Taking Care of Business: Psychologist Self-care in a Neoliberal Age

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Psychological practice is complex and demanding, particularly for rural-remote practitioners, and occupational risks of clinical practice are expected to be managed through ongoing professional self-care. This is widely positioned as the personal responsibility of individual clinicians, yet it has public implications given psychologists' role in national mental health strategies. That social risk is transferred from state to individual arguably reflects a neoliberal rationality that holds the individual accountable, leaving structural conditions unquestioned. This study adopts a post-structural framework and Foucault's concept of governmentality to consider self-care in light of neoliberal political power. It investigates how neoliberal discourse constructs the way self-care is understood and enacted by clinical and generally registered psychologists working in rural-remote organisations. Interviews with 8 registered rural psychologists are examined using Foucauldian discourse analysis. Neoliberal discourses of the rational, autonomous, responsibilised subject are (re)produced in ways that both enable and constrain self-care practices. As a technology of neoliberal governmentality, professional self-care encourages clinicians to shape themselves to meet the demands of the market, with particular consequences for rural-remote clinicians. Moments of resistance and counter-discourses open possibilities for alternative understandings and practices of professional self-care.

Psychological practice is often described as challenging. To deny the work is "demanding and gruelling" is argued to be "mendacious, deluded or incompetent" (Norcross, 2000, p.712). Whilst clinical work is described as rewarding, it is also positioned as "one of the most stressful professions in the world" (Dattilio, 2015, p.393) and "risky work indeed" (Kottler, 2017, p.9). These risks extend to the public sphere with psychologists a key resource in most westernised health plans, as with the Australian Government's Better Access plan (Department of Health, 2006). Yet psychologist self-care, despite having such social consequences, is predominantly constructed as an individual responsibility.

The "Tremendous Risks" of Clinical Practice

While the practice of psychology may involve many variations in work, this paper focuses on the endorsed clinical and generally registered psychologists who provide the majority of therapeutic and clinical care to Australian communities (in which community psychologists may often be involved). Clinical practice is said to be challenging because of two key domains: challenges presented by clients and systemic pressures. Clinicians work with clients who often have intractable problems and histories of trauma (Norcross, 2007). Clients may show little or no improvement, and some will attempt or complete suicide (Norcross, 2000; Trimble, Jackson, & Harvey, 2000). These experiences are common enough to be considered occupational hazards, yet they are profoundly disruptive (Veilleux, 2011). Additionally, clients live in a society that may predispose them to mental distress. Income and wealth inequity have increased exponentially in Australia over the last 20 years (Richardson & Denniss, 2014) and such inequity has been linked to increased risk of stress, anxiety and depression (Patel et al., 2018).

Clinicians also face systemic pressures. In Australia there are continual changes to the funding of psychological services, the latest iteration being the 2016 roll-out of the National Disability Insurance Scheme (NDIS) (NDIS Act, 2013). Clinicians are often employed under short-term contracts and may face job insecurity (Hammond, 2018). Caseloads are increasing in an economic climate that pressures psychologists to work long hours (Mathews, 2014) and fulfil more complex roles (Smith & Moss, 2009). There is a focus on paperwork, with higher audit and accountability demands, and pressures to provide short-term psychological therapy with 'evidence-based' outcomes (APS, 2015a; APS, 2019; Department of Health, 2006; Hammond, 2018). Overall, there is "a requirement to do more with fewer resources" (Osborn, 2004, p.327). Moreover, psychosocial practice is reported to take place within a system that is "extremely fragmented and based on short contract cycles, which make it harder to deliver quality services on a continuous basis to people" (Australian Government Productivity Commission, 2019, p.44). This is simultaneously within an economic system that, according to the former governor of the Reserve Bank of Australia, causes misery and social division (Karp & Hutchens, 2018).

Rural and remote mental health service delivery has been described in Australia as "a fragmented approach with band-aid solutions" (Commonwealth of Australia, 2018, p.8). Many rural-remote communities rely on agricultural industries vulnerable to climate breakdown and the concomitant social, economic and mental health impacts (National Rural Health Alliance, 2017). There are high levels of co-morbid mental health and substance use disorders and higher rates of attempted and completed suicide (Vines, 2011). As a result, self-care and burnout are said to have "particular relevance" for rural-remote practice (APS, 2017, p.178). Recruitment and retention of psychologists to these communities present a major challenge (Roufeil, Robson Thomas, & Boxall, 2015),

and the lack of clinicians further contributes to inequities in service provision (Mathews, 2014; Vines, 2011).

Ongoing demands are said to put clinicians at risk of chronic distress, anxiety, depression, substance abuse or dependence, and burnout (Gilroy, Carroll, & Murra, 2002; Pakenham, 2015a; Rupert, Miller, & Dorociak, 2015; Smith & Moss, 2009). The Australian Psychological Society (APS) considers stress and burnout, along with vicarious trauma and compassion fatigue, to be "occupational hazards" (APS, 2015b, para 1). In this way they are positioned as natural and unavoidable outcomes.

Professional Self-care in the Literature

Professional self-care has been described as purposeful engagement in activities that promote "well-functioning", that is "the enduring quality in one's professional functioning over time and in the face of professional and personal stressors" (Coster & Schwebel, 1997, p.5). Frameworks include Norcross (2007): 12 principles that involve nurturing relationships and creating a flourishing environment; and Wise et al. (2012): mindfulness-based positive principles that emphasise flourishing, intentionality, reciprocity and integration of self-care into daily practices.

Specific recommendations are framed as self-care strategies (APS, 2015b; Barnett et al., 2007; Norcross, 2007), career-sustaining behaviours (Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004), and enduring professional well-functioning strategies (Coster & Schwebel, 1997). Recommendations are often presented as an exhaustive list:

> Psychologists should engage in… actions such as striking a balance between personal and professional demands and activities, seeking diversity in professional activities and caseloads, taking regular breaks from work, getting adequate rest and exercise, having a balanced and healthy diet, and attending to emotional, physical, relationship, and spiritual needs outside of the work

setting. (Barnett et al., 2007, p.606)

Utilising the suggestion in Pakenham (2015a) that strategies would be more usefully classified into three overlapping domains – intra-psychic, career-related and lifestyle – this research conceptualises the literature as follows. *Intra-psychic* self-care incorporates self-awareness; self-regulation; mindfulness-based positive practices; values-oriented acceptance-based therapies; cognitive techniques, and cultivating spirituality. *Career-related* strategies advise: diversifying work responsibilities; exercising control over workload; finding work-life balance; engaging with supervision, peer support and personal therapy; participating in continuing education and developing stamina to endure work stresses. *Lifestyle self-care* proposes: wellness behaviours (nutritious diet, adequate sleep, regular exercise); pursuing leisure activities and taking regular breaks from work. (Three domains sourced from: APS, 2015b; Baker, 2003; Barnett et al., 2007; Evan, 2015; Kramen-Kahn & Hansen, 1998; Mathews, 2014; Norcross, 2000, 2007; Osborn, 2004; Pakenham, 2015a; Rupert et al., 2015; Shapiro, Brown, & Biegel, 2007; Stevanovic & Rupert, 2004; Walsh, 2011; Wicks, 2007; Wise et al., 2012).

Quantitative research evidence supporting the effectiveness of these strategies is methodologically problematic. It relies on self-report survey data collected primarily from North American convenience samples and it is contradictory and inconclusive. For example, supervision has been rated low in importance in some surveys (Stevanovic & Rupert, 2004) and high in others (Coster & Schwebel, 1997; Kramen-Kahn & Hansen, 1998). Personal therapy is considered by some an important strategy (Barnett & Cooper, 2009; Norcross, 2000), yet in an Australian study, engaging in personal therapy showed a significant positive association with burnout (Di Benedetto & Swadling, 2013).

What is striking about the majority of professional self-care recommendations is that they act primarily upon the individual and disregard the role of the workplace:

Given the changes in the … mental health system that have resulted in more client/patient hours, lower status, greater chance for litigation, generally lower financial reward given the importance of the work, and overall insecurity at many levels, what creative ways have you developed to ensure that you don't lose sight of the wonders of being a clinician? (Wicks, 2007, p.51)

As this quote illustrates, the literature acknowledges enormous systemic challenges yet looks to the individual practitioner as the locus of responsibility, and this is pervasive in the literature. Osborn (2004) argues that systemic challenges such as funding cuts exacerbate psychologist burnout, yet presents individual-focused recommendations based on "resources to keep one's outlook positive" and the stamina "to work within a demanding system rather than changing or resisting it" (p.321). Rupert et al. (2015) describe the impact of excessive paperwork and long work hours on burnout, but their self-care recommendations look to the individual practitioner to monitor those demands and adjust them to fit with their workload capacity. Similarly Norcross points to the "rising industrialisation" (2000, p.713) of psychotherapy, yet nine out of ten of the recommended self-care solutions are intra-psychic.

Where there are calls for the involvement of professional bodies, the focus is on introducing self-care into training (e.g., Pakenham, 2015b) or professional development (e.g., Baker, 2003; Barnett & Cooper, 2009), with occasional reference to national bodies showing initiative (e.g., Smith & Moss, 2009; Norcross, 2007). However, these calls still look to individual self-care (teaching it, promoting it, supporting it) rather than exploring structural changes. Of the studies reviewed, only Andrew and Krupka (2012) explicitly question the material realities – the "new, more nakedly savage socio-economic landscape" (Penny, 2017) – that potentially make self-care extremely difficult: "continuing to embrace the madness that we

can each find our own healthy path through economic rationalism only serves to strengthen a system that is harming us" (Andrew & Krupka, 2012, p.46).

Neoliberalism: The More Nakedly Savage Socio-economic Landscape

Responsibility to maintain professional well-functioning is so firmly placed at the feet of the individual practitioner that it is argued to reflect a political rationality that transfers social risk from state to individual (Lemke, 2001), positioning solutions "almost exclusively within the self, leaving the social order conveniently unaffected" (Prilleltensky, 1994, p.35). Andrew and Krupka (2012) refer to this political rationality as economic rationalism – neoliberalism by another name. Neoliberalism is a contested term (Whelan, 2015), but arguably it is sufficiently coherent a project to have extended into all areas of political, social and cultural life (Lawn & Prentice, 2015). Put simply, neoliberalism assumes "all aspects of human life can be organised on market principles" (Barnes et al., 2015, p.8).

Neoliberalism can be understood as three intersecting social realities (Whelan, 2015). As a *political economy* it describes pro-market policies such as deregulation that "facilitate free trade, maximise corporate profits and challenge welfarism" (Brown, 2003, p.39). Governments, once concerned with fostering people's wellbeing through the provision of social services, leave market forces to allocate resources fairly (Larner, 2000). One consequence is that mental health care services in Australia are increasingly contracted out to the private sector through non-government organisations. These organisations must demonstrate efficiency, competitiveness and accountability (Yeoman, 2012; Sugarman, 2015). This has relevance in rural-remote communities, where organisations are less suited to practices such as competitive tendering (Commonwealth of Australia, 2018).

As the dominant way of understanding and describing the world, neoliberalism has become so pervasive as to be considered unquestionable common sense.

As a *hegemonic rationality*, neoliberalism insists there is no alternative (Harvey, 2005).

Most notably for this article, neoliberalism can be understood as a form of *governmentality*. Post-structuralism theorises that knowledge is not discovered but is constructed by the powerful as a means through which power is exercised (Rose, 1999). Hegemonic knowledges like neoliberalism are maintained by techniques of governmentality. "Government" here refers to any deliberate shaping of human lives and behaviour (Hook, 2004) and extends from political government through to forms of self-regulation (technologies of the self) (Lemke, 2002). Through particular techniques and discourses (technologies), neoliberal political power comes to shape behaviours and attitudes of people in line with market values (Dean, 1999; Foucault, 2008; Rose, 1999). At the same time individuals shape themselves to meet the interests of this political economy (Hamann, 2009). Neoliberalism is therefore both "out there" and "in here" (Ball & Olmedo, 2013, p.88).

Beyond these realities, neoliberalism comes to be "true" in part through *discourse*, a key instrument of governmentality (Hook, 2004). Discourses can be understood as ways society communicates shared beliefs and assumptions (Langdridge, 2009). In themselves they are neither true nor false (Hook, 2004), but they are productive, in that they constitute the objects they describe, "speak certain kinds of subjects into being" (Southgate & Bennett, 2014, p.25), and produce real effects (Cheshire & Lawrence, 2005). According to Monbiot (2016), neoliberal discourses and practices seek to deliberately reshape human life in terms of market logics.

Neoliberal discourses of the market construct *discursive subjects* that are like businesses: inherently rational, competitive and self-interested (Brown, 2003). The neoliberal subject is constituted as a free, autonomous entrepreneurial agent who must continually invest in her skills so as to maximise her economic value (Brown, 2003; Hamann, 2009; Rose, 1999; Sugarman,

2015). Individuals are subjectified as free to choose and therefore entirely responsible. Neoliberalism "entails shifting the responsibility for social risks…into the domain for which the individual is responsible and transforming it into a problem of 'self-care'" (Lemke, 2002, p.59). Self-care thus becomes an essential part of the responsibility of neoliberal citizenship (Barnes et al., 2015).

Neoliberalism and Psychologist Self-care

Arguably, professional self-care as constituted in the literature is shaped by neoliberal governmentality, and at the same time the broader economic and cultural context in which self-care is practised is shaped by a neoliberal economic rationality. Applying the lens of neoliberal governmentality to the professional self-care literature extends this introduction into the space of critical analysis. This is important, not only because it illustrates the hidden ways psychologists are normalised as neoliberal subjects, but also because it begins to look critically at literature that has thus far gone unscrutinised.

Psychologists are discursively constructed in the professional self-care literature as inherently rational: to be persuaded by evidence-based recommendations (Walsh, 2011) and self-care strategies that are "clinician recommended, research informed and practitioner tested" (Norcross, 2000, p.710). Psychologists are expected to identify risk factors and make rational self-care choices to prevent future harm they may cause to themselves, to their clients and the profession. They are subjectified as a potential threat and encouraged to engage in self-surveillance, to "check specific thoughts and feelings that emerge" (Dattilio, 2015, p.396).

If psychologists "neglect" self-care, it is a failure of personal agency – a "chronic disregard for self-care … dragging their feet about obtaining help" (Datallio, 2015, p.393); or it is a failure of personal attributes – a tendency "to focus more on the needs of others than their own, [to] have unrealistic self-expectations and … [to] be overinvolved with their work" (APS, 2015b, para 2).

Psychologists are positioned as free to choose supervisors, workload, diversity of client presentations, to say "no to inhumane working conditions" (Norcross, 2007, p.103). This discourse of freedom ignores the fact "there is increasing pressure on psychologists to work long hours and the current economic climate appears to be compounding this pressure" (Mathews, 2014, para 6). In response to increasing pressures, they must reconfigure themselves by "managing and promoting resiliency" (Stevanovic & Rupert, 2004, p 302), adopting "resilience-building attitudes" (Wise et al., 2012, p.488) and utilising "effective coping skills" (Dattilio, 2015, p.395).

Psychologists are positioned as entrepreneurs of their selves, encouraged to "focus on ways to grow one's assets" (Pakenham, 2015a, p.406). In Pakenham (2015a), professional self-care incorporates behavioural goals in "each life domain…career, family, leisure, health, friends" (p.407). Wise et al. (2012) look to the "transformation of existing ways of thinking, doing and being" (p.489). Clinicians are asked to continually work on the body (sleep, exercise, diet), the mind (intra-psychic strategies) and the spirit (cultivating spirituality) to ensure their well-functioning.

Thus psychologists' self-care may be characterised as a neoliberal technology of the self; that is, a "highly individualised… self-steering mechanism" used to regulate self-conduct (Hook, 2004, p.264). This is institutionalised through a code of ethics and national practice standards that construct self-care as a professional competency. The APS Code of Ethics (2007) uses a competency framework, implying assessment of proficiency and expertise rather than care. Clinicians must engage in the surveillance of their emotional, mental and physical state (APS, 2007) so that their competency is not impaired.

All Care and No Responsibility

Given that psychology has been described as constructing a subjectivity that internalises the principles of a neoliberal culture (Ferraro, 2016; Rose, O'Malley, & Valverde, 2006), it is perhaps no surprise that neoliberal discourse of the rational, autonomous, responsibilised practitioner are normalised in the professional self-care literature. Whilst it may be common sense that psychologists ought to exercise, eat well and get adequate sleep, self-care when constituted as a purely individual matter disguises the way responsibility has been privatised. Little or nothing is asked of government, professional organisations, licensing bodies or workplaces. Thus, for example, professional bodies such as AHPRA and APS are not asked to ensure, as Pakenham (2015b) recommends, that self-care is incorporated into accreditation standards for psychology programs. Government is not asked to fund psychologists' personal therapy as part of its Better Access scheme, despite personal therapy being widely recommended for self-care (e.g., APS, 2015b; Baker, 2003; Norcross, 2000).

Constituting care of the self as an individual matter consigns it to the private sphere, yet care is not easily divided into private and public (Tronto, 2010). Psychologists have been constituted as a key resource in the Better Access mental health scheme (Department of Health, 2006). The demand for services has increased continually since the initiative's inception in 2006, and the number of treatment sessions provided by psychologists rose from approximately 0.6 million in 2006 to 3.9 million in 2013 (Littlefield, 2017). This would suggest then that psychologist welfare has public as well as private implications.

Dominant constructions of self-care obscure alternative ways of thinking about the practice. For example, a feminist care ethics challenges the ontological aloneness of neoliberalism by arguing that humans are relational beings, dependent on others for their capacity for autonomy (Robinson, 2011, Tronto, 2010). Within this framework care needs are met through relationships between people; this is in stark contrast to care needs met by isolated psychologists continually working on themselves. Johnson et al. (2012) argue for professional competency to be not only an individual ethical obligation but also a collective moral duty. A similar perspective on self-care might emphasise the obligations of the community of psychologists. A code of ethics might protect psychologists' care interests alongside the interests of the people with whom they work.

Aims of the Study

Neoliberal discourses may profoundly influence the way professional self-care is constituted, but individuals are not merely "passive recipients of discourses", they constantly adopt, adapt and resist them (Thomas & Davies, 2005, p.700). Given this complex interplay, critics call for examinations of local variations of neoliberal discourses in order to describe the way they are (re)produced within the particular circumstances of people's lives (Yeoman, 2012; Chun, 2016). In addition, although examining discourses from afar provides insight, it is valuable to engage with the experiences of people subject to those discourses (Watson & Fox, 2018). Thus this research aims to explore how neoliberal discourses construct the ways self-care is understood and enacted by psychologists located in a very particular context – those working in rural-remote government and non-government organisations. Rural-remote communities have been heavily impacted by neoliberal economic policies, and organisations have been shaped by economic reforms that render them business-like (Davies, 2017). Thus this "local variation" makes for a rich space of investigation. Additionally, professional self-care has not thus far been a focus of discursive research. A post-structuralist approach aims to question how professional self-care came about, to challenge the established "truths" of it and to construct alternative understandings and practices.

Methodology

This study adopts a critical realist ontology and a poststructural epistemology that assume a pre-existing material world

which is *re*constructed, rather than constructed, through language (Parker, 1994). That is to say, there is a real, material world upon which neoliberal rationalities and policies can act, and underlying social and material conditions out of which particular discourses – in this case, of professional self-care – grow and are sustained (Burr, 2015; Sims-Schouten, Riley, & Willig, 2007). This allows that neoliberalism has effects that are not purely discursive, that as a set of free-market principles it has an impact on people's material worlds.

Method
Procedure
Ethical approval for this research was granted by the Human Research Ethics Committee of Charles Sturt University under protocol number H19091. Registered psychologists working for government or non-government organisations in one town were informed of the project through local professional networks. Anonymity was enacted carefully, given the complexity of maintaining confidentiality in rural-remote communities.

Participants took part in face-to-face semi-structured interviews with open-ended questions. The interview questions related to professional self-care: information about employment and organisations was not sought. All interviews were face-to-face and were between 45 and 63 minutes in length.

Participants
Interviews took place with eight registered psychologists working in a NSW town classified as remote by the Australian Standard Geographical Classification system (Australian Institute of Health and Welfare, 2004). The town has a population of approximately 5000 and services a regional population of around 33,000. Eight interview subjects was considered appropriate for a Foucauldian Discourse Analysis (FDA) study which examines in an in-depth manner and therefore tends towards much smaller numbers in terms of data (Parker, 2005).

Three psychologists worked for government organisations and five for non-government organisations. Six were female, reflecting the proportion of female psychologists in Australia (78.9% in 2017) (AIHW, 2020). Six were generally registered, two were clinically endorsed. Their ages ranged between 35-65 and they included early-, mid- and senior-career clinicians. They all appeared to be of European heritage, and they have been assigned pseudonyms in the results of this paper.

Analysis
Interview transcripts were analysed using FDA, which explores ways people both conform to and resist discursive positionings. It positions all knowledge as subjective and partial; both interviewer and interviewee are seen to be constructing the "truth" of their experience through language (Southgate & Bennett, 2014). The findings are considered actively constructed by the author; thus the reading presented here is only one of many possible alternative readings (Burr, 2015). There is no strict method of FDA; however, the current research used as a roadmap Willig's (2013) six stages: discursive constructions, discourses, action orientation, positionings, practice and subjectivity. Due to time constraints it was not possible to explore the genealogy of discourses, so in FDA terms this is a somewhat partial analysis. These stages were not followed sequentially, partly because they developed together, each informing the other, and partly because of the research aims. Given that neoliberalism had been identified by the research rationale as a hegemonic discourse within which professional self-care was discursively located, the initial focus was on how this discourse positioned psychologists as particular kinds of subjects (positionings), as well as ways it constituted objects such as self-care (discursive constructions). What functions were served as a result (action orientation) and the potential consequences to clinicians' lived experience (subjectivity) and the ways self-care could legitimately be performed (practice) developed alongside the researcher's (first author) reflections on her own subjectivity and the impact of this on what was produced (see "Reflexive process"). Given that the research rationale had identified neoliberalism as a hegemonic worldview, particular attention was paid to

contradictions, counter-discourses and resistances in order to find what was unexpected in the transcripts. Thus whilst looking to see how neoliberalism reproduced certain power relations, the account could also identify potential spaces of challenge (Parker, 2005).

Results

The following analysis aims to explore how, in psychologists' accounts of professional self-care, a neoliberal discourse of the rational, responsibilised, autonomous subject is adopted, adapted and resisted. Whilst the analysis considers these discourses separately, they are interconnected, interacting in complex and contradictory ways to produce subjective experience. This analysis did not "emerge" out of the transcripts; it is actively constructed by authors adopting a neoliberal lens. A myriad of other lenses might have been adopted; gender, for example. The aim is not to discover some pre-existing "truth", but to interrogate unexamined assumptions about an essential part of psychological practice that has thus far avoided critical scrutiny.

The Rational Self

Repeatedly interviewees worked discursively to construct themselves as rational ("I'm pretty rational", Wendy), reliant on research evidence ("if there's no evidence base for it we're not going to do it", Nina), utilising cognition in their work ("I do like to think things through very much", Jude) and adopting cognitive frameworks ("you've got to construct models that are sustainable in your head", Nik). After discussing difficulties in disconnecting from hearing stories that are "traumatic" and "pretty confronting", Wendy ends with:

> *You can [...] have had you know a traumatic visual of this person's visual [...]it's kind of hard sometimes it's a hard thing to close off. Um, so yep, but I would I usually just I'm pretty rational about those things.*

This suggests that a rational subject position protects against stresses of practice. Nik refers to "systems thinking", "systems point of view" and cognitive "models and frameworks"; here the psychologist is

repeatedly positioned as rational. This subjectivity appears to insulate Nik against the stresses of the job, the constant "invitations to overextend yourself":

> *I think you've got to have a systems point of view where if you just pick up the slack [... it] doesn't actually help your client for you to go past your limit, because you'll just fail and then it fails for them, so what is actually better is for you just to stick to your limit and just keep saying to them, no I'm not taking that on, that's not what we do.*

In adopting an objective, bird's eye perspective, the psychologist is positioned as able to identify limits and to refuse to step beyond those limits. Whilst this may foster a sense of control and order, it rests on assumptions that are undermined by the National Mental Health Commission's assessment of the Australian mental health system as "poorly planned, fragmented [and] badly integrated" (2014, p.8).

A number of the specific self-care strategies referred to in the interviews relied on discourses of the rational mind, with practices such as mindfulness (Valerie), visualisation (Wendy) and "thought-challenging tasks" (Nina). These cognitive-based strategies were positioned as a defence against work stresses exacerbated in rural-remote practice, where "there's a real gap in services", referral resources are "hopeless" (Carla), and where there's "a huge shortage of psychologists" (Wendy). Carla articulates the way these elements of rural-remote practice combine to impact on clinicians:

> *C: the further you go away from the city centre the less there is available in the community to, for even things like neighbourhood houses and groups run at neighbourhood houses so linking people into those, they're just not here. [...]*
> *I: I'm just wondering whether [that]*

adds an extra level of stress or anxiety.

> *C: It's enormous actually. Yeah, because you have to be all things to someone.*

Valerie gave a poignant account of how the rational self is positioned as a defence against these material stresses of rural practice. She described having recently had an uncharacteristically "awful" response to being asked to take on a fourth case involving a profoundly painful life event she herself had experienced. When asked about her self-care response in this instance, she employed a discourse of mindfulness:

I'm actually being really mindful now, I'm being mindful in my practice with those four separate clients to actually treat them as four separate clients and not kind of view them as [...] a collective presentation [...] So for me at this stage I'm just really mindful of that that's good self-care for me.

Despite an extremely difficult experience, "good self-care" is positioned as something straightforward and achievable through a mindful approach to practice. This focuses on a clinician's intra-psychic experience at the expense of material conditions.

In summary, a discourse of the rational self appears to both support and undermine clinicians' capacity for self-care. A rational subjectivity is positioned as protective for clinicians, but simultaneously normalises self-care practices that encourage individuals to work on themselves rather than question the status quo. It is not solely the tyranny of distance that produces limited services in rural-remote communities. The government's narrative of budget deficit looks to the reduction of welfare spending whilst prioritising tax cuts for business (Denniss, 2018). By obscuring these material realities, a rational subjectivity encourages individuals to shape their conduct in ways that suit economic imperatives.

The Responsibilised Self

Neoliberalism requires that individuals assume a moral obligation "to provide for their own needs" (Brown, 2003, p.42.). Professional self-care as a discursive object was uniformly constructed by all the participants as an individual responsibility:

I have to take responsibility for that [self-care], I'm not going to blame my organisation for saying well you just ignored me. (Jude)
We all go into it [psychology] because we want to care about people and help people [...] but you're no good, you're not going to be able to keep doing that if you don't step up and help yourself. (Carla)

Here the only subject is the individual "I", positioned as both subject and object. In part the term "self-care" similarly positions the self as subject and object; in contrast, a phrase such as "care of the self" allows other agents (such as organisations) into the process. None of the interviewees included organisations or professional bodies in their account of professional self-care until the possibility was raised by the researcher (first author). Indeed, in Jude's quote above, the organisation is actively excluded from responsibility.

Responsibilised discourse appears to have broad implications that not only treat self-care as a personal responsibility but also treat structural and economic problems, what Nik describes as "systems shortfalls", as individual problems. Shortfalls are positioned as endemic in rural-remote communities: limited specialist referral services, "hopeless" community resources (Carla), shortages of psychologists and long waitlists. The psychologist is positioned as caught between the economic needs of the organisation and the clients' needs for "consistency and longevity" of care (Jude). Both sets of needs are constructed as intractable, so the psychologist responds individually:

I do all sorts of juggling acts and then I would start seeing people on a fortnightly basis and then because of the money problems I'd have lots of people booked in, they didn't all come [...] no one ensuring I'm still managing and I'm on top of it and "you're doing enough" - that's about self-care [...] and then when the managers were getting really concerned about the loss of income, they'd say right, well book five people in every day. (Jude)

Here the psychologist is positioned as responsible for the actions (the "juggling acts") that balance opposing needs. Organisational concern is not for the practitioner's self-care but for the "loss of income", which the psychologist must remedy.

Laurie narrates a similar tension between client and organisational imperatives and admits taking personal responsibility for that by ensuring client needs come first and so not always working in "quite the way I'm *supposed* to work" or "doing what the organisation expects". The impact of this is described as "anxiety-provoking" and Laurie has "just worn the anxiety around that". Similarly Carla provides a cogent account of this stress:

> *It's quite stressful to let somebody go […] and know there's not a private psychologist you can link them into because the waitlists are so long […] I've got to do as much as I possibly can and work as hard as I can in this session, to maximise their experience […]and that puts pressure on your day because you go oh, let's just have another half an hour, you know you make your sessions longer […]and then you don't get lunch breaks and you run late for meetings and you know, it might be because I'm disorganised.*

Here the clinician is constructed as the only solution to systemic inadequacies, the limited services available in the community. Significantly, despite the systemic pressure presented, the psychologist still suggests blame for being "disorganised".

The responsibilised self of neoliberalism emphasises personal responsibility over communal and collective responsibility. It necessitates a subject who is independent, self-reliant and in control of her life; that is to say, autonomous.

The Autonomous Self
The independent, in-control agent.
The discursive work done to position clinicians as autonomous agents was evident throughout the interviews, utilised directly –

"I'm quite autonomous in that role" (Carla) – and indirectly:

> *You've got to know where you're at emotionally, psychologically, physically, you have to have that insight into yourself to know that you need to do something different* (Nina)

Here the psychologist is positioned as reliant on herself to independently assess her status, then as being in control of changes. This is potentially empowering, but conceals barriers to self-care that are impossible to control and that constrain choice.

Valerie is positioned as in-control agent when managing caseload, refusing to book more than five clients a day when the "organisation really specifies that we book six". Other interviewees are similarly constructed as in control of their workload:

> *I can dictate how much I do.* (Carla)
> *There's things I could keep saying yes to which I don't.* (Wendy)

Literature constructs control over workload as a self-care strategy which reduces burnout (Maslach & Leiter, 2016; Rupert et al., 2015). However, this discourse of work control is undermined in Valerie's account when she describes pressure to take on more clients:

> *I resisted resisted resisted but it's got to the point where we've got a waitlist and yeah, it would be helpful if I could take them on […] it's not comfortable knowing that there are people who are not getting a service.*

The emphasis on resistance and thereby agency and control cannot last in the face of clients' needs. Valerie's account further describes types of clients she would rather not take, yet compromising to "make it work for work". For this she will need to undertake "some specified training" and "extra supervision". The toll of this compromise is felt not by the organisation but by Valerie herself:

> *I'm already imagining that I'm going to probably spend a little bit of more of my own time upskilling, which challenges me because I feel like I never have enough of my own time anyway […] I'm going to have to*

reprioritise over the next two or three months and make room for that, my balance will be what gives. What do I give up, which will be my evening Netflix.

Significantly Valerie repositions herself as an autonomous in-control subject by constructing the unwelcome caseload as a "professional challenge". Although this may allow her to focus on the personal benefits of taking on these cases, she is arguably being shaped through the discourse of the autonomous self as an entrepreneurial actor who invests her "own time upskilling" in order to maintain her capital value.

A similar kind of repositioning is visible in Nik's account in which there is a reframing as "opportunity" the pressure felt, as one of only four clinical psychologists in the area, to provide assessments for disability support pension applications:

I don't particularly want to do them, and I don't feel particularly skilled at doing them, but if I don't do them, who's going to do them? Yeah, so you could view that as a pull but you know, I just reframe it and go okay so […] it's an opportunity to get skilled at something new.

Nik is positioned at first as having little control over workload, then a version of autonomy reframes the negative as a professional opportunity. Thus within a neoliberal discourse of the autonomous subject, clinicians can be persuaded of their own agency and freedom to control work, despite the political-economic realities that mean services to rural-remote communities are limited.

The failing self. According to the construction of the autonomous subject, failure to prosper is the result of personal choice (Türken et al., 2015). Thus the individual clinician becomes the site of blame if self-care is neglected, no matter what systemic barriers prevent care practices.

Of all the participants, only Valerie and Rose admitted to inadequate self-care. None of the other participants described themselves as having poor self-care, although indirect references suggested self-

care may be less than optimum ("I probably only do a portion of what I say other people should be doing", Wendy). Time was positioned as a significant challenge throughout the interviews, and so self-care had to be weighed against other demands:

[Self-care] it's things like you know it's stuff that everybody says, you know, have a bath, light a candle, go for walks, like the reality of doing that and kids, so my balance is just, it's running around after kids and taking them for play dates with their friends who have parents that I like and that's great, that's a win-win.
(Carla)

Here commonly espoused self-care practices are impossible when the psychologist has more pressing family demands, so self-care and family activities are combined in a way that is not an entirely convincing "win-win".

Rose is explicit that her self-care is inadequate ("I've always been aware that it's something that I'm not doing well"), as is Valerie:

Obviously my self-care's not great because it means I'm not able to still do everything, there's something I'm either doing too much or I'm not taking good enough care of myself.

Significantly, self-care is positioned here as a practice that allows psychologists to "do everything".

Although most participants framed themselves as undertaking adequate self-care, responsibility and blame were applied to those whose self-care practice was positioned as inadequate. Nik positioned those clinicians who "aren't functioning very well" in contrast to those who "function marvellously well" and concludes that the latter are "resilient because they actively work on it" while the former "from what I see, they don't". Wendy described clinicians who "carry too much of everyone else's stories with them at home, and don't do enough of that separating work".

The failing self was constructed through a discourse of proactive individual effort, despite structural and organisational impediments, such as lack of time:

I find that challenge of getting ten personal leave days a year which also includes my carers' leave for my [young children] and then I'm physically unwell… but I go, well I can't take a day sick because I don't have any or I need to save that for my kids, so I'm going to come to work anyway and maybe just wear myself down a bit more. (Valerie)

Here the psychologist is located within an inflexible system that forces her to choose between her children's care needs and her own. In the concluding statement the psychologist is both subject and object ("I'm going to come to work anyway and maybe just wear myself down"); she is the agent responsible for choosing to go to work and for the negative consequences of this choice. The organisation is not positioned as agent of responsibility, despite the fact it determines personal leave.

Constituting neglect of self-care as a failure of personal choice potentially makes it more difficult to admit to poor self-care. It is possible that the majority of interviewees are not neglecting self-care; alternatively they may not wish to be blamed for not doing enough to "regularly attend to self-care" as recommended by ethical guidelines (APS, 2017, p.133).

The bounded self. An autonomous subjectivity assumes a self that is bounded and untethered by social relationship. This bounded self was repeatedly constructed in the interviews as protective in rural-remote practice where there is a "much much much much higher rate of contact with your clients in non-professional settings" (Nik) and the "potential for blurring boundaries is immense" (Jude). This positioning appears to act as a defence against inter-connected communities, so that having clearly bounded roles helps clinicians manage high visibility by creating space to step aside from the performance of the role of expert:

One of the things I'll always say to clients is it's a small town and you know I might see you in Woolies […] or I might even see you in the pub on a Saturday night

and I might have had two or three wines (laughs). (Valerie)

Here it is made explicit to the client that expert is not the only subjectivity the psychologist performs and that away from the therapy context the client might encounter alternative subjectivities. However, in Nina's narrative, even with "good boundaries" it is almost impossible for clinicians to relinquish the role of psychologist in public:

It definitely stops me from letting my hair down too much in public […] I scan kind of who the audience is before I'd be too kind of, happy or, you know, like you've got to watch your professional reputation.

Imposing and managing boundaries and clarifying these through consent discussions is positioned as a way of practising ethically ("within the ethical domain"), reflecting APS ethical guidelines for rural-remote practice. This provides a level of clarity and certainty that is positioned as protective: "our ethical guidelines are there to protect us as well" (Nina). Inherent, however, was a tension between the social norms of interconnectedness in rural-remote communities and a code of ethics that adheres to the principle of boundary maintenance: "Those strict lines that APS and AHPRA want you to have aren't necessarily transferrable into regional rural areas" (Valerie).

Although the APS ethical guidelines acknowledge this tension (see APS, 2017, p.178), urban-centric standards still construct the clinician as bounded and separate from community. Consequently there is a sense of awkwardness and self-consciousness around being in public spaces (see Nina's quote above). Psychologists appear to have a choice: either "just experience that awkwardness" (Nik) of overlapping relationships to pursue self-care activities in the community, or accept restricted self-care practices: "I know that my self-care activities probably do get restricted to a degree because of knowledge of clients of places they may frequent" (Valerie). In this way, the very thing that might attract clinicians to

rural-remote practice – a sense of community connectedness ("we'll move to the country because there's this great sense of community", Carla) – produces unease and self-consciousness.

What is not accounted for in ethical standards that construct the clinician as bounded and separate is an understanding of the self as "existing within networks of ties and reciprocal connections" (Barnes, 2015, p.35). Belonging, pride in the community and reciprocity could be valued as important ways of supporting clinical self-care practices, rather than elements of rural-remote practice to be guarded against.

The relational self. The narrow conceptualisation of the bounded self, untethered to social relationship, constructed through the neoliberal discourse of the autonomous subject, was adopted but also resisted by the participants. Whilst Valerie positioned not having "that history of relationships and the connections and the issues" as a positive for a psychologist working in a town where "everyone knows everyone", Nina constructed disconnection as risk:

I think inherently we're a bit of a disconnected team because […] we don't cross over al all […] so that's a little bit risky in that you're not checking in with each other regularly.

Jude also raised the risks of becoming a "lone ranger", of "not sitting in teams that are sitting closely with you".

Across the interviews, self-care, especially when discussed indirectly, was often constituted through social relationship. Nina described once being part of a "really tight team" with a "terrific leader who modelled really good self-care"; as a result "we were almost each other's self-care plans". Carla described being "safe and […] connected" at work as a component of self-care, and Laurie spoke about the importance to self-care of a "culture of mutual concern". Self-care was positioned in the accounts given by Nina and Jude as something learned through informal relationships. Wendy positioned relationships with colleagues as central to identifying when she was stressed

at work and her self-care needed attention. This is in tension with APS ethical guidelines that "psychologists monitor their own levels of stress" and "monitor their own self-care" (APS, 2017, standard 6.8.2).

Although rarely explicitly described as self-care, informal peer relationships were positioned as highly valuable for debriefing, case conferencing and mutual, informal supervision. Throughout however, it was assumed organisations could not bear time or financial cost for these practices. Interviewees were finding faster ways to relate to others or ways to do so outside work hours. Consequently practices that emphasise relationality were pushed beyond the boundaries of the organisation and the paid workday. Nevertheless, relational accounts of self-care have the capacity to resist the neoliberal individualistic construct of autonomy and reconstitute self-care as occurring through relationships between people.

In summary, the discourse of the autonomous self is (re)produced and resisted in ways that expose its tensions and limitations. Through this discourse clinicians are persuaded of their own control over work, despite material realities that restrict that control. As Jude says, in a culture where everyone's got "too much on their plate", the idea of self-care can become a "mockery". Even so, clinicians are to blame if they cannot practise adequate self-care, whether or not there are structural impediments to doing so. Constructing the clinician as autonomous undermines the inter-connected, relational nature of self-care, both in its learning and its practice, and places rural-remote norms of mutuality in tension with ethical standards.

The Private Domain of the Self

For the neoliberal subject, agency is confined to the private domain of the self so that any notion of collective agency is removed (Chun, 2016). This process of privatising responsibility constructs self-care through a discourse of individual difference. Self-care is "a conversation for each person" (Nik), dependent "on their personality type" (Wendy), despite self-care

strategies being described in remarkably similar ways across the accounts. Self-care was also positioned as an "assumed" private practice:

> So I guess you're just assuming that everyone's doing what they need to do. It's probably quite different what everyone's doing. (Wendy)

> There's a level of assumed stuff there rather than it being that formal (Valerie)

If self-care is positioned as "so different for everybody" (Nina) and "amorphous" (Rose), hard to pin down, it becomes an individual, private performance that does not need to be formalised. Addressing professional self-care needs in a more systemic way thus becomes less likely: "Thirty years ago the union would have been helping you look after reasonable workloads and that emphasis too has gone" (Laurie).

Self-care was reinforced as private through discourses of work-life separation. Wendy described avoiding burnout by "separating work, the stuff that's going on at work and, um, my life". Wendy and Jude described separating transitions: the drive home for Jude and changing clothes for Wendy. Separation was positioned as a way of containing work concerns:

> Once I pull up in my driveway that's it. So a lot of people they'll have like a physical point you know on their journey home like that's it, you know I don't think about it again now. (Wendy)

This discourse of work-life separation appeared to function in ways that support clinician self-care. However, self-care practices that relate to work, which arguably belong to the work sphere, are consigned almost entirely to private domains. "People's little package of self-care" (Jude), described by Carla as "have a bath, light a candle, go for walks", include exercise, diet, sleep, social and familial relationships, spirituality – and, for three interviewees, having a bath. The irony of having a bath being a solution to the "tremendous risks" of professional practice and the systemic pressures of "doing more with less" (Rose) is striking, yet it is so normalised by neoliberal rationality that it becomes almost invisible. In neoliberal regimes, even spending time with family becomes co-opted as a calculated act to ensure workplace performance (Davies, 2015).

Where discourses construct a distinct division between work and private life and consign professional self-care to the latter, the individual becomes solely responsible and practices are constituted as so personal and private as to be beyond organisational or systemic jurisdiction: in Wicks (2007) "making love with your spouse" is considered self-care. Additionally, the cost of neglected self-care is borne privately ("I'm grumpy with the kids", Carla; "not having much personal resource to invest in other areas of your life", Rose), so that organisations have no real motivation to become involved.

This private control of self-care did not extend to actions taken in the workplace, where instead managers and organisations were positioned as being in control:

> A great thing for self-care would be just being able to have a paperwork day […] we can technically do that ourselves but it's probably you know the manager. (Carla)

> A good team manager, for example, will say, yeah, yeah, go [for a walk after having had a difficult client] because I trust you to come back and do what you're supposed to do. (Laurie)

Here authority and legitimisation are positioned within the organisational management structures and the culture of the organisation:

> Can you go to your team manager who you're accountable to and say, I'm having a dreadful time at home at the moment? […]Depends very much on what the organisational culture is. […] If I know Joe Blogs has mentioned something to their manager and found that they're up before HR because of some minor […] I'm going to be more reticent. (Laurie)

If the organisation does not want to "look after its people", or it is constrained by financial imperatives that mean it is "always resource poor" (Jude), self-care practices that cost the organisation can be subtly

discouraged, as will be discussed in the final section.

Organisational Responsibility: "Not Just a Yoga Class at Lunchtime"

Interviewees used phrases such as "feels like a family" (Valerie), "flexibility", "collaboration" (Valerie) and "supportive" (Rose), to describe the organisations they worked for. They suggested being valued, cared-for, agentic and in dialogue with their workplace. One consequence of this could be a willingness to accommodate an organisation's needs (for example Valerie and Nik being prepared to take on cases despite their reluctance, outlined earlier). The institutional technologies that persuade clinicians to "make it work for work" (Valerie) are therefore argued to be subtle and persuasive, but problematic.

One such institutional technology is the discourse of the supportive workplace, which on closer analysis reveals a gap between discourse and practice. This was evident in Jude's narrative:

We have to be trauma-informed at every level of the organisation […] and there are toolkits that come with all this, about how you do self-care correctly and how does the organisation enforce that kind of stuff.

Here support transforms into policing. As Jude describes further, the organisation's trauma-informed clinician care model includes care meetings which "check how everybody's feeling […at the] beginning of the day and the end of the day". Again support transforms into regulation and surveillance – to "check in", "record" and "follow up":

If anybody actually lets people know they're not doing so okay that's recorded by that group. You don't leave them hanging and you finish at the end of the day with checking in on every level, you know, how are you feeling now, what was your achievement, what was your best part of the day, what did you feel you achieved, what are you going to do for self-care.

Here clinicians are responsible for identifying that they need assistance. The organisation then checks on how the clinician is feeling, on work productivity ("achievement") and what self-care practices the clinician will do privately, beyond the workday. The organisation is not required to make structural accommodations. When asked what structures were in place within the organisation to enable a person to attend to their self-care during the workday, Jude replied:

Look, I don't think that's in place yet […] You know, maybe actually what you really need to do is, do we need to give you an hour where you can go get out of the office but […] there's this amount of work to do, it's dependent all this funding is dependent on everybody getting these bits of whatever in and, have we really got time to let you go off and have an hour on your own? No, we don't.

The consequences of this gap between discourse and practice are evident in Rose's account; having described her workplace as supportive, she states:

So, in fact really we are doing more with less, and so you know if you're going to juggle, am I going to have this conversation about the pressure that I'm under, or am I going to see this person who's booked in to see me and deal with my emails? Unless you've got an actual physical structure set up to protect that area of discussion it's going to be silenced, not necessarily intentionally but still effectively.

Here the clinician is positioned as having a choice: either complete increasing work tasks or address work pressures. Intentional or not, the discourse of the supportive workplace suggests that invitations to superficial out-of-work activities present an adequate organisational contribution to professional self-care:

The [organisation] does have a um, a program […]psychologists are certainly invited to it, but they do out of work hours […] it's all about team-building activities together, you know, um, like a trail walk or a barefoot bowls night (Nina)

Several technologies come into confluence here. First is an organisational discourse that arguably pays "lip service" to self-care – as Valerie says, "it's more in the

language that people use"– without formal structures and practices to underpin this discourse. Laurie puts it succinctly:

> Not just let's all have a yoga class at lunchtime, but these are the things we think you as workers need to do to look after yourselves, this is what we're doing in terms of our work design to ensure that you do that.

This "lip service" intersects with a neoliberal subjectivity that encourages individuals to see themselves as the site of solution to systemic failings, failings which are particularly stark in rural-remote communities. This system insists mental health services "do business" (Jude) and "provide greater outputs for similar funds [… in] a culture where more and better outcomes are internally demanded" (local NGO vision statement).

This confluence has important consequences for psychologist self-care. Firstly, clinicians are persuaded that there is nothing more organisations can do to support their self-care:

> I don't know if there's anything else the [government organisation] could do about that to make it easier, other than putting more psychologists on (laughs) hiring more staff. (Carla)

Here, organisational options are positioned as implausible, even laughable, rendering invisible the choices that have been made about the allocation of funds, both at an organisational and government level.

Secondly, clinicians are subjectified in ways that mean they will work to accommodate the market imperatives that drive the organisation, even if the consequence is a neglect of self-care. This may be reinforced by what is positioned in Carla's account as a professional culture that normalises this neglect:

> You see the imbalance a lot in this field […] normalised to feed into lunchtimes or after work times in order to do the paperwork or do what is necessary to be actually be with clients as much as you can.

When asked whether organisations or professional bodies ought to play a role in clinician self-care, interviewees rejected the idea outright or framed the possibility within a discourse of fantasy ("Imagine if…"; "Imagine how amazing that would be"). However, in reality it was not difficult for them to come up with concrete and practical ways organisations might support their care:

> A great thing for self-care would be is just being able to have a paperwork day. (Carla).

> In [regional town] we got five weeks annual leave instead of four because of a local agreement with the unions […] that was amazing because that took into account so it takes you a bloody day to get anywhere […] So that would be something that organisations could do to really support self-care. (Valerie)

> Imagine if you were paid to go and do some self-care (laughs). Self-care hour at work. (laughs) (Nina)

> Managers checking in all through supervision, how are you going, do you need a day, do you feel like it's too much. (Carla)

> Embedding self-care at an institutional level, um, so … um, a worker self-care impact statement in policies. (Laurie)

> I find that challenge of getting ten personal leave days a year […] in terms of my self-care, well ten days is better than nothing but ten days is nothing. (Valerie)

> A certain amount of your PD that has to go towards self-care or um, you know, your supervision context having a self-care component and it's compulsory. (Nina)

> The APS should be taking […] an advocacy role around this sort of issue. (Laurie)

The discourse of the supportive workplace persuades clinicians the organisation is doing all it can to support their self-care whilst disguising the fact that increasing work pressures, exacerbated in rural-remote practice, combine with a lack of formal organisational structures to make it extremely difficult to address professional self-care issues at work. This reinforces the idea that professional self-care belongs in the private domain and organisations have no real part to play. That clinicians are easily able to articulate practical ways organisations

could support their self-care powerfully disrupts these assumptions.

Discussion
Reflexive Process

In discursive research, reflexivity is the practice of interrogating the researcher's own subject position, attempting to explore the effect this may have had on the research relationship (Fox, Prilleltensky, & Austin, 2009; Parker, 2005). Reflexivity acknowledges the central position of the researcher in the construction of knowledge, and points to a dialogical relationship in which subjectivity influences research influences subjectivity in a complex loop of re-subjectification (Fryer & Nic Giolla Easpaig, 2013).

In engaging in research within an academic system that has normalised neoliberal practices (Davies & Peterson, 2005), the researcher was continually re-subjectified as the ideal neoliberal subject. The difficulty of practising self-care within an academic context where "too much work is never enough" (Davies & Petersen, 2005, p.90) reflected the difficulty of psychologists practising self-care in an economic climate that compounds the "increasing pressure … to work long hours" (Mathews, 2014, para 5). This constructed a certain shared understanding between researcher and participant, reinforced by the researcher's position as an emerging psychologist, but risked reproduction of generic claims about neoliberalism as entirely constraining of self-care. The researcher thus paid attention to what was surprising and contradictory in order to make visible ways in which neoliberal discursive practices enabled self-care.

Becoming a researcher in a neoliberal academia invites a certain kind of subject, reinforced by a neoliberal political economy that means academia is available primarily to those who are socio-economically well resourced: typically white, able-bodied and middle-class (Leathwood & O'Connells, 2003). The researcher and the participants (all of whom had completed a minimum of four years academic training on the pathway to registration) were from these social groups. Social and cultural positioning shapes what can be known and communicated (Wood, 2005), and so this commonality limits the knowledge constructed.

Summary and Consequences of Findings

This research set out to explore how neoliberal discursive practices construct ways self-care is understood and enacted by rural-remote psychologists working in government and non-government organisations and the resultant impact on their experience. In participants' narratives of self-care psychologists appeared to be discursively constructed as neoliberal subjects: rational, responsibilised, autonomous agents, acting as self-entrepreneurs to increase their human capital. In light of Foucault's theory of governmentality, which posits that neoliberal political power comes to shape people's attitudes and behaviours through discursive practices (Dean, 1999; Foucault, 2008; Rose, 1999), professional self-care can be characterised as a neoliberal technology of the self. That is to say, it acts as a "highly individualised….self-steering mechanism" (Hook, 2004) through which psychologists are encouraged to regulate themselves in line with neoliberal interests and values.

The individual becomes the locus of responsibility and the psychologist is positioned as solely responsible for managing the stresses of psychological practice, even when these stresses are the result of systemic inadequacies endemic to rural-remote practice. Clinicians work in non-market organisations that have been reformed to be competitive, efficient and market-like (Davies, 2017). Systemic shortfalls are reconfigured as individual problems. In this light neglected self-care, rather than being a consequence of an irresponsible psychologist, is a consequence of a neoliberal political rationality that looks to resolve system shortfalls through the actions of responsibilised individuals (Harvey, 2005).

In part the term self-care itself allows no other agent but the self into the process. However, participants repeatedly utilised a counter-discourse of relationality when indirectly discussing self-care. This suggests that in practice professional self-care occurs through relationships between people and within networks of people. It might then be better understood as the collective responsibility of a community network of psychologists, including peers, colleagues, mentors, supervisors and professional bodies.

Professional self-care is positioned as a private matter, and therefore of no public or political significance. Practices become constituted as so personal and private (even sex becomes included in Wicks, 2007), as to be beyond organisational or systemic jurisdiction. In this way all the intimate spaces of private life can be reconfigured as opportunities for professional self-care, as in Pakenham (2015a) in which "family, leisure, health, friends" become the focus of professional behavioural goals. Lifestyle self-care strategies colonise all areas of personal life in the service of productive work; at the same time, organisations are excused of any real responsibility. This is despite research that suggests improving work systems and structures is more effective than focusing on burnout of workers, in addressing job stress (Prosser, Tuckey, & Wendt, 2013).

Psychological practice is certainly positioned in any frame of reference as stressful. While the neoliberal approach places blame with individuals who are not adequately managing their work and their self-care practices, this research goes some way towards revealing the systemic, cultural and economic discourses in which such stress might be argued to originate. Discursively, beyond this, as subjects who are part of the system and are invited to enact practices which are individualising, blaming and neoliberal, upon others, psychologists may experience 'stress' in relation to such a position. Psychologists may also experience a certain amount of 'stress' in relation to the tensions and contradictions that lie in those practices, between desiring to relationally care for fellow humans and practice that

requires distancing and objectification. These ideas would merit further work.

Rural-Remote Practice

Rural-remote practice lies at the intersection between neoliberal governmentality and neoliberal economic politics, and occurs in the context of a neoliberal hegemonic worldview that posits there is no alternative to the way things are. Neoliberal policies have exacerbated socio-economic inequity in rural-remote communities so that people are especially vulnerable to mental health problems (Cheshire & Lawrence, 2005). Clinicians are embedded in a market-driven mental health system that is acknowledged to be particularly detrimental to rural mental health services which struggle to operate along the competitive, short-term funding cycles currently in place (Commonwealth of Australia, 2018). No amount of individualised self-care practices will change the fact rural-remote clinicians are under increasing pressure to work harder with fewer resources, with clients whose needs are made more complex by social disadvantage, and in organisations that must provide greater outputs for similar funds.

Concluding Remarks

This research aimed to construct lived effects of neoliberalism in a highly specific context. It does not aim to make positivist claims of generalisability, either to other rural-remote communities or to urban contexts. Potentially, neoliberalism is more congruent with urban practice, where it may be easier for clinicians to control workload or to practise as though untethered to community, and therefore its impact may be less significant there. However, in constructing ways in which taken-for-granted assumptions about professional self-care are shaped by the discourse of neoliberal political power and are inadequate to the needs of rural-remote clinicians, this study does raise critical questions about the consequences of neoliberalism in other practice contexts.

Foucauldian discourse analysis has been criticised for claiming that resisting the constitutive powers of discourse is possible

but failing to provide any clear understanding of how (Hanna, 2014). Yet making visible ways neoliberalism shapes psychologists' practice and experience is the first step in challenging it (Davies & Petersen, 2005). If its effects remain obfuscated, clinicians are likely to blame themselves for neglecting self-care. If professional self-care is to ameliorate pressures it cannot be outsourced to the private individual to the exclusion of organisations and professional bodies. This is not to say that self-care is not a personal act but that it is not only a personal act. It requires changes to work systems rather than individuals.

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