, the split-off affective orrelational aspect of the work that has been disowned and relocated within their psychotherapeutic colleagues.

In order to elaborate on this, I want to return briefly to the concept of projective identification which I see as a psychological concept capable of considerable subtlety and sophistication in analysing organizational culture. Contemporary psychoanalytic theory and practice have become increasingly interested in the ways in which the most vulnerable and subjective parts of the therapist unconsciously come to be sought out and evoked by the client within the therapeutic relationship, and many writers have been interested in elucidating the vicissitudes of the therapist in tolerating and thinking about this
process. Writers such as Searles (1978) and Symington (1986), as well as recent relationally-oriented psychoanalytic theorists (e.g. Aron, 2007; Orbach, 2007), have argued that the patient’s unconscious projections may ‘latch on to’ and amplify very specific aspects of the therapist’s unconscious, which then becomes ineluctably involved in therapeutic process and progress. I would like to suggest that much the same process applies at the organizational level, where members of a mental health team may unconsciously latch on to the relational and reparative project of those in the service who, as we have seen, may be unconsciously identified with ‘anxiety work’. Indeed, in some services, these team members, including psychotherapists, are now being called on to undertake overtly reparative activities such as support groups for IAPT staff to help them manage and contain the emotional strain associated with high workloads.

As such, I think it is likely that services will be highly ambivalent toward these practitioners. On the one hand, those undertaking ‘anxiety work’ are idealized for their phantasied – and actual – capacity for psychological care, as well as for their willingness to engage with and to manage complex and difficult clients from whom IAPT services seek to distance themselves. On the other hand, they may be unconsciously envied, denigrated and attacked as symbolizing unwanted contact with feelings of vulnerability and dependence that have been deemed antithetical to the IAPT agenda of health and well-being. Equally, some practitioners who are identified with ‘anxiety work’ feel burdened by what are perceived as unreasonable demands on their emotional capacities and are resentful of colleagues whose ‘well-being work’ is felt to be less psychologically demanding. In the following brief case example, I will try to illustrate the way envious feelings have been enacted within one particular IAPT service in which I have been involved.

**Envy and Projection in the IAPT Team: Case Example**

Over a period of two years, a small part-time primary care psychotherapy service serving the local community had become absorbed into a new IAPT-funded service staffed by 38 new full-time low and high-intensity workers. The sudden advent of a large, new and cheaper workforce meant that the psychotherapists were for some time under threat of redundancy and anxiety about their job security was high. This did not begin to subside until it was clear how the new team was to be integrated and where it was to be housed. New premises and a new management structure meant considerable re-organization of primary care mental health services in the area, and, whilst team members gradually adapted to the new *status quo*, fresh anxieties emerged as a result of the increased pressure to accept more referrals as well as to provide the local PCT with high quality clinical outcome measures.

There was an exceptionally high level of referral to the new service in its first year. This was largely due to the publicity surrounding the redesign of services as well as to the instigation of a self-referral telephone line for the public. Over a period of months it became clear that the overall increase in referrals to the service included a large number of complex cases being referred by GPs for
assessment and psychological help. These cases tended to involve significant risk issues including self-harm, suicide attempts and patients presenting with complex histories involving abuse, neglect and trauma.

The service had established a weekly multidisciplinary meeting to which all team members were invited. This was perceived as a favourable innovation within the service, and practitioners were generally pleased to be invited and asked about their views and recommendations for treatment. In the early days of establishing team working, a group of about six practitioners, including a psychotherapist, low-intensity IAPT worker, CBT clinical advisor, gateway worker, employment advisor and the team lead would meet to go through each referral, and via joint discussion allocate to the most appropriate member of staff. It soon became clear that the psychotherapists in the team were being asked to work with most of the complex cases as the low-intensity IAPT workers were not considered by the team to be sufficiently experienced to manage the psychological issues raised by these patients. In addition, strict exclusion criteria meant that patients with multiple co-morbidities and those with significant relationship problems – characteristic of the bulk of referrals – were not considered eligible for ‘high intensity’ CBT work.

Unsurprisingly, after about six months, the waiting lists for psychotherapy had substantially increased, a situation that was exacerbated by the retirement of two very experienced psychotherapists in the service. In order to investigate the situation, the team lead undertook an audit of referrals into the service, and found that not only were there more complex cases being referred to the psychotherapists, but that the low-intensity workers, undertaking telephone assessments, had been re-referring multiple cases on to psychotherapists in the team as they felt their own skills were insufficient to help address the relationship issues arising from the assessments they had undertaken. This had not only added to the psychotherapists’ waiting lists, but had the effect of significantly reducing the low-intensity workers’ caseloads at a time when they were under considerable managerial pressure to increase their client activity. Failure to meet nationally-agreed IAPT targets resulted in criticism of the IAPT staff in the service and a reduction of morale amongst the low-intensity workers, several of whom abruptly left the service after only a few weeks or months in post. This was experienced as bewildering and upsetting for their colleagues, many of whom did not understand why they had left.

Three courses of action then ensued. Firstly, the departing low-intensity workers were very quickly replaced by new staff and there was little opportunity to discuss or think about the reasons for their exit. Secondly, managers made a decision to stop psychotherapists attending the referral meeting. When this was queried by one of the team, it was claimed that, as their waiting list was already so high, there was no point in any further referrals being made. It was suggested that psychotherapists use the time for much-needed clinical work instead. However, this had the effect of removing psychotherapists from a central plank within the team structure, causing considerable resentment, frustration and anxiety amongst them about their future role and possible isolation within the service. More importantly, this change had a decisive effect on the
referral meeting itself, which, over a matter of weeks, dwindled – without comment or intervention by management – to only two or three participants, with the bulk of referrals being passed to low-intensity workers apparently by default. However, this did not prevent referrals into the service from increasing. GPs continued to refer high risk cases, which managers subsequently encouraged the low intensity workers to take on. This in turn had further consequences: lower client turnover levels in the low-intensity workers as these cases were found to be more time-consuming; the closure of a local voluntary sector partner’s waiting list for counselling following a sudden increase in referrals from the low-intensity workers whose anxiety about high-risk cases could no longer be contained by their psychotherapeutic colleagues in the team; and a series of formal complaints from patients referred to the service who felt they were continually being asked to provide a large number of clinical outcome measures whilst not getting the psychotherapeutic work they had been promised by their GPs.

Thirdly, despite the clinical lead’s repeated reports to IAPT managers and commissioners pointing out the increased number of referrals and the high level of complex cases managed by a very small number of psychotherapists, the commissioners for the service made a decision not to replace the 30 hours per week which had been lost through retirement. The accretion of referrals to psychotherapists in the service was subsequently criticized as an example of poor time management and evidence that psychotherapists were not capable of meeting targets. This resulted in psychotherapists adopting an increasingly defensive position, tightening their own referral criteria to further reduce numbers of patients entering psychotherapy; and increased pressure on the low-intensity IAPT workers to accept those individuals who were expecting psychotherapy. This in turn perpetuated a situation where psychotherapists, already envied by team members as a valuable but now substantially reduced resource, became the focus of a growing number of complaints by senior managers and commissioners who perceived them as becoming yet more ‘difficult’ due to their tighter referral criteria and subsequent insistence on an increased number of sessions to work with the most demanding clinical cases. Low intensity workers, on the other hand, progressively more anxious about the clients they felt unable to manage, were persuaded by managers either to offer brief treatment, or to assess and quickly ‘signpost’ clients on to community or voluntary sector services. This strategy further marginalized the psychotherapists in the team who resented ‘their’ clients being referred elsewhere, and also resulted in dissatisfaction and increasing levels of complaint expressed by both clients and GPs referring to the service.

**Discussion**

The above example illustrates how the unconscious allocation of anxiety work may create deeps rifts at both team and organizational levels, negatively impacting on clinical outcomes for the service. Within the service, psychotherapists were deemed to be highly experienced, and other team members were explicitly encouraged by managers to discuss difficult cases with them and to make
referrals of complex or high risk cases. However, at the same time they were seen by managers as demanding in terms of their low patient turnover relative to their low-intensity colleagues, and as expensive in terms of their seniority, length of time in service and higher pay banding. Their removal from the referral meeting can be seen both as a conscious attempt by management to reduce costs associated with professional staff attending a meeting, as well as an unconscious envious attack on their professional skills and experience that were explicitly valued and needed by referrers and patients.

This case example also clearly demonstrates the overwhelming anxieties for staff under intense political and organizational pressure to demonstrate the success of the IAPT project, itself predicated on what is arguably an omnipotent fantasy about the programme’s presumed ability to provide evidence-based psychological help for vast numbers of the population. Within the highly bureaucratized structure of an IAPT service, this capacity to help was measured largely in terms of IAPT staff activity and client turnover. Where this fell below planned targets, there was considerable anxiety at a managerial level which filtered through to low-intensity workers, some of whom responded by prematurely leaving the organization. However, the IAPT activity targets, particularly for low-intensity workers, proved to be radically at odds with the reality of the more complex work that needed to be done by more experienced staff. Thus the refusal to fund more psychotherapists – as well as to replace the two who had retired – appeared to sacrifice the general good of clients referred to the service in order to ensure that activity for IAPT low-intensity workers was increased to an acceptable level. Moreover, when it became apparent that the IAPT workers were re-referring cases on to psychotherapists in the team, managers enviously intervened to alter the multidisciplinary nature of the referral meeting by insisting that IAPT workers took on the majority of cases that had previously only been deemed appropriate for those with more training and experience. So whilst all team members had initially acknowledged the reality of the complexity of cases being referred to the service – and, importantly, the anxiety this raised in all the staff – there was subsequently a contradictory denial by managers of the very real implications raised by working with these clients in terms of staffing and experience necessary in order to manage risk issues, cross-service liaison and the clinical demands of working with multiple co-morbidities.

I would like to suggest that the multidisciplinary referral meeting very quickly emerged as an arena where some of these contradictory views could be brought, expressed and potentially, at least, be thought about and discussed. These disparate viewpoints not only included the realistic and indeed consciously articulated need for the service to manage and treat a wide variety of clients referred for differing levels of psychological problems, but also the more unconscious agenda permeating the service’s entire organizational structure: to defend against anxiety evoked by such clients by undertaking ‘well-being work’. The contradiction between these two agendas was thrown into sharp relief during team discussions, where the complexity of many of the referrals threatened to re-establish the primary need for ‘anxiety work’ within the
service. This was perceived by managers as a serious threat to the nature and identity of the IAPT ‘well-being’ programme; and this threat was evaded, firstly, in effect, by disbanding the referral meeting and isolating and attacking those who were identified with ‘anxiety work’, and, secondly, by ensuring that large numbers of inexperienced staff were deemed able – and were indeed required – to manage large numbers of high risk, anxiety-provoking clients – despite clear evidence from both referrers and clients that that such staff were struggling to cope.

I have so far characterised the psychotherapists in the team as unconsciously tasked with the ‘anxiety work’ of holding psychological complexity and painful feelings in mind. However, it is curious that this capacity was not harnessed in the service of the team in dealing with the above predicament. It was as if the contradictions in the service were simply too anxiety-provoking to think about and so were put out of mind by all concerned, even by the psychotherapists themselves. This contributed to a ‘basic assumption’ group mentality (Bion, 1961) where the virtually unchallenged disbanding of the referral meeting led to subsequent fragmentation of the team and a catastrophic failure to contain anxiety in the service. Why should this be? It could certainly be argued that the above systemic pressures on what Armstrong (1991) has termed the ‘organization as container’ resulted in the erosion of the psychotherapists’ capacity to establish and sustain a ‘third position’ (Britton, 1999) for reality-based, depressive thinking in the service where anxiety could be contained on behalf of the team. I suggest, however, that this failure of containment was to some degree, at least, sponsored by the psychotherapists’ own unacknowledged envious feelings in relation to their younger, less experienced IAPT colleagues. There is no doubt that the IAPT workers’ adherence to NHS-endorsed cognitive–behavioural models of therapy, not to mention their relatively advantageous pay banding, was perceived by the psychotherapists to be a serious threat to their position within the service, as well as to their long-standing and cherished theoretical models of practice. It is possible that these hidden envious feelings underpinned ongoing difficulties in accepting that IAPT workers might, after all, have a useful contribution to make to the service, and in accommodating to different, less familiar models of practice and patient care. In the event, the removal of psychotherapists from the referral meeting, and the resulting slide into a single default position whereby all patients ended up being assessed – and most subsequently treated – by inexperienced low-intensity IAPT workers, may be seen as an example of what Steiner (1993) has called ‘the perverse solution’: in effect, a covert agreement by all concerned to iron out clinically-relevant differences between patients as well as to evade addressing constructively the substantial differences in training, experience and clinical priorities between staff. The contrived homogeneity of this organizational quasi-solution, whilst undoubtedly serving to protect staff from anxiety in the short term, ultimately signified the foreclosure of meaningful professional discourse via the elimination of power struggles and conflict in the team, and resulted in the eradication of more realistic and differentiated thinking within the service about the most effective way to work with patients.
**Conclusion**

Whilst many of the current debates about the relevance and appropriateness of the IAPT model centre round its commitment to evidence-based practice in general, and to cognitive–behavioural therapy in particular (e.g. Samuels & Veale, 2009), this paper has tried to argue that the contemporary trend towards re-organizing primary care mental health teams around ‘well-being work’ represents a distortion of the role and function of mental health services. I have suggested that IAPT programmes risk misrepresenting the anxiety-containing role that society allocates to mental health practitioners by ensuring that ‘anxiety work’ is split off and exiled elsewhere in the team. Those who are projectively identified with such work may be subject to envious attack and may in turn themselves be recruited into the envious organizational dynamic. In the above example, the anxiety was not eliminated, but rather re-surfaced in the surge of complaints expressed by patients and GPs, something that itself contributed to increased pressure on the team to achieve its targets. In this way, a failure to contain anxiety within the service can be seen to drive the need for yet more unconscious splitting and envious attacks within teams, and to perpetuate an unhelpful, even destructive, organizational *status quo*.

Of course, what I have characterised as IAPT’s focus on ‘well-being work’ may also be seen more centrally as an entrenched organizational defence against the very real limitations and constraints of any service aiming to help people suffering from emotional and psychological distress. Working with those in mental pain is undoubtedly time-consuming, frustrating and usually thankless: there are limits to what is achievable. It is precisely these limits that become painfully apparent when working within a multidisciplinary team, where other professionals bring alternative views, experiences and ways of working to bear. Bollas (1992) has pointed out that, under pressure of anxiety or envy, an unconscious ‘fascist state of mind’ in individuals and groups may emerge where an ideology, belief or conviction is established and sustained via the elimination of all opposition. He goes on to describe the loss of humanity in groups and organizations in the grip of a fascist state of mind, and this is perhaps the more uncomfortable prospect in store for IAPT programmes that do not permit the free circulation of ideas, ways of working and theoretical models within their teams. In this sense, mental health services are persuasive templates for democracy which, after all, depends on listening to a range of competing voices; on sustaining and celebrating what Geertz (1983) has wonderfully termed ‘a disorderly crowd of not wholly commensurable visions’ (p. 161). Indeed, it is precisely the incommensurability of differing psychotherapeutic and philosophical visions – CBT versus psychoanalysis, well-being work versus anxiety work, utilitarianism versus humanism – that, I suspect, underpins and fuels the fervour of ongoing political and clinical debates and disagreements about the place of IAPT within mental health services.

At the end of this paper, I seem to have reached the point of suggesting that psychotherapists may have a particularly valuable symbolic role as part of this ‘disorderly crowd’, particularly in their unconscious ambassadorial role as a disowned, split-off affective aspect of the new IAPT primary care mental health
services. As such, I suggest that they will urgently need to find ways of preventing burn-out and of remaining in touch with the relational aspect of the work, sustaining mutually respectful links with colleagues despite a sense of pressure, via envious attack, to succumb to unhelpful or unthinking ways of working and relating. This is by no means easy, as Menzies Lyth (1959) and Jaques (1955) have already noted and as the above case example suggests. The instigation of practices such as ‘reflective practice’ groups for staff, as a means of facilitating and maintaining a space where different perspectives can be held and thought about, rather than eliminated or homogenized, can be valuable, as Morante’s (2005) discussion of a working group for nurses in the NHS highlights. Of course, the value of any such group depends on the team members’ willingness and sustained capacity to reflect on their emotional role and significance within the organization; and we should not underestimate the difficulties in establishing and retaining a ‘culture of enquiry’ (Main, 1983) within the NHS, given its potential for destabilizing the kinds of organizational and social defence systems discussed earlier.

Nor, though, should we underestimate the generation of unconscious hope that may be an unexpected consequence of IAPT programmes. Society’s ongoing search for a cure for unhappiness is currently enacted by the field’s idealization of evidence-based practice, by the development of the NICE guidelines and the Health Professions Council’s psychotherapeutic ‘competences’ as well as by the onward march of professionalization within the talking therapies generally. Phillips (2002) reminds us that ‘the contesting of cures keeps the hope of cure alive’ (p. 172), and I suspect that the debates, disagreements and rivalries entailed by the re-organization of mental health services and the implementation of IAPT programmes across the NHS, if they do nothing else, ensure that we keep the wish, indeed the obligation, to alleviate emotional and psychological distress at the forefront of our minds. Of course, the advantages and limitations of the IAPT programme have yet to be fully explored and researched; this paper has been an attempt to clarify some of the unconscious dynamics that have a bearing on its future success or failure.

Note

1. Since this paper was completed, the new Coalition Government in the UK has expressed its commitment to continue rolling out the IAPT programme. However, plans for GPs to take over commissioning of primary care services mean that the future development and implementation of IAPT services remain unclear at the time of writing (October 2010).

References


