“I know I have to look after myself”: A thematic analysis of neoliberal discourse in an online forum for Canadians suffering from depression

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Abstract

"I know I have to look after myself": A thematic analysis of neoliberal discourse in an online forum for Canadians suffering from depression

Janelle Levesque

Neoliberalism is an approach to government and policy that favours welfare state retrenchment and free-market economics, as well as a sociocultural ideology that promotes the market values of individualism and personal responsibility. These intensified values have transformed mental healthcare and the ways in which individuals experience, discuss, and manage chronic mental illnesses such as depression. As such, the aim of this qualitative study was to investigate the extent to which neoliberal discourse informs sufferers' everyday experiences and management of depression. Posts by members of an online Canadian depression forum were analyzed using Thematic Analysis (Braun & Clarke, 2006). Findings revealed that neoliberal ideology was implicit in members' discussions about depression vis-à-vis their engagement with solitary and healthist self-management practices, their experiences of stigma, and their continued endorsement of the biomedical model of mental illness despite repeated negative encounters with the mental healthcare system. These findings call for further qualitative investigation into the ways in which individuals suffering from depression understand, discuss, and cope with this illness. More research on depression forums in particular is warranted.

Acknowledgments

They tell you in grad school that it is important to choose a thesis topic for which you are passionate. After all, you will be spending years of your life intimately enmeshed with this topic. In my case, it was five years. Half a decade of my life has been dedicated to understanding the personal and political experiences of depression in all their fraught, heartbreaking complexities. It was, as I commonly joked to those who asked me about my thesis, frankly depressing. Having lived the dismally arduous and at times comfortably mundane realities of depression for so long, I had an undeniable personal connection to this work. So much so that it became increasingly difficult to disentangle myself from the thoughts, feelings, and experiences of my study members.

Although like many qualitative social researchers, I reject any notion that separating oneself from one's work to maintain the illusion of objectivity or neutrality makes for better quality research, the boundaries between my own lived experience and the research I was conducting throughout this project were increasingly unstable in a way that progressively compromised my own mental health. Despite being comfortably seated in my ivory tower armchair, far from the frontlines and not even directly engaging with the people whose stories I became familiar with, I was affected by constantly reading, writing, and thinking about the psychological warfare wrought by oppressive political structures, and it led to the same feelings of hopelessness described by many of the people in this study.

The great irony was that the more time I spent on this project, the more I isolated myself, the less I reached out for help, and the more I blamed myself for not being able to finish it on my own. Not unlike the individuals in this study, I myself had internalized the rigid ideals of neoliberal selfhood—the compulsive self-sufficiency, the personal responsibility, and the antisocial versions of "self-care" that temporarily placated my depressive symptoms, which were deeply rooted in a desire for connection and community that I had unwittingly denied myself in favour of advancing my academic career.

In the last few weeks of writing, I experienced a "rock bottom" moment in which I was forced to reckon with this cognitive dissonance, which had led me far astray from the fundamental values that brought me to sociology in the first place: community, social connection, and love. It is these values, and my belief that we are social creatures above all else—that I am because you are—that we must lean on one another if we are to be led out of darkness. I fail to see how it could be any other way, when, despite how much solitary effort was poured into these pages, I could not have succeeded without the people who lifted me up and led me out of my own dark room of depression, time and again. I would like to extend my utmost gratitude to these people.

First and foremost, I would not be where I am today if it weren't for the unconditional love and support given to me by my parents. To my mother and father, thank you for all you do for me and for always being there for me when I needed it most.

To my partner, Justin, you are the light in my life that never goes out. Thank you for caring for me, for making me feel seen, heard, and accepted for who I am, and for bringing me back every time I lost sight of who that person is. Thank you for your patience with me throughout this

tumultuous journey, and for believing in me. I love you deeply.

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To my therapist, M, thank you for holding space for me during one of the hardest times of my life. I will always be grateful for the empathy and care that you gave me when I needed it most. Thank you for going beyond individualized cognition-based models to provide a sociologically informed approach to mental healthcare, and for making that care accessible to Canadians in a time in which these essential services are so difficult to access.

To my supervisor Dr. Shelley Reuter, I cannot thank you enough for your mentorship and guidance throughout this project and the opportunities you have given me along the way. I have learned so much from you in the past five years, and I'm fairly certain I would have quit a long time ago if it weren't for your patience, compassion, and unwavering support. Thank you for believing in me.

I would like to thank my committee members Dr. Sylvia Kairouz and Dr. Marie-Pier Joly for their invaluable feedback on this project. Thank you for your interest in my research, for the engaging discussions, and for the important work you do in advancing the sociology of mental health.

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This list would not be complete without extending my thanks to Eve Girard, who patiently and graciously answered all of my questions and helped me navigate all of the administrative hurdles, kindly extending the resources and accommodations that I needed to succeed. Eve, you are an indispensable member of the Concordia community.

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Introduction

Though the term "neoliberalism" is rarely used, an awareness of the general malaise catalyzed by a distinct manifestation of late or "hyper" capitalism (Fox Piven, 2015) is often evoked in popular culture. For example, book titles such as *Profit Over People: Neoliberalism and the Global Order* (Chomsky, 1998), *The Loss of Happiness in Market Democracies* (Lane, 2000), and *How Politics Makes Us Sick* (Schrecker & Bambra, 2015), to name a few, capture the troubling impact of neoliberalism on individual well-being. A quick Google search of the phrase "neoliberalism and depression" brings up newspaper articles with even more descriptive titles like "How neoliberalism is damaging your mental health" (Cain, 2018), "Is neoliberalism making our depression and anxiety crisis worse? How capitalist culture is making us sick" (Hari, 2018), and so on. The connection between these two phenomena appears intuitive on some level, yet the specific ways in which neoliberalism has influenced how we experience, understand, and talk about mental health and illness comprise a story that is only beginning to be told.

Although, as George Monbiot (2016) points out, neoliberalism is a polysemous term, a "zombie doctrine" whose meanings and theoretical relevance have been widely contested, it remains a powerful governing force not despite, but because of, its elusiveness—an "invisible doctrine of the invisible hand […] promoted by invisible backers" (Monbiot, 2016, para. 33). Philip Mirowski, a leading historian on the topic, designates neoliberalism "the movement that dare not speak its name", arguing that its ability to seep into every pore of society has been achieved precisely because it has defied any reliable categorization, concealing its true political aims by repackaging them into the hackneyed slogan "market good, government bad" (Mirowski, 2018, para. 13). Feldman (2019) insists that despite its semantic challenges, neoliberalism remains a highly relevant and useful concept that "can help us understand the

relationship between the state, the market and citizens in the current era" (2019:340). I agree with Feldman and join an array of Foucauldian scholars in arguing that it also helps us understand the contemporary experience of depression (e.g. Lane, 2000; Moncrieff, 2006, 2008, 2014; Ehrenberg, 2009; Cvetkovich, 2012; Teghtsoonian, 2009, 2017; Sugarman, 2015; Gooding, 2016; Rogers-Vaughn, 2014, 2016; Brijnath & Antoniades, 2016; Cvetkovich & Wilkerson, 2016; Bell, 2019; Roscher, 2020).

Depression and the DSM

While depression is an exceptionally complex human condition that can be defined in any number of ways, in western democracies it continues to be regarded primarily as a clinical entity in accordance with the hegemonic status of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM is a classification system that was first published by the American Psychiatric Association (APA) in 1952 and has since served as the central authority for psychiatric diagnosis (Horwitz, 2011). Although the text has been revered as the "bible" of psychiatry (Frances, 2013, as cited by Karp, 2017), there has been a broad array of unresolved conflicts among researchers and clinicians on how best to classify and measure depression, including controversies over whether it should be viewed as categorical or dimensional, how many subtypes it entails, and how it might be distinguished from the "normal" emotional distress resulting from everyday life stressors (Horwitz, 2011:51).

In the first two editions of the DSM (in 1952 and 1968), depression was viewed as a relatively rare and severe psychotic disorder, a classification that was influenced by the dominance of psychodynamic theory during that period (Horwitz, 2011:43). However, the lack of a reliable classificatory scheme within these publications created a range of conflicting

perspectives that compromised the credibility of psychiatry as an authoritative branch of medicine. As such, the DSM-III (1980) aimed to provide an operationalized definition of depression by establishing a single standard of measurement. The diagnosis that emerged was called Major Depressive Disorder (MDD) and captured all previous heterogenous categories of depression under a single diagnostic label, ultimately becoming "the sole depressive diagnosis of any importance", defining what depression was within clinical and community settings as well as within western culture at large (Horwitz, 2011:47-48). It was this third edition of the DSM that served as the linchpin of psychiatry, confirming its legitimacy as a discipline both in the medical community and broader society. The MDD diagnosis in the DSM-III succeeded in creating a standard of measurement for depression that was nearly universally accepted and led to dramatic transformations in mental healthcare practice, epidemiology, and treatment (Horwitz, 2011:50).

Despite its success in generating consensus among clinicians and practitioners, the diagnosis of MDD, and indeed the DSM itself, have not gone without criticism. Psychiatrist and Chair of the DSM-IV Task Force Allen Frances has been a markedly vocal critic of the expanding borders of psychiatry and the diagnostic inflation resulting from the field's overreliance on the DSM at the expense of other approaches to understanding and treating mental illness (Karp, 2017:33). As Frances wrote of the DSM-III in his book *Saving Normal* (Frances, 2013:63):

> Diagnosis should be just one part of a complete evaluation, but instead it became dominant. Understanding the whole patient was often reduced to filling out a checklist. Lost in the shuffle were the narrative arc of the patient's life and the contextual factors influencing symptom formation.

The most recent edition of the manual, the DSM-5, has elicited fierce opposition from patients, activists, and critical psychiatrists who argue that it continues to perpetuate the medicalization of normal human behaviour by casting an increasingly wide net of what constitutes pathological

distress (Wakefield, 2013). Although the criteria for MDD have gone virtually unaltered in subsequent editions, the DSM-5 Task Force removed the only remaining exclusion criterion for the diagnosis outlined in the DSM-IV, namely the "bereavement exclusion", which stipulated that grief following bereavement which could be regarded as normal be distinguished from prolonged grief that could indicate mental illness (Pickersgill, 2014:522). This removal has meant that an even higher proportion of patients may qualify for a diagnosis of major depression, yet as Karp (2017) points out, the shift toward quantitative inventories and checklists to increase diagnostic reliability has drastically compromised the validity of diagnosis. In other words, although clinicians are able to replicate findings using such tools, it does not follow that what is being measured is a veritable biological disorder (Karp, 2017:28). This discrepancy becomes particularly salient when considering that, unlike other areas of medicine, "psychiatry has not generated a single diagnostic test to affirm the biological dysfunction presumed to exist in the brains of depressed persons" (p. 32). Yet despite the highly tenuous relationship that exists between depressive symptoms, diagnoses, and treatment outcomes, which casts major doubt on the validity of the psychiatric disease model, the healthcare system and the public continue to embrace biological notions of depression that have been enshrined in the DSM since 1980 and that ultimately disregard the personal experiences of patients and the social, political, and cultural context of their lives (p. 31).

Although some argue that rising rates of depression in recent decades have been a direct result of the expansion of the criteria for MDD, which has led to an inflation in its diagnosis (e.g., Horwitz & Wakefield, 2007; Horwitz, 2011), there is research suggesting that rates of depression have increased rapidly during the period of neoliberal ascension beginning in the late 1970s and early 1980s (Rogers-Vaughn, 2014:509). Beyond the heightened medicalization and

disease mongering that has veritably been perpetrated by each successive edition of the DSM, several authors have supported the notion that depression is not merely an aggrandized clinical category, but a state of mind that epitomizes the sociopolitical climate of our current era (Lane, 2000; Ehrenberg, 2009; Cvetkovich, 2012; Hidaka, 2012; Rogers-Vaughn, 2014, 2016).

The Depression Epidemic

Depression has reached epidemic proportions in advanced Western democracies (Ehrenberg, 2009; Lane, 2000; Fullagar, 2009; Philip, 2009; Rogers-Vaughn, 2014). In a 2017 report issued by the World Health Organization, the global prevalence of depression was estimated at over 300 million (WHO, 2017) and depression-related suicides have seen mortality rates more prevalent than the HIV/AIDS epidemic (Seligman, 1990, as cited by Lane, 2000:21-22). In Canada, suicide is the second leading cause of death among youth and young adults aged 15-34 (Statistics Canada, 2019).

While the ubiquity of depression in modern life has been undeniable since the 1970s, when it was first deemed "the most widespread mental pathology on the planet" (Ehrenberg, 2009:106), the epidemiology, symptomology, and treatment of depression continue to be informed by the field of biopsychiatry and corporate pharmaceutical interests, which together have constructed depression as a product of dysfunctional brain chemistry and thus an individual pathology with individual and chemical solutions (Moncrieff, 2006; Fullagar, 2008; Teghtsoonian, 2009). This biomedical narrative effectively dislodges depression from its wider sociopolitical context (Moncrieff, 2014). Depressive symptoms are more often attributed to personal maladies rather than systemic forms of oppression characterized by the social determinants of mental health (Rogers-Vaughn, 2014) and the more general and widespread

distress propelled by a culture of neoliberalism that has colonized definitions of human happiness and well-being as commodities to be bought and sold in a market economy (Lane, 2000; Binkley, 2014; Esposito & Perez, 2014).

The Biomedical Model of Mental Illness

Despite its sociological dimensions, which have been observed since Durkheim's influential work on the social nature of suicide (Durkheim, 2005), depression continues to be conceptualized as an individual pathology informed by the biomedical model of mental illness. Engel (1977) defines the biomedical model as a paradigm that "assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables" (Engel, 1977:130). Derived from the scientific method, it is a model characterized by reductionism, "the philosophic view that complex phenomena are ultimately derived from a single primary principle", and mind-body dualism, "the doctrine that separates the mental from the somatic" (p. 130).

The biomedical model became firmly entrenched in mental health discourse and practice by the late 1970s and early 1980s, at which time the professional status of psychiatry was under threat from the anti-psychiatry movement. Organized psychiatry espoused the biomedical model in the wake of these threats in order to establish itself as a scientific, and therefore legitimate, branch of medicine—a commitment that was fortified by the third edition of the DSM in 1980, which was lauded by the APA as a "monumental scientific achievement" (Deacon, 2013:848). In the context of mental illness, the biomedical model postulates that mental illnesses, including depression, are brain diseases and are best treated with pharmaceutical drugs that target specific abnormalities in the brain resulting from imbalanced neurochemicals (Deacon, 2013; Engel,

1977). This is known as the "chemical imbalance theory" (Leo & Lacasse, 2008, as cited by Deacon, 2013:51) and has dominated our contemporary understanding of mental illness, its causal variables, and its appropriate treatments for over three decades (Deacon, 2013). Even four decades on, after Brett Deacon's cogent article in *Clinical Psychology Review* (2013), the chemical imbalance theory shows no signs of being abandoned by either medical professionals or the general population. Its endurance as a dominant discourse and "cultural imperative" (Engel, 1977:130) has been largely achieved through its widespread endorsement by patient advocacy groups, psychiatrists, and pharmaceutical companies in promoting the business of psychopharmacology (Healy, 1997, 1990, 2000).

The use of psychotropic drugs to treat "chemical imbalances" has increased exponentially since the first treatments were introduced to the market in the 1950s (Deacon, 2013; Whitaker, 2005), making the pharmaceutical industry one of the most profitable industries in the world (Healy, 2000:19). This immense commercial success has been achieved as a result of vigorous marketing tactics buoyed by the authority of the biomedical model, which has led to billions of federal dollars allocated toward biomedical research aimed at identifying biomechanisms to substantiate pharmacological treatments (Healy, 2000:19; Deacon, 2013:849). Psychiatrist David Healy has written extensively on the political and economic incentives undergirding the history of psychopharmacology, uncovering the questionable science backed by Big Pharma, psychiatrists and even the FDA in activities ranging from the concealment of unfavourable clinical results about psychotropic drugs to the ghostwriting of scientific papers (Healy, 2000:16). He argues that we are living in an era of "corporate psychiatry" in which "knowledge in psychopharmacology doesn't become knowledge unless it has a certain commercial value" and in which economic concerns have superseded human health (Healy,

1997:176). It has become clear in light of such critiques that the chemical imbalance theory of mental illness upheld by the biomedical model is far from a neutral paradigm, but an episteme that has reigned because it remains deeply profitable.

Yet despite the cultural tenacity of the chemical imbalance theory, in reality, the biomedical era has seen a dearth of clinical innovation, and neuroscientists have remained unable to identify a single reliable biological marker for any mental illness (Deacon, 2013:847). Moreover, although psychotropic medications are designed to target and adjust imbalanced neurotransmitters, there exists no credible evidence that this is how they actually work, or that mental illnesses are even caused by such imbalances, and the "the etiology and pathophysiology of mental disorders remain unknown" (p. 847). Given the lack of knowledge about the biological basis of mental illness, Deacon contends, the propagation of the chemical imbalance theory is "best understood as the product of ideological, economic, or other non-scientific motives" (p. 852).

Tseris (2017) draws attention to the connection between the continued success of the biomedical model of mental illness and the emergence of neoliberal ideology (Tseris, 2017:169), especially how the former has supported the latter by "disabling an awareness of social structures by replacing them with [individualized] notions of disease" (p. 170). According to Tseris, neoliberal ideology has also played a critical role in permitting psychiatric and pharmacological discourses rooted in the biomedical model to flourish within Western countries (p. 173). Moncrieff (2008) points to the key function that psychopharmaceuticals have played as a covert mechanism of social control by chemically modifying the behaviour of populations to align with neoliberal ideals of citizenship, or in other words, improving their ability to contribute to the market as both workers and consumers (Moncrieff, 2008; Esposito & Perez, 2014). Ultimately,

what is clear is that the biomedical model is well positioned to uphold the neoliberal market economy and its incentives of profitmaking for capitalist corporations.

Evidence that mental illnesses have become increasingly chronic and debilitating in recent years suggests that the biomedical model is no longer an adequate framework for responding to the complex needs of individuals suffering from such conditions (Engel, 1977; Deacon, 2013:847). Although the biomedical model has been promoted in national campaigns by governments and mental health organizations to reduce stigma by framing mental illness as non-volitional, studies documenting public attitudes have shown that levels of stigma have remained consistent or even increased over time, and that stigma remains a key barrier in accessing treatment (e.g., Pescosolido et al., 2010, as cited by Deacon, 2013:852). By explaining disease in terms of individual somatic or biochemical dysfunction, the biomedical model treats mental illness as an entity independent of social context, prioritizing physical signs of illness which may be altogether absent at the expense of patients' lived experiences, which involves any number of social, psychological, or cultural variables (Engel, 1977:130-131). To be sure, the incompatibility of the biomedical model and subjective experiences of depression has led to considerable gaps in our knowledge about depression (Brown, 2019:152). As such, Engel has deemed our continued adherence to the biomedical model a "crisis" for medicine and psychiatry, proposing its replacement with a biopsychosocial model that considers the sociocultural context in which we live (Engel, 1977). The *psychosocial* component of such a model necessitates an understanding of the various and intersecting social determinants that impact the psychological well-being of individuals and populations alike.

The Social Determinants of Mental Health

Research and public health interest in the social determinants of health have grown considerably in recent years (Shim & Compton, 2018). Referred to by the World Health Organization as "the conditions in which people are born, grow, live, work and age" (WHO, 2008, as cited by Shim & Compton, 2018:844), the social determinants of health include environmental factors such as discrimination and other forms of social exclusion, income inequality, unemployment, food insecurity, and poverty, among other factors, which create and perpetuate health inequities for disadvantaged populations in accordance with variables such as race, gender, age, class, sexuality and (dis)ability (Shim & Compton, 2018). It is well established that social determinants impact not only physical health, but mental health as well (Compton & Shim, 2015). Low income, unemployment and precarious employment have been continuously linked to mental distress, even in countries with universal healthcare (Alegría et al., 2018). Critical feminist research has shed light on depression in relation to gender inequality and gender-based discrimination (Belle & Doucet, 2003, Stoppard, 1998, Ussher, 2010, as cited by Chowdhury, 2020:1351) as women are at least twice as likely to experience depression as men, and up to a quarter of women become depressed in their lifetime (Ussher, 2010, as cited by Brown, 2019). Gender-based violence, compliance with traditional gender roles, economic inequality and the performance of various caretaking roles and unpaid labour are all factors that contribute to higher rates of depression among women (Brown, 2019).

Racism is also strongly associated with poor mental health, including major depression and PTSD (Shim & Compton, 2018). In the context of globalization, increased migration and international displacement, the mental health of immigrant, refugee, and racialized populations in Canada has become a growing public health concern in the country, with increasing recognition

that these populations face microaggressions, social exclusion, and ethnocentrism among other forms of racial discrimination (McKenzie et al., 2016, Falicov, 2007, as cited by Morrow et al., 2020). There also continues to be significant mental healthcare disparities between Indigenous and non-Indigenous populations in Canada that are rooted in a legacy of colonization (Patel, 2019). Intergenerational trauma passed down by survivors of cultural genocide often manifests as substance abuse and mental illness in Indigenous communities facing continued marginalization. Indeed, the burden of mental illness is considerably higher in Indigenous communities as compared to other ethnic groups, and Indigenous youth are nearly six times more likely to commit suicide than their non-Indigenous counterparts (Patel, 2019).

Despite suffering worse mental health outcomes, racialized and low-income populations are more likely to be excluded from the Canadian mental healthcare system due to institutionalized racism and pervasive financial barriers (Fante-Coleman & Jackson-Best, 2020). Research shows that access to mental healthcare is disproportionately hindered for racialized people (Fante-Coleman & Jackson-Best, 2020) and immigrants, refugees, and visible minorities access mental healthcare services less often than their Canadian-born white counterparts (McKenzie et al., 2016, George et al., 2015, Thomson et al., 2015, Kalich et al., 2016, as cited by Morrow et al., 2020). Moreover, racism is "historically entrenched in mental health pedagogies" (Alexander, 2018, as cited by Fante-Coleman & Jackson-Best, 2020:129), overlapping with the persistent stigma of mental illness that continues to impact service provision in a system that remains Eurocentric and is often ill-equipped to provide culturally competent care (Moodley et al., 2017; Fante-Coleman & Jackson-Best, 2020). This research highlights the importance of viewing depression as a social, cultural, and political phenomenon that is rooted in ongoing legacies of slavery, colonization, and genocide, rather than a biological or medical one

(Cvetkovich, 2012:86).

Recent results from a nationally representative Canadian survey indicated that mental health challenges related to the COVID-19 pandemic are not distributed equally but are stratified according to pre-existing social inequities (Jenkins et al., 2021). Indeed, the widespread prevalence of deteriorating mental health during the pandemic demonstrates how strongly population-level mental health is shaped by social determinants in specific populations (Jenkins et al., 2021). Women, Indigenous peoples and visible minorities, people with a disability, people who identified as LGBTQ+ and those with a household income of less than $25,000 were all more likely to report mental health challenges than their male, settler, white, able-bodied, non-LGBTQ+ and higher income-earning counterparts. These findings are part of a growing body of empirical data suggesting that the pandemic is interfacing with pre-existing social inequities and widening mental health disparities, disproportionately impacting the most marginalized (Jenkins et al., 2021).

While psychiatry continues to rely on the dominant biomedical paradigm that frames depression as an individual pathology, many scholars and practitioners have made apparent that consideration of the social determinants of mental health and illness is indispensable to fully understanding and addressing the problem of depression in meaningful ways. It is clear from the standpoint of public health that the implementation of strategies aimed at eliminating systemic social inequalities is also required (Alegría et al., 2018). Moreover, there is a solid evidence base indicating that neoliberal policies have exacerbated the social determinants of health by accelerating socioeconomic inequalities (e.g., Manseau, 2014; Burns, 2015; Feldman, 2019), yet the neoliberal emphasis on individual freedom and choice may conceal the reality of institutionalized forms of oppression, “reinforcing the notion that something is wrong with

clients [patients] rather than with the economic-political system itself" (LaMarre et al., 2019:240).

Neoliberalism and Mental Healthcare

As a policy approach premised on advancing a "market governance" (Larner, 2000) within which the welfare state and the public sphere are eroded and human agency is reconstituted as a series of individualized choices and financialized pursuits, neoliberalism has played a significant role in shaping the changing landscape of mental health in the Western world. Among other transformations, the increasing privatization of mental healthcare under neoliberalism has been coextensive with the corporatization of psychiatry in accordance with a "market logic" (Esposito, 2011) that locates the solution for mental distress in human consumption, most often in the form of psychotropic drugs (Moncrieff, 2006, 2008; Fullagar, 2009; Fullagar and O'Brien, 2014). As such, neoliberalism has endorsed the medicalization of mental illness that has been on the rise since the first psychotropic medications entered the market in the twentieth century (Moncrieff, 2014; Esposito & Perez, 2014; Dyck, 2011).

These trends have led scholars to link growing rates of depression to distinct "market rationalities" characteristic of the current neoliberal political climate, including responsibilization, individualization, competitiveness, and entrepreneurialism (Lane, 2000; Clarke, 2005; Rose, 2007; Teghtsoonian, 2009; Crawshaw, 2012; Esposito, 2013; Esposito & Perez, 2014; Moncrieff, 2014). Some have argued that inherent to these practices is an underlying motive to maintain productivity and consumerism aligned with a neoliberal agenda that is directly positioned to uphold the economic goals of late capitalism (Philip, 2009; Fullagar & O'Brien, 2014; Esposito & Perez, 2014; Gooding, 2016; Brijnath & Antoniades, 2016). The

ideological heft of neoliberalism is such that any actions, beliefs, or behaviours that divert from these market-oriented norms, in other words, fail to position the individual's primary role in society as a self-sufficient consumer, are often regarded as irrational or even pathological (Esposito & Perez, 2014).

Thus, more than merely a bundle of austerity policies, neoliberalism has assimilated a culture in which individuals are encouraged—responsibilized—to adopt a prudent, active, and informed relationship to their health and well-being. Being self-accountable and self-actualized citizens who maximize health through individual lifestyle efforts and who avoid costly dependence on public resources is now a cultural imperative (Rose, 2007; Crawford, 1980). In the context of this contemporary culture of "healthism" (Crawford, 1980) and alongside a burgeoning global wellness industry selling the highly profitable concept of "self-care" to the masses, mental healthcare and mental illness itself have become increasingly commodified such that patients are viewed as consumers with "choices" in a free market rather than citizens entitled to universal care (Rissmiller & Rissmiler, 2006; Esposito & Perez, 2014).

The Canadian Context: Self-Management

The neoliberal trend toward commodification has created particular tensions in Canada, a country that prides itself on its universally accessible, publicly funded healthcare system in which health care is advocated as a human right rather than a privilege. While Medicare covers the cost of many essential health services such as hospital visits, doctor and nursing services and diagnostic testing, mental health care has been largely omitted from its purview, making it largely inaccessible to those without the means to pay for private services. Despite the prevailing biomedical conception of mental illness, pharmaceuticals taken outside of hospital are not

covered by Medicare and psychological services including psychotherapy and psychiatry are notoriously difficult to access (Flood & Thomas, 2017). Rather than a comprehensive package of necessary entitlements, mental health care in Canada more closely resembles a patchwork of services mediated by varying provincial coverage and private insurance plans that result in persistent access disparities, the repercussions of which are felt by the most vulnerable populations across the country—indeed, those who often need care the most (Dyck, 2011; Patel, 2019; Flood & Thomas, 2017; Fante-Coleman & Jackson-Best, 2020).

While very basic psychological assessment and pharmaceutical prescriptions are accessible through general practitioners, there is a nation-wide shortage of primary care physicians in the public sector accompanied by long waitlists for those who are unable to pay out of pocket for access to more timely services in the private sector. And where primary care physicians are involved, they are often underqualified and undermotivated to address mental health concerns (Flood & Thomas, 2017). The intensifying fragmentation and two-tiered nature of the Canadian system reflects the influence of neoliberalism on mental healthcare in Western democracies, which has laid the foundation for what is known as "self-management"—a term that is now "ubiquitous in government policies and strategies, and health promotion initiatives and programs across most of the Western world" (Brijnath & Antoniades, 2016:1) and in which "recovery" from illness is pursued by patients through practices such as self-monitoring, mindfulness and resilience (Lorig & Holman, 2003; Weiner, 2011). Self-management has emerged as a cost-effective way to treat mental illness in the wake of a growing economic burden of disease attributed to mood disorders such as depression, and in a neoliberal context in which the burden of caregiving has shifted from the state to the community and individual families (Weiner, 2011).

Self-management reflects the influence of two core tenets of neoliberalism—individualization in that the treatment is focused on the individual patient, and responsibilization in that the responsibility for managing depression is undertaken by the patient. In the context of mental healthcare, self-management signals a larger set of ideas about the origins of mental illness and how it should be treated; namely, the active and ongoing medical, behavioural, and emotional management of the self (Lorig & Holman, 2003). Nikolas Rose and other scholars drawing from the work of Foucault have compared the behaviour-modifying and self-correcting practices characteristic of self-management—practices which have been translated into more colloquial notions of "self-help" or "self-care"—to Foucault's "technologies of the self" (Foucault, 1988). This refers, in other words, to "ways in which human beings come to understand and act upon themselves […] by means of certain techniques directed to self-improvement" (Rose et al., 2006:90). According to Foucault, the ideal modern subject under a neoliberal regime is an economic subject, or *homoeconomicus*—an "entrepreneur of himself [sic]" (Foucault, 2008:226). In this context, technologies of the self serve to bring the subject into alignment with a specific vision of citizenship that is hailed by neoliberalism; namely, a productive and enterprising subject that is continuously engaged in an endless project of self-improvement (Reveley, 2016). From meditation to self-medication, the adoption (and purchasing) of self-management strategies in the treatment of mental illness has allowed the state to remain capable of "governing at a distance" as individuals are encouraged to take on the labour and responsibility of their own subjugation into neoliberal subjectivity, all while stimulating the market in the process (Rose & Miller, 1992).

While self-management has emerged as an economically viable and thus widely favoured treatment modality in a post-asylum context in which the government has increasingly

transferred the locus of mental healthcare away from hospitals and into the community and private home, this shift has not been accompanied by adequate state funding for home care, social programs and various community supports, and none of these services are protected by the Canada Health Act (Flood & Thomas, 2017). Despite its promise of patient empowerment, many scholars have pointed out that self-management, in its extreme valorization of individual agency, may in fact impact negatively on mental health outcomes and overall quality of life by contributing to a culture of accountability and individual blame that obscures the role of wider sociocultural factors in the onset or exacerbation of mental illness such as class, poverty, gender and race-based inequities—all of which have become intensified under a neoliberal state with drastically diminished resources in the provision of social services (Gattuso et al., 2005; Teghtsoonian, 2009; Peacock et al., 2014; Brijnath & Antoniades, 2016; Weiner, 2017). The social determinants of mental health are further obscured when mental healthcare providers operating under a self-management model regularly rely on Cognitive Behavioural Therapy (CBT), which frames depression as a problem associated with distorted thought patterns and behaviours that can be corrected through positive thinking and behaviour modification (Teghtsoonian, 2009; Philip, 2009; Reveley, 2016).

Situating the Problem

As is apparent in the sociological literature, neoliberalism has expanded beyond merely a set of policy prescriptions into a hegemonic project that permeates all aspects of social life (e.g., Polzer & Power, 2016) and has had profound implications for mental health (e.g., Lane, 2000; Teghtsoonian, 2009; Hochschild, 2012; Hickinbottom-Brawn, 2013; Layton, 2014; Binkley, 2014; Bell, 2019; Rimke, 2016; Cosgrove & Karter, 2018). The connection between neoliberal

forms of government and rapidly rising rates of depression since the 1970s has been well documented (e.g., Teghtsoonian, 2009; Rogers-Vaughn, 2014; Esposito & Perez, 2014), and it is thus more pressing than ever to address the sociological dimensions of depression and to interrogate the human costs, even structural violence (Esposito & Perez 2014:427) of performing oneself as a "neoliberal patient" (Brijnath & Antoniades, 2016).

Research to date on this topic is scarce. While there is considerable research about the self-management of other chronic health conditions such as arthritis and diabetes, little is known about the self-management model of depression and about how and with which self-managing practices individuals engage—particularly from the patient's perspective (Chambers et al., 2015). Moreover, while the body of literature addressing neoliberalism and self-management more broadly is vast, very little empirical work has been published about how neoliberal discourses are taken up by individuals living with mental illness and what implications this has for their well-being. There are a few comprehensive studies to date—all of them, notably, based in the West—that have addressed these questions.

Specifically, Chambers et al. (2015), in the UK, aimed to understand how people with longer term depression manage their condition, in order to investigate the perceived efficacy of self-management strategies. Through interviews and focus groups, their participants expressed the need for more information in order to develop strategies and acquire necessary resources. They highlighted the importance of choice and control in developing and using their own personalized coping strategies and valorised an individualized holistic model of mental health care (Chambers et al., 2015).

In the US, Weiner's (2011) ethnographic work with members of a bipolar support group found that the more that patients engaged in the project of self-management to harness self-

efficacy and construct themselves as rational agents, the more ambiguity they faced toward their condition, which is inherently unpredictable and "irrational", demonstrating that the attempt to self-manage a mood disorder on one's own often leads to distress rather than empowerment (Weiner, 2011).

In Australia, Brijnath and Antoniades (2016) explored the imperative to self-manage in individuals suffering from depression, observing that neoliberal ideas of personal responsibility were internalized by participants whose self-management practices were taken up as a result of unsatisfactory interactions with the healthcare system. Having low expectations of the capacity for psychiatrists and psychologists to help, patients undertook transformative lifestyle practices that required a considerable amount of labour and expressed the belief that their depression was an individual problem that required individual solutions (Brijnath & Antoniades, 2016). Fullagar and O'Brien (2014) found that women in recovery from depression engaged in normative practices such as medication consumption, therapy and various lifestyle activities while experimenting with more individualized self-care practices, which reinforced their self-surveillance and internalized sense of responsibility and self-blame (Fullagar & O'Brien, 2014).

Finally, in her qualitative investigation into postfeminist subjectivities influenced by neoliberal ideology (i.e., "the top girl" identity), Chowdhury (2020) observed the tendency among young professional women in New Zealand to adopt self-management techniques as a way of practicing the "ideal depressed self". She found that this valorized identity hinged on individualizing and responsibilizing practices rooted in neoliberal rhetoric, entailing a number of harmful implications for women who align with such ideals (Chowdhury, 2020).

These studies have begun to carve out a phenomenology of depression self-management as it manifests in culturally and politically specific ways—indeed, as it is lived within the

confines of Western mental health systems that are increasingly influenced by the core values of neoliberalism. This small body of work is invaluable in that it prioritizes the perspectives of those who experience depression firsthand. However, with the exception of Weiner's (2011) study, which incorporated naturalistic observation, all of these studies have relied on the same method of data collection, namely, semi-structured interviews, which prevents an understanding of depression discourse as it unfolds in a natural setting. Moreover, the Canadian context has remained unexplored. As such, the present study adds to existing scholarship by examining how Canadians living with depression talk about their experiences in an online depression forum.

The Present Study

The primary objective of this study was to examine the ways in which neoliberal discourses informed people's experiences of managing depression as shared in a Canadian online support group. To my knowledge, there are no studies to date that explore the topic of neoliberalism and depression using an online forum as a source of data, despite the methodological advantages of these platforms. This thesis adopts a Foucauldian theoretical perspective on neoliberal governmentality in order to understand the extent to which group members orient to their experience of depression as responsibilized and self-managing "neoliberal patients" (Brijnath & Antoniades, 2016) and in what ways they adopt "technologies of the self" (Foucault, 1988) to assist them in performing the physical and emotional labour that is required of the self-management model of depression.

Research Questions and Expected Contributions

By focusing on support group participants' written online interventions, this thesis addresses the

following research questions:

(1) How do forum members talk about their experiences of depression? In other words, what kinds of discourses do they draw from in their narratives?

(2) What coping mechanisms or "technologies of the self" (Foucault, 1988) do members adopt and/or recommend in the self-management of depression?

(3) To what extent do members uphold ideals of neoliberal citizenship and/or negotiate, re-interpret or reject such narratives?

In answering these questions, this thesis provides insight into the imperative of depression self-management that has emerged within deinstitutionalization. By exploring the phenomenology of depression in the context of an online forum, it is a novel contribution to the empirical scholarship on neoliberalism and depression that has only just begun to germinate. In particular, this study focuses on the Canadian context which has been largely ignored to date yet is important to explore given its socialized approach to health care delivery. Using Thematic Analysis (Braun & Clarke, 2006), this research documents the experience of depression and its discursive underpinnings as well as the various self-management strategies that are undertaken in order to manage depression in a contemporary context. As such, this study sheds light on the current self-management model of mental healthcare and its associated therapeutic techniques, with the aim of effecting meaningful policy change.

Literature Review

Though the perceived relationship between neoliberalism and depression is widely acknowledged in academe and elsewhere as a "public feeling" (Cvetkovich, 2012), it is far from straightforward and entails a complex matrix of social, political, and discursive practices. To understand how government and public policy has trickled into the personal realm of mental health, it is first necessary to understand the ways in which neoliberalism has succeeded in reconfiguring subjectivity through a series of structural and institutional changes, albeit always through discursive means and as an ascendant political, but also *sociocultural*, rationality.

To that end, the following literature review begins by providing an overview of the concept of neoliberalism and its relevance for this thesis as informed by Foucault's theory of governmentality. The second section examines the two core tenets of neoliberalism, namely responsibilization and individualization, and how they operate discursively to produce neoliberal subjects. The third section traces the influence of neoliberalism in the realm of public health through the ideology of "healthism" (Crawford, 1980). In the fourth section, the emotional, psychological, and ontological penetration of the neoliberal doctrine is brought to the forefront in a body of work that elucidates various links between neoliberalism and depression. Finally, to situate the problem within the Canadian context, section five provides an overview of the Canadian mental healthcare system and how it has been transformed by neoliberal reforms, leading to self-management as the prevailing model of mental healthcare and the concomitant creation of "neoliberal patients" (Brijnath & Antoniades, 2016).

Defining Neoliberalism

Neoliberalism is a nebulous term that has been conceptualized in multiple ways within

and beyond the academy (Mirowski, 2018). It is conventionally associated with the fiscally conservative, laissez-faire politics of Margaret Thatcher in Britain and Ronald Reagan in the United States in the 1980s. However, its origins as an economic philosophy and political project can be traced as far back as the 1940s, when the term was articulated by Austrian economist Friedrich von Hayek in his influential book *Road to Serfdom* (1976), and further developed with economists of the Chicago School led by Milton Friedman (Jones, 2014, as cited by Feldman, 2019:341). Although French philosopher and historian Michel Foucault (2008) found that neoliberal ideas had been conceived even earlier by the Ordoliberals, a group of German economists active from the 1930s to the 1950s, it is increasingly recognized in the relevant literature on economic history that the gestation of neoliberal ideas was rooted in a thought collective formed by Hayek, Friedman, and a number of other prominent thinkers in 1947 known as the Mont Pèlerin Society (MPS) (Mirowski & Plehwe, 2015). These thinkers viewed the interventionist model of Keynesian welfare economics as a threat to economic growth and individual freedom and formed a neoliberal thought collective advocating free market economics, which later gained traction during the economic crisis of the 1970s (Harvey, 2007; Mirowski & Plehwe, 2015; Monbiot, 2016; Feldman, 2019).

While scholars recognize its unstable contours, neoliberalism is generally accepted in the literature as a political movement and set of economic policies broadly characterized by processes of privatization, the deregulation of industries, responsibilization, financialization, and a drastic decline in the governmental provision of social services and programs, all of which are intended to promote economic growth and cultivate a "free" market (Harvey, 2007; Brown, 2015). In large part a reaction by conservatives and liberals alike to the perceived state-dependency engendered by Keynesian welfarism in the latter part of the twentieth century

(Harvey, 2007; Esposito & Perez, 2014), the rise of neoliberal government and its resurgence of capital and corporate globalization has effectively dismantled the welfare state through "the predominance of the market over the state; the subjugation of the public to the private; and the subordination of social policy to the economy" (Clarke, 2005:452). Because of its public profile as an approach premised on individual freedom and small government, neoliberalism is often falsely conflated with libertarianism, however as Mirowski crucially points out, "the political goal of neoliberals is not to destroy the state, but to take control of it, and to redefine its structure and function" (Mirowski, 2018, para. 25). Unlike laissez-faire liberalism, neoliberalism in fact necessitates the power of a strengthened state to impose its ideology across all domains of society (para. 15).

Far from benign, neoliberal policies have had dramatic material consequences including the intensification and reproduction of social inequalities on a global scale and what some have pointed to as the accelerated re-distribution of wealth into the hands of an economic elite (Harvey, 2007; Brown, 2015). The retrenchment of the welfare state that has reduced or even eradicated public social services has exacerbated income inequality and poverty since the neoliberal turn of the 1970s (Moncrieff, 2006, 2014; Layton, 2014; Rogers-Vaughn, 2014; Polzer & Power, 2016; Bell, 2019), and it is now well-established that neoliberal policies are associated with poor health outcomes (Polzer & Power, 2016:8). Yet despite the structural nature of these insecurities, it is "the community" and individual families who are exhorted to take responsibility for that which is no longer protected by the state, and they are encouraged to do so by seeking market solutions; namely, by purchasing products (Anderson, 2016; Mirowski, 2018). Indeed, the central defining characteristic of neoliberalism is arguably its proclivity for free-market fundamentalism—that is, the tenacious belief that all social problems can be solved through the

market (Harvey, 2007; Esposito, 2011; Brown, 2015).

Homoeconomicus and the Market Society

According to Foucault (2008), the very way in which we understand human nature, ethics and democracy has been transformed under neoliberalism, as the market has come to represent a regime of truth through which neoliberal governance is rationalized and individuals are constituted as rational market actors. He traces the historical emergence of this "market veridiction" as far back as the Middle Ages in his *Birth of Biopolitics* lectures, wherein he argues that up until the eighteenth century, the market represented a site of *jurisdiction* that was subject to stringent governmental control in order to assure fair prices. As he writes, "the rules of the market operated to ensure that, if not all, then at least some of the poorest could buy things as well as those who were more well-off. So in this sense the market was a site of distributive justice" (Foucault, 2008:30). In the mid-eighteenth century, the market shifted to a site of "veridiction"—"a site and a mechanism of the formation of truth" (p. 30). It was understood that when it was free from political intervention, the market would establish the "true price"— "a certain price […] which will adequately express the relationship, a definite, adequate relationship between the cost of production and the extent of demand" (p. 31). No longer concerned with justice, but with the freedom of individuals to accrue private profit, the "free" market has been reinvigorated under neoliberalism and extensively pursued in policy agendas that minimize state support at all costs. Indeed, central to neoliberal philosophy is the idea that all societal developments should be left to the "wisdom" of the market, and that market relations are the very foundation of democracy (Giroux, 2003:196).

As such, market principles have come to inform every domain and activity, including

those that are not directly monetizable, from reproduction to planning one's death (Brown, 2015:67). This penetration of the market into previously noneconomic domains has had radical epistemological and ontological implications, argues Brown (p. 56), as social relations are recast in an economic frame and are increasingly characterized by competition, the core principle and regulatory mechanism of the market (Foucault, 2008:147). The individual is everywhere exclusively figured as *homo economicus*— "an entrepreneur of himself [sic]" (Foucault, 2008:226)—who is urged to conduct their life as a project of enterprise by competing for stratified resources and opportunities in a market society that is increasingly characterized by social Darwinian conditions (Lane, 2000:95; McGuigan, 2014:236; Bell, 2019:82).

The way in which neoliberalism has transformed the portrait of the self into a figure of constant capital investment can be easily observed "in every college and job application, every package of study strategies, every internship, every new exercise and diet program" (Brown, 2015:36) and is also evident in social media sites such as Facebook and LinkedIn, as well as dating apps that have recently become mainstream, where online profiles are curated to market oneself as a personal enterprise (Rogers-Vaughn, 2016:244). These types of normalized market relations have had many ramifications, including the erasure of class distinctions and identity politics (Paltrinieri, 2017; De La Fabian & Stecher, 2017). When every individual is understood to be their own entrepreneur, regardless of their position in the socioeconomic stratum, intersectional class conflict and exploitation under late capitalism is effaced as a source of under/unemployment, poverty, disease, and mental illness, and instead, individuals facing these challenges are charged with irresponsible human capital investments or a mismanaged portfolio (Brown, 2015). According to Brown, inequality is the foundation of a market society comprised of competing capitals that give way to "winners" and "losers" rather than equal citizens (p. 38).

Foth and Holmes (2018) concur that the neoliberal "economization" of society only deepens social inequalities, because "disparities are part and parcel of a society based on competition" (Foth & Holmes, 2018:2). The logic of a society ruled by the market is such that one's position in the socioeconomic world is sooner attributed to one's hard work, competitive prowess, and enterprise rather than a result of disproportional privilege or opportunity (Randolph, 2013:25).

Ultimately, the penetration of the market into a range of human experiences and relationships has had severe implications for the well-being of western populations and is routinely linked to symptoms of depression (Lane, 2000; Esposito, 2011; Esposito & Perez, 2014; Brown, 2015; Hochschild, 2003, 2012). Yet, in a society ruled by market logic, the social determinants of mental health and the role of the state are undermined in favour of individual-level explanations and solutions. Scholars following the Foucauldian tradition have pointed to the ways in which neoliberalism has achieved these discursive goals by operating as a form of governmentality, producing responsible, self-regulating, and self-sufficient citizens.

Neoliberal Governmentality

A considerable body of critical scholarship in the Foucauldian tradition argues that rather than serving merely as a set of economic policies, neoliberalism operates as a distinct form of *governmentality* (e.g., Rose, 1993, 1996a; Larner, 2000; Lemke, 2001; McGillvray, 2005; Rose et al., 2006; Ayo, 2012; Brown, 2015; Teghtsoonian, 2017; Mirowski, 2018; LaMarre et al., 2019; Bell, 2019). Foucault defined governmentality as "the conduct of conduct" (Foucault, 2008:186) because it administers populations not through the forms of command and punishment that reigned in the pre-modern era, but indirectly and "at a distance" (Brown, 2015:117) through modes of subjectivation that produce, normalize, and regulate neoliberal conceptions of the

competitive, responsible, and enterprising self (Anderson, 2016:738). In its establishment of a "normative order of reason" (Brown, 2015:9-10), neoliberal governmentality locates regulatory mechanisms at all levels of social institutions, from the family to bureaucratic agencies (Lupton, 1995:9), to ensure the production of subjects who do not require governmental intervention as they come to voluntarily, if unwittingly, govern themselves (Rose, 1993:291). In this way, as Rose and Miller (1992) argue, under neoliberal governmentality, power acts on and through subjects vis-à-vis "a kind of regulated freedom"—autonomy is thus not opposed to political power, "but a key term in its exercise, the more so because most individuals are not merely the subjects of power but play a part in its operations" (Rose & Miller, 1992:272).

Perhaps the most profound entrenchment of neoliberalism lies in its capacity to govern as common sense (Harvey, 2007; Brown, 2015; Sugarman, 2015), a hegemony constructing certain truths that render its reality intelligible and practicable for individuals who are "obliged to be free" yet remain amenable to political intervention by distant authorities (Rose, 1993:289). No longer confined to government and economics in the conventional sense, the societal influence of neoliberalism is far-reaching and thorough—"a principle of civilization that shapes the socio-cultural makeup of people through socialization in the broadest sense" (McGuigan, 2014:224), shaping both public discourse and, increasingly, private life (Binkley, 2014:31). As Bell (2019:18) aptly puts it:

> The increasing penetration of the market form into our lived lives, the transformations of human activities into commodities, becomes so pervasive, so naturalised, that we cease to see it—and where ideology coincides with what we take to be "just the way the world is" we have ideology in its purest and deadliest form.

Research into this phenomenon has made apparent that neoliberal governmentality has emerged as an ascendant political rationality with widespread rhetorical influence in shaping societal institutions, cultural customs, and individual psyches alike in accordance with market norms.

Among the most entrenched and influential of these norms are responsibilization and individualization, which are outlined in the next section.

Responsibilization

A central policy tenet and discursive mechanism of neoliberalism is the concept of responsibilization, a process whereby the state systematically divests itself of its responsibility for economic management, capital regulation, and protection of the welfare of its citizens. These responsibilities have shifted to individual citizens and their families, who are required to manage what are regarded as their "personal affairs" rather than public problems requiring governmental intervention (Clarke, 2005; Harvey, 2007; Rose, 2013; Polzer & Power, 2016). Responsibilization emerged as a key policy strategy in light of criticisms leveled at welfare states in the closing decades of the twentieth century, which were charged with threatening citizens' personal responsibility and freedom (Rose, 2013:349). This notion that individuals must be held solely accountable for their own well-being and success has transmuted into a normative interpretation of the world and an increasingly compulsory ethic of behaviour (Harvey, 2007; Brown, 2015; Sugarman, 2015).

Previously understood in terms of welfare, citizenship in neoliberal society is now largely defined by the capacity to exercise free choice (Higgs, 1998, as cited by Henderson, 2005:243). Couched in the benevolent language of freedom and empowerment, neoliberal conceptions of choice are particularly influential because they "resonate with, appropriate, and co-opt […] forms of activism that have struggled for autonomy, justice, recognition, and self-determination" (Polzer & Power, 2016:14). Though "free choice" is framed as empowering for those who wish to take control of their own health, work and life, responsibilizing individual citizens for their

life outcomes that were previously protected under the purview of government has the effect of making them culpable when they fail to exercise ostensibly "proper" choices, as "failure is generally attributed to personal failings, and the victim is all too often blamed" (Harvey, 2007:76). By framing the individual citizen as the solely accountable actor and author of "do-it-yourself biographies" (Beck & Beck-Gernsheim, 2002:24), choice discourse serves to depoliticize the sociocultural context of people's lives thereby undermining the structural barriers that impede access to resources and constrain agency. Well-established social determinants of health such as un- or under-employment, poverty, and lack of education are thus conceived as "poor choices made by freely choosing citizens" (Ayo, 2012:201).

Although the ability to exercise choice has been shown to have positive consequences for the motivation, health, and well-being of individuals, these consequences are distributed unequally across socioeconomic contexts (Adams et al., 2019:195) as not everyone has the means to be a responsible consumer (Bauman, 1999). Choice discourse sanctions the further exclusion and marginalization of those who are unable to conduct their lives "responsibly" by making the "right" choices (i.e., those that are self-enhancing and economically productive) (Polzer & Power, 2016:16), while obfuscating the state as a potential source of ill health (Teghtsoonian, 2009). Neoliberal policies and discourses of responsibilization construct a regime of accountability in which self-worth and identity become tied to one's capacity to responsibly self-govern in accordance with neoliberal norms of citizenship (Brown, 2019:157). Yet this capacity is highly limited by a late-capitalist environment characterized by perpetual social and economic precarity, in which anxiety, hopelessness and depression are the almost logical responses (Stern & Brown, 2016:336). Rendering individuals responsible for increasingly uncontrollable risks such as illness and unemployment only serves to exacerbate mental health

outcomes through the internalization of victim-blaming attitudes (Charmaz, 2020). As Alain Ehrenberg has argued, depression in the contemporary era manifests as "a problem of responsibility in which the dominant feeling is that of failure" (Ehrenberg, 2009:4). The impact of this burden of responsibility is manifold for those with marginalized identities, many of whom carry the heaviest loads yet are met with the highest levels of contempt when encountering the system.

As some feminist scholars have made apparent, neoliberal responsibilization is a highly gendered phenomenon (e.g., Gattuso et al., 2005; Fullagar, 2009, 2017; Polzer & Power, 2016; Fullagar & O'Brien, 2013, 2014; Teghtsoonian, 2009, 2017; Brown, 2015; Brown, 2019; Chowdhury, 2020). In addition to balancing the unpaid and largely invisible labour of maintaining the social reproduction upon which capitalist economies depend, it is women who are often expected to undertake the responsibilities that are discarded by the state under neoliberalism (Henderson, 2005, as cited by Airth & Oelke, 2020:2). Previously delegated to a number of welfare programs, these additional roles closely resemble the forms of unpaid and taken-for-granted work that women already perform in the home. Because of their historically gendered roles as caregivers, mothers in particular are a source of support for the neoliberal transition from the public to the private domain (Polzer & Power, 2016:19). Responsibilization thus uniquely disadvantages women to the extent that "they remain disproportionately responsible for those who cannot be responsible for themselves" (Brown, 2015:105-106), even while employed full-time. It is perhaps unsurprising, then, that women are twice as likely to be diagnosed with depression (WHO, 2002), a reality exacerbated for women living in poverty who experience higher levels of stress (Belle & Doucet, 2003), queer and transgender women who experience staggering rates of severe depression and suicidality (Hoffman, 2014), and

Indigenous and racialized women who face gendered racism rooted in histories of colonization and violence (Benoit et al., 2016; Nelson et al., 2021). Yet norms of neoliberal responsibilization ignore these contingencies, re-inscribing and intensifying gendered social roles that require women to take responsibility not only for themselves but for their families and communities.

To be sure, it is well documented that the adverse effects of neoliberal policies are also experienced disproportionately by racialized communities generally (Roberts & Mahtani, 2010:3), and responsibilization has fostered the depoliticization of race and racism by framing the latter as a problem of personal responsibility rather than collective action (Roberts & Mahtani, 2010; Feagin & Hohle, 2017). Reified by notions of individual choice that attribute success and material wealth to personal merit rather than social position, responsibilization has intensified racialized health disparities such as "John Henryism" in which people of colour are required to exert extraordinary efforts in the face of structural adversity to earn the same esteem as their white counterparts, which leads to exhaustion and burnout and ultimately diminishes mental health (Adams et al., 2019:201). Neoliberalism mobilizes these new, more covert forms of racism while concealing them behind a guise of individual agency that attributes the collective struggles of racial minorities to individual lack of initiative, hard work, or moral responsibility (Giroux, 2003:192), "respond[ing] to the sufferer as if they were the author of their own misfortune" (Rose, 1996a:159). In a market society in which everyone is evaluated chiefly in terms of their economic productivity and must realize their own success through responsible decision-making (Polzer & Power, 2016:40), people of colour are obligated to "free themselves from their victim status and act responsible […] through the spirit of principled entrepreneurialism" (Stelle, 1990, as cited by Giroux, 2003:194), and variables such as race are no longer perceived as relevant determinants in one's success (Roberts & Mahtani, 2010:3).

Social justice is thus increasingly displaced as a civic goal and public policy interventions to address the social determinants of mental health are routinely undermined in favour of individual-level solutions that aim to modify "risky" behaviours and promote self-care (Ilcan, 2009, Raphael, 2011, Raphael et al., 2008, as cited by Polzer & Power, 2016:8).

Ultimately, the goal underlying neoliberal responsibilization is to promote productivity and efficiency in accordance with the free-market principles that neoliberals espouse, yet its influence has extended beyond policy agendas into a "highly value-laden […] code of ethics, an obligatory duty of citizenship" (Ayo, 2012:103) through which individual hardships are sooner attributable to "laziness" and a lack of self-discipline (Cederström & Spicer, 2015:25, as cited by Rimke, 2020) than the various ways in which "responsible" choices are constrained—from poverty and limited access to education to under/unemployment (Sugarman, 2015:114), all of which, for marginalized groups, are compounded by the discrimination and exclusion that is perpetuated by the intensified inequities of the neoliberal system itself.

Individualization

The discourse of responsibilization is intimately bound up with neoliberalism's promotion and glorification of individualism. Indeed, what sociologists have referred to as "individualization" has exerted profound influence on Western notions of selfhood in late modernity (see Giddens, 1991; Beck, 1992; Beck & Beck-Gernsheim, 2002; Bauman, 2013b; Rimke, 2020). As Beck and Beck-Gernsheim contend, there is scarcely a human desire more widespread in the West than to live a life of one's own: "the ethic of individual self-fulfillment and achievement is the most powerful current in modern society" (Beck & Beck-Gernsheim, 2002:23). Subjectivity in contemporary culture is characterized by a new consciousness, not only

of one's individuality, but of one's separateness from others (Lupton, 1995:7).

Through the ideological framework of individualization and corresponding policies, the neoliberal state undermines notions of shared obligation, collectivism, and the systemic nature of inequalities, pathologizing dependency and atomizing social problems by framing them as irresponsible choices made by individuals (Randolph, 2013). Through the mutually reinforcing discourses of responsibilization and individualization, the self-responsible individual emerges as "the only viable unit of concern and analysis" and as such, "human agency is understood as simply a matter of individualized choices and private pursuits" (Esposito, 2011, Giroux, 2008, as cited by Esposito & Perez, 2014:421). As such, social problems are routinely re-formulated as psychological dispositions that must be managed on an individual basis (Beck & Beck-Gernsheim, 2002:24). At best, individualization encourages us to prioritize our own well-being and close ourselves off from others (Rimke, 2016:9-10), and at worst, it fosters social isolation and alienation, dissuading us from seeking social support by condemning human vulnerability and need (Rogers-Vaughn, 2014:512; Randolph, 2013:81). This has profound implications for mental health, as loneliness and social isolation are strongly associated with depression (Matthews et al., 2016) and are as deadly as consuming alcohol or smoking (Teo, 2013). As a policy directive and rationale that has become culturally diffuse, individualization has progressively displaced values such as diversity, inclusion, and social solidarity, which has had a disproportionately negative impact on people with marginalized identities, who are more likely to feel isolated and have pre-existing mental health problems.

In the context of gender, individualization has informed post-feminist discourses that locate the source of liberation in the market and consumerism, ultimately undermining feminist aims by "locating the problem *within* women, thus upholding patriarchal structures" (Gill, 2016,

as cited by Chowdhury, 2020:1350; emphasis in original). While the feminist movement of the 1960s and 1970s emphasized solidarity in the denouncement of systemic sexism, feminism in the neoliberal age has been redefined as economic and individual freedom, social mobility, and enhanced consumer choice (Randolph, 2013:27), indicating a depoliticization of feminist aims and the effacement of sexism as a source of the continued disenfranchisement of women.

In the context of race, neoliberal individualization has "collapse[d] the political into the personal" (Giroux, 2003:201) by favouring conceptions of racism as an individual problem requiring personal management, rather than the social obligation of a society that is collectively responsible for eradicating racial injustices (Randolph, 2013:21). Sooner attributed to individual prejudices or feelings of "hate" (Giroux 2003:192) than a culturally and institutionally sanctioned system of exclusion, racism is effectively depoliticized by individualizing discourses that frame human struggle as a function of personal merit and capability rather than a consequence of one's position in a hierarchical society stratified along racial lines (Randolph, 2013:24). This narrowing of the definition of racism as a product of individual bias ultimately minimizes the centuries-long historical injustice and violence of racism that remain deeply entrenched in societal relations and institutional structures that continue to uphold white supremacy today. The eradication of racism thus constitutes a "a less pressing social issue [that] requires less stringent measures to address" (Adams et al., 2019:200).

Together, the mutually reinforcing policy directions of responsibilization and individualization have transmogrified into ideological norms that have fostered the ongoing depoliticization of social inequalities (Rimke, 2020) by prioritizing the private realm over the public sphere (Esposito & Perez, 2014:421), valorizing individualism at the expense of solidarity (e.g., Rimke, 2016), and placing responsibility entirely on the shoulders of individuals whose

access to resources and capacity for well-being is drastically compromised by the gendered, racialized, and classed power relations that are intensified under neoliberal economics (Rogers-Vaughn, 2014:512; Scharff, 2016:109; Polzer & Power, 2016:9). For those who are socially and economically excluded by neoliberal policies, access to the resources necessary to sustain a baseline of well-being—housing, education, a stable income, freedom from discrimination, and health care, among others—becomes volatile at best (Polzer & Power, 2016:9), and nowhere is this more apparent than in the realm of public health.

Healthism

There is a substantial and growing body of literature dedicated to examining the contingencies of public health and economics against the backdrop of a neoliberal political climate in the West. Scholars have observed the influence of neoliberal discourse both in the public health sphere and how it has trickled into the private realm of health behaviours (e.g., Petersen, 1996; Crawford, 1980; Polzer & Power, 2016). In accordance with neoliberal reforms, there has been a discursive turn in Western healthcare toward a model of predictive and preventive medicine which increasingly relies on the individual patient to take on the role of health expert (Rose, 2013). The subject under this model of healthcare must have a continual, active, and informed relationship to matters of health and wellness and maintain a scrutinizing awareness of negative consequences by maximising health through diet, lifestyle, and work (Rose, 1992a; Rose, 2007; Fullagar, 2009; Fullagar & O'Brien, 2014). What scholars have variously referred to as "the will to health" (Kickbusch, 2007:144), the "the pursuit of healthiness" (Ayo, 2012:100), "the imperative of health" (Lupton, 1995:2), and most commonly, "healthism" (Crawford, 1980; Burrows et al., 1995; Greco, 1993; Ayo, 2012; Godrej, 2017),

denote the ways in which health-seeking behaviours have become an increasingly compulsory tenet of neoliberal citizenship, "a primary, often THE primary focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of lifestyles" (Crawford, 1980:368).

Contemporary definitions of health and illness have been invariably shaped by neoliberal rationality in advanced democracies (Ayo, 2012:99). Previously identified with hospitals, clinics and other medical bureaucracies, the concept of health is now increasingly equated to happiness and general well-being and no longer conceived as an end in itself, but a perpetual project of "self-care" and optimization to be achieved through various forms of labour including self-surveillance, medical screenings, and the consumption of health-related goods and services in an ever-expanding health and wellness market (Nettleton, 1997; Bunton, 1997; Peterson, 1997; Lupton, 1995; Burrows et al., 1995; Roy, 2008). Once regarded as passive victims of medicalization, patients can now occupy active positions as empowered consumers with "free choice" by selecting from an array of "healthy" options in the marketplace (Rose & Miller, 1992; Petersen, 1996; Nettleton, 1997; Rose, 2013). Yet in this economy of health, patients and caregivers alike are tasked with the responsibility of not only maintaining health, but *maximizing* it (Rose, 1996a), which requires the ongoing cultivation of such contemporary and often elitist skills as "health literacy" and "health competence" (Kickbusch, 2007:130), as well as the active management of a range of health risks that are often largely uncontrollable and incredibly costly to mediate. The healthy lifestyle culture that healthism promotes thus caters to those who can afford the resources necessary to achieve the lifestyle investments required of the exemplary neoliberal citizen. Such investments—chiropractics, massage, naturopathy, "holistic" health remedies, pills and supplements, "superfood" diets, reiki, yoga, pharmaceuticals, among many

others—also tend to be excluded from public healthcare coverage and many insurance plans and are thus largely inaccessible to a majority of the population. In many contexts, it is the affluent who are the most equipped to make "healthy" lifestyle adjustments (Crawford, 1980:378), yet in accordance with neoliberal rationality, healthism "reinforces the privatization of the struggle for generalized well-being" (p. 365) and "brings blame to the forefront" by framing poor health outcomes as personal failings (p. 378).

While the idea of being in charge of one's health is appealing to most, such choices are further complicated in the context of a "risk society" (Beck, 1992) in which myriad social, economic, political, and environmental threats to health and safety have emerged in the wake of industrialization, globalization, and unprecedented levels of production, consumption, and resource extraction fueled by capitalist economies (Petersen, 1996:45; Beck, 1992:200). From infectious viruses to climate change disasters, such risks are largely uncontrollable (Kickbusch, 2007:151), yet "the active citizen thus is to add to his or her obligations the need to adopt a calculative prudent personal relation to fate now conceived in terms of calculable dangers and avertable risks" (O'Malley, 1986, 1992, as cited by Rose, 1996a:158-59). As a result of this "duty to be well" (Greco, 1993), health and disease have become moral signifiers of one's worth in which the "good" neoliberal citizen is one who is responsible in their successful adoption of healthy lifestyles, avoids "risky" behaviours, and actively manages health risks, and the "bad" neoliberal citizen is one who fails to do so of their own accord (Greco, 1993; Petersen, 1996; Ayo, 2012).

Despite the social, structural, and environmental origins of looming threats within the risk society, the neoliberal strategy of rendering individuals personally responsible for health now involves "shifting the responsibility for social risks such as illness, unemployment, poverty, etc.,

and […] transforming it into a problem of 'self-care'" (Lemke, 2001:201), concealing the political dimensions and social determinants of health as well as the generalized life circumstances that impact upon one's chances of leading a healthy lifestyle (Crawford, 1980; Polzer & Power, 2016:8; Kickbusch, 2007:140). Yet as Geoffrey Rose (1992) points out, "the primary determinants of disease are mainly economic and social, therefore its remedies must also be economic and social" (Rose, 1992:129). The fatal contradiction inherent to healthism is that those who are the most vulnerable to risk are those who are the least equipped to prevent it and whose health is the most likely to be already compromised, which means that its benefits are elusive for those who need them the most (Crawford, 1980:385).

As an ideological extension of western medicine and its focus on the biomedical model of disease (Crawford, 1980), healthism has assumed a central regulatory role in neoliberal society through the promotion of lifestyle regimens through which individuals are responsibilized and thus ostensibly governed "at a distance" (Rose, 1996a:148). While medicine has long been identified as a major institution of social control (e.g., Foucault, 1973) and health and illness have always been moral concepts (Crawford, 1980:378), healthism has emerged as a distinctly neoliberal cultural imperative that is ideologically positioned to achieve the same social control, albeit in less overtly oppressive ways, by influencing the health-related behaviours of individuals. Healthist discourse promotes an entrepreneurial subjectivity in which the individual orients to their health in self-enterprising, self-improving and self-maximizing ways (Bunton, 1997, Lupton, 1995, Robertson, 2000, as cited by Roy, 2008:465). While such a discourse emphasizes the widely shared values of autonomy and freedom, as Rose (1996a) points out: "such lifestyle maximization entails a relation to authority in the very moment as it pronounces itself the outcome of free choice" (Rose, 1996a:159). In this way, the discourse of healthism can

be viewed as an extension of neoliberal governmentality (Foucault, 2008) that has influenced not only popular beliefs about health and illness but has helped justify a self-management paradigm of healthcare in which the patient is expected to undertake their own care through the modification of individual behaviours (Burrows et al., 1995:11). This imperative has had significant political implications for how health and illness is understood, evaluated, and treated in our contemporary moment, as well as framing who has access to healthcare and who gets left behind.

Neoliberalism and Depression

Scholarship on neoliberal discourses of responsibilization, individualization, and healthism has been pertinent in illustrating how neoliberalism has had an indirect but powerful regulating effect on both public perceptions and private decisions pertaining to health. This research has been pursued by viewing neoliberalism as a distinct form of governmentality that produces particular kinds of subjects constituted by discourse (Foucault, 2008). However, there is comparatively little academic work that addresses the ways in which neoliberalism has shaped mental health, and in particular, its relationship to depression. The relative lack of scholarly attention to this topic is surprising given the current prevalence of depression, which is among the most common mental health problems worldwide (World Health Organization, 2017) as well as a leading cause of disability and excess mortality in Canada (Tanner et al., 2020:339).

Neoliberal Affects

As depression has emerged as an endemic public health concern across advanced industrial democracies, there has been a growing number of social theorists devoted to

diagnosing this contemporary condition in terms of the broad sociocultural impacts of neoliberal development (e.g., Lane, 2000; Moncrieff, 2006, 2008, 2014; Ehrenberg, 2009; Teghtsoonian, 2009, 2017; Cvetkovich 2012; Rogers-Vaughn 2014; Sugarman 2015; Gooding, 2016; Cvetkovich & Wilkerson, 2016; Bell, 2019; Roscher, 2020; Olivier, 2020). Claims have been advanced about the connections between neoliberalism and contemporary psychological life, and specifically the ways in which the former has increasingly shaped the latter (Sugarman 2015; Bell 2019). Some have typified depression as a defining affect under neoliberalism (Cvetkovich 2012; Cvetkovich & Wilkerson, 2016; Anderson, 2016), notably Ann Cvetkovich, who contends that depression is how neoliberalism feels (Cvetkovich, 2012), and Alain Ehrenberg, who maintains that depression is a state of mind that characterizes the current political moment (Ehrenberg, 2009).

Indeed, neoliberalism is often associated with a re-emphasis on feelings that some scholars have referred to as the "affective turn" in the social sciences (Clough & Halley, 2007, as cited by Teo, 2018; Anderson, 2016). Anderson notes, for example, that neoliberalism has often been described as a contemporary feeling or mood characterized by a climate of risk that drives constant fear and anxiety that can lead to depression (2016:736). The awareness of one's susceptibility to risk accompanied by the pressure to flourish and succeed in spite of such risks leave us in a perpetual state of unease—"a general and heightened sense of expectancy of what has not yet to come" (Clough & Wise, 2011:2, as cited by Anderson, 2016:736). Risks ranging from the consumption of GMOs to the looming threat of total environmental collapse take a psychological toll and can manifest as feelings of helplessness leading to depression in the construction of a subjectivity that is constantly "at risk".

The emotional reflexivity required of postmodern neoliberal selves is such that we must

reflect upon, scrutinize, and know our emotional states as never before so that we can modify and manipulate them for self-directed ends (Binkley, 2018:581). Binkley argues that neoliberalism requires us to cultivate certain "affective assets" (Binkley, 2018:585) such as optimism and emotional resilience, not only as necessary mechanisms in coping with the realities of a risk society, but as resources for the advancement of our personal capacities in a competitive market society (p. 581). The way in which affect has become instrumentalized is evidenced, for example, by the popularity of the concept "emotional intelligence" as a professional skill promoted in the psychology and business management literature (p. 582). The ideal neoliberal citizen must be not only self-governing and self-enterprising but harness affective dispositions in the interests of labour and capital (Bialostok & Aronson, 2016:98).

These shifts have had significant implications for how we feel and experience our emotions. Rather than repressed, feelings in the neoliberal era are approached as tools of self-mastery in the project of personal enterprise and "…it is now our feelings and our expressions that we must count as commodities on a labour market" (Binkley, 2018:582). As Anderson points out, "ideology works affectively" (Anderson, 2016:747)—and neoliberal rationality manifests as a "thinking-feeling" that informs human identity in increasingly intimate ways (p. 747). As the usage value of commodities has diminished, for example, emotional "need" has replaced material necessity as a motive for purchasing market goods and services (Teo, 2018:589). The emotional objective of neoliberalism, then, "is the analogue of market rationality itself" (Binkley, 2018:581).

The field of positive psychology has been highly influential in promoting this "utopia of emotional governance" (Binkley, 2014:6), constituting what Binkley calls the new discourse on happiness—namely, that each individual is the "CEO" of their own happiness and is responsible

for monitoring and modifying negative thoughts to maximize positive emotions (p. 19). Based on Albert Bandura's concept of self-efficacy and the principles of cognitive-behavioural therapy, this relatively new branch of psychology has quickly become one of the most powerful and influential currents of psychological thought in contemporary popular culture (Binkley, 2011:375). Its influence has extended across a range of professional fields, and in the propagation of a booming therapeutic subculture comprised of lay "experts" such as life coaches and social media influencers sermonizing the importance of positive affect in phrases like "You have to believe in yourself before anything is possible" and "You have to love yourself before you can love someone else" (Twenge, 2006, as cited by Adams et al., 2019:197). Such sentiments have become not only commonplace but common sense, and as Adams and colleagues argue, have particular traction in the context of neoliberal individualism (Adams et al., 2019:196).

Related to this is positive psychology and its associated therapeutic discourses, which in combination have proven to be a massively profitable enterprise, particularly in a western population gripped with increasingly chronic and debilitating mental illnesses (Deacon, 2013:847). In a turn toward "mental healthism", the health industry has expanded to include an array of products designed to monitor, control and manage emotional states in order to maintain and improve mental health (Fimmano, 2019:15). There are now up to 20,000 mental health apps available for download including mood tracking devices, meditation apps, and self-directed therapy apps (Clay, 2021). Importantly, the intentional cultivation of happiness required of positive psychology is not achieved through any treatment regimen or therapy but is undertaken by individuals themselves in their everyday lives, by adopting any number of self-help technologies available on the market (Binkley, 2014:375), a novelty which aligns well with the

neoliberal imperative to create productive, self-managing subjects who actively maximize mental health and prevent mental illness (Fimmano, 2019:16).

Self-Help and Psychocentrism

Another striking development in modern therapeutic culture has been the rise of the self-help genre of literature. The last three decades have witnessed the proliferation of self-help books on a global scale (Lee, 2017) with the most prevalent topic being how to overcome depression in order to live a happier life (Philip, 2009). A number of researchers have explored the discourses embedded in such texts (e.g., Bunton, 1997; Gattuso et al., 2005; Roy, 2008; Philip, 2009; Lee, 2017), revealing that they reinforce neoliberal norms of citizenship by constructing responsibility for mental health in moralising terms; namely, what one *ought* to do in order to take control of their lives (e.g., Roy, 2008; Lee, 2017; Philip, 2009). By drawing connections to neoliberal governmentality, it has been argued that the prevalence of self-help, from popular magazines (e.g., Bunton, 1997; Roy, 2008) and clinician-prescribed "bibliotherapy" (Philip, 2009:151), to best-selling self-help books (e.g. Hochschild, 2012; Binkley, 2014; Lee, 2017), reflects a culture deeply invested in the logic of not only positive psychology, but of all the "psy" disciplines—from psychiatry to psychopharmacology—that prescribe endless ways of aligning individual aspirations and values with the broader political and economic objectives of neoliberalism; including consumption, productivity, and profitability (Rimke, 2000, Hazelden, 2003, as cited by Philip, 2009:152-53).

This cultural mania surrounding all things "psy" reflects what Rimke (2000, 2020) has called psychocentrism: "the dominant or hegemonic assumption that all human problems reside within, or are an effect of, the individual mind and/or body rather than a product of and

expression of social, political, historic, or economic problems" (Rimke, 2020:38). Through the guise of expert authority and pseudo-scientific language, self-help texts rely on psychocentric logic to produce "a self-governing citizenry critical of the self rather than society or authorities" (p. 38). In this way, the atomized practices promoted by self-help texts act as technologies of power that reflect and reinforce societal understandings of health that are invariably shaped by, and profitable for, the neoliberal state in the contemporary management and governance of citizens (Foucault, 1988; Rimke, 2000:72: Roy, 2008).

In the parlance of some popular self-help texts, one might try to connect with their "inner child", avoid pathological "co-dependency", "manifest" their desired lifestyle through the power of positive thinking, or engage in any number of the now ubiquitous self-directed practices that appropriate traditional Eastern, Indigenous, or other "alternative" healing methods (Rimke & Brock, 2012:194). The common thread that runs through such texts is a veneration for independence and self-reliance and a corresponding disregard for dependency and reliance on others that is symptomatic of neoliberal rationality. The widespread enthusiasm and devotion with which they are taken up by their target audience is a powerful example of the ways in which human identity is constituted and shaped by discourse, and how this process is always necessarily political (Hacking, 1986, Rose, 1996, Ward, 1996, as cited by Rimke, 2000:69). When we endorse and adopt the advice of "psy" experts and partake in the technologies of the self (Foucault, 2008) that are popularized in these forms of media, "we are being governed, we govern ourselves, and this also leads us to govern others" (Rimke & Brock, 2012:95).

Feminist scholars also have analysed self-help books as sites for the dissemination of capitalist values and patriarchal norms that have eclipsed feminist aims (e.g., Rowe, 2006, Hochschild, 1994, as cited by Philip, 2009:152). Roy's (2008) research, for example, revealed

the ways in which popular women's magazines prescribe gendered expectations of responsibility, namely, women's twofold responsibility of pursuing good health for themselves and their families in order to "demonstrate one's moral worthiness as a citizen and woman" (Roy, 2008:471). Women were primarily characterized by their roles as mothers and wives through the promotion of idealized mothering and self-care practices (p. 473). Although certain challenges outlined in the magazines analyzed were depicted as commonly experienced among women, solutions offered were constructed at the individual level, as women were advised to help themselves, precluding a consideration of the sociocultural context of women's lives (Ballaster et al., 1991, Berns, 1999, McRobbie, 2000, as cited by Roy 2008:471). The magazines seldom acknowledged the various gendered barriers in place that limit women's abilities to engage in health-enhancing activities, nor the power relations that inform such barriers, which include women's unpaid work and caring responsibilities (p. 473).

Philip (2009) conducted a Foucauldian analysis of self-help literature using David Burns' top-selling and clinically endorsed book *Feeling Good: The New Mood Therapy* (1999) as a case study. Her research revealed that psychological expertise was conferred legitimacy and authority in constructing truths about depression and was used to rationalize certain techniques for governing individuals (Philip, 2009:156). Readers of *Feeling Good* were provided with a number of psychological scales and assessments used to calculate their moods and compare their scores against those that were considered "normal" with the implication that "abnormal" scores required prompt self-improvement by adopting the self-help techniques presented in the book (p. 159). By drawing from the dominant biomedical paradigm that depression is a function of faulty brain chemistry and the notion advanced by cognitive-behavioural therapy (CBT) that this is exacerbated by distorted thought patterns, Burns situates his advice as expert knowledge offered

in the form of individualized technologies of the self (Foucault, 2008) meant to overcome procrastination and idleness, such as meditation, journaling and self-talk (p. 160). Philip argues that self-help books such as *Feeling Good* contribute to the depoliticization of depression by using psychocentric discourse to frame depression as an asocial cognitive experience and to promote the distinctly neoliberal values of self-reliance and productivity. Situating her research in a governmentality framework, she points out that the neoliberal rhetoric of self-help books penetrates into the private sphere, shaping our most personal decisions and relations in the interest of the state, as "healthy citizens are more likely to be productive workers and consumers" (p. 164).

It is perhaps unsurprising that self-help is one of the largest and fastest growing genres of literature in the world, as there is tremendous profit to be gained from widespread social and political problems, evidenced by the colossal commercial success of the medical-industrial complex (Rimke, 2020:38). The unwitting irony of the psychocentric mindsets promoted by self-help literature is that they conceal the root cause of the very problems that lead people to consume self-help literature in the first place. Rimke argues that psy-influenced self-help discourse "individualizes, depoliticizes, and capitalizes on what are ultimately social problems" by urging individuals to locate problems within themselves, ultimately diverting attention away from large-scale issues of social justice and inequality (Rimke, 2020:47).

Market Subjectivities

There is evidence that rising rates of depression since the 1970s have corresponded with the advent of neoliberal ascendancy in the same period (e.g., Rogers-Vaughn, 2014:506; Schrecker & Bamba, 2015:53), during which market values began to increasingly colonize social

relations and human subjectivity. As Rogers-Vaughn argues, the conditions of neoliberalism "establish the current sociopolitical context of depression" (2014:506). More specifically, it is argued that the contemporary prevalence of depression is largely attributable to the precarious social conditions of a market society in which the emphasis on personal profit supersedes that of social bonds and community, assimilating a culture of social alienation, isolation, and anomie (Esposito & Perez, 2014:416). In subordinating civic obligation to individual responsibility and public interests to private ventures, market logic has penetrated at the level of ontology, as understandings of human nature itself have been redefined as an enterprise conducive to commodification, maximisation, and capital gain (Esposito & Perez, 2014; Sugarman, 2015).

Sugarman (2015) argues that neoliberalism has thoroughly reconfigured what it means to have selfhood and identity in a market society characterized by social disembeddedness and "flexible" capitalism (Sennett, 1998) wherein life narratives are increasingly fragmented and incoherent, and personal branding has replaced the sharing of civic values as a way of forging identity:

> The buying and wearing of brands has become our way to belong, find our place, and lend coherence to our identities. Our personal commitments, identifications, and orientations are defined not through discovering and defending communal values and civic virtues, but instead, by sporting Nike, drinking Starbucks, buying iPhones, and driving BMWs (Sugarman, 2015:106-107).

Neoliberalism necessitates a subjectivity that is ostensibly adaptable to the demands of flexible capitalism and is able to build, market, and sell the self as a brand, like any other good or service that is subject to the constantly oscillating conditions of a volatile market (Sugarman, 2015, as cited by Teo, 2018:585). Teo (2018) argues that this neoliberal self is based on calculative, utilitarian reasoning while moral reasoning rooted in the principles of collective obligation and solidarity has become increasingly counter-intuitive or even irrelevant (Teo, 2018:588).

Cosgrove and Karter (2018) concur that market values penetrate subjectivity in ways that encourage individuals to become self-concerned agents rather than members of a polis or community, highlighting the detrimental implications this has for mental health (Cosgrove & Karter, 2018:670).

Echoing this line of reasoning, Casalini (2019) maintains that the negative affects she argues are intrinsic to neoliberalism originate from the incessant pressure to compete with others (2019:136)—for resources, credentials, and capital—in a precarious marketplace that has regenerated the "survival of the fittest" logic of social Darwinism (Bell, 2019:82), and is unable to distribute these things equitably, much less provide stability to populations (Roscher, 2020:2). In her analysis of the social, political, and economic impacts of neoliberalism on mental health, Roscher (2020) argues that when individuals exist in competition with one another in order to succeed, their capacity for meaningful social affiliation is hindered, as relationships are more likely to be instrumental and contingent upon mutual benefits rather than non-market values such as love (p. 16). Such trends are often observed in the context of paid employment, a sector which has been increasingly targeted by the policy agenda and governing ethos of neoliberalism.

Precarity and Labour Intensification

A number of scholars have documented both the material and psychological consequences of the labour intensification and increased precarity of work propelled by neoliberal policies in recent decades (e.g., Moncrieff, 2014; Sugarman, 2015; Teghtsoonian, 2009, 2017; Casalini, 2019; Feldman, 2019; Roscher, 2020). Such scholars point out that employment in the neoliberal era is characterized by flexibility, mobility and instability, as long-term meaningful vocations have been increasingly displaced by temporary positions and short-

term contracts with fewer benefits and higher demands for productivity (Sugarman, 2015; Feldman, 2019). These changes have been set in motion by neoliberal approaches prioritizing market-based managerial practices and organizational structures conducive to economic gain (Crowley & Hodson, 2014) and have had profound psycho-social consequences for employees in the industrialized west (Sennett, 1998; Sugarman, 2015; Teghtsoonian, 2017; Roscher, 2020).

For one, it is argued that neoliberalism has promoted a culture of workaholism that has blurred the boundaries between labour and leisure, as individuals are routinely encouraged to take their work home and to spend their leisure time productively (Roscher, 2020:14). This has led to increased levels of exhaustion, burnout, and diminished social contact where market consumption and passive forms of entertainment such as social media often take precedence over social engagement in what little leisure time individuals are afforded (p. 6). As Sugarman argues, in the context of precarious work "it becomes difficult to preserve the value and viability of long-term commitments and relationships. A society of individuals frequently switching jobs, relocating, and preoccupied with personal risk and self-interest, is conducive neither to stable families nor cohesive communities" (Sugarman, 2015:106). He adds that this type of work has bred discordant and atomized "neoliberal selves" (Orbach, 2001, as cited by Sugarman, 2015:106) who are encouraged to approach social relationships as "assets" when they increase social capital, and disposable when they are no longer profitable (Sugarman, 2015:111). Because social affiliation is integral to mental health, it is perhaps unsurprising that these transformations have had negative consequences for the psychological well-being of the western population (Roscher, 2020:6), leading to an emotional climate characterized by isolation, anxiety, and depression (Casalini, 2019:136). These trends are rendered all the more concerning, contends Roscher, as one's ability to secure fundamental needs such as employment and housing in

precarious neoliberal economies is increasingly dependent upon social capital derived from stable relationships (Roscher, 2020:6).

Casalini (2019) argues that the sense of precarity that underpins work in neoliberal societies is not limited to the confines of the workplace but is an "existential condition" that extends beyond the office and into our affective environment, leading to increased symptoms of social suffering, including depression (Casalini, 2019:134). She regards the psychosocial effects of neoliberalism through a governmentality lens, which emphasizes the role of the state in "producing a particular kind of subjectivity" (p. 136), not by guaranteeing security, but by purposefully cultivating conditions of insecurity that solicit austere, entrepreneurial subjects who are risk-taking and economically expedient (p. 135). A purely Foucauldian analysis falls short, however, in exposing the connections between workplace depression, neoliberalism, and the structural inequities constituting gendered, racialized, and other marginalized identities (Teghtsoonian, 2017). Feminist scholarship has done much to highlight these contingencies by drawing attention to the ways in which women, for example, already face a range of gendered barriers to leisure time that "constrain [their] ability to exercise regularly, relax or enjoy adequate sleep" (Fullagar, 2003, as cited by Teghtsoonian, 2017:243), including the increasing reliance on forms of unpaid labour still largely undertaken by women as a result of neoliberalizing policies (Brodie & Bakker, 2007, Creese & Strong-Boag, 2008, Neysmith et al., 2012, as cited by Teghtsoonian, 2017:244). These observations also shed light on the fact that women are twice as likely to be diagnosed with depression as men (Goldner et al., 2002:7, as cited by Teghtsoonian, 2009:30), merely one statistic that signals the gendered discrepancies of depression exacerbated in the context of neoliberal workplace cultures.

Feldman notes that it is primarily workers in low wage positions who have been affected

by the precarity imposed by neoliberal developments that have also resulted in a large number of working people living in poverty, referred as "the working poor" (Feldman, 2019:344). Indeed, it is difficult to overstate the contribution of neoliberal welfare reforms to rising rates of poverty in recent decades, which have created the conditions for the emergence of a "global precariat" comprised of many millions of people living in exceedingly unstable conditions (Standing, 2011:1, as cited by Feldman, 2019:344). Poverty has been well-established as a major social determinant of mental health (Murali & Oyebode, 2004; Lund et al., 2010; Manseau, 2014; Burns, 2015), a fact that lends further credence to the apparent connection between neoliberalism, workplace conditions, and the prevalence of depression.

There has been growing attention to the problem of depression in the workplace among Canadians in the past fifteen years, which is invariably framed by neoliberal rhetoric as an economic burden measured in terms of lost productivity and the rising costs of sick leave and long-term disability benefits (Teghtsoonian, 2017:229), such that "existential suffering has been successfully recast in market terms and statistics" (Cosgrove & Karter, 2018:672). As Teghtsoonian has revealed through an analysis of policy documents in British Columbia, efforts to address depression in the workplace have overwhelmingly served neoliberal aims by responsibilizing employers and individual employees for both the prevention and management of depression, while erasing the government "as a potential source of deteriorating mental health [and] a site to which citizens might look for services or other resources" (Teghtsoonian, 2009:31). Depression is thus approached as an individual problem, with privatized solutions, yet as Teghtsoonian (2009:30) aptly remarks:

> Since poverty, stress, fatigue, and a lack of control over one's environment are all factors understood to be associated with depression, it is arguably the case that these [neoliberal] policy directions—and the increased levels of job insecurity, the intensification of work, and the reduced level of public services which they have entailed—have themselves

contributed to its widespread prevalence…

In short, it is apparent that neoliberal policy developments that have created a culture of intensified and precarious work have had clear deleterious effects on mental health by prioritizing the market values of competition and productivity, and the commodification and erosion of human relationships, which have in turn fostered increasing rates of depression in the workplace and elsewhere. These trends have been most harmful for marginalized populations who already face barriers in work and life, and especially those at the bottom of the socioeconomic ladder (Feldman, 2019:345). This body of work suggests that depression is not a solitary illness but, as Casalini puts it, "intrinsic to neoliberalism itself" (2019:138).

Neoliberal Discourses and Depression

As an ideological machine, neoliberalism penetrates our psyches through the powerful discourses at the heart of its modus operandi: responsibilization and individualization. The ways in which these dominant discourses influence our perceptions of ourselves and others helps illuminate the connection between neoliberalism and depression.

Responsibilization

By denigrating dependency and rendering people responsible for unfavorable life outcomes, neoliberal responsibilization attributes blame for human misery to individual oversight, foreclosing the possibility that depression could arise as a result of sociopolitical oppression. Rather than viewing themselves as the victims of an increasingly inhabitable culture of overwork, competition, economic precarity or social inequality, individuals internalize this blame which can lead to depressive symptoms, and ultimately exacerbates suffering for those

who are already depressed (Rogers-Vaughn, 2014, 2016).

Responsibilization tasks the worker, the student, the consumer, and the parent with a great deal of labour in undertaking the project of human capitalization (Brown, 2015:132-133). Responsibilized citizens are expected to provide for themselves and take ownership of their welfare despite the political contingencies that drastically hinder their ability to do so (Brown, 2015:134; Henderson, 2005, as cited by Airth & Oelke, 2020:2). This can have clear implications for mental health by leading to feelings of inadequacy (Ehrenberg, 2009:21). Given that mental illnesses, like depression, interfere with market incentives to maximize consumption and productivity, depression can be deemed as a personal failure to the extent that it diminishes one's market value and represents an economic burden associated with worker latency in terms of days lost from work (Roscher, 2020:16).

Responsibilization also intensifies the stigmatization of mental illness by facilitating individualized critiques that frame depression or depressive symptoms as a consequence of "laziness" or "unfocused mental habits" (Fimmano, 2019; Cederström & Spicer, 2015:25, as cited by Rimke, 2020). Indeed, in the context of exceedingly unattainable neoliberal demands, depression manifests as "a problem of responsibility in which the dominant feeling is that of failure" (Ehrenberg, 2009:4).

Individualization

Scholars have also forged the connection between depression and neoliberalism in terms of the latter's extreme valuation of the sovereign individual at the expense of social connection (e.g., Lane, 2000; Bauman, 2013a; Ehrenberg, 2009; Hochschild, 2012; Rogers-Vaughn, 2014; Esposito & Perez, 2014). Tracing the historical emergence of depression in the twentieth century,

Ehrenberg argues that depression is inherent to modern individualism, presenting itself as a "chronic identity pathology" (Ehrenberg, 2009:164) in tension with individual initiative, a skill that "has moved to the top position among the criteria that measure a person's value" (p. 183). In *Speaking of Sadness,* David Karp describes depression as a "disease of connection" in which social relationships are impaired by the conditions of global capitalism, including unstable working conditions and mass unemployment (Karp, 1996). Robert Lane has documented the decline of community as the leading source of unhappiness in market democracies, a phenomenon he argues is largely attributable to processes of individualization (Lane, 2000).

Beyond the social alienation it incites, which has long been established as a major contributing factor to depression (Rogers-Vaughn, 2014:512), some scholars have gone even further to suggest that neoliberal individualization has promoted narcissism (Layton, 2014), and has diminished our capacity for empathy, a fundamental component of human relationships (Olson, 2013, as cited by Rogers-Vaughn, 2014:512). As Layton (2014:65) writes:

> Neoliberal versions of autonomy might take the form of a narcissism marked by grandiosity, devaluation of the other, withdrawal, and indifference; neoliberal versions of dependence might take the form of a hostile dependence marked by self-deprecation, idealization of the other, longings to merge.

In its radicalization of individualism and aversion to vulnerability, Rogers-Vaughn argues that neoliberal governance has eroded social institutions and intimate relationships that provide meaning and belonging, and by extension, has profoundly eroded the individual self: "Without strong, vibrant collectives to support them, individuals are more or less left to their own devices to deal with distress" (Rogers-Vaughn, 2016:126). Neoliberal governance has, by the same token, privatized suffering—the only narrative recourse left with which individuals can make sense of and voice their psychological distress are hegemonic market discourses of "personal recovery" (p. 126) in which individuals are expected to "own" their emotional pain as a capitalist

owns property, rather than viewing it as something that might be shared with others, or humanity at large (p. 97). The result is a society of acquiescing neoliberal selves that must advance mental health "within ontological confines of the marketplace" (Esposito & Perez, 2014:416-418) rather than in social collectives, and who are unable to achieve class consciousness, much less organize politically—a fact that critics have argued is a deliberate goal of the neoliberal agenda (Rogers-Vaughn, 2016:96).

Mental Healthcare in Canada

A growing body of scholarship theorizing the connections between neoliberalism and mental health has provided rich insights into the ways in which neoliberalism has transformed not only the political and economic spheres, but the very cultural fabric and psychological landscape of "every society it touches from top to bottom" (Rogers-Vaughn, 2016:109). There is mounting evidence that neoliberalism and its associated discourses have given rise to a form of human suffering that is as pervasive as it is insidious—a development that is historically distinct from previous stages of capitalism. With some notable exceptions (e.g., Teghtsoonian, 2009, 2017; Chambers et al., 2015; Brijnath & Antoniades, 2016; Airth & Oelke, 2020) most of what is written about neoliberalism and mental health is theoretically driven and takes place outside the formal policy context of mental healthcare systems. Moreover, compared to other western democracies, there is less research dedicated to the Canadian system and how neoliberal policies and practices have become imbricated within its design. Interrogating mental healthcare policy is an integral component of addressing the widespread problem of depression in Canada—how it is framed and treated, and the implications for patients. To that end, this section provides a brief outline of the Canadian mental healthcare system and its transformation under the neoliberal

regime toward an individualized and responsibilized self-management model of care.

Despite its reputation among advanced industrialized countries of leading a progressive healthcare system based on universality, accessibility, and comprehensiveness, Canada has consistently fallen behind in its establishment of all-inclusive mental health policy (Bartram, 2017, as cited by Wiktorowicz et al., 2020:6). In a 2002 report issued by the Royal Commission on the Future of Health Care in Canada, former premier of Saskatchewan Roy Romanow declared mental health as the "orphan child" of Canada's healthcare system—a sentiment that has since reverberated in debates and public commentary on Canadian healthcare and that reflects the system's chronic omission of critical mental health services (Flood & Thomas, 2017:1; Bartram & Lurie, 2017:7). There are a number of historical factors that led to this longstanding exclusion of mental healthcare services, which can be traced to the advent of deinstitutionalization—a movement that took place in Canada and other industrialized economies beginning in the 1960s (Romanow & Marchildon, 2003:287).

Historical Context: Deinstitutionalization

Deinstitutionalization in Canada involved the gradual, transnational closure of mental hospitals in the second half of the twentieth century (Dyck, 2011, 2018; Gooding, 2016; Flood &Thomas, 2017; Wiktorowicz et al., 2020), which led to the release of many long-term psychiatric patients back into home and community environments (Romanow & Marchildon, 2003:287). This process was coextensive with a number of contemporary transitions associated with the economic and political changes wrought by neoliberal restructuring, as well as developments in the discipline of psychiatry following the Second World War that culminated in what some scholars have called the psychopharmacological revolution (Dyck, 2011:186-87).

Such developments included the introduction of psychotropic medications, the publication of the first comprehensive classification system of mental disorders: the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychological Association, the increase of federal funding for research into mental disorders, as well as the privatization of psychiatry, which led psychiatrists to increasingly move to practice in the private sector at the expense of general practitioners, who inherited the burden of this shift (p. 186).

In the wake of these changes and alongside a declining welfare state, a shifting socio-political climate gave rise to a series of grassroots, antiestablishment initiatives centred around self-help and peer support. These included the anti-psychiatry movement led by "ex-patient" activists who sought to dismantle what they viewed as a paternalistic and oppressive mental healthcare system that undermined the autonomy and dignity of institutionalized individuals (Rissmiller & Rissmiller, 2006; Gooding, 2016). Bolstered by the enactment of the Charter of Canadian Rights and Freedoms in 1982, which introduced "a new language of rights […] that was based on the citizen as a consumer" (Graham & Phillips, 1997, as cited by Bhatia, 2010:42), advocates of this movement identified as consumers and survivors of the asylum-based system and embraced a civil rights discourse that emphasized healthcare as a matter of individual citizenship (Boschma & Devane, 2019:3). Meanwhile, as the state proved increasingly inept at providing for the basic needs of its citizens in the context of a crumbling welfare system, proponents of neoliberalism adopted this language of civil rights and the rhetoric of self-help as a governmental strategy to justify fiscally conservative policy agendas and cost-cutting procedures, making a more favourable case for private financing and ultimately displacing collective social concerns with a focus on individual rights and responsibilities (Bhatia, 2010:39-40).

Deinstitutionalization further coincided with changes in mental health service delivery influenced by the introduction of Medicare in the early 1960s (Marchildon, 2011; Dyck, 2018), which implemented the universal funding of hospital services, and subsequently, universal public health insurance for primary medical care services outside of hospitals—a model that became adopted nationwide by 1972 (Romanow & Marchildon, 2003:284). While Medicare did not trigger deinstitutionalization, it was positioned to facilitate the transition away from long-stay hospitalizations and catalyzed the integration of psychiatry into general medicine, where family physicians provided the first point of care (Dyck, 2018:267). In an attempt to equalize the treatment of mental illness and physical ailments that was largely led by the Canadian Mental Health Association's (CMHA) campaign to destigmatize mental illness, the Royal Commission On Health Services (The Hall Commission) made the following recommendations: that mental healthcare be integrated into primary care settings in the form of psychiatric wards and wings in general hospitals designated for acute care, and that people with mental illnesses otherwise be treated in community or home settings (Romanow & Marchildon, 2003:287).

A new post-asylum system thus emerged whereby long-stay psychiatric institutions were displaced by an integrated hospital system and mental healthcare became "a complex matrix of services [that] were not under the jurisdiction of any one governmental department and did not necessarily fit neatly into Canada's constitutional federalist framework" (Dyck, 2011:187). Despite the purported goal of eradicating stigma, merging psychiatry with the general healthcare system created tensions as formerly long-term patients were moved out of stand-alone wards and into a world without sufficient infrastructure to accommodate their needs, ultimately creating a "revolving door" policy in which patients were routinely readmitted to emergency rooms and penitentiaries, or in many cases, forced into the streets (Romanow & Marchildon, 2003; Dyck,

2011:190-93). Some scholars use the term "trans-institutionalization" to better capture the reality of patients who remained institutionalized albeit for shorter-term admissions in a variety of public and private settings (Dyck, 2011:190). In a written submission to Commission on the Future of Health Care in Canada (CFHCC), the Canadian Mental Health Association reported that deinstitutionalization ultimately meant the abandonment of many former hospital residents as evidenced by the increasing number of homeless mentally ill people, and those living in "grim, institution-like conditions" (CMHA, 2001:8).

The mental health service delivery model was ultimately transformed by Medicare and deinstitutionalization into "one that relied on a more individualized and client-oriented series of services" in which the onus for care moved "from the state and medical authorities to consumers, patients and families" (Dyck, 2018:275). Flood and Thomas argue that deinstitutionalization was in essence a form of privatization that transferred the locale of care into settings devoid of public funding—a shift that has not been met with sufficient investment into community mental health services and that has led to greater caregiving burdens placed on friends and families (Flood & Thomas, 2017:7). Matheson (2021) maintains that deinstitutionalization was one of the first leading neoliberal health policies, guided by the medical model, and did little in the way of remedying the mental health crisis (Matheson, 2021:40), ultimately leaving behind a large sector of the Canadian population.

Medicare and the Shift to Community

Despite the shortcomings of deinstitutionalization in Canada, community has remained a guiding concept in mental health policy, practice, and research (Frederick et al., 2018:5). According to Flood & Thomas (2017), community mental health care refers to "a network of

services including: assessment, prevention, education, counseling, case management, crisis intervention, peer support, housing and employment assistance, and other useful social services" (Flood & Thomas, 2017:17). However, community mental health programs are commonly known to be highly fragmented and difficult to navigate due to the variability in both the degree to which they are publicly funded and the jurisdiction to which they belong (Flood & Thomas, 2017:7; Little, 2021:13). As the locus of mental healthcare has increasingly shifted from hospitals to the community, funding has not followed suit (Flood & Thomas, 2017:1) and in most provinces, there has been very little effort to enhance the infrastructure for home and community care (Romanow & Marchildon, 2003:287).

Indeed, the lack of accessible mental health care in Canada is a well-documented issue (CMHA, 2008, as cited by Little, 2021:11), and among available treatments, community-based psychological services are the most difficult to access (Sunderland & Findlay, 2013, as cited by Little, 2021:12). Only procedures deemed "medically necessary"—that is, general physician and hospital services, are covered by Medicare (Dyck, 2018:270). With the exception of some emergency services, mental healthcare was thus excluded from the definition of medically necessary health services in the Canada Health Act (Wiktorowicz et al., 2020:6). As a result, most psychiatric and psychological services, homecare, and a variety of community supports are not covered by Medicare (Romanow & Marchildon, 2003; Flood & Thomas, 2017). This means that patients must either pay out of pocket or rely on third-party or employer-based health insurance plans, yet such plans are often inaccessible to low-income and unemployed or precariously employed citizens (CMA & CPA, 2016, as cited by Little 2021:13). While every province has implemented its own drug plan to provide coverage for certain prescription drugs, with the growing demand and rapid influx of new and expensive medications on the market

accompanied by insufficient federal transfers, these plans have become considerably strained, leading some provinces to withdraw public coverage (Romanow & Marchildon, 2003:292).

This overall funding arrangement signals the prevailing biomedical view that mental illnesses and physical conditions are fundamentally different and require separate treatments (Flood & Thomas, 2017:5), leading to longstanding gaps in care (Bartram & Lurie, 2017:7). For example, although twenty percent of Canadians will experience a mental illness in their lifetime (Flood & Thomas, 2017:1), a study from 2010 reveals that only a third of adults and a quarter of children had access to mental healthcare that year (AGO, 2016a, MHCC, 2012, as cited by Wiktorowicz et al., 2020:2). This discrepancy between the demand for mental health services and the provision of care in Canada still exists over a decade later, and the urgency of the situation has only increased in the context of the rapidly deteriorating mental health and increased suicidality of Canadians reported since the onset of the COVID-19 pandemic (CMHA, 2020, as cited by Shour & Tan, 2022:4).

Mounting demands for community services accompanied by severe access gaps and underfunding has also led to the over-crowing of emergency rooms across Canada (Moroz et al., 2020:283). Research has shown that although emergency departments (ED) are designated for the treatment of acute and severe cases of mental illness, many Canadians with non-acute symptoms resort to the ED because they are unable to access community care (CMHA, 2008, as cited by Little, 2021:8), or because of the exceedingly long wait times associated with accessing counselling and therapy (Moroz et al., 2020:283). For the majority of patients, family physicians are the first point of contact with the mental health system, from whom they must obtain referrals in order to access out-patient services (Flood & Thomas, 2017:10). Physicians thus often act as gatekeepers, and access is further constrained by long wait times and the cost of treatment even

when referrals are obtained (CIHI, 2017, CIHI, 2019b, as cited by Little, 2021:12-13). Moreover, many doctors are ill-equipped to treat mental health problems and by relying on the biomedical model of disease, may serve to reproduce stigma surrounding mental illness. In a qualitative study by the Canadian Mental Health Association (CMHA), patients reported that doctors held stigmatizing views of mental illness and substance abuse, which both service users and providers felt was linked to inadequate education about mental illness (CMHA, as cited by Flood & Thomas, 2017:9-10).

Community Care as Neoliberal Responsibilization

Despite the longstanding relevance of the concept of community in mental healthcare, it is often poorly defined and decontextualized in prominent policy documents and the mental health and human services research literature (Frederick et al., 2018). In a discourse analysis of the Mental Health Commission of Canada's 2009 national mental health framework, Frederick and colleagues identified a distinctly neoliberal vision of community as "a decontextualized 'place out there' […] in which people have an opportunity to strive towards self-improvement" (Frederick et al., 2018:6). The authors also found that measures of "community" as outlined in the literature ultimately reflect neoliberal rationality by underscoring the importance of striving toward self-reliance and employment, implying that community integration is merely about becoming independent (p. 8). This individualized definition "does not attend to systemic issues such as sanism [prejudice toward individuals with mental illness], racism, and poverty that impact the ability of individuals to choose how and where they live and to participate in community life" (p. 6). The authors point out that such dominant conceptualizations are significant because they influence both how services are provided and how psychiatric

conditions are evaluated by service providers (Frederick et al., 2018).

To be sure, the shift toward community mental healthcare as a result of deinstitutionalization was propelled by a neoliberal policy agenda that introduced market values into the healthcare system, ushering in an era of budget cuts with a focus on efficiency, productivity, and cost containment (Boschma & Devane, 2019:2). Funding allocated towards mental health services was dramatically decreased and privatization compromised the accessibility of care for a large number of Canadians, ultimately leading to a service void that continues to impact the mental health of the country (Roscher, 2020:7). As a result of these policies and upheld by the rhetoric of the highly influential Lalonde Report (1974) and the Canada Health Act (1984), both of which promoted preventative healthcare and the importance of individual accountability for well-being (Boschma & Devane, 2019:7), patients became increasingly responsibilized for their own health care plans, from financing prescription regimens to securing safe housing (Dyck, 2018:263). Indeed, as Poole (2011) aptly points out, the neoliberal agenda advocates the outsourcing of services to cheaper providers (Scheid, 2000, as cited by Poole, 2011:93) and the cheapest provider available happens to be the patient with a mental health condition. If one can be held accountable for the management of one's own care, Poole argues, "there are many dollars to be saved" (Poole, 2011:93). Overall, an understanding of the distinct historical developments in Canadian mental healthcare policy and practice and how these processes did not occur in a political vacuum, but rather were influenced by a strong neoliberal policy agenda, illuminates the current state of mental healthcare in Canada, which is now largely guided by the concept of self-management.

The New Recovery: Mental Health Self-Management

Self-management is a paradigm of healthcare that is now dominant across western countries, including Canada (Health Council of Canada, 2012). Based on Canadian psychologist Albert Bandura's theory of self-efficacy and the principles of cognitive behavioural therapy (CBT), self-management programs emphasize the central role of patients in the management of chronic illness (Lorig & Holman, 2003). It involves the adoption of various self-directed strategies, skills and tools that allow patients to effectively learn how to take care of themselves and become active participants in their own treatment and recovery (Sterling et al., 2010:133). Originally appearing in the chronic disease literature in the 1970s (Lorig & Holman, 2003), the concept of self-management was taken up by the ex-patient recovery movement in the 1980s which emphasized notions of consumer choice and empowerment for psychiatric survivors dispatched into the community following deinstitutionalization (Weiner, 2011:457). As some scholars have argued, the language of recovery and self-management has since been co-opted and mainstreamed by governments to support neoliberal policy agendas (Morrow & Weiser, 2012:28; Beresford, 2019). As Bury writes: "Where once the 'new age' rhetoric of personal growth, autonomy, empowerment, and the like were used by social movements to challenge state-controlled bureaucratic structures and systems, today they have become part and parcel of state activity itself" (2010:176).

Because of its emphasis on patient autonomy and responsibility, critics have argued that psychiatric self-management aligns closely with the broad-based goals of neoliberalism—namely, to create self-correcting patients who utilize market resources rather than draining healthcare systems (Greenhalgh, 2009; Teghtsoonian, 2009; Scott & Wilson, 2011; Crawshaw, 2012; Brijnath & Antoniades, 2016). As such, self-management approaches have become

increasingly common in the mental health field over the last decade (Sterling et al., 2010:130), especially in light of a rising economic burden of chronic mental illnesses like depression. Despite its poor evidence base, western governments have increasingly embraced the self-management model because of its apparent promise of cost-containment and reduced demand (Bury, 2010; Brijnath & Antoniades, 2016), an approach that dovetails seamlessly with neoliberal austerity politics.

In Canada, self-management now plays a central role in guiding mental healthcare policy and delivery across the country (Health Council of Canada, 2012, as cited by Ould Brahim, 2019:1) and has been recommended by the Canadian Network for Mood and Anxiety Treatments as part of the standard treatment of depression (Patten et al., 2009). In its 2009 mental health strategy *Toward Recovery and Well-Being,* the Mental Health Commission of Canada (MHCC) reported that two thirds of Canadians living with mental illness do not receive the care they need and recommended as its primary goal that citizens become actively involved in their own recovery and well-being (MHCC, 2019). Although it is widely acknowledged that primary care services in the Canadian system are overburdened and severely ill-equipped to treat mental illnesses due to limited resources, time constraints and inadequate training, Canadian governments and policymakers have nonetheless favoured self-management programs because of their economic efficiency and adaptability to the existing system. As Blisker and colleagues write: "A self-management workbook or website can be made available free or at minimal cost. [Self-management] can be provided within the brief visits typical of primary care and does not require primary care practitioners to receive extensive training for it to be effectively implemented" (Blisker et al., 2012:206). They add that self-management requires "expanding the circle of care" to increase "collaboration among care providers, distressed people, families, and

peers" (p. 208). The language of community care underlying such descriptions is a clear reflection of the responsibilizing policies and discourses at work in the promotion and implementation of these strategies of care. As Bury (2010) notes, terms such as 'shared decision-making', 'partnership' and 'collaborative care' have become widespread in policy documents and "are meant to impart a feeling of engagement in health care and a move away from expectations of services simply being provided by professional practitioners" (Bury, 2010:175). Brijnath and Antoniades (2016) argue that self-management in practice has involved more emphasis on the patient as the sole arbiter of care than such terminology would suggest, and a corresponding reduction in government funding of existing social and care services coupled with a growing reliance on market forces and patient consumerism (Brijnath & Antoniades, 2016:1). Most self-management programs and policies also adopt methods that conform to the biomedical model of mental illness (Greenhalgh, 2009:630), thus obscuring the social determinants of mental health and perpetuating narrow, biologically essentialist conceptions of mental illness that are disembedded from the richness and nuance of patients' lived experience.

Ultimately, the discourse of mental health self-management has transformed from one of unanimity at the heart of a social justice movement to an individualized "fundamental component of citizenship" (Weiner, 2011:458) in which successful self-management requires the adoption of a reflexive neoliberal lifestyle and identity characterized by prudent self-surveillance and incessant self-labour (Scott & Wilson, 2011:41). The imagined result is a patient who is the expert of their own recovery (Bury, 2010:175)—in essence, their own therapist—who will not deplete scarce governmental resources, but instead will turn to the market in the pursuit of well-being. The contemporary paradigm of self-management in Canada has not emerged in a vacuum but has been intimately bound up within a larger project propelled by neoliberal market

economies to transform healthcare and mental healthcare into “a managed and controlled system of production and consumption” (p. 175), the results of which have had profound ramifications for the mental health of the population.

Theoretical Framework

This thesis takes a critical sociological approach to the study of neoliberalism and depression that is guided by Foucauldian theory and the social determinants of mental health. In what follows, the relevant theories and key concepts that guide this research are presented. Briefly, I outline Foucault's definition of discourse, his theory of governmentality, as well as his concept "technologies of the self". I then provide a synopsis of his influential work on mental health and illness to further establish the relevance of Foucault's ideas to this thesis. Finally, drawing from intersectionality theory, I situate these concepts within the context of the varied and intersecting social determinants of mental health that coalesce with, and are intensified by, neoliberal politics.

Foucauldian Discourse

Michel Foucault viewed discourse as effectively a system of social control that produces knowledge and meaning and that signals the broader episteme of the historical period in which it originates (Foucault, 1969; Adams, 2017). Foucault's concern with discourse has centred on its circulation of norms and how it serves to reproduce the normative social order and, when dominant, uphold a particular view of reality that obscures all alternatives: "The effects of discursive practices is to make it virtually impossible to think outside them; to be outside them is, by definition, to be mad, to be beyond comprehension and therefore reason" (Young, 1981, as cited by Hook, 2007:2). Unlike discourse in the linguistic sense, then, Foucauldian discourse is always implicated in power relations, and involves "practices that systematically form the objects of which they speak" (Foucault, 1969:49). Foucault thought of power as a generative force—a network in which individuals are always entangled, simultaneously exercising and

undergoing this power (Foucault, 1980:98).

According to a number of theorists, the success of neoliberalism is precisely its discursive appeal, which has made it a "technology" for governing at a distance by culturally indoctrinating populations to adhere to certain attitudes, behaviours and beliefs that are economically viable—namely, individualism, competitiveness, entrepreneurialism, and personal responsibility (Harvey, 2007; Rose, 2007; Crawford, 1980). As such, any actions that divert from these norms and fail to position the individual's primary role in society as a self-sufficient consumer are often regarded as irrational or even pathological (Esposito & Perez, 2014). While to conceive of neoliberalism as merely a discourse fails to capture its profound influence since the late twentieth century, it is arguably best theorized as an ascendant political rationality, operating largely by means of discursive practices that uphold its rule (Foucault, 2008; Rose & Miller, 1992). According to Foucault, political rationalities are historically contingent, "world-changing, hegemonic orders of normative reason, generative of subjects, markets, states, [and] law" that when ascendant, govern as objective truth unless challenged by another political rationality (Brown 2015:121).

Following political theorist Wendy Brown who problematizes neoliberalism as an assault on democracy, I conceive of neoliberalism in the Foucauldian sense as a *market* rationality—one in which the language, logic and spirit of economics is suffused across all spheres of human existence (Brown, 2015). Within a neoliberal regime that is predicated on competition, enterprise, and productivity and in which market principles have come to shape all domains and transactions including those that are not directly monetary, modern subjects are configured exclusively as *homo oeconomicus,* enhancing personal market value through continuous self-investment and rigorous entrepreneurship. As Cosgrove and Karter aptly put it, the neoliberal market acts as an "epistemological machine that produces new modes of

subjectivity" (Cosgrove & Karter, 2018:670).

Indeed, by institutionalizing market values, neoliberalism has colonized subjectivity to reformulate happiness as an entrepreneurial project that can only be advanced by autonomous, risk-taking individuals who maximize well-being by seizing opportunities to gain a competitive advantage in the economy (Binkley, 2014; Sugarman, 2015). The resources to become this ideal neoliberal subject, however, are unevenly distributed across socioeconomic classes and ultimately hinge on a system in which the metric for success depends on competition and inequality (Scharff, 2016; Adams et al., 2019; Brown, 2015). As Rose and Miller (1992) point out, neoliberalism is a political rationality that is "based upon a particular conception of the nature of society and its inhabitants" (Rose & Miller, 1992:191) that has only intensified in the past three decades, effectively reshaping our ontological status as humans into marketable, always improvable human capital.

As Rose (1996b) points out, neoliberal societies are dominated by forms of subjectivity that are based upon notions of personal choice, independence, and responsibility (Rose, 1996b). As such, for individuals experiencing chronic mental health conditions that challenge these normative discourses, such as depression, the various ways in which one goes about governing their life and managing their illness are ultimately bound up with moral dilemmas (Townsend et al., 2006). By the same token, the therapeutic strategies that constitute the dominant self-management paradigm of depression are deeply discursive practices, in that they reflect and reinforce neoliberal strategies of power. By persuading them through notions of freedom and choice, the self-management paradigm ultimately shapes how individuals with depression come to think of who they are and how to live (Wilson et al., 2018).

Governmentality

Closely tied to the ways in which political rationality is made operative, governmentality signals a historically specific shift in political power and modes of governance in western democracies (Foucault, 2008). Foucault defined "government" in general as the ways in which the state, through various technologies of governance, goes about shaping the behaviours of citizens (Foucault, 2008). Governmentality denotes *how* governance is deployed according to the distinct logic that underpins practices of government in modernity (Burchell et al., 1991; Cotoi, 2011). According to Foucault, modern governmentality emerged in a historical context in which state power shifted from the authoritarian relations of command and punishment ("do this or die") to the more insidious "conduct of conduct" ("this is how you live"), a more decentralized form of power which is self-administered by the very subjects it is meant to control (Foucault, 1984; Brown, 2015). In this way, individual agency is not at odds with political power, but "a key term in its exercise" (Rose & Miller, 1992:272). What makes governmentality distinct is that it connects political power to subjectivity through its ability to influence the attitudes and behaviours of individuals without any direct governmental intervention at all (Sugarman, 2015).

Crucially, Foucault developed his theory of governmentality to describe how neoliberalism is implicated in modes of subjectivation without acting directly on subjects, but "through the intentional curtailing of the apparatus of government itself thereby effecting an indirect manipulation of the background conditions for individual conduct" (Binkley, 2014:21). Indeed, as a political strategy that advances social mores of individual freedom, responsibility and self-enterprise, neoliberalism is uniquely positioned to unobtrusively and ostensibly govern at a distance by administering populations through their own voluntary self-management (Esposito & Perez, 2014). As a style of government that was devised so the state could divest

itself of many obligations and download them onto the individual (Rose et al., 2006), neoliberalism represents a form of governmentality that is discursive in nature, through its reorganisation of policies and programs tailored toward the government of personal life. Despite its deliberate disengagement with governmental affairs, as Crawshaw observes, neoliberalism maintains an arms-length influence that crosses public and private boundaries, permeating even the most private of human activities, including health-related decisions (Crawshaw, 2012). In neoliberal governmentality, discursive practices reinforce and shape behaviours according to the values of the market. Esposito and Perez argue that the market is given the status of ontological category, and virtually everything must be understood and attained within its confines, especially mental health and illness (Esposito & Perez, 2014).

Mental Health and Illness

Foucault's work on "madness" and mental disorder (Foucault, 1965) has remained relevant for theorising the ways in which mental health and illness have been problematized in Western cultures through various power-knowledge relations—including, as Simone Fullagar outlines, oppositional binaries such as "sane/insane, normal/abnormal, healthy/ill, mind/body, masculine/feminine, white/black, and expert/patient" (Metzl, 2010, Ussher, 2011, as cited by Fullagar, 2017:40). In his first work *Madness and Civilization,* Foucault described how the modern subject was constituted by medical discourses and how institutions such as hospitals, asylums and prisons served to exert social control over the mentally ill through outwardly coercive means (Foucault, 1965; Reveley, 2016). Whereas under this regime of sovereign power patients were directly controlled by state-sanctioned institutions through methods ranging from involuntary shock treatments to eugenic cleansing, under neoliberal governmentality, social

control has involved the normalization of chemical consumption in the treatment of mental distress (Ehrenberg, 2009; Moncrieff, 2006).

The market orientation of society under neoliberalism has also meant that mental healthcare is measured by market standards and mental illness is recast in economic terms, such that mood disorders like depression are framed as economic "burdens" assessed in terms of loss of worker productivity and increased state spending (Layton, 2014; Cosgrove & Karter, 2018). Mental health becomes commodified and pharmaceutical consumption in the treatment of mental illness is increasingly normalized. Esposito and Perez see this "largely [as] a self-induced form of violence as people, mostly willingly, chemically modify themselves to better adjust to the market reality demanded by neoliberalism" (Esposito & Perez, 2014:425). The influence of neoliberalism on mental healthcare is further evidenced by a rapidly proliferating international market for pharmaceutical companies, resulting in abundant and expensive over-the-counter psychoactive drugs marketed to mental healthcare "consumers" (Rissmiller & Rissmiller, 2006; Crawshaw, 2012; Rose, 2013). From this perspective, psychoactive drugs constitute a technology meant to modify unruly and problematic behaviours in order to bring individuals into alignment with the ideal neoliberal subject position (Ehrenberg, 2009; Esposito & Perez, 2014). I argue that it is useful to conceive of such drugs as one of many "technologies of the self" marketed to individuals in order to shape themselves into neoliberal citizens.

Technologies of The Self

In his last two volumes of *The History of Sexuality* (1976-1984), Foucault develops his theory of technologies (or "techniques") of the self, which he defines as forms of knowledge manifest as intentional and voluntary strategies "through which men [sic] not only set themselves

rules of conduct, but also seek to transform themselves, to change themselves in their singular being" (Foucault, 1984:10-11). In essence, they are methods through which human beings constitute themselves as subjects (Kelly, 2013; Reveley, 2016). In accordance with Foucault's genealogical approach, this theory posits that subjectivity is something that is historically constituted through culturally specific practices (Kelly, 2013). Crucially, technologies of the self are disciplinary practices that produce normalization; they are not invented by the subject but "imposed upon him [sic] by his culture, his society, and his social group" (Foucault, 1988:291). Foucault connects these self-directed practices to the ways in which humans engage in the "care of the self"—a precept he traces back to Antiquity and that informed much of Greek and Roman philosophy as well as early Christian spirituality (Godrej, 2017; Faustino, 2020). As Faustino points out, the "care of the self", or what is now known in popular discourse as "self-care" (Lemke, 2001; Godrej, 2017), remains a strikingly relevant practice in Western therapeutic and psychiatric discourses (Faustino, 2020). Indeed, most of modern psychotherapeutic approaches are premised on various technologies of the self adopted by the patient in order to cope with mental illness. An example is Cognitive Behavioural Therapy (CBT), perhaps the most popular therapeutic modality employed by "psy" practitioners in the West and emblematic of what Burchell et al. (1991) call "the new psychological culture"—"that cornucopia of techniques of the self which symbiotize aptitude with self-awareness and performance with self-realization […]" (Burchell et al., 1991:44).

Neoliberal directions in mental health policy have been aimed at the reduction of healthcare costs through the deregulation and privatisation of services, reflecting a general move toward an individualizing, patient-centered approach where patients must play an active role in recovery through agency and self-determination (Townsend et al., 2006; Rose, 2013; Gooding,

2016; Teghtsoonian, 2017). In this self-management model, both the experience of depression and its treatment are positioned as a function of individual responsibility through informed acts of choice and self-care (Lemke, 2001; Teghtsoonian, 2017). Patients are now often encouraged to manage alone, whether through the use of medication or self-transformative practices (Brijnath & Antoniades, 2016) and government policies have even increasingly endorsed bibliotherapy, the reading of self-help literature, as a form of treatment for depression (Philip, 2009). I propose that it is useful to theorize these self-directed practices as technologies of the self that are adopted by individuals to shape themselves into the emotionally robust subjects that are demanded of neoliberal capitalism (Reveley, 2016). Foucault's concepts of governmentality and technologies of the self illuminate the neoliberal discourses that undergird the current self-management model of mental healthcare, and its individualizing, responsibilizing, and depoliticizing consequences.

Methodology

The intent of this research project was to understand the extent to which neoliberal discourses inform the narratives and experiences of Canadians suffering from depression, using an online depression forum as a source of data. Data were analyzed following principles of Thematic Analysis (Braun & Clarke, 2006) with the aim of providing a qualitatively rich, in-depth account of the phenomenological and discursive dimensions of depression as it is experienced within the context of neoliberal policy and culture. In this section, I briefly review existing research into online forums to highlight the value of these platforms for researching mental health communities. I then provide a discussion of relevant ethical considerations implicated in this research design. Finally, I describe the methodology used for this study, outlining the tenets of Thematic Analysis, and the step-by-step procedure used to carry out the data analysis.

The Online Forum in Research

Research into online forums began in the early 1990s, as the Internet became a growing source of health information (Stommel & Lamerichs, 2014:198). Also referred to as self-help or support groups, these platforms have become important spheres of knowledge exchange for those wishing to discuss health and illness-related issues and to receive information and support from others with similar experiences (Barney et al., 2011; Stommel & Lamerichs, 2014; Nimrod, 2012). This growing field of research has demonstrated that the online forum is a powerful site of self-disclosure surrounding mental health issues (De Choudhury & De, 2014; Manikonda & De Choudhury, 2017, as cited by Yates et al., 2017) and in the context of the cybernetic revolution, it is now a leading technology used to seek support, especially among those with

chronic and stigmatized mental illnesses like depression (Nimrod, 2012; Smith-Merry et al., 2019). There is also recent evidence that accompanying increased rates of mental distress reported since the outbreak of the COVID-19 pandemic, there has been a significant increase in the use of digital technologies to support mental health (Sorkin et al., 2021), especially as mental healthcare service delivery has rapidly shifted online (Feijt et al., 2020). This research suggests that mental health forums have become as important a therapeutic resource as ever before. Some examples of popular depression forums that have been pursued in research include "The Depression Forums", which is one of the largest peer-to-peer mental health forums in North America (Pan et al. 2020:4), "The MoodGarden" (Ellis et al., 2011), "PsychCentral.com" (Breuer & Barker, 2015), "BeyondBlue" (Fullagar, 2008; Nimrod, 2012, 2013a), and "Reddit (r/depression)" (De Choudhury & De, 2014; Tadesse et al., 2019).

There are many benefits associated with using online forums, including their 24-hour accessibility independent of geography as well as their relative anonymity, which allows for more uninhibited expression than in face-to-face encounters, especially for those with stigmatized illnesses who may fear judgment in other social settings (Bowker & Tuffin, 2004; Seale et al., 2010; Barney et al., 2011; Nimrod, 2012; Stommel & Lamerichs, 2014). Studies have found that people with stigmatized illnesses use the Internet for health information significantly more than those with non-stigmatized illnesses (Berger et al., 2005, as cited by Nimrod, 2012:23), and among those with chronic conditions, people with depression use online forums the most (Millard & Fintak, 2002, as cited by Nimrod, 2012:23). Some motivations for turning to online forums when depressed include the therapeutic benefit associated with formulating and sharing mental illness narratives online (Stommel & Lamerichs, 2014), and the ability to combat the social isolation and loneliness that frequently accompany depression by

forging social connections and receiving peer support in a nonjudgmental environment (Smith-Merry et al., 2019). Although there is mixed evidence concerning the potential to alleviate symptoms of depression, prolonged participation in online depression forums has been found to lead to positive emotional change (Park & Conway, 2017) and on a more fundamental level, forums address two basic needs of people with depression: the need to gain insight into possible treatment options and to learn about coping mechanisms in the management of depression (Lamberg, 2003, as cited by Nimrod, 2013b:431).

As a research tool, online forums provide a vast and semantically rich source of naturally occurring data and are especially useful for critical researchers seeking to explore everyday discussions about sensitive topics for which data might otherwise be difficult or impossible to obtain (Jowett, 2015:288). While online forums are now increasingly being used as a source of data, existing qualitative research into stigmatized illness experiences such as depression has tended to use interview data (e.g., McCabe & Leas, 2008; Weiner, 2011; McCann et al., 2012; Fullagar & O'Brien, 2013; Holm et al., 2013; Highet et al., 2014; Chambers et al., 2015; Brijnath & Antoniades, 2016; Smith-Merry et al., 2019). While this method can generate valuable phenomenological insights, it entails limitations that may be addressed by using online forum data (Seale et al., 2010). Specifically, interviewers have the advantage of directing a discussion to conform to relevant research questions as well as posing follow-up questions. However, this also tends to render the method inflexible and potentially contrived, and the presence of a researcher can lead to interviewer bias, especially in the case of particularly sensitive topics (Salazar, 1990:568). In particular, individuals suffering from a stigmatized illness may be less willing to share their experiences openly in front of a researcher than they would in a more informal setting such as the Internet (Seale et al., 2010). Moreover, as Seale and colleagues point

out, the way in which interviews tend to be retrospectively oriented demands a narrative recall of past experiences that is influenced by both the physical and semantic locale of the interview. Conversely, exchanges shared on the Internet represent everyday experience in action, rather than probed self-reconstructions: “The comparison of interviews and Internet messages is also one between what people say in a performance and what people do in lived experience” (Seale et al., 2010:604).

Whereas the nature of interviewing a vulnerable population such as those suffering from a stigmatized illness can prove challenging and require considerable experience and sensitivity training on the part of the interviewer, the Internet is an already-existing guide to the everyday concerns and experiences of those living with a particular illness, and the anonymity of online communication makes it an ideal medium for the sharing of diverse and detailed illness narratives. Indeed, the wealth of information available in these widely accessible narratives is the main advantage of the online forum as an object of sociological research (Seale et al., 2010). Moreover, online support groups are often conceptualized as communities in their own right, in that they share many features of “offline” communities, including norms, values, roles, rituals and culture (Lamerichs, 2003; Herrin, 2004, as cited by Stommel & Koole, 2010:359). As such, they can be used as a research tool to observe how people interact in the social world (Bowker & Tuffin, 2004), and how people talk about and “do” illness (Seale et al., 2010:605). To investigate an online forum as a community requires a concept of community that is not static but based on active participation (Stommel & Koole, 2010:358). Indeed, the posting that takes place on an online forum is rarely unidirectional, especially because such forums are often staffed by moderators and administrators whose duty it is to welcome newcomers, and whose thread replies often come in the form of advice sharing (Yates et al., 2017:1). This advice sharing is a central

feature of online forums, enabling the researcher to observe peer-to-peer discussions in a more naturalistic setting that is not influenced by the presence of a researcher (Jowett, 2015:288).

Existing Research

Existing studies on online support groups have tended to address one of two broad inquiries (Kaufman &Whitehead, 2018): the first focusing on evaluating the effectiveness of such groups as a therapeutic tool (e.g., Griffiths et al., 2009; Griffiths et al., 2012; Horgan et al., 2013; Nimrod, 2013a, 2013b; Breuer & Barker, 2015; Park & Conway, 2017) and the second focusing on the interactional and discursive dynamics that take place therein (e.g. Lamerichs, 2003; Lamerichs & Te Molder, 2003; Vayreda & Antaki, 2009; Horne & Wiggins, 2009; Stommel and Koole 2010; Smithson et al., 2011; Barney et al. 2011; Stommel & Lamerichs, 2014; Gough 2016; Kaufman & Whitehead, 2018; Feldhege et al., 2020). Those in the latter camp have adopted qualitative methods concerned with the interactive work that goes into constructing illness narratives and negotiating identity through discourse, such as Discursive Psychology (DP), Conversation Analysis (CA) (e.g.. Lamerichs, 2003; Lamerichs & Te Molder, 2003; Stommel & Lamerichs, 2014), and to a lesser extent, Thematic Analysis (TA) (e.g., Barney et al., 2011; Gough, 2016). Researchers using these approaches emphasize the importance of viewing online interaction not merely as a way to "reach people behind the screen," but as everyday social interaction that involves the deployment of various discursive devices (Lamerichs & Te Molder, 2003, as cited by Flinkfeldt, 2011:763).

These scholars have explored a range of topics including the participation styles of group members (Kaufman & Whitehead, 2018; Feldhege et al., 2020), the informational needs of people who participate in online forums (Barney et al., 2011), the construction of community and

identity (Stommel & Koole, 2010; Stommel & Lamerichs, 2014), and the ways in which problems are presented and advice is solicited and given (Vayreda & Antaki, 2009; Smithson et al., 2011; Kaufman & Whitehead, 2018). A prevailing theme in the discursive literature has been the concept of accountability and authenticity, and how these are negotiated within the performative context of the illness narrative. Lamerichs' (2003) study of everyday interaction in an online forum on depression was among the first to articulate the ways in which, particularly in the absence of an official medical diagnosis, individuals with depression must undertake discursive work to actively construct a depression identity that is legitimate to evade attributions of blame and responsibility for one's illness by other group members (Lamerichs, 2003). Presenting the source of depression as external rather than personal, for example, enabled members to "present themselves as depressed, while reducing the extent to which this disease can be regarded as the result of some personal shortcoming" thus allowing them to maintain a sense of competence (Lamerichs, 2003:77).

This laid the groundwork for subsequent studies including Horne and Wiggins' (2009) study of users in an online forum on suicide. They found that users paradoxically worked to construct their identities as authentically suicidal in order to warrant group membership, while simultaneously presenting themselves as rational and competent individuals who did not require help. Being depressed in this context required ongoing micro-management as users attended to concerns of blame and accountability (Horne & Wiggins, 2009). Gough (2016) identified similar themes in his analysis of help-seeking and support formulations in an online depression forum for men. Medical discourse, including a medical diagnosis, was found to be essential for the validation of men's accounts of depression in the forum; however, men without a diagnosis were still able to receive support if they formulated their narrative in ways that highlighted their

proactiveness and authenticity (Gough, 2016). Using Conversation Analysis to explore how social support was offered in initial postings on an online forum on Bipolar Disorder, Vayreda & Antaki (2009) uncovered the apparent contradiction between a new user's first thread and the unsolicited advice offered in response by other forum members. By focusing their analysis on the critical moment of a member's introduction into an online forum, the authors provide a compelling account of the online forum as a culture in which unsolicited advice may function ideologically to "induct the new user into the mores of the group [and] into the very meaning of bipolarity itself" (Vayreda & Antaki, 2009:931).

While the studies I have outlined are invaluable contributions to the literature, most of the existing work on online forums is dedicated to forums about physical health problems (notably diabetes and cancer), and comparatively little has been written about depression forums. Moreover, in the larger body of empirical literature on neoliberal discourse, the online forum is seldom used as a source of data, despite its methodological advantages. To my knowledge, there are no existing studies that have explored the topic of neoliberal discourse in an online depression forum. As such, in the interest of expanding on the existing literature and taking advantage of a rich data source that lends itself to the observation of depression discourse in action, the object of analysis for the present study is an online depression forum. There are a number of ethical questions to consider when using an online mental health platform as a source of data in social research. Before describing the methods deployed in the current study, I will outline some of these considerations.

Ethical Considerations

Whether or not one is required to obtain informed consent from members of an online

support group has been a matter of ongoing debate in the literature on social research ethics—the central issue being whether online forums are to be considered public or private domains (Vayreda & Antaki, 2009; Gough, 2016). While some argue that online communities exist with varying degrees of expected privacy even when they are publicly accessible (e.g., King, 1996) others contend that when the content of a forum is openly accessible, this constitutes public spaces akin to the "offline" spaces used in traditional naturalistic observation, making them exempt from research ethics review (Nimrod, 2012; Roberts, 2015). As Flinkfeldt points out, Internet interaction is public in a way that regular talk is not (Flinkfeldt, 2011:764). The Internet in general, and online forums in particular, are relatively anonymous as users often adopt pseudonyms and tend to omit or limit any identifying information in their contributions, aware that they are addressing an audience of strangers (Jowett, 2015). Moreover, there are many other communication functions on the Internet that are private in nature such as email or private chat windows, and members of public forums will occasionally opt to move more sensitive discussions to one of these platforms with particular group members, thus showing an awareness of the forum as a public domain (Flinkfeldt, 2011).

In Bond and colleagues' interviews with users of an online health information forum, it was generally accepted by participants that material posted on an open forum is publicly available and thus could reasonably be used for research purposes without necessitating users' permission (Bond et al., 2013). While participants expressed a desire for their words to remain confidential, they generally agreed that social research into the health issues of their concern is important, acknowledging that forums serve as a source of data with the potential to raise awareness about the issues they raise (Bond et al., 2013). Moreover, as past research demonstrates, the task of reaching forum members to seek informed consent raises some

important concerns: Bowker and Tuffin point out that publicly notifying an online community about potentially using their interactions as the subject of research may have a negative impact on participants' sense of safety in personal disclosure (Bowker & Tuffin, 2004). And, the known presence of a researcher has the potential to limit or alter members' personal disclosures and ultimately compromise the quality of otherwise naturalistically occurring data, which is one of the main strengths of researching the online medium (Seale et al., 2010). Finally, contact information is rarely available because of users' anonymity while forum membership is often transient, as some contributors may no longer be active in the chat or may have since left the forum (Bond et al., 2013). These barriers make obtaining informed consent largely unworkable.

For all of the reasons mentioned, there has been a considerable history of qualitative studies on forums that have bypassed ethical review due to the inapplicability of standard ethical guidelines on this type of research (e.g., Seale et al., 2010; Nimrod, 2012; Rodriguez, 2013, Schotanus-Dijkstra et al., 2014, as cited by Roberts, 2015). Researchers' acceptance of online forums as public platforms is what has invariably provided the justification for these procedural circumventions because when online spaces are deemed public, many otherwise relevant ethical considerations disappear (Roberts, 2015). Nevertheless, researchers investigating online forums have adopted certain ethical protocols in order to best protect the privacy of members, such as anonymising personal usernames as well as the name of the forum or associated websites (e.g., Horne & Wiggins, 2009; Stommel & Koole, 2010; Flinkfeldt, 2011; Gough, 2016). For example, in her research on an online forum for sufferers of Chronic Fatigue Syndrome, Flinkfeldt substituted the letter "F" where the name of the forum was mentioned in the data (Flinkfeldt, 2011). Many others have opted to use pseudonyms to protect users' identities, even where usernames are already anonymous (e.g., Stommel & Koole, 2010; Yates et al., 2017). A more

rigorous approach to ensuring privacy has been to avoid the use of direct quotes that could potentially be traced back to members. This can include anonymising and paraphrasing excerpts, or otherwise making minor changes to quotes to ensure they remain untraceable in search engines (e.g., Malik & Coulson, 2013, as cited by Roberts, 2015).

Overall, there have been many techniques designed and adopted over the years that have allowed researchers to probe into the vast and semantically rich social world of online communities, all while maintaining the ethical integrity of research. Without the adjusted stipulations surrounding the process of obtaining informed consent, the discursive and sociological depth of these studies might not have been possible. As such, in my own research, I adopt the perspective of online forums as public spaces. The forum of interest for this study is open access, meaning that archived and ongoing threads can be read by anyone on the Internet. A membership is not required to access the forum and read its contents, although it is required in order to post to the forum. Members who join the forum are required to read and consent to the terms and conditions laid out by the administration of the website. In these terms and conditions, users are strongly encouraged not to include any identifying information in their username, or in their posts. Membership and participation in the forum are voluntary, and members are aware that it is not a private group and that their posts are open to the public Internet community. Accordingly, I took the position that because the forum is "open access," obtaining informed consent was therefore not applicable. (This decision was affirmed by the Coordinator of Research Ethics at Concordia University as exempt from review by the Research Ethics Board; K. Gregg, personal communication, June 10, 2020). This exemption was made on the basis that the study met the following three criteria, in accordance with the ethical guidelines outlined by the most recent Tri-Council Policy Statement for research involving humans (TCPS, 2018):

1 - The online forums are public.

2 - There is no reasonable expectation of privacy.

3 - There is no direct interaction between the researcher and the individuals on the forum—the research is purely observational.

Despite meeting these criteria, in order to ensure the privacy of forum members, I have further anonymized all usernames using pseudonyms randomly selected from an online name generator. I have also refrained from using the name of the forum, referring to it simply as "the forum". All extracts presented in the analysis have been slightly altered or paraphrased in order to prevent the digital traceability of posts, while preserving the original meaning.

Data Collection

The data collected for the present study were messages exchanged by members of a publicly accessible online forum for Canadians experiencing depression. The forum was selected due to its Canadian scope and its relatively small volume of threads, which allowed me to yield a manageable data set conducive to close qualitative analysis. The sample selected for analysis comprises a total of 804 messages within 117 separate discussion threads posted by 108 different group members over a period of 2 years, from January 2018 to April 2020, i.e., the period during which I completed my data gathering for this project. There were no inclusion criteria for this study, so every post in the selected sample was analyzed. The sample is not randomized and is therefore not intended to be representative of the wider population of forum users. Members adopted pseudonyms in order to post messages in the group anonymously and as a result, information about the sociodemographic characteristics of members was limited, although members did occasionally indicate their age, gender, or other personal information to provide

context to certain posts. The forum is overseen by two moderators whose role is to welcome newcomers to the group and to respond to every post in show of support, in addition to sharing their own personal experiences and advice. The majority of forum members disclosed that they suffered from either clinically diagnosed or undiagnosed depression; otherwise, members were family members or partners of depression sufferers.

Thematic Analysis

After printing out the entire transcript, the data were analyzed using Thematic Analysis (Braun & Clarke, 2006). According to Braun and Clarke, Thematic Analysis (TA) is a systematic research method for "identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2006:6), where a theme is thought to capture "something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (p. 10). Rather than attending to what is unique or uncommon in a data set, although it does not limit the exploration of such themes when they are meaningful, TA is a way of identifying and making sense of commonalities in the way a topic is discussed or written about (Braun & Clarke, 2006).

Braun and Clarke outline two general approaches to Thematic Analysis: an essentialist and inductive approach in which analysis is data-driven and allows the researcher to report on the semantic experiences of participants, versus a constructionist and deductive approach, which is driven by theory and goes beyond semantic content to examine "the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society" (Braun & Clarke, 2006:79). This latter approach, which I follow, allows analysts to probe for meaning at the latent level with a view to uncovering underlying assumptions or

ideologies that are then theorized as shaping the semantic content of the data (p. 84). Thematic Analysis in this form often shares features with Discourse Analysis (DA) and Conversation Analysis (CA), however Braun and Clarke highlight that unlike DA and CA, TA conducted in a constructivist paradigm does not seek to describe the detailed ways in which language is formulated in the construction of individual accounts, but rather to theorize the sociocultural contexts and broader societal discourses that inform and connect individual accounts (p. 85).

My constructivist approach to TA is theoretically guided by Foucauldian governmentality in order to contextualise the ways in which depression narratives are informed by the political, cultural and social structures that give them meaning. Of particular interest to this analysis were: the ways in which depression is talked about; how depression is managed and through what techniques; and more specifically, how these accounts of living and coping with depression are informed by or signal more hegemonic neoliberal discourses of individualism, responsibilization, self-management and self-care.

The data analysis was conducted in accordance with the six-phase process of TA outlined by Braun and Clarke (2006), as follows:

(1) *Familiarising oneself with the data and identifying themes* – The analysis began with conducting a preliminary review of the data transcript in order to identify general patterns of interest. After this initial review, I actively read the transcript multiple times to further familiarize myself with the data. This involved annotating the transcript by hand using margin notes.

(2) *Generating initial codes* – After identifying patterns of interest, I began systematically coding each segment of data that was interesting or relevant in addressing my research questions. This phase involved organizing the data into meaningful categories by using

key words or memos that represented specific ideas or potential themes. I considered features of the data that appeared most frequently, as well as those that were uncommon yet salient, while paying particular attention to the topics that corresponded with neoliberal discourses.

(3) *Identifying potential themes* – After coding the entire data set, I collated and sorted all of the relevant coded extracts into potential themes. Following the advice of Braun and Clarke, I used visual cues to help with this process, including coloured highlighters and post-it notes which corresponded with each theme. This allowed me to better understand the relationship between codes and themes, as well as consider the importance of each theme and whether it should serve as a main theme or a subtheme.

(4) *Review of potential themes* – This step involved reviewing the candidate themes and collapsing some into subthemes while expanding others into more overarching main themes. Potential themes that were not supported by enough data, or for which the data were too diverse, were discarded. The goal in this phase was to revise and identify final themes that were distinct from one another, represented a coherent pattern, and articulated something uniquely significant in the data

(5) *Defining and naming themes* – After reviewing my potential themes, I identified six final themes: the biomedical model, neoliberal stigma, technologies of the self, loneliness and the importance of social support, a broken mental healthcare system, and challenging the neoliberal narrative. These overarching themes contained fourteen subthemes in total, which I elaborate in the results section below.

(6) *Production of the report* – In this final phase, I constructed an analytic narrative of my findings. To present this narrative, I collected the most compelling data excerpts that best

captured the essence of each theme and that helped to frame my argument and address my research questions. The excerpts are represented in italics, indented, and separated from the main body of the text.

This method of analysis was best suited to my purposes in this study for a number of reasons. First, the flexibility of TA allowed me to explore my research questions within the unique context of my own epistemology, theoretical lens, and methodological design, but without confining my explorations to any of these frameworks. This flexibility also allowed me to focus on patterns that were pertinent in the data without limiting an exploration of less recurrent yet interesting topics that offered an original perspective.

Second, because TA was developed primarily for use within a qualitative paradigm and emphasizes the active role of the researcher in coding and theme development (Braun & Clarke, 2017), using this method provided the space for me to approach the data organically and reflexively, allowing for a qualitatively richer analysis that would otherwise be confined by more rigid analytical tools. Like Braun and Clarke, I consider this reflexivity an advantage rather than a limitation, especially given that my research involves prioritizing the lived experience of individuals with a complex illness that remains largely stigmatized and taboo. As someone who has firsthand experience with depression, I had a personal connection to the experiences that were narrated in this study. This "insider" perspective coupled with my sociological practice enriched my understanding of the ways in which these experiences were embedded in power relations and informed by particular discourses, which was enhanced by the reflexivity and versatility of TA as an analytic tool.

Lastly, the compatibility of TA with a critical framework allowed me to identify not only the manifest (explicit) patterns in the data, but also to delve further into the latent (underlying)

meanings behind the beliefs, practices, and lived experiences of the individuals in this study (Braun & Clarke, 2017:298). This kind of fine-grained analysis is particularly well suited to theoretically driven, qualitative sociological research aimed at interrogating the social and political meanings of a given topic, like my own. I now turn to my findings.

Results

My interest in pursuing this project was to understand the ways in which depression is talked about, experienced, and managed by Canadians who suffer from it. In other words, this study aimed to explore the discourses that inform depression narratives in a Canadian context, with a particular interest in uncovering dominant neoliberal discourses such as individualism and personal responsibility and the extent to which these might have been internalized, negotiated, or otherwise rejected by sufferers. As indicated, there were six themes identified in the analysis: (1) the biomedical model of mental illness; (2) neoliberal stigma; (3) technologies of the self; (4) loneliness and the importance of social support; (5) a broken mental healthcare system; and (6) challenging the neoliberal narrative. For the purposes of clarity and nuance of analysis, these themes also contained subthemes, of which I identified fourteen in total. In what follows I present my findings by elaborating upon each theme in the order indicated above.

"It's not you, it's just a chemical imbalance in the brain": The biomedical model of mental illness

The day-to-day experiences of depression described by members of the forum were at once varied and resonant. Commonalities emerged in the ways in which people with depression feel and think, as well as the struggles they encounter on a daily basis. In terms of symptomology, patients reported feeling fatigue, a lack of motivation, low confidence, social withdrawal, and loneliness. Although forum members routinely described a range of social and environmental causes of depression, the predominant way in which members talked about and made sense of their depression was through the use of biomedical discourse. In this way, members appeared to have internalized the dominant biomedical view that depression is a

function of individual neuropathology that must be managed with psychotropic drugs (Engel, 1977; Deacon, 2013). Members deployed biomedical discourse through the discursive separation of self and illness, by accepting medical authority, and by viewing medication as the primary pathway to recovery.

Self vs. illness

Members often used metaphors to describe their depression as an experience separate from identity. Such metaphors included depression as a "black dog" or a "black cap" which conveyed feelings of detachment from who they really are and a desire to return to their "true" selves. In this way, they appeared reluctant to accept depression as part of their identity, but rather as a chemical imposter that had "hijacked" their brains. Although the nature of depression was chronic for most members of the forum, there was a general understanding that they were temporarily afflicted by an illness that had inexplicably struck them, and that full recovery and a return to authentic selfhood was attainable with the right resources, and in particular, the right medication.

> *I just want to be the person I was before.. happy laughing and enjoying life. I miss the old me so much. Life is different as I know it and I want to be back to myself. (Harper)*
>
> *I just want to get over this so I can get back to being myself. (Oliver)*
>
> *Sometimes I feel like I'm going to "wake up" someday and be myself again. (Penelope)*

By describing depression as something separate from selfhood, these members articulated the Cartesian dualism inherent to the biomedical model, which views disease as an entity that is isolable from the person, and which targets the former as an "object of intervention" (Weiner, 2011:453). The assumption of a natural distinction between self and illness is a finding that has been similarly observed by Weiner (2011) and Wilson et al. (2018) in their studies of patients

suffering from bipolar disorder. Both authors found that the mind-body dualism inherent to the biomedical model, which posits a rational self-managing agent, is ultimately at odds with their bipolar disorder, wherein the patients' rationality is called into question. In conveying this presumed split between selfhood and depression, the members in the present study nonetheless articulated the unstable boundaries between the two, as they described confusion and difficulty distinguishing between their own "rational" thoughts and the intrusive, pathological thoughts of depression:

> *I've been depressed for so long I don't know when I actually don't like things or if it's just my depression talking, and I don't know which aspects of my worldview are inherent to my depression or actually rational evaluations. (Dawn)*

As Engel (1977) contends, the distinction between 'disease' and what he calls 'problems of living', as well as the boundaries between 'healthy' and 'sick' are always unclear because they are far from discrete variables, but rather mediated by various sociocultural factors (Engel, 1977:132-133). While the notion of self-management is understood as the method by which an individual manages their condition, Wilson et al. (2018) ague that rather than the condition, "it is the self that ends up being the target of such practices and […] illness and self are not necessarily distinct constructs as medical discourse would suggest" (2018:5). This idea links with the Foucauldian notion that discourse plays a powerful role in shaping subjectivity. It became apparent that the individuals in this study adopted "biomedical subjectivities" (Weiner, 2011:453) in constructing an identity as "depressed" and adopting discursive cues from the biomedical model of mental illness. This process was further advanced by members' often unquestioned acceptance of medical authority.

Accepting medical authority

Members frequently appealed to biomedical expertise which allowed them to legitimize their experience of depression, and the authority of medical professionals was emphasized throughout many discussions. Members ascribed to the chemical imbalance theory of mental illness by framing depression as a brain disease:

> *It's the synapses in our brains that aren't releasing enough serotonin or dopamine. Scientists are coming closer and closer to understanding how our stomachs and brains interact when it comes to depression. If you had Lupus, Multiple Sclerosis or Cancer … you and everyone around you would take it serious. Depression is no different. (Quinn)*

These framings legitimized depression as a "real" illness and helped to combat stigmatizing attitudes that depression was the result of laziness or weak willpower. Having a diagnosis also gave legitimacy to the experience of depression, and in the absence of a diagnosis, members struggled with feelings of guilt for "feeling bad for no reason". For example, a newcomer expressed uncertainty as to whether her symptoms could be labeled "depression" or just "regular sadness", undermining her suffering because it was not of a clinical nature:

> *I know people with clinical depression feel much worse than I do but I don't know, something just doesn't feel right. (Penelope)*

There was a common understanding that the first step in addressing feelings of depression was to receive a diagnosis from a medical professional. In response to the above post, another member expressed the utility of a diagnosis in moving forward:

> *Whether you have the disorder called depression, I really can't say. Some of us seem to be born more prone to mood fluctuations than others. If those mood changes interfere badly enough in a person's life, then a diagnosis may help and you can go from there. (Ursa)*

Based on posts such as these, it appeared that diagnosis had discernable impacts on members' identities. By allowing them to label their suffering as the disease called "depression" a diagnosis in many cases alleviated uncertainties surrounding symptoms as well as a sense of blame. In

other cases, diagnosis generated even more uncertainties and exacerbated suffering, particularly when members received conflicting diagnoses from multiple practitioners. One member lamented the recent publication of the DSM-V, which interfered with his original diagnoses, and thus challenged his illness identity:

> *After successfully keeping my life mostly positive with a diagnosis of Major Depressive Disorder and Generalized Anxiety Disorder, the DSM-V came out, I changed GPs and things went downhill. All of a sudden I was diagnosed with Bipolar II by one pdoc and BPD by another. (Perry)*

Without the diagnosis that he felt best represented his experience, Perry felt that he was stuck and unable to receive proper treatment. His experience demonstrates the ways in which objectifying medical practices led by the biomedical model can serve to undermine patients' personal experiences by prioritizing discrete definitions of disease that are decontextualized from their environmental and phenomenological realities.

The most common advice given to fellow members was to seek the help of a medical practitioner, typically a general physician or a psychiatrist, and when other forms of advice were given, they were frequently qualified by statements such as "I'm not a doctor" or "I'm no expert". These disclaimers and frequent recommendations to seek professional help, despite the fact that most members reported negative experiences with both medical practitioners and biochemical therapies, suggests that they accepted and even revered medical expertise even when it had repeatedly failed them. This finding has been observed elsewhere (e.g., Giles & Newbold, 2011; Wilson et al., 2018) and signals the ways in which the modern subject continues to be constituted by medical discourses, albeit in less overtly coercive ways than in the context of the nineteenth century asylum (Foucault, 1965). In the era of neoliberal governmentality, as Foucault might suggest, social control involves the normalization of expert biomedical and "psy" discourses of mental illness and its corollary treatments of chemical consumption.

Although forum members engaged in their own self-directed practices outside of the formal medical system, depression narratives were largely shaped by medical knowledge which limited a more contextual understanding of depression by re-inscribing it as a neurochemical deficit. Fullagar and O'Brien (2014) have observed that the dominant biomedical approach to mental illness promotes the creation of "deficit" identities that limit the capacity of depressed individuals to cultivate alternative forms of self-relating beyond a pharmacological or cognitive-behavioural framework (Fullagar & O'Brien, 2014).

From a Foucauldian perspective, the normalised "expert" discourses that circulated in the forum serve to reinforce the notion that depression is a pathological entity, and the depressed and therefore deficient individual must comply with medical authority to return to a state of normality. By applying Foucault's analytic framework of ethical self-formation, it could be argued that the members in this study adopted biomedical knowledge as the basis upon which to construct an ethical self—that is, dutiful, self-managing biomedical consumers "who are 'medicine compliant', keep appointments, are able to assess their coping performance in a way that aligns with the assessment of professionals" (Rose, 1996b:14). The unique life stories of individuals with depression are thus subordinated, and alternative and collective pathways of healing are limited by the hegemony of individualizing biomedical discourses.

Reliance on medication

The vast majority of forum members reported having been prescribed medication to treat their symptoms of depression. While some described positive outcomes, overall experiences with medication were negative, leading to a range of debilitating side effects which in many cases worsened depression. Despite these repeated failed attempts at finding therapeutic relief, there

was a strong perseverance to continue trying different medications in order to find the "right one." Robin, who had suffered from chronic depression since the age of twelve, reported being "treatment resistant" but nonetheless remained determined to find a pharmacological solution:

> *My treatment was finally started when I was about 22 and we have been through all the medications and medication combinations that my psychiatrist could throw at me. Have been through ECT as well. I have been treatment resistant and we are down to waiting for the next new medication to hit the market and hope it works. (Robin)*

That so many members in the forum framed medication as the only viable treatment option even after repeatedly experiencing adverse effects suggests that they implicitly endorsed the biomedical model of mental illness, which favours pharmacological interventions as the most suitable treatment (Engel, 1977; Deacon, 2013).

A number of members also reported experimenting with or wanting to try different medico-technological interventions which included invasive procedures such as Electroconvulsive Therapy (ECT). Robin, the member who had been declared treatment resistant, was encouraged by his psychiatrist to try Deep Brain Stimulation (DBS), a highly invasive procedure that is currently undergoing clinical trials as a treatment for depression:

> *The other treatment that my psychiatrist is pushing for is called Deep Brain Stimulation (DBS). It is an open brain surgery where they connect two neural transmitters to the section of the brain that releases the proper chemicals. Two wires are connected to the neural transmitters and the wires are run down the neck under the skin to a device in the chest under the skin as well. The device sends small electrical charges to the brain throughout the day. (Robin)*

A number of others had undergone ECT to treat their severe or treatment-resistant depression, most of whom recounted having suffered irreparable damage, such as severe memory loss and impaired brain functioning. One member even reported being forced to take an early retirement because he could no longer function, having lost all knowledge of his career following the procedure.

The reverence with which members spoke about novel medical procedures they wanted to try, and the lengths they were willing to go to find a biochemical cure—even if it meant putting their health at risk—suggests that the conceptual parameters of depression continue to be limited to the biomedical model of disease. The repeated failures of biomedicine to provide long-term therapeutic relief to forum members reveals the challenges that chronic illnesses like depression continue to pose to biomedicine (Williams, 2010:211), exposing the limitations of the chemical imbalance theory in addressing the social, cultural, and political dimensions of depression. Overall, although most of the everyday experiences of depression self-management happen outside of the formal healthcare system, this theme demonstrated that the lives of the depressed continue to be closely entangled with biomedicine (p. 211).

However, to echo the words of The United Nations in an official statement for World Health Day in 2017, there remains a pressing need to move beyond a focus on "chemical imbalances" to a focus on "power imbalances" (UN, 2017, as cited by Hari, 2018). It is to this that I turn next.

Neoliberal stigma

Stigma was a theme that featured prominently in the accounts of many forum members, whether explicitly or more latently through expressions of internalized shame and self-blame. Members lamented the stigmatizing attitudes they encountered on a daily basis from healthcare providers, friends and family who "just don't understand" and society at large, and made active efforts to counter such attitudes by expressing the legitimacy of depression as a "a real illness", by equating depression to physical illnesses that are taken more seriously:

Depression is a real illness and you don't need a circumstance or situation to be

> *depressed if you have this illness. If you had Lupus, Multiple Sclerosis or Cancer…you and everyone around you would take it serious. Depression is no different. (Quinn)*
>
> *Depression is not laziness. It is also not something that you can just 'snap' out of. (Andy)*

A large body of research has revealed that people with mental illness experience high levels of stigmatization (Thornicroft et al., 2010, Corrigan et al., 2004, as cited by Whitley & Campbell, 2014:2). This is particularly true for people who suffer from severe mental illness (SMI), who often face barriers in finding meaningful employment or necessary accommodations (Whitley & Campbell, 2014). Erving Goffman described stigma as "an attribute that is deeply discrediting" and that "turn[s] a whole and usual person to a tainted and discounted one" (1986:3). Graham Scambler has made the useful distinction between *enacted stigma* which entails "actual discrimination due to unacceptable conformance and compliance" and *felt stigma* which denotes "internalisations of shame and blame and the fear, inhibiting in its own right, of encountering enacted stigma" (Scambler & Hopkins, 1986; Scambler, 2018:771). Forum members experienced felt stigma that caused them to hide their depression from others, often retreating into social withdrawal. This was often described as wearing a "mask" that concealed their true emotional states, and led to feelings of social alienation:

> *It's like I'm wearing a different mask. They don't really know about my depression. I try to hide it when I'm around other people. As soon as I get home my mood gets really low again. At home I feel really lonely, sad and disconnected. (Sloan)*
>
> *I'm great at wearing the mask of 'I'm fine' but I feel unloveable and really am without support of any kind. (Pamela)*

This practice of masking is consistent with a body of work that has documented the various ways in which patients with chronic and stigmatized illnesses engage in the constant labour of impression management surrounding the concealment and disclosure of illness, and the disruption to identity that this balancing act entails (e.g., Glaser & Strauss, 1975; Bury, 1982;

Scambler & Hopkins, 1986).

Members also encountered enacted stigma in situations wherein they disclosed their depression to others, or in negative encounters with medical practitioners who held stigmatizing attitudes toward mental illness:

> *I'm really worn out from the endless bureaucratic circles of the so-called health system and the humiliation of it. Decades of saying this and that but they blame it on your mental illness, wow talk about stigma with them. (Pamela)*

> *Sometimes I wonder if my family really think I have depression or I just do not want to work. Sometimes I think my doctor has the same feelings (Oh it's him again. He doesn't want to work again). I have depression and I hate it. I'm not lazy I have an illness. (Mason)*

In the latter excerpt, Mason articulates a sense of felt stigma regarding being perceived as lazy and unwilling to work—an unproductive and therefore deviant member of neoliberal society. Although he provides no account of having been directly confronted by either his family members or his doctor as lazy or malingering, he has clearly internalized the stigmatized notion that depression is an illegitimate excuse used to evade productivity and personal responsibility. Alain Ehrenberg (2009) has suggested that in a society that glorifies personal initiative and active self-fulfillment, depression is largely pathologized as a failure to perform the responsible and enterprising roles required of neoliberal agency. In this way, depression is arguably the antithesis of normative neoliberal subjectivity. As Cosgrove and Karter (2018) point out, the depressed individual "who is unable to pursue opportunities, who is not pleasure seeking, and who lacks the energy to be a competitive entrepreneur, could be seen as the quintessential anti-neoliberal" (2018:675). And to be anti-neoliberal in neoliberal society is to be stigmatized; to have a discredited or discreditable identity in accordance with current norms of responsible and productive citizenship.

While Goffman's concept of stigma remains highly relevant, its focus on micro

sociological interactions have limited a broader consideration of the power dynamics that inform such interactions and that coalesce with relations of class, race, and gender, among others (e.g., Scambler, 2004, 2006, 2018; Tyler & Slater, 2018; Charmaz, 2020). Indeed, the dominant perspective advanced by social psychology and at the heart of anti-stigma campaigns across the west that stigma reflects individual attitudes has been stagnant in terms of identifying the sociocultural and political origins of such attitudes. Scambler re-frames stigmatization as a process embedded in neoliberal ideological practices and policies (Scambler, 2004), arguing that stigma has been 'weaponized' by the neoliberal state to increasingly hold individuals with chronic illnesses personally responsible for their conditions in a post-welfare era (Foucault, 1979, as cited by Scambler, 2018:780). In this regard, stigma can be understood as a form of governmentality used to legitimize austerity-driven reforms since the advent of neoliberalism (Scambler & Hopkins, 1986; Scambler, 2006; Tyler & Slater, 2018). Tyler and Slater (2018:727) explain:

> The promotion of the idea that a large 'underclass' of people are 'trapped' in conditions of stupefying dependency on state hand-outs has been a central mechanism through which public consent for draconian cuts to services has been produced. In short, 'stigmatisation is intimately linked with neoliberal governance', that is with attempts to manage and/or change the behaviour of populations through deliberate *stigma strategies* which inculcate humiliation and shame.

The legacy of this rhetoric was present in members' expressions of fear of reaching out for help, of being "a burden", of failing to take responsibility for their well-being, and of being perceived as lazy or unproductive.

The individuals in this study demonstrated internalizations of shame and self-blame that are not sufficiently explained by Goffman's notion of stigma, but better understood as manifestations of what might be called "neoliberal stigma"—that is, technologies of shame that create self-governing individuals who will enact norms of independence and personal

responsibility and take sole accountability for failures thereof. From this perspective, the stigma of depression can be understood not merely as an isolated event or a reflection of personal attitudes, but as a mechanism of social control that is culturally constituted in the service of neoliberal government. One of the ways in which members expressed internalizations of neoliberal stigma was through actively taking accountability for their depression in order to evade attributions of blame from others.

Managing Accountability

As Wilson et al. (2018) point out, while the biomedical model of mental illness does not ascribe blame to the individual for their illness, "a person with a mental illness can be held accountable for how they live with it" (Wilson et al., 2018:4). This notion became apparent as members deployed discursive devices to evade attributions of personal blame for their depression by presenting themselves as responsible and proactive patients who are legitimately depressed, rather than merely complaining or malingering. This impression management often involved presenting a "causal history" (Lamerichs, 2003:103) in which members explained at length various external factors that had led to their depression in order to situate it outside of the personal realm and therefore foreclose the consideration that they were personally responsible for having become depressed. This type of discursive work, as outlined in the Methodology chapter, has been identified by a body of research into online illness forums that has explored the ways in which individuals manage issues of accountability and legitimacy regarding their depression (e.g., Lamerichs, 2003; Horne & Wiggins, 2009; Flinkfeldt, 2011; Stommel & Lamerichs, 2014; Gough, 2016).

Many of the members engaged in this delicate discursive dance, on the one hand

attempting to prove to other group members that they were authentically afflicted by a condition that was beyond their control, and on the other hand, naming the various ways in which they had taken initiative and assumed responsibility for their depression—from adopting transformative lifestyle and self-management practices to remaining assertive and resilient in their encounters with the mental healthcare system. Members wanted to assure their peers that they could not be held to the same standards as "healthy" people, yet simultaneously held themselves to those very standards and expressed self-blame and shame when they fell short. For example, in the following excerpt, Theo actively takes responsibility for his depression by relaying the actions he undertook to "change his circumstance":

> *I went through two major episodes of depression during high school and again in my early 30s. Both related to family issues and life uncertainties at the time. I worked hard to change my circumstance around and even moved to a new city. I have a stable job that I'm really good at and have a girlfriend whom I have not told about my depression issues. (Theo)*

Theo constructs a depression narrative that presents him as a good neoliberal subject; that is, as someone who works hard, is self-improving, and performs well at work despite his illness. Another example of this internalized neoliberal stigma is present in the following exchange between forum administrator Andy and forum member Oliver, who laments the money he wasted on naturopathic services:

> *Dumping all this random stuff into my body has me having second thoughts about the whole thing. I also feel very misled about some of the stuff the Naturopath has told me and the tests he had me do. I really wish I had researched a little more prior to seeing him. Shame on me I guess for falling for it as I usually do lots of research on things before spending a bunch of money. (Oliver)*
>
> *I like to do my own research, from reliable resources, which is sometimes a challenge. My questions are usually similar. Will it hurt to pursue this? For how long? What about cost? What measurable evidence do I have that it is worthwhile? (Andy)*

In the first post, Oliver expresses self-blame ("shame on me") for having failed to conduct proper

research before consulting a naturopathic doctor. He makes a point of assuring his peers that he usually does "lots of research" to make responsible decisions about his health. Both members articulate a discourse of personal responsibility in expressing the importance of taking control of one's healthcare by doing independent research, which for Andy involves asking oneself a series of questions in order to make informed healthcare decisions. Andy also hints at the notion of risk management by expressing the importance of maintaining skepticism toward resources which may be unreliable; although it is "sometimes a challenge," it is nonetheless up to the individual patient to find the right resources and make the right choices with respect to their mental health, even before they enter the doctor's office. Moreover, Oliver's expression of regret at having failed to exercise prudence and "falling for it" points to a healthcare landscape that is fraught with uncertainties and risks that the mentally ill patient must actively navigate in order to find proper care. This encounter reflects the workings of a culture of accountability and blame that is characteristic of neoliberal society (Rose, 1996b). Such narrative exchanges suggested that members inherently valued productivity, mental fortitude and taking initiative, and they actively worked to reassure others that they possessed these qualities despite their depression.

This subtheme demonstrates members' desire to avoid the perception that they are merely passive victims of their illness, as they actively confront the neoliberal stigma undergirding notions of depression as an illness of failed responsibility and pathological dependence. This finding aligns with Lamerichs' (2003) research, which found that individuals discursively constructed an identity as "depressed" yet competent, which helped to establish their membership in the forum as authentic and deserving (Lamerichs, 2003). What constitutes "competence" in the context of my own study appears to involve the internalization of a distinctly neoliberal cultural imperative to self-manage and recover from depression through

one's own emotional resilience and personal responsibility. This widely shared ideal was such that members avoided leaning on others when they needed support, and seldom encouraged their peers to do so.

Feeling like a burden

When members felt as though they were unable to take control of their illness and were dependent on others, more latent feelings of stigma emerged. This was often expressed in terms of feeling like a burden to loved ones, preventing them from reaching out and leading to patterns of social withdrawal. Such feelings were further entrenched by encounters with loved ones who framed their depression as a lack of self-control or personal initiative, thereby reinforcing their sense of stigma. One member, Rory, expressed the toll depression has taken on his marriage due to his spouse's "tough love" approach:

> *Her way of helping me is one of tough love… read this book! You have to be the one to come to me! Your depression is to blame for our troubles! I can't take you anymore! I am not going to give you what you say you need! You are a burden! She still refuses to come to therapy with me saying that I need to work on myself. (Rory)*

Another member attempted to reconcile her own belief that she is not a burden with the lived experience of being rejected by her partner because of her depression:

> *I know I am not a burden. I am sharing my vulnerability and humanity. But I can't quiet the voice that questions the validity of that idea. How can I not be a burden if I am demanding the emotional energy of people around me? Recently, I have been open with my partner about my depression but he seems to have no energy or time for me. In fact, shortly after I opened up to him, he confronted me to tell me he only wants to be committed to himself… (Lesley)*

The notion that opening up about depression is an empowering act of sharing one's humanity is arguably at odds with a preoccupation with self-interest and a corresponding denigration of human vulnerability and dependence. This marked disdain for dependence was also salient in a

study by Peacock and colleagues, whose participants disavowed virtually all forms of dependence and viewed leaning on others and expressing the need for help as a form of weakness (Peacock et al., 2014). While the authors did not talk about stigma *per se*, they found that neoliberal discourses had been internalized by participants who assumed self-responsibility for maintaining their wellness, an experience shared by the forum members in this study. Both the felt and enacted neoliberal stigma experienced by members instilled fears of succumbing to pathological dependency, and as a result, fortified the moral imperative to manage depression on their own through the use of self-directed coping strategies.

"I've used all the tools in the toolbox": Technologies of the self

The most common coping strategies reported by members involved individual adjustment, which included taking medication, transformative lifestyle practices, and positive thinking. The vast majority of these practices involved solitary work that was oriented to one's duty to recover from depression and to (re)establish normative states of productivity. Members believed that it was their own responsibility to manage their depression:

> *I know I have to look after myself day to day and thank heaven I have learned that. Posting on here is one of the ways that helps me look after myself. (Ursa)*

In this way, although most members did seek professional help from psychologists, psychiatrists, and other practitioners, they viewed self-management (practices at times referred to as "self-care") as an integral component in treating depression. From a Foucauldian perspective, these self-directed practices can be viewed as technologies of the self that "permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault, 1988:18).

Although the coping strategies with which members engaged conferred a level of agency and empowerment in helping them control the symptoms of depression, and indeed members selected the strategies that worked best for them in the context of their own unique experiences, these self-technologies nonetheless coalesced with Foucault's concept of governmentality, as members constituted themselves as responsible, independent, and hard-working neoliberal subjects. Few pathways to healing were forged outside of the desire to return to productive roles.

Medication

Medication was one of the most prominently featured topics in the forum and the most common resource that members reported using to self-manage depression. A large proportion of posts were dedicated to discussing various medications, notably anti-depressants, and their side effects as well as their interactions with other medications, in which members often solicited the advice of their peers. Despite its often-elusive benefits, medication was a central component of depression self-management. Members expressed hopes of finding a medication that would allow them to achieve or return to a desired state of normalcy and return to productive roles at work and home:

> *I started with Citalopram, I thrived on it. It cleared my head and sharpened my wits, I was able to take on more responsibility at work and reaped the rewards. (Taylor)*

Rose has argued that the consumption of psychotropic drugs that alter neurochemistry serve to create self-managing patients or "neurochemical selves" with a desire to control unruly aspects of the self (Rose, 2017). In a similar vein, Fullagar and O'Brien have theorized anti-depressants as "biotechnologies of the self" that depressed individuals use to transform themselves chemically in order to align themselves with particular gendered and neoliberal subjectivities (Fullagar & O'Brien, 2013). In their research on women's experiences with anti-depressant

treatment, they found that participants suffered severe side effects from medication which led them to challenge biochemical pathways of recovery. While the medicated individuals in my study similarly suffered a range of debilitating side effects, very few of them developed resistance to biomedical expertise and even fewer withdrew from pharmacological solutions entirely. Their lack of therapeutic relief simply meant that they hadn't found the "right" medication (or combination) yet:

> *Sometimes it takes awhile to find the right medications. While experimenting, if a medication doesn't work in 4-6 weeks then I will try something different. (Patrick)*

Like Fullagar and O'Brien's participants, the forum members in this study were "active biomedical consumers" urged to comply with biomedical authority by maintaining biomedical regimens to regulate their emotions "and hence their 'conduct' as responsible and productive citizens" (Fullagar & O'Brien, 2013:159-160). For example, in the following exchange, forum member Marley reports struggling with depressive thoughts, but questions the utility of seeking a medical diagnosis. Forum administrator Patrick responds to Marley's post with advice to seek help from a doctor, insisting that medical treatment has cured many people by allowing them to fulfill productive societal roles, citing formerly depressed celebrities as an example:

> *I have these sad moments that happen randomly and seemingly without cause. I don't have any diagnosis from a doctor. I haven't asked and I don't want to know, because what difference does it make if I'm clinically depressed or just a sad person? Either way I'm stuck with these feelings. (Marley)*

> *Talking to your doctor about medication might help. Many people who suffered from severe depression have gone on to lead productive lives after treatment. Googling celebrities with depression will show you a long list of famous people who battled and overcame depression with the help of their doctor. (Patrick)*

Despite Marley's clear opposition to medical intervention, Patrick references productivity as the ultimate goal of recovery from depression, a desired state which can be achieved by taking medication. Medication is thus reinforced as a technology used to bring the self into alignment

with productive neoliberal citizenship, an idealized subject position that is emblematized by recovered celebrities.

Transformative lifestyle practices

Aside from medication, members engaged in a variety of transformative lifestyle practices such as exercise, diet regimens, journaling, and meditation. Together, these practices were referred to as a "toolbox" or a "toolkit" from which members could draw to cope with everyday life. These types of self-management practices have been observed elsewhere (e.g., Fullagar & O'Brien, 2013, 2014; Brijnath & Antoniades, 2016; Fimmano, 2019) and, like medication, can be conceptualized as technologies of the self (Foucault, 1988) used to alleviate the symptoms of depression and thus bring oneself into alignment with the ideals of neoliberal citizenship (Rose, 1996b). One member expressed that he felt ready to quit his medication after having undertaken a range of practices including abstaining from alcohol and caffeine, eating a more plant-based diet, going to the gym twice a week, taking a wide range of vitamins, and being "a lot more spiritual". He reports:

> *The Cipralex helped when I was deep in a hole but I dug myself out and feel I don't need it anymore, I'm using every natural method possible to combat my anxiety. (Dane*)

The phrase "I dug myself out" conveys a sense of pride in having put in the work to promote recovery without needing to rely on medication or the help of others. In this way, Dane uses technologies of the self to take control of his depression, conforming to the ethical ideals of good neoliberal patienthood—namely, the responsible, autonomous, and self-managing patient.

In many cases, self-management practices did provide therapeutic relief and gave members a sense of agency and empowerment even in cases when they were not effective. One member who had tried many treatment avenues reported being comforted by the self-knowledge

she had gained along the way:

> *I have spent as much time as possible learning about depression and other mental health issues. I have done variations of CBT. I have been in groups, both online and in person. I have talked with social workers and therapists. And taken medication too. It has taken all of these things to get me through. I still find myself struggling, but I am comforted knowing that I now have so much more knowledge about my depression… a toolbox of knowledge to help ease the pain. (Kay)*

Foucault argues that technologies of the self can be transformative and confer agency while also being enmeshed in power relations that seek to create self-governing subjects who are "experts of themselves" and "adopt an educated and knowledgeable relation of self-care in respect of their bodies, their minds, their forms of conduct" (Foucault, 1988; Rose, 1996a:159). It is important to acknowledge that the members in this study were not merely passive victims of the totalizing power of neoliberal governance, as some did experience positive change as a result of undertaking self-care practices and exercised agency in selecting what worked for them. However, members were limited by the dominant psy discourses and therapeutic strategies that were culturally available to them, which tended to have an atomizing effect. With the exception of spending time with friends and "leaning" on one's support system, the ways members described coping with depression involved solitary activities such as reading a self-help book, meditating, or eating a low carb meal. It appears that "the cultural tyranny exerted by the imperatives of health and happiness can be isolating, working against the creation of solidarities" (Godrej, 2017:908). As this quote suggests, there is a significant incongruity here, between forum members' sense of social disconnection and the solitary nature of their predominant therapeutic approaches to self-care. Indeed, loneliness was among the struggles they reported most often.

Healthism

In describing the diet and exercise regimens they undertook to improve their depression, members expressed internalized healthism (Crawford, 1980) regarding the sources and treatments of depression:

> *I'm trying a keto diet, where I don't eat more than 20 grams of carbs per day. Hoping this will help me. Once I get past the first week it becomes way easier (Quinn)*
>
> *I've been off anything that has caffeine since the incident, no alcohol for at least 2 and a half months and no smoking either. (Parker)*

Fimmano (2019) uses the term "mental healthism" to denote the extension of healthist ideology to mental health, which emphasizes the individual's role in preventing mental illness by engaging in "healthy" behaviours such as exercising and eating a healthy diet (Fimmano 2019:16). This discourse is firmly rooted in neoliberal ideology by emphasizing that "responsible citizens 'should' actively monitor and control their behaviours to reduce instances of [mental] illness and disease" (Crawford, 2006, as cited by Fimmano, 2019:29). The stigmatizing implications of mental healthism are apparent in the following passage, in which David, a member in his late fifties expresses anxiety at the thought of growing older, lamenting the actions he didn't take in his youth to ensure his long-term health:

> *As I get older, I am finding that managing the depression is becoming more difficult, anxiety too. My anxiety is really around health and impending death from cancer. I had one of those moments where I 'woke up' and realized I am about to turn 60. I am full of questions about whether I did the right things health-wise in my youth. Did I exercise enough? Did I drink too much? (David)*

Using Bourdieu, Scott and Wilson (2011) point out that the internalization of healthist discourse by individuals living with severe and chronic mental illness is particularly problematic because such people are often marginalized and affected by poverty, and thus lack the cultural capital [assets that confer status and promote social mobility] necessary to construct a "reflexive health

habitus [socially ingrained habits, skills and dispositions]" (Bourdieu, 2011, 2020; Scott & Wilson, 2011:43).

The following excerpt demonstrates the limitations inherent to healthism as a self-technology when applied to a chronic mental illness like depression:

> *I'm not drinking anymore, I am eating clean, working out every day and sadly suicidal thoughts happen way more frequently than they ever did. (Terry)*

By focusing on individualized habits, the origins of depression are further displaced from their sociocultural context and the potential for collective healing is diminished by an often-obsessive preoccupation with the self-disciplinary mechanisms (i.e., fasting, eating "clean", excessive exercise) necessary for achieving and maintaining a healthist lifestyle. As Terry's post demonstrates, even when depressed people are able to successfully achieve such lifestyle changes, they are not necessarily therapeutic.

Self-surveillance

Through practices such as journaling and keeping mood charts, members engaged in forms of self-surveillance, leading to a constant awareness of their mental states and an implicit tendency to measure themselves against 'ideal' states of normalcy:

> *I keep a rough homemade mood chart and can see that I'm having fewer times of emotional turmoil, and more times of engaging in life with some actual interest. It's still a rough go and will be for some time I expect. (Ursa)*

Journaling was a therapeutic tool that many members favoured for its capacity to foster self-knowledge. One member writes:

> *Writing is a great way to get to know yourself, a way to start recognizing patterns, triggers. Organizing my thoughts on paper has been vital to my survival. (Kay)*

For more active members, posting in the forum was one of the ways that they monitored their

moods and kept up accountability for their daily regimens of self-management, often relaying the various steps they had taken on a particular day to manage their symptoms and improve their mood as well as detailing the various thoughts or feelings they experienced throughout the day. In this way, like a public journal, the forum acted as a tool for self-monitoring and practicing illness accountability. Although members viewed the self-knowledge they gained through journaling and mood charting in a positive light, keeping up these habits required a great deal of self-motivation and consistency, things that individuals suffering from severe depression often struggle to maintain, and excessive self-monitoring often led to rumination and anxiety or failed to provide any solutions:

> *I have never found the usual suggestion of journaling helpful. I find the more I write about what I am thinking the worse it gets. (Wendy)*
>
> *I returned to keeping a mood chart on a daily basis. Yesterday I perused the chart and it's clear that my mood is consistently low in the morning. I'm not sure what to do about it. I've tried a few things in the past but have never really figured out a good way to change it. (Ursa)*

While many members did find self-monitoring techniques to be effective, they were often oriented to as a duty or obligation—as something they *should* do in order to maintain an effective self-management regimen. Yet, members often lacked the time and emotional resources to keep up with their journaling, and this sense of duty ultimately led to confessional-style expressions of shame and self-blame for straying from their routines. As such, members would sooner interpret their low moods in terms of their own lack of self-reflection and self-knowledge rather than the many external factors that affected their daily lives.

The double-edged nature of these practices is well-illustrated by Foucault's concept of governmentality, which links political power to subjectivity. He argues that in contemporary manifestations, state power is mobilized through and undertaken by individuals themselves, who

come to internalize a "disciplinary gaze" by engaging in projects of self-surveillance (Foucault, 1979). Journaling and mood-charting can be viewed as examples of such contemporary projects, yet as Foucault has observed, the desire to document thoughts, feelings, or moods in the interest of cultivating self-knowledge has a long history, the motivations of which have changed over time and in different places (Foucault, 1979; Kelly, 2013; Godrej, 2017). According to Foucault, the ancient philosophical project of self-care was an emancipatory practice that has since undergone political transmutations within particular historical contexts. In antiquity, self-directed practices such as journaling were far more sovereign acts than when they were later influenced by various religious, pedagogical, medical, and other institutions (Foucault, 1997:282). For instance, the rise of Christianity transformed classical forms of self-care into disciplined and moralized practices with the goal of avoiding sin (p. 250), such that "the concern for oneself was transformed into a concern for one's salvation" (Kelly, 2013:518). Foucault also observed the ways in which the confessional drive that surfaced in early Christianity became secularized into a more general compulsion to know oneself (Foucault, 1998, as cited by Kelly, 2013:518), a compulsion similar to that expressed by the forum members in this study.

In the current neoliberal era, practices of self-care and self-knowledge have been instilled and institutionalized through discourse as a method of social control, administering populations in accordance with the dominant political rationality (Foucault, 1997, as cited by Godrej, 2017:910). In this sense, journaling can be viewed as both an autonomous act of self-care, as well as an oppressive inclination to track and monitor various aspects of the self that is tied to power-knowledge discourses that "imprison the project of self-care" (Godrej, 2017:911). Indeed, Foucault asserts that the subject "constitutes itself in an active fashion through practices of the self" while at the same time acknowledging that the subject is never purely self-creating, relying

on the techniques that are culturally and discursively available to them (Foucault, 1997:291). While forum members found a sense of temporary relief in turning to their journals and mood charts and took pride in having undertaken these practices as productive and responsible patients, the dutiful orientation and ruminative quality that they often assumed ultimately constrained their therapeutic capacity, perpetuating a cycle of self-blame when members failed to conform to the norms of discipline and self-control required of a consistent self-management regimen, and indeed, of neoliberal subjectivity.

Positive thinking

In addition to monitoring moods through techniques of self-surveillance, members drew from psy discourses rooted in the fields of positive psychology and cognitive-behavioural therapy to manage and regulate difficult emotions. Several members subscribed to a "mind over matter" framing of depression, namely, that one can train one's mind to cultivate positive thoughts and overcome negative emotions. In this way, they believed that change has to happen within oneself in order to adapt to adverse circumstances:

> *No one is going to be perfect in life, we all will struggle. But through any struggle, we can prevail by changing our minds and changing our perspective… (Ezra)*

> *I have always believed that if we talk ourselves into believing something negative, the same can be done in the opposite. So just being aware of when you aren't being kind to yourself, and then changing the way you self talk. Even if in the moment you don't believe the good stuff, you will eventually. (Percy)*

Several members advanced the notion that happiness exists within the realm of personal choice and can be attained through self-work on the mind. In this way, they appeared to overestimate individual agency and reinforced depression and recovery as an individualized, cognitive pursuit of "brain training". Keeping up a positive attitude was viewed as an important component of

recovery, and this often involved a great degree of emotional labour and suppression.

> *It is so hard to maintain a positive attitude when battling depression. One way I fight the negative thoughts is by telling myself over and over again that I'm a good person with a bad illness, not a bad person. (Patrick)*

The importance of positivity was also reinforced by other people in their lives. Some members feared social rejection as a result of being perceived as "toxic". For example, Lesley describes the difficulty of having to carefully navigate her behaviour and control what she shares in order to avoid negatively affecting the mood of her partner:

> *I have to be careful with what I say or don't say, how I act and what I do around him to try not to spread my darkness to him… (Lesley)*

Ursa explains needing to do "self talk" while spending time with a friend, in order not to negatively affect their mood:

> *I had to do a little self talk, if for no other reason than not wanting to drag my friend down with my glum outlook. (Ursa)*

According to Binkley, the cognitive techniques advocated by the field of positive psychology act as forms of neoliberal subjectivation by encouraging a specific type of self-work that exemplifies productivity, independence, and entrepreneurialism (Binkley, 2011). Rather than acting on subjects through "experts", as in most traditional psychology, positive psychology "offers a set of exercises and practices that anyone can do on their own" (De Fabian & Stecher, 2017:601). In this way, by practicing positive thinking members became "experts of themselves" in the privacy of their day-to-day lives (Rose, 1996b; Binkley, 2011:375), having internalized the mental healthist and psychocentric standards of neoliberal patienthood (Fimmano, 2019; Rimke, 2000, 2020). These examples demonstrate that, as a powerful discourse sanctioned by "psy" expertise, positive thinking was used as a means by which individuals governed themselves and others (Burchell, 1991; Miller & Rose, 1992), namely, by "work[ing] on themselves and their

emotional states as open-ended problems of self-government" (Binkley, 2011:381), and by encouraging others to do the same by adopting positive attitudes.

Members articulated the importance of cultivating positive affect from within, despite living in situations in which external oppressive factors had severely limited their ability to do so. As such, happiness was viewed as a function of individual willpower, intentional choice, and personal responsibility, and was pursued as a personal project rather than a collective endeavour, all inclinations that align closely with neoliberal principles (Adams et al., 2019:206). These examples bear witness to the emotional colonization of neoliberalism (e.g., Anderson, 2016; Casalini, 2019; Stern & Brown, 2016), and the intermediary role of social and medical institutions in this process (Foucault, 1965; Adams et al., 2019). As members engaged in positive thinking, working to manipulate their thought patterns "as a fitness guru might shape a desired muscle group" (Binkley, 2011:391), they undertook self-management on perhaps the most intimate level—the interiority of their private, psychic worlds.

Overall, the theme "technologies of the self" demonstrates that self-management practices may be (re)producing forms of subjectivity that are based on neoliberal norms of individualism and personal responsibility. The forms of self-care with which members engaged did confer a sense of agency and control over one's life against the backdrop of the uncertainties and disruption that characterize chronic illness. However, the obsessive ritualization of self-cultivation, self-surveillance and self-mastery required of mental healthist standards of being are at risk of re-inscribing the perception that the individual patient is solely responsible for their well-being, which ultimately depoliticizes larger socioeconomic and political factors that perpetuate social inequalities. Even when members expressed a sense of empowerment and fulfillment at having discovered a technique of self-care that worked for them, more often than

not such techniques were steeped with the moral undertones of healthism and were difficult to sustain because of the excessive labour they required. Indeed, from daily exercise to journaling, self-management practices reflect the "unending work and care" involved for patients at home (Corbin & Strauss, 1988), which must be tacked onto the already existing work that depressed individuals undertake in their daily lives. As such, members often felt overwhelmed and struggled to keep up with their regimens, which led to guilt and self-blame and in many cases worsened mood by reinforcing members' stigmatized identities as "lazy", "unmotivated" or "unproductive". If their symptoms did not improve, members took full responsibility rather than acknowledging the responsibility of governmental institutions to help. Although certain techniques, such as journaling or meditation, had the intrinsic potential to foster meaningful pathways to healing, individuals tended to orient to these strategies less as a way of cultivating more fulfilling states of being for *themselves* and more as a duty or moral imperative to recover and (re)establish normative states of productivity in accordance with capitalistic standards. As Nettleton (1997) points out, the forms of self-knowledge produced by technologies of the self have become increasingly useful for governments in the neoliberal era as a method of shaping and enhancing individual behaviours and, indeed, entire lifestyles (Nettleton, 1997:210).

On the one hand, although it could be argued that forum members use their self-management strategies to forge their own subjectivity, to constitute themselves "in an active fashion" (Foucault, 1997:291), as Foucault has shown us, power relations are inescapable and what may on the surface appear as acts of pure self will ultimately remain embedded in a matrix of power-knowledge discourses that shape projects of self in accordance with political and institutional aims. Thus, while self-management practices can in certain contexts create freedom and resistance to totalizing forms of power, they are "nevertheless…imposed upon [the subject]

by his [sic] culture, his society, and his social group" (Foucault, 1988:291). Forum members engaged in often enthusiastic discussions about the types of self-cultivation and self-care that were meaningful to them, combining expert and lay discourses in weaving a personal pastiche of know-how. Yet, discussions of political solutions to the shared struggles they faced both in and outside of the healthcare system remained conspicuously absent as they retreated into their personal toolkits, often appearing to perpetuate the cycle of loneliness and disconnection that so many of them lamented.

"Alone in a room full of people": Loneliness and the importance of social support

There is reason to believe that the largely solitary nature of the self-management routines with which forum members engaged ultimately served to increase their sense of social isolation and loneliness, the most salient forms of suffering that were expressed on the forum. The motivation behind pursuing these self-management strategies was not only to alleviate the symptoms of depression, but to engage in the intentional act and ethical duty of self-care, and in particular, caring for the self *first*. In this theme, I describe how members internalized neoliberal discourses of individualism through a preoccupation with self-care and a corresponding subordination of sociality which appeared to exacerbate feelings of loneliness. I then consider how, in turning to the forum, members sought social support and community, things that neoliberal discourses of individualism had constrained, establishing a relational self and intersubjectivity that allowed them to care for themselves by caring for others.

Caring for the self first

In describing their personal coping mechanisms and actively taking accountability for

them, many members expressed the importance, even obligation, of taking care of oneself, even when faced with debilitating depression. This imperative to self-manage did not appear to emerge from within, but was routinely reinforced through encounters with other people who encouraged individual-level solutions, including other forum members who advocated solitary activities, such as meditation or visualization:

> *Something that I think may help you right now is to change your focus. You can start by forcing a positive idea into your head, you can do this by visualizing or finding that thing that makes you feel ok. (Ezra)*

healthcare practitioners who administered self-help worksheets:

> *Went to my appointment. Got a few sheets of paper I could have downloaded myself and an incomplete diagnosis, along with more admonitions to "fix myself". So much compassion… (Perry)*

and family members who reinforced the stigmatizing belief that depression can be overcome through individual willpower:

> *When I told my parents about my symptoms, they said everyone is like that, you just need to motivate yourself and be less lazy. I'm too scared to go to a walk-in clinic because what if there's actually nothing wrong with me, and I just end up embarrassing myself? (Bailey)*

The imperative to manage one's depression on one's own was further steeped in media sources such as online articles that depicted depression as a problem of self-care:

> *I've read various articles and things around when a partner has depression and one thing that comes up a lot is to take care of yourself. I thought I was, but I don't think I have and now feel like I'm struggling. (Joe)*

All of these sources tended to emphasize individualized solutions and as such, the patient's own responsibility in healing and recovery. In the context of neoliberal society, dominant conceptions of selfhood that hinge on notions of personal choice, responsibility, and self-fulfillment act as norms against which "individuals govern themselves and are governed by others, and against which differences are judged as pathologies" (Rose, 2017:18). Nikolas Rose argues, for example,

that in the current self-management paradigm of psychiatry, professionals have become "tutors" of self-management whose role is not to cure patients so much as it is to "teach the skills of coping, to inculcate the responsibility to cope" (Rose, 1996b:12-14).

Indeed, there was a sense of ethical obligation not only to focus and work on the self, but to do these things *before* turning to or caring for others. In response to a member's post expressing their struggle to maintain romantic relationships, Penelope emphasized the value of being single in the path toward self-discovery and constructing individual identity:

> *I believe that being single is the best way to find out who YOU are, to be comfortable with yourself before you find someone who will truly make you a better version of yourself. (Penelope)*

Forum administrator Andy responded to the same post emphasizing the importance of taking care of oneself before others and putting one's own needs first:

> *It is great that you want to be a supportive partner and cared enough to come here and post, however you need to take care of yourself. In the end, you both need to do what's best for yourselves. I know it sounds selfish, but we can only offer a supportive hand (Andy)*

In these examples, relationships with others are framed more in terms of a hindrance than a benefit to individual growth and well-being. A more extreme example of this disdain for sociality is expressed by Sam, who argues that we are limited by our social nature:

> *I believe our egos are a problem and our species need to be more independent and individual. Growth is inhibited by social things, for example, the tradition for the sake of tradition doesn't make any sense to me. All beings should find out for themselves what they value and why. (Sam)*

This focus on attending to the self first was similarly observed by Kurki (2020) in her research into self-care discourse on social media. She found that while individuals understood themselves to be embedded within a matrix of social relations and obligations, that these social facts were more often presented as a problem than as a solution to individual well-being and that one had to

set strong "boundaries" with others, finding happiness within oneself rather than from social relationships (Kurki, 2020:72). This concept of boundaries is now immensely popular in self-help literature and culture and is based on the idea that "the individual is immersed in a web of social obligations and that individual needs are often left as second to the needs of others" (Kurki, 2020:70). Although the forum members in this study did not explicitly use this term, they nonetheless articulated the necessity of prioritizing one's own wellness over others, even if it led to feelings of selfishness or guilt.

Godrej (2017) suggests that the cultural obsession with ritualized forms of self-care that characterize our contemporary moment is ultimately at odds with collective engagement, as we increasingly respond to social problems through apolitical personal pursuits (Godrej, 2017:908). It appeared that this learned disregard for collectivities and the valorisation of self-care at the expense of *mutual* care exacerbated the feelings of loneliness and isolation at the heart of so many members' experiences of depression. In referring to the various constraints on romantic relationships, for example, Ursa appears to bemoan the propensity to care for oneself first, which prevents partners from relating to and supporting one another:

> *Each person is so preoccupied with their own disabilities that they don't see what the other one is dealing with. And it's nobody's fault, they're just trying to look after themselves. (Ursa)*

Based on sentiments such as these, I suspect that the individualized notions of self-care promoted by the individuals in this study provided fertile grounds for the sense of social disconnection that largely led them to turn to the forum in the first place.

Seeking connection

Although the discourses of self-care that pervaded the forum discussions were largely

individualistic and most coping strategies were undertaken as solitary practices, the social was not absent from these discussions. Many members talked about their depression in relation to the difficulties it imposed on their families and their social relationships, suggesting that social connections are an integral part of recovery. While the most common advice members offered to their peers was to seek professional help, a minority also emphasized the importance of seeking support from other people including friends and family:

> *I believe in leaning on one another as needed. I have a friend who, when I start apologizing for laying too much on them says "a burden shared is a burden halved" and I think so too. (Ursa)*

> *This is just my personal opinion, but I think having physical and emotional support from people is vital. I have tried getting better without support, it did not go well! (Kay)*

Feelings of loneliness, isolation, and social alienation were nearly universal, yet were more pronounced among members who did not report social time as part of their daily self-management routine. Although advice was often solicited, the thing that members appeared to seek more immediately in turning to the forum was a space to vent, to be listened to, and to be validated by others who understand the struggles they face:

> *Sometimes I think I just need to talk to someone and get things off my chest but therapy is crazy expensive and I don't want to burden friends or family with my problems. (Oliver)*

Members described their loneliness as a feeling that did not necessarily originate from a lack of social relations; indeed, most of them were well surrounded by loved ones yet felt unable to turn to them. Rather, the feelings of loneliness that resounded within many discussions were experienced as a more pervasive sense of social alienation; an inability to "fit in" or connect with others, even in a room full of people:

> *Does anyone else feel lonely, even though you are surrounded by other people? I've begun to realize that connections I have are mostly superficial. It's hard feeling as though you don't fit in. (Emery)*

Even when responders were unable to offer any advice, members appeared to be comforted by messages that reassured them that they were not alone and thanked them for taking the time to respond. This suggests that the actual advice they received was less important than simply being acknowledged and heard. In this way, the forum provided a safe space to which members could turn when they needed the social support they were often unable to find elsewhere. The forum also acted as a community in which the overarching feeling was that of acceptance. It was a place where members felt they could seek and receive peer support without fear of judgment, and for many members this support was invaluable to their sense of well-being and recovery. This is consistent with several studies that have shown the valuable nature of forums as a way of forging online communities that support and improve mental health and well-being (Nimrod, 2012, 2013a, 2013b; Stommel & Koole, 2010; Stommel & Lamerichs, 2014; Smith-Merry et al., 2019).

In responding to the posts of others, forum members offered unconditionally positive regard, emotional support, and empathy. Several members explicitly thanked the forum administrators for their engagement, and cited the forum as a vital source of support throughout their battle with depression:

> *A shout out to Patrick and Andy. Kudos to you both for keeping this shelter in the storm available to all of us prodigal warriors! I will never forget how this forum saved me (Drew)*
>
> *Months of posting and reading here helped me to understand my situation better and to find the courage I needed to make an appointment and see someone. This forum has been pivotal to my survival and growth. (Kay)*
>
> *I remain eternally grateful for this forum and the people on it. (Ursa)*

The ritualized nature of interactions that took place on the forum reassured each member that their pain was recognized. In this way, the forum provided a narrative space for members to cultivate a “relational self” based on mutual understanding rather than the narrow conceptions of

selfhood atomized by neoliberal norms of individualism (Ould Brahim, 2019). Sik (2021) argues that online mental health forums can allow people to overcome feelings of helplessness by becoming helpers themselves (Sik, 2021). Although in their initial posts, members were focused more on venting and resolving their own problems, as they gained more experience and became accustomed to the cultural mores of the forum, several took on the role of "recovering helper" (Rácz et al., 2015; Sik, 2021), making the effort to welcome each newcomer to the group with words of support, and encouraging them to continue sharing. This appeared to allow members to foster an intersubjectivity that was founded on emotional reciprocity and social embeddedness (Sik, 2021). This sense of intersubjectivity is largely absent from the self-management paradigm of mental illness which emphasizes autonomy and individual responsibility and was desperately needed by the forum members in this study to feel connected and to be led out of feelings of isolation, if only temporarily.

Cvetkovich (2012) argues that although depression often manifests in antisocial ways, such as social withdrawal and inertia, it has the capacity to "create new forms of sociality…because it serves as the foundation for new kinds of attachment or affiliation" (Cvetkovich, 2012:6). In other words, the isolation that is often inherent to the experience of depression can be countered through the creation of new forms of relating socially. Depression can unite people to the extent that is creates the conditions for a sense of shared pain and humanity, and indeed, community. In the context of the online forum, its capacity to establish an intersubjectivity through the sharing of experiential lay knowledge has the potential to generate alternative framings of depression outside of the limiting confines of the biomedical model and psy expertise. As Sik (2021) puts it, the experience of depression can thus "be reconfigured on a level biomedical intervention is incapable of operating" and as such, promote resistance against

the individualizing and objectifying biomedical discourses of mental illness (Sik, 2021:768). Although, as indicated, the members in this study were far from immune to these discourses, by simply responding to a post in offer of recognition, understanding, and personal wisdom, the forum allowed members to carve out alternative pathways to healing that were rooted in the social, combatting their loneliness and isolation by both sharing their pain and holding the pain of others. In this way, they turned an act of self-care into mutual exchange of ongoing care and support.

"The revolving door treatment": A broken mental healthcare system

Members who sought help from the mental healthcare system in order to treat their depression faced considerable barriers in accessing the help that they needed. These experiences were informed by a system of care in which, despite its socialized nature, access to affordable resources is severely limited and the responsibility of help-seeking largely rests on the individual patient. Members reported being unable to afford the cost of care and faced difficulty navigating a heavily bureaucratic and fragmented network of services that they were expected to figure out on their own as knowledgeable "expert" consumers:

> *My doctor advised me that there were several therapies that could work but they are very expensive. This is why an elite tiered medical system hurts people. (Casey)*

> *I'm really worn out from the endless cycle of various bureaucracies of the so-called health system and the humiliation of it. (Pamela)*

The responsibility to find the right healthcare provider or to know when and how to change providers often rested solely on individual patients. Maintaining these personal responsibilities and commitments—scheduling and showing up to appointments; procuring, taking, and refilling prescription medications; and finding out where to look for help in the first place—involved

levels of motivation and energy that were often elusive for members, especially those with severe and debilitating cases of depression for whom it was a struggle to leave the house or even get out of bed. When members did receive care, they were also tasked with synthesizing the advice of multiple providers, which was often conflicting:

> *I am finding it frustrating working with both a pdoc and a nurse practitioner. It seems the pdoc acts as a consultant, while the np makes the treatment decisions based on the pdoc's notes, usually weeks apart. My nurse suggested I try levothyroxine and stop taking Wellbutrin, which I've been taking for many months along with Effexor. I had my regular appt with my pdoc yesterday and she suggested I talk to my nurse about going back on Wellbutrin and forgetting about the levothyroxine. So many cooks!! (Shay)*

Some members did not have access to a family doctor because of a lack of providers and were placed on waiting lists that were many months long. Members also lamented the inordinately long wait times they had to endure for psychiatric services, which severely compromised access to services in times when they were needed most. For those who had acute mental health crises, including suicide attempts, the emergency department was often the only place they could go for help, and they were often turned away:

> *There is nowhere to go other than the ER. They've turned me away every time and won't even refer me… the Nova Scotia Health Authority is the enemy. (Ellis)*

> *What Ellis said. I just got another appointment with the mental health nurse (gatekeeper) who pushed me out the door last time I went to Community Health. Seems their main goal is to avoid "wasting" resources on the mentally ill. (Perry)*

Members were so desperate for quality mental healthcare that several reported having uprooted their lives to move to different provinces or bigger cities in order to have better access to services, and several others considered doing the same. One member who had moved from Toronto to a small town across the country and was unable to find a new family doctor even considered travelling back to Toronto each time she needed care:

> *I hope I can get my old family doc (in Toronto) again. I feel it will be worth the travel just to have consistency with my health care over time. I tried to get another NP in my small*

> *town but they have wait lists in the hundreds and people with health conditions get first priority for care which makes sense but it means I will always be at the bottom of the list. (Ruth)*

Accounts such as this attest to the desperation that is felt by Canadians suffering from depression and the high demand for comprehensive mental healthcare in Canada that is not being met in a neoliberal climate in which responsibility is downloaded from the state onto the individual patient. Although members from across the country reported facing various barriers in their pathways to treatment, it was members from the Atlantic provinces that seemed to fare the worst, and Nova Scotia in particular was heavily critiqued for its overall lack of mental healthcare, and the high expense of psychiatric services and therapy. Members demonstrated a clear understanding of the political, economic, and social barriers that restrict access in the Canadian system:

> *I hate how health care becomes a pawn in the game of politics, and it happens so often. (Ursa)*

> *The politicians in charge of health care are incompetent. When a person has to wait more than 10 years to get a family doctor if they aren't rich or connected, what does that tell us? (Eli)*

> *May sound like conspiracy theories but the govts and health authorities in these provinces have engineered systems where NOBODY gets mental health care. In the East, at least, there is a 'war' on the mentally ill. I have given up hope. Is it any better ANYWHERE in Canada?!? I would move to get adequate health care. (Ellis)*

Members who resided in or close to urban centres were better positioned to access care from mental health professionals due to the higher availability of mental health clinics. Yet the experiences of those who did access mental healthcare ranged from unsatisfactory to traumatizing, and these encounters were regularly informed by stigma and led many to lose trust in the system.

Despite these repeated negative experiences with the mental healthcare system, the most

common advice offered to fellow members was to consult a professional, even when acknowledging the difficulty of doing so. There was a shared notion that you must be your own advocate and fight for your healthcare:

> *Be persistent as you navigate through the medical system. Our bodies really are the temple of all that we are as beings. (Andy)*
>
> *Keep asking for the help you need until you get it. It can be a frustrating process, but well worth it (Andy)*
>
> *Don't let a bad diagnosis be the final answer! trust yourself! and if the doctor is not willing to see that your treatment is not working… look for help somewhere else! (Kay)*

Even when faced with various barriers in the system, most members did not stop seeking professional help. Rather, they felt it was important to actively seek out information and do their own research to become knowledgeable about their condition in order to compensate for the gaps in care they regularly experienced. There was an understanding that you had to be an active patient who stayed informed and asked questions, rather than passively accepting medical advice:

> *Sometimes doctors do not even know how the drugs they prescribe can affect a person. I'm not saying to quit the Wellbutrin, just read up on it and be able to present your case in a more effective way to the doc. You've already done the smart thing and started to ask questions. (Patrick)*

In this way, members appeared to have ascribed to the principles of the self-management model of care, not necessarily because they were explicitly encouraged to do so, but often because they felt a lack of support from their providers. By the same token, members strongly valued the capacity to prevail in the face of adversity by taking personal initiative for their mental healthcare. In this way, they largely fulfilled the role of responsible neoliberal patienthood by becoming expert patients who were assertive, resilient, and in control of their own illness.

Members were keenly aware of the social, political, and economic barriers built into a

mental healthcare system that seemed to have abandoned them. They were engaged in meaningful critical dialogue about these structural injustices and cognizant of their potential to incite a critical consciousness. Yet it appeared that the only alternative available to them so long as they wanted to find relief was to align their behaviours with the principles of neoliberal patienthood prescribed by the self-management model of mental healthcare.

"Life is depressing": Challenging the neoliberal narrative

By and large members demonstrated a clear internalization of neoliberal norms in relation to their depression experience; they articulated discourses of personal responsibility and individualism and engaged in self-blame and shame characteristic of both felt and enacted neoliberal stigma. And yet, a minority of members expressed ambivalence toward neoliberal discourses of mental illness and in some cases actively countered them.

Resisting the biomedical model

Although biomedical thinking was deeply embedded in the narratives of forum members and largely shaped their understandings of depression as a biological disease and of themselves as neurochemically deficient, there were a few members who articulated ambivalence toward this discourse, especially when they experienced adverse side effects from taking antidepressants. One member, Lucy, actively challenges the biomedical model:

> *I think there is a danger in reducing depression to sheer biochemistry. That is one facet, sometimes, but I'm a firm believer in looking at the whole person. Life happens. Life is depressing and anxiety provoking. We experience interpersonal conflict, financial problems, bereavement, political unrest to name just a few. Combine that with our unique personality and ways of dealing with the world and I don't think depression can be reduced to a "six percent solution. (Lucy)*

By warning of the "dangers" inherent in biological reductionism, Lucy highlights the importance

of a broader epidemiological framework for depression that considers the patient in their sociocultural context. In this way, she appears to advocate a biopsychosocial model of mental illness, arguing that individual biology is a relevant factor, but that it has eclipsed many other, equally relevant factors. Her critique serves as a powerful instance of resistance to a hegemonic discourse that presents an alternative discursive space for understanding experiences of depression.

While most members told the story of their depression with reference to various environmental stressors—from family abuse and alcoholism to various forms of social discrimination—they nonetheless interpreted their depression primarily as a biochemical pathology that originated from chemical imbalances in the brain, with the exception of one member from Nova Scotia who explicitly references the social determinants of mental health in critiquing the failures of the mental healthcare system to provide accessible and adequate care:

> *I don't have a family doctor and I've given up hope of getting one. Going to a walk-in clinic is no way to get proper psychiatric help. I can't even find a support group in my area. For a province with all the social conditions that make the prevalence of mental health issues high and severe, the professionals generally don't have a clue or a care it seems. I applaud the ones that do try and care, but I can't seem to find them.* (Eli)

In this passage, Eli frames depression in terms of social conditions that contribute to high rates of mental illness in Nova Scotia. Although the critique here is aimed at incompetent or uncaring individual professionals, there is nonetheless potential for opening a discursive space for considering how the mental healthcare system could better address these social determinants, and how dominant individualized approaches to mental healthcare that hinge on the biomedical model and self-management are failing.

Matter over mind

Resistance to normative psy discourses was also evident within certain threads that challenged the "mind over matter" logic of positive psychology and cognitive behavioural therapy:

> *There's too much bs with mental health help. And naturopathy is not even covered. I tried going to one about depression and anxiety and her response was 'okay you need to love yourself more' ?? You can't mind over matter depression and say 'I'm going to love myself and feel better'. There's so much useless help and cons for money in this country. (Yann)*

Ahmed (2010) has pointed to the depoliticizing consequences of the compulsive positivity institutionalized by positive psychology, arguing that it individualizes and silences logical emotional reactions against social inequality and injustice such as anger and melancholy as a means of placating so-called killjoys into submission (Ahmed, 2010). Although it did not happen in the context of the thread analyzed, Yann's expression of frustration and anger with the tenets of positive psychology has the potential to spark critical dialogue about the perils of toxic positivity perpetuated by positive psychology. Although only a small minority of members actively resisted neoliberal discourses, this theme nonetheless serves as an important reminder that individuals who suffer from depression are not simply passive recipients of the sweeping power-knowledge discourses of neoliberal governmentality, but rather, play an active role in critiquing and re-constructing these problematic messages. These types of conversations have the transformative potential to promote meaningful social and political change.

Conclusion

This thesis explored the ways in which members of an online depression forum engaged in depression self-management and how the self-directed practices therein acted as "technologies of the self" (Foucault, 1988) that reified the imperatives of neoliberal government; namely, to influence the behaviours of depressed individuals by governing them at a distance. Findings revealed that the vast majority of members relied on medication as the primary method of treatment and routinely endorsed the biomedical model and the authority of medicine. However, many sought alternative pathways to healing, combining expert medical knowledge with experiential knowledge by drawing from a "toolkit" of transformative lifestyle practices, including healthy diets, exercise regimens, journaling, and positive thinking. Although curating their own self-management strategies provided a sense of agency and empowerment to forum members, there was an underlying belief that one should manage alone, and the strategies deployed and recommended by members in the forum were more often than not solitary tasks of self-care. These activities, despite having therapeutic benefits, also involved a considerable amount of labour and were tacked onto the existing duties that members were already responsible for in their daily lives as parents, spouses, community members, and employees. This balancing act was further compounded by the risk management that often accompanies living with a stigmatized and chronic mental illness, and the work involved in navigating a complex, bureaucratic and fragmented mental healthcare system.

Members expressed a number of external, sociocultural factors that impacted their lives and contributed to their depression. However, depression was primarily framed as a neuropathology in accordance with biomedical discourse. This finding suggests that the dominant biomedical framework, and its reinforcement by neoliberal discourses of

individualization, inhibits a broader understanding of depression and its sociocultural dimensions. This narrow frame of understanding ultimately limits the capacity to foster an interrelatedness surrounding the experience of depression. Németh et al. (2020) point out that the hegemony of the biomedical model is such that even if the social determinants of mental illness "are acknowledged on a theoretical level, they seldom find a way to the level of interventions. In this sense, the social component of depression remains in the background of therapeutic discourses" (Fuchs, 2014, as cited by Németh et al., 2020:1). This discrepancy was reflected in this thesis, as forum members frequently acknowledged the social determinants of depression but sought primarily biomedical and self-directed solutions.

This thesis sought to understand the neoliberal discourses that inform individual experiences of depression as expressed in an online forum. I found that the forum members in this study had internalized neoliberal values of personal responsibility and independence, and as a result, the "neoliberal stigma" of shame and self-blame associated with depression. Such feelings, which often manifested as feeling like a burden to others, were reinforced through daily encounters with peers, loved ones, and medical practitioners alike. The valorisation of self-sufficiency and corresponding denigration of vulnerability and social dependence characteristic of neoliberal stigma had troubling consequences, appearing to increase isolation and constrain social connection, ultimately exacerbating suffering. These discourses are deeply problematic because they encourage individuals to overburden themselves rather than reach out to others and divide the load, which in the case of severe depression and suicidality, can have devastating consequences. They also limit the capacity for collective healing, eroding social solidarity and thus the ability to address the responsibilities of the state and promote meaningful social and political change.

Although it is well-established that mental illnesses including depression remain heavily stigmatized, this thesis provides insight into the potential origins of this stigma; namely, the cultural imperatives of neoliberal biocitizenship that continue to vilify forms of social dependence associated with welfarism since the 1970s. In the context of this study, these imperatives involved being a responsible, autonomous patient who complies with medical authority and maintains emotional resilience and a positive attitude in the face of adversity. There were clear external barriers in place that prevented members from attaining this ideal of neoliberal patienthood, yet these were seldom acknowledged, and members often blamed themselves when they were unable to attain their goals. In this sense, members appeared to have become "neoliberal patients" (Brijnath & Antoniades, 2016).

The most salient barrier to depression management faced by the individuals in this study was the inaccessibility of mental health services, which routinely left them feeling excluded, dejected, and stigmatized. The Canadian system was criticized for its lack of comprehensive and quality mental health services, the most of which were unaffordable. In the Canadian context, the privatization of healthcare which has increasingly led to a tiered system, the lack of Medicare coverage for essential mental health services, the bureaucratic and fragmentary nature of services which must be actively navigated by the patient, and health provider scarcity resulting in chronic waitlists, led members to lose trust in the system, go without care, and left them no choice but to self-manage through their own "toolbox" of coping strategies. These barriers did not prevent members from seeking professional help, but often exacerbated the severity of depression, leading them to rely on emergency services that were poorly equipped to provide support. Even members who had the time and energy to successfully navigate the system reported dissatisfaction and frustration with incompetent care. Many more suffered from severe

depression which made simple tasks difficult, severely limiting their capacity to seek help.

Many members credited the forum as an important component in their recovery and regularly expressed gratitude to the forum and its members for having "saved" them when they had no one else to turn to. The therapeutic value of the forum expressed by members suggests that social support and a sense of community are essential for individuals experiencing depression. Although members had clearly internalized neoliberal ideas and stigma surrounding pathological dependency and compulsive self-sufficiency, they nonetheless found therapeutic relief in sharing an intersubjectivity and in helping others through exchanging experiential knowledge, compassion, and support.

By using an online forum as the data source for this study, I was able to observe conversations about depression as they unfolded within a natural setting. As a distinct mental health community, the forum acted as a safe space in which members were able to open up about their experiences with a heavily stigmatized illness, generating nuanced phenomenological insights into the lived experience of depression. Using Thematic Analysis to analyze my data and Foucauldian theory to theorize my findings in turn allowed me to uncover the critical discursive and semantic underpinnings of these invaluable insights, filling a gap in the sociological literature pertaining to neoliberal discourses and depression—a topic that has scarcely been pursued in the context of an online forum. For these reasons, I agree with Bury's (2010) assertion that foregrounding the nature of the everyday experience of chronic (mental) illness as it exists in naturally occurring community settings "remains an ongoing necessity for both research and national debate" (Bury, 2010:176).

That said, there were limitations to this research that are worth considering. For one, using the forum as a method of naturalistic observation meant I was unable to ask questions or

request clarification or elaboration from forum members. As Jowett (2015) points out, this may generate misunderstandings or limit the capacity to address research questions more directly and comprehensively (Jowett, 2015:3). There are also concerns that people who participate in online forums may differ in significant ways from those who do not, and that sampling reflects inequalities in access to the Internet (Seale et al., 2010:596). Depression sufferers who belong to society's most marginalized social groups are less likely to have access to digital resources such as forums, yet understanding their experiences of depression is of equal, if not more, importance. It is also worth mentioning that the sample did not represent people living with clinical depression *per se*, but rather people directly or indirectly affected by clinical or non-clinical depression. However, due to the critical stance toward biomedical conceptions of depression that this thesis takes, defining depression as a clinical concept was not considered a necessary criterion for data collection.

Secondly, because the forum is anonymous, the demographic characteristics of forum members were often unknown, which compromised my ability to inquire into the identity politics that uniquely informed their narratives. Moreover, although many theorists have demonstrated the relevance of governmentality theory for understanding the current constitution of health and wellness in western societies (e.g., Crawford, 1980; Peterson, 1997; Kickbusch, 2007; Crawshaw, 2012; Brijnath & Antoniades, 2016), Foucault's perspective tends to be myopic, exclusive of the contingencies of race, gender, and class, among other variables that disadvantage certain populations over others. Feminist scholars have done much in the way of elaborating Foucault's work in the context of gender inequality, and to a lesser extent, race (e.g., Bartky, 1997; Bordo, 2002; Butler, 2013; Fullagar, 2009, 2017). In the context of neoliberalism and depression, for example, Simone Fullagar has usefully adopted what she terms a feminist

governmentality approach by emphasizing the ways in which responsibilization and self-management of depression is exacerbated for women, who must often manage their own health as well that of their families (Fullagar, 2009). As useful as a governmentality approach is in this context, it does, however, have certain limitations best addressed by an "intersectional" approach.

First theorized by Kimberlé Crenshaw (see Crenshaw, 1991) in the context of legal studies and critical race theory, intersectionality has informed a long history of activism and scholarship by Black and Indigenous feminists (Morrow et al., 2020). In the twenty-first century, the term has been widely adopted by scholars, activists, and practitioners in varying contexts, yet a general definition of intersectionality captures the notion that intersecting power relations lead to structural disadvantages based on a range of identity categories beyond race, including class, gender, sexuality, age, ability, and more (Collins & Bilge, 2020). An understanding of intersectionality underscores how the social determinants of health operate in accordance with various identity categories to disproportionately disadvantage certain social groups over others. It also allows us to consider that social determinants do not exist in isolation but intersect to produce differential outcomes across many different identities. According to Khan and colleagues, multifactorial discrimination (discrimination based on multiple minority identities) is a fundamental cause of depression and mental health inequities (Khan et al., 2017, as cited by Alegría et al., 2018). As an analytic framework, intersectionality offers a more nuanced perspective on the complex interactions between white supremacy, colonization, ableism, heteronormativity, and patriarchal power relations that influence mental health outcomes in the context of neoliberalism (Morrow et al., 2020). Adopting an intersectional approach as a corrective to the Foucauldian governmentality framework would enhance future research by

contextualizing the experience of depression as the outcome of multiple, intersecting variables and social determinants that are intensified in neoliberal societies. Understanding the ways in which neoliberal ideology shapes the phenomenology of depression in accordance with the particularities of racialized, gendered, classed and other marginalized identities warrants further qualitative exploration.

Lastly, although a Foucauldian critique of neoliberalism provides a rich understanding of the political economy of the mental health system as well as the cultural and discursive dimensions of depression, it can also assume a level of theoretical abstraction that would be enhanced with more grounded and embodied approaches to understanding more intimately what it means to live with depression in neoliberal times. Several authors have begun to write this story, combining critical analysis with reflexive methods such as autoethnography (e.g., Stern & Brown, 2016), and memoir (e.g., Cvetkovich, 2012), and taking cue from queer, feminist and affect theories (e.g., Hochschild, 2003, 2012; Fullagar & O'Brien, 2014; Stern & Brown, 2016) to help fulfill C. Wright Mills' foundational sociological advice of connecting public issues to private troubles (Mills, 2000). Applying these approaches to natural community settings such as online forums would be a fruitful endeavour for future research.

On a policy level, the findings of this thesis shed light on the shortcomings of not only the biomedical model of mental illness, but of the more recent self-management paradigm of mental healthcare that has become dominant in Canada and other neoliberal countries. As Wilson and colleagues indicate, self-management is a relatively unchallenged terrain of mental healthcare that has assumed the status of "common sense", resulting in a limited critique of self-management practices (Wilson et al., 2018). This thesis draws attention to the ways in which self-management practices, in tandem with neoliberal policy and discourse, shape subjectivity

through norms of individualism and self-reliance that may increase social isolation and loneliness, ultimately exacerbating depression. In this way, although self-management programs have the stated intent of promoting agency and self-determination for patients, in practice they may serve to produce or exacerbate forms of suffering rooted in asocial tendencies.

On a more general level, these findings serve as a call to action for amending the Canada Health Act to ensure the accessibility and affordability of essential mental health services for *all* Canadians, regardless of geography, income, or identity. They also have the transformative potential to redress current policy and practice in favour of more integrated approaches that honour social interdependence and human vulnerability, forging pathways to healing that lie outside the rigid confines of oppressive neoliberal ideologies, and helping to lead Canadians out of the darkness of depression.

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