

Medicating the Crisis: Investigating the links between precarious employment, mental health issues, and the reliance on antidepressants as treatment

by

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## Abstract

My research engages in literature that discusses the relationship between precarious employment conditions, declines in mental health, and the way mental health issues are treated with pharmaceutical technologies – namely antidepressant medication. In this dissertation, I contribute to this discussion by a) situating the relationship between precarious labour conditions and mental health within a specifically capitalist society, and b) investigating the pharmaceutical treatment of individual illness experiences and mental health issues that can be linked back to broader social structures. In doing so I provide an analysis of the process of medicalization, which locates mental health aetiology as primarily biochemical and focuses on medical, commodity-based interventions, specifically antidepressants, in response to illness experiences – where dis-ease becomes disease. My primary method is a theoretical analysis of capitalist commodity production, the social process of medical knowledge production, medicalization, and development of pharmaceutical technologies. The goal of my theoretical analysis is to achieve new insight regarding my research questions by bringing together existing bodies of literature, much like a grounded theory approach. A narrative analysis of stories gathered through in-depth interviews and autoethnographic accounts complement the main theoretical analysis, and are used to explore personal experiences of precarious social conditions related to mental health and work. I pay particular attention to systems of oppression enabled and fed through capitalism, such as gender, ability, and class relations. I argue that a reliance on antidepressant medication in response to the distress of working people and the unemployed poor plays an important role in enabling the continuation of dysfunctional social conditions. I argue that classifying mental health issues as purely medical erases social structural factors in the development of illness, and removes the serious consideration of such factors from diagnosis and treatment. This erasure also limits people's capacity to act on pertinent questions they may have regarding their own emotional fulfillment and social wellbeing. Such disempowerment frustrates the radical imagination and pursuit of more sustainable and equitable ways of developing and maintaining genuine health.

## *Dedications*

*This dissertation is dedicated to those who are struggling to survive in conditions of precarious employment and poverty. To those part-time workers, temp workers, contract workers, migrant workers, and all those who are dehumanized and hurt by a system of exploitation and oppression. To those who are denied care and to those who face humiliation, isolation, and inequitable treatment due to the stigmatization of mental health. You are not alone.*

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## **Chapter 1: Introduction**

## 1.1 Introduction

The upsurge of precarious employment in recent decades has meant rising levels of vulnerability, precarity, as well as the dismantling of job security, workplace safety, and employment benefits (Sennett, 2006; Beck, 2000). Canada is no exception to this trend, showing a sharp increase in temporary, part-time, and casual forms of paid work in recent decades (Camfield, 2011; Amman, Carpenter, and Neff, 2007; Vosko, 2006). There is a developing literature about the connections between precarious employment and declines in the mental health of workers (Lewchuk et al, 2013; Lewchuk, Clarke, and de Wolff, 2011; Thomas and Hersen, 2002). In this dissertation, I aim to contribute to that discussion by a) situating the relationship between precarious labour conditions and mental health within a specifically capitalist society, and b) investigating the pharmaceutical treatment of individual illness experiences and mental health issues, particularly with antidepressant medication, that can be linked back to broader social structures. As Gill (2009) puts it, I engage in a critical look at “the relationship between economic and political shifts, transformations in work, and psychosocial experiences” (230). My analysis points to the embodied experience of labour under conditions of precarity. I aim to contribute to scholarly research and explore the connections between theoretical literature and personal stories (Wall, 2008).

The goal of my theoretical analysis is to achieve new insight regarding my research questions by bringing together existing bodies of literature, much like a grounded theory approach (Strauss & Corbin, 1994). In this dissertation I discuss 1) the social structures that underlie the deepening of precarious conditions, 2) the ways in which these conditions are damaging for precariously employed workers and the unemployed poor, and 3) how

that damage is addressed once it has manifested as psychological distress. In doing so I provide an analysis of the process of medicalization, which locates mental health aetiology as primarily biochemical and focuses on medical, commodity-based interventions in response to illness experiences. An important part of the medicalization process is to reinforce the role of medical authority and the establishment of institutionally approved pharmaceutical technologies, such as antidepressants, as the dominant treatment. An important part of my discussion, therefore, speaks to medicine's relationship with commodity and profit generation as the main motivating factor in the development and marketing of pharmaceutical treatment. Classifying mental health issues as purely medical erases social structural factors in the development of illness, and removes the serious consideration of such factors from diagnosis and treatment. The effective removal of structural factors from mental health largely erases the potential of social and economic change with the goal of improving collective mental health. Ultimately, I argue that the dominant conception of functional health, which serves the needs of capital, is a reflection of current social and economic dysfunction. As such mental health issues have become a normalized in many workplaces.

## **1.2 Statement of the Problem**

### *Neoliberalism and Mental Health*

The detrimental effects of current social and economic conditions on health, particularly mental health, motivate this research. In recent decades, neoliberal restructuring and fiscal austerity have resulted in massive casualization, an upsurge of precarious employment, and cuts in public funding to healthcare and education. Neoliberal ideology, based in part on the notion of individual resilience and the maximization of self-

interest, has also reinforced an individualist approach to health. An individualist approach to health is compatible with the medicalization of everyday stress, thereby reframing broader structural problems as individual medical concerns. Individualist approaches to health carries a moralizing tone that erases the structural violence and discrimination experienced by people in poverty. Instead, the responsibility of health is placed on individual lifestyle choices and risk behaviours (Crawford, 1977).

In this way, people unable to work are blamed for their ill health and even seen as an economic burden on society because of their need for medical services for problems that are perceived as preventable. People are then perceived as sick, not because they live in poverty, but because they have also chosen to live poorly (Crawford, 2006). This results in blame being placed on the individual for an apparent inability to resolve conflicts between maintaining one's health and the dysfunctional social and economic conditions in which one lives. When physical and mental health are rationalised in this way illness is removed from its context of structural oppression and socioeconomic inequality (Fenwick & Tausig, 2007).

The failure to address broader structures in an analysis of mental health enables the continuation of oppressive social relations that operate within a capitalist mode of production, where illness hits marginalized, poor communities earliest and hardest (Church, K., Shragge, E., Ng, R., and Fontan, J.M., 2008). Furthermore, this impacts people on potentially three interrelated levels – 1) the individual, including the micro everyday lived experiences of precariously employed workers and the unemployed poor, 2) the social, including the disempowerment of labour and the depoliticization of the

workplace, and 3) the global, referring to shifts in capitalist globalization and the international labour market.

It is clear that when medical issues within the population are estranged from social factors, what we are in fact doing is removing an analysis of power and privilege that could shed light on the roots that spread harm in society (Meikle & Campbell, 2015; Haines, 1979). In recognition of this estrangement, growing attention is being paid to the structural factors contributing to illness by health professionals. This demonstrates a potential turning point in approaches to health in contemporary capitalism. One example of this is a call to the UK government, made by over 400 mental health professionals and academics, for a formal inquiry into the “profoundly disturbing” effects of economic austerity measures on mental health, particularly cuts to public funding of adequate mental health services (Meikle & Campbell, 2015). The group “Psychologists Against Austerity” (PAA) claims that there is clear and undeniable evidence that fiscal austerity results in financial and emotional devastation, and that substantial changes to social policy are needed to improve wellbeing and prevent further damage to mental health in the UK (Psychologists Against Austerity, 2015).

My position as a researcher is very much in line with the argument put forward by PAA, which emphasizes the connection between financial devastation and mental health. This argument connects constraining economic conditions to illness experiences, drawing attention to the underlying social and economic factors in mental health. This dissertation addresses mental health as framed in two main ways – 1) *functional* health, and 2) *genuine* health. Borrowing from Sander Kelman’s (1975) dual conception, functional health is defined as the capacity to perform tasks necessary for active participation in the economy

as a productive body. An example of this is the capacity to carry out job tasks, or what I refer to as “work ability.” I employ the term “functional health” to mean mental health according to the needs of capital – namely the commodification of labour and profitability of commodity production. In contrast, Kelman defines experiential health as not only the absence of illness, but also the absence of alienating social relations. Here, experiential health requires equitable social conditions. Borrowing from this, I use the term “genuine health” to mean mental health according to the needs of humans around meaningful labour, relationships, and the development of human potential. As such this dissertation points to the need for a cultural shift in how we, as a society, approach mental health to seriously take broader social structures into consideration. Sadly, dominant capitalist and neoliberal values – productivity, profitability, and individual resilience – currently inform popular and professional conceptions of (functional) health.

### *The Role of Pharmaceuticals*

The pharmaceutical industry is a driving force behind medicalization. Individual, medicalized responses to mental health issues include an emphasis on awareness raising and disease promotion by medical communities, as well as “condition branding” by the pharmaceutical industry. For example, antidepressants are designed to affect brain biochemistry. Therefore, in order for antidepressants to be branded as an appropriate treatment for a particular mental illness or condition, the condition must be framed as biochemically treatable. While this emphasis is not the only factor involved, I argue that it has certainly contributed to a reliance on pharmaceutical technologies as treatment for experiences of mental illness, locating mental health within the biochemical functioning of individuals. Part of condition branding is exclusively marketing a particular product as the

best solution, such as Paxil for the treatment of social anxiety disorder (this example is discussed in more detail in chapter 4). This type of marketing has resulted in consumers expressing their interest in specific brand name medications to physicians, which may encourage their prescription.

To be sure, the number of life threatening and infectious diseases has been greatly reduced by the advances of Western medicine, including the development of pharmaceuticals. Advancements in medical technologies have resulted in longer lives, higher levels of immunity, and pain relief for multitudes of people. This point is not to be ignored. However, it is important to acknowledge that the privileging of medical knowledge and intervention also obfuscates the social relations that limit people's access to effective treatment making health maintenance possible for some and a struggle for others (Kirkland & Metzl, 2010). On a global scale, as the work of Farmer (2003) demonstrates, this obfuscation enables the devaluing of poor people's lives under an oppressive and market-driven economy where the primary motivation for the treatment of illness is the generation of profit (I discuss this last point in more depth in chapter 3).

In short, for the pharmaceutical industry, preferred drugs are those that can be patented and sold at a high profit relative to the cost of production. It is also ideal if the drugs are designed to treat ongoing conditions affecting a significant portion of the population. It is for these reasons that many pharmaceutical companies choose to invest in drugs marketed to treat chronic conditions in richer countries instead of infectious diseases in poorer countries (Busfield, 2006). The proliferation of antidepressant medication in the treatment of distress related to precarious living and employment conditions then, represents a highly lucrative market.

In this dissertation I focus specifically on antidepressant medication due to its wide application for various complaints, such as chronic stress or feelings of anxiety and depression, which are commonly expressed by precariously employed workers. I use the term “antidepressants” to refer to medications included in five main classes of drugs – monoamine oxidase inhibitors (MAOIs), noradrenaline and specific serotonergic antidepressants (NASSAs), serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), and tricyclics. These classifications are based on each drug’s active element and its prescribed usage, or “label.” The most common classes of antidepressants currently prescribed are SSNRIs (such as Cymbalta and Effexor) and SSRIs (such as Prozac, Paxil, Cipralex, and Zoloft) (Royal College of Psychiatrists, 2015).

### **1.3 Research Approach and Objectives**

Sociology, anthropology, and political economy have all explored mental illness as rooted in historical and social processes, which has been crucial in the legitimizing of a more integrated, structural approach (Horwitz, 2013). Medical sociology has developed in parallel to the popular movement away from positivism in the social sciences (Cockerham, 2014); but even today, positivism in the social sciences is not dead. A critical approach to the social studies of health and medicine requires confronting the notion of medical authority and the reliance of empirical data as the foundation of medical knowledge and technology (Wright, 1980). I reject positivism due to its reification of social processes, and therefore of capitalism, as naturally unfolding thereby removing social-historical trajectories. A deductive, positivist approach to research also erases people as social actors

resulting in the further alienation of participants from their engagement in social process and institutions.

In contrast, my theoretical intervention is phenomenological in orientation. My approach situates social reality and the social construction of meaning around work and health in relationship with material conditions of contemporary capitalism (Husserl, 1995). I examine how social and economic conditions contribute to mental health issues and illness experiences, and the way mental health is then interpreted and addressed by society as primarily medical – where dis-ease becomes disease. Also in line with a phenomenological in approach, I am concerned with labour, specifically precarious employment, as an embodied experience and the ways in which those experiences are articulated and understood.

#### *Research Objectives and Questions*

The primary objective of this research is to present a theoretical analysis. Through the use of current research on precarious employment and mental health, my theoretical analysis is two-fold: 1) to present an analysis of the medicalization of mental health as a socio-historical process shaped by a capitalist mode of production, and 2) to present an analysis of the ways in which the detrimental effects of precarity are treated with antidepressant medication. Theoretical analysis is then complemented with the experiential accounts collected through individual interviews. These accounts explore precarious living and working conditions and how they affect health, as well as how these effects are being managed through pharmaceutical treatment. Additionally, I include the accounts of unemployed participants in order to consider the role of systems of social precarity outside of, but related to, employment (such as social assistance programs). Through the reflective

recounting of personal experiences, the individual circumstances of participants are situated in relation to broader social structures and processes related to mental health and the political economy of labour. To be clear, the interviews represent distinct narratives representing a case study of a limited number of participants (N=8). The data collected from the interviews in no way is meant to be statistically representative or generalized to a broader population. The purpose of the interviews is to explore in-depth the experiences and reflections of these particular participants around work and health.

Although my research is rooted in the spirit of praxis and a Marxist critical social science, my contribution remains largely theoretical. Praxis can be defined basically as the real-world application of research; in other words, putting a theoretical understanding into practice. A primarily theoretical focus here is not unusual considering that much scholarly work, including Marxist and neo-Marxist research, has become encapsulated within academia, thereby limiting its potential for praxis.<sup>1</sup> Regardless of my intention to apply insight derived by my research to political activism in future, this application lies beyond my immediate objectives here. That said, the oppression experienced by precariously employed workers and the unemployed poor are the inspiration for my theoretical investigation of structural conditions and social processes. I believe that an understanding of these broader conditions is an important component in sparking genuine social change.

In Chapter 2, I discuss in detail the theoretical basis for my analysis and provide a theoretical overview of the dissertation. I also locate my research in existing scholarly literature. However, it is worth noting at this point this dissertation's potential for a

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<sup>1</sup> For a more detailed discussion of a return to an explicitly praxis oriented critical social science see Comstock, 1982.

theoretical contribution to current analyses of work and health. More specifically, a contribution to the connections between declines in mental health and the upsurge in precarious employment conditions. Where this dissertation makes its theoretical intervention is by highlighting how precarious working conditions jeopardize the mental health of workers and relating this to the inadequacies of individualist, medicalized approaches to mental health (including pharmaceutical treatment). Tied to this is the delineation between two main notions of mental health – *functional* health, which is framed according to the needs of capital for the expansion of productivity and profitability; and a second notion of *genuine* health, which prioritizes human fulfillment and is rooted in the intrinsic and material needs of people. Here, emphasis is placed on the need for a more structural approach to mental health. In this way, it becomes evident that structural change is needed in order to improve the health of workers and unemployed people living in precarity.

As its secondary objective, in addition to presenting a critique of the ideologies that inform oppressive social and economic practices, I present participants’ understanding of work and health. This understanding is situated in relation to everyday life experiences. In this way, individual circumstances and personal choice are linked back to overarching social processes of capitalism. For this purpose I conducted semi-structured, in-depth interviews to explore general perceptions of current social and economic conditions as contributing factors to mental health. In this dissertation, I explore how participants have sought to manage the damaging effects of oppressive conditions by way of the medical community with the use of antidepressants. Participants reflect on their personal

experiences of antidepressant use and overall attitudes regarding antidepressant medication.

Overall, my research questions are framed in such a way as to recognize research participants as experts of their own bodies, emotions, and lived experiences. Furthermore, I acknowledge mental health as a socially constructed conceptualization. My main points of inquiry are:

- How is mental health framed, both as a concept and a practice, within a capitalist mode of production? How has neoliberal ideology influenced dominant perceptions of mental health?
- How is work and mental health experienced within current social and economic conditions?
- How are pharmaceuticals, specifically antidepressant medication, used and understood in the management of mental health in relation to broader social structures?

#### **1.4 Map of the Dissertation**

This research applies a structural analysis to mental health issues and experiences of illness within contemporary capitalism. My methodological approach to this research is outlined in chapter 2. I discuss my research orientation as critical, employing theoretical analysis as my primary research method. I present my approach to health as structural and situated in broader social processes. I then briefly discuss my approach regarding the major threads in my research with regard to the relationship between labour and mental health, the production of medical knowledge as a social process, and the use of antidepressants in health management. Theoretical analysis situates personal experiences within broader

social contexts, and is complemented by a case study of eight participants and my own autoethnographic accounts. Participants' personal stories are gathered through in-depth interviews for the purpose of narrative analysis. This is in line with validation strategies that maintain deeper understandings of social phenomena that are gained through analyzing data from a diversity of sources. I also discuss the rationale for the interview sample as well as its limitations.

Chapter 3, "Medicine Under Capital," explores the socio-historical and current context in which medical knowledge is produced. I discuss the ways in which medical research has developed in line with capitalist aims of profitability and market expansion. Part of this discussion centres on medicalization, which is the social process whereby illness experiences are reinterpreted as individual occurrences of disease, which removes underlying social, political, and economic issues. For capital, maintaining medicine as a profitable industry requires its commodification, as well as market expansion through the growth and proliferation of certain disease categories. The commodification of medicine leads into a discussion of medical research and the influence of private industry with particular reference to the development of pharmaceutical technologies, specifically antidepressants, as an example. This example also raises the issue of a reliance on antidepressants to treat individual illness experiences that may be rooted in broader structural issues.

Building on chapter 3's focus on medicalization, chapter 4, "Mental Health and the Disease Model," outlines medical ideology as reinforcing the prevailing political and economic order through the formation of medical authority and the medical expert. I consider the ways in which mental health has been approached through the medicalizing

discourse of psychiatry, and the ways in which this profession replicates broader structures of domination within the doctor/patient relationship. I perceive this relationship to be a space in which dominant normative discourse is transmitted through a medial authority to the patient, who is expected to comply. Connecting to the previous chapter's discussion of the development of pharmaceutical technologies, I tie the contributions of the pharmaceutical industry into the role of the medical expert in diagnosing and distinguishing classifications of mental disorders from "normal" functioning. These classifications are then disseminated through the population through awareness-raising campaigns and, using the example of social anxiety disorder (SAD), I illustrate how these disease categories can be related to everyday life. I also discuss the reliance on pharmaceuticals, specifically antidepressant medication, as a medical response to mental health issues with underlying social triggers.

Chapter 5, "Precarious Labour," shifts the discussion to a more focused consideration of the social and economic conditions that shape everyday life in ways that may result in individual illness experiences. Based on Marx's (1972 [1867]; 1959 [1844]) writing about dispossession and commodity production, I discuss alienation and precarity as inherent characteristics of capitalism. This is useful as a way of perceiving, and responding to, the damaging effects of precarious labour, as well as overall social precarity. This leads to an examination of current working conditions and their implications on the mental health of workers, specifically precariously employed workers. This requires a clear definition of the characteristics of precarious labour as well as its recent development, which I offer. I then consider the advancement of information-technology in the workplace, or the "new economy," paired with the advancement of neoliberalism, which produced a

massive casualization of labour. Part of the purpose of this chapter is to demonstrate how precarious employment has contributed to the depoliticization of the workplace and an individualizing of health issues as independent from the structure of work. Mental health under capital is then framed as functional – the ability to perform job duties and participate in the capitalist market as a productive body. I consider capital’s desire for, not only productive labour, but also cheap labour using temporary foreign worker programs (TFWPs) as my main example. This example illustrates the opportunistic nature of nation-states to impose neo-colonial and imperial relations on a global labour force, resulting in the “super-exploitation” of impoverished international workers. TFWPs also contribute to the increased precarity experienced by domestic workers, and break ties of solidarity between workers, thus increasing the exploitative potential for capital on both sides.

In chapter 6, “Precarity and Mental Health,” my objective is to link the exploitation of precariously employed workers with experiences of mental health. Because this discussion closely relates to the individual experiences of workers and the unemployed poor, it is at this point in the dissertation that I begin to include interview excerpts and autoethnographic entries. The purpose is to outline the lived realities of individual workers, and the ways people interpret these experiences, as social and economic conditions continue to shift to more drastic situations of precarity. This chapter includes a discussion of how neoliberal restructuring has been extremely damaging to precariously employed workers and the unemployed poor. I argue that neoliberal policy jeopardizes individual as well as population health through fiscal austerity and cuts to social services. Neoliberal ideology also informs the notion of the sovereign worker, who is responsible for their own maintenance through individual resilience and expected to endure the damaging

consequences of a “precarious work-society.” The chapter ends with a conceptualization of how this has created a “work ethic of fear” and disciplines workers to remain “work able” regardless of their working/living conditions, even though they may be experiencing illness.

Chapter 7, “Precarious Conditions / Precarious Treatment,” draws from the narratives offered by participants in three main areas of discussion. First, participants reflect on the way in which health is framed within current capitalist society. Interviewees themselves also put forward two main ways of defining mental health – 1) health as informed by the capitalist values of productivity and profitability (again, work ability is the primary component), and 2) health as informed by the human need for genuine wellbeing and fulfillment. Second, interviewees shared their thoughts around the ways in which distress and mental illness are perceived by the medical community and popular society. They also told stories of navigating the medical community in seeking help for distress and reflected on their impressions of the care they received. Third, interviewees shared their experiences with antidepressant medication as a go-to treatment for distress prescribed by doctors. Some interviewees spoke of the usefulness of antidepressants in coping with everyday stress. However, some recounted shocking stories of adverse reactions to the medication resulting in further harm. The chapter ends with a discussion of communal care and collective action as central to cultivating genuine mental health.

As the conclusion, chapter 8 pulls on the thread that runs through the dissertation to weave a complete picture of the structural components of rising mental health issues among precariously employed workers and the unemployed poor. The chapter includes a callout to the medical community to begin addressing the structural issues at play, and to

publicly recognize the limitations of individual medical treatment as limited and acknowledge that much more is required. The chapter ends with a consideration of more sustainable and community-based ways of coping with, and resisting, the lived realities of current social and economic conditions.

## **Chapter 2: Methodological and Theoretical Frameworks**

## **2.1 Introduction**

This chapter will outline my theoretical and methodological approach to this project, as well as my research design. I take an emic perspective to social research and begin this chapter by outlining how my involvement in political activism contributes to my academic work. I then describe how I engage in critical research methods and the importance of reflexivity throughout the research process. I also discuss briefly my use of triangulation, a validation strategy, as a way of ensuring the meaningfulness of my research.

I employ a mixed-methods approach. My primary method of analysis is theoretical, grounded in medical sociology and critical political economy. I engage in literatures pertaining to medicalization, precarious employment, the neoliberal restructuring of work and health services, and their related impact on the mental health of individual workers. My analysis is rooted in a structural approach to mental health, which considers mental health from within its broader social, political, and economic context. This is in direct opposition to a purely medical approach, which locates all health issues within biological processes. In this chapter I present my framework for understanding labour conditions and their effects on the mental health of individual workers. I discuss medical research as a social process located within a capitalist mode of production and tied to a particular socio-historical trajectory. I then discuss the use of antidepressant medication in the management of mental health issues within an occupational context, and the framing of these issues as depoliticized and separated from workplace conditions. I also discuss the ways in which mental health issues are managed with regards to productivity. Finally, I present an overview of my research, which traces the theoretical threads of my analysis and locates it

in the literature. Here, I explain how I build on existing research to develop new insight into my research questions and show the authors with whom my research is in conversation.

I then provide an outline of my complementary method – narrative analysis through a case study of eight participants and autoethnographic accounts. Here, theoretical analysis is complemented by lived experience gathered from participants with a history of antidepressant use, as well as my own autoethnographic accounts. The purpose of the interviews and autoethnographic accounts is to illuminate broader social and economic conditions with data reflective of individual participants' values, experiences, and perceptions at the micro (everyday) level of social functioning. I explain the process of gathering narratives from participants in terms of sampling of interviewees, their relevant qualities, and my research goals in relation to sample size. Finally, I briefly outline my approach in the interpretation of interview findings as situated within broader theoretical analysis. The chapter ends with a consideration of the importance of informed consent and the ethics approval process.

### *On Being an Activist-Academic*

It is important for me to engage in both social activism and research in a way that reflects my location within the bureaucratic structure of academia as a doctoral student, researcher, and employee of the university. Taking up issues regarding capitalist exploitation, the labour movement, and the dismantling of systems of oppression are particularly meaningful to me. My approach to research is one that strives to be in line with the concerns of the participant population of which I am a member, in this case people with experiences related to antidepressant use. It is my aim to combine academic rigour with everyday practice and personal reflection.

As an academic who engages in activist work, I feel that it is important to understand not only how the production of knowledge gets taken up by broader society, but also how it plays out on the ground and affects people's lives from their vantage point. This can be described as an emic perspective. An emic perspective is open to emergent and varying intersectional categories of experience meaningful to participants and places first-hand accounts at the forefront of analysis (Bickman & Rog, 2008). Therefore, my interpretations and abstractions are grounded in the raw interview data, allowing it to speak for itself much of the time. This is evidenced in my use of more *in vivo* presentation of interview extracts throughout the last two chapters – chapter 6, “Precarity and Mental Health,” and chapter 7, “Precarious Conditions / Precarious Treatment.” This project also includes an autoethnographic component, which incorporates my own experiences as an “insider” identifying with the target research population.

This dissertation is a product not only of scholarship, but also of the skills and knowledge I have acquired as a result of my continued investment in activism. Harmonizing academic and activist work is a difficult and ongoing process. Several authors have outlined ways in which academia is a useful site for activism and that, as producers of knowledge, academics often do influence social change whether they intend to or not (see Flood, Martin, and Dreher, 2013; Stavrianakis, 2006; and Maxey, 1999). I find myself particularly in line with researchers who seek to challenge the belief within academia that activist work has little to offer scholarship or that it actually hinders academic progress. For example, Flood, Martin, and Dreher (2013) argue that activism has the potential to enrich academic work in four concrete ways – 1) as an entry point into applied research that may influence social change (for instance, policy), 2) as a way of exploring factors

involved in social change itself, 3) as a space for the development of progressive pedagogies, and 4) as a means of challenging structural oppression and inequities that exist within particular spaces and institutions. My research most closely relates with this last point, both in connection to my examination of mental health within the broader organization of casual work and, more specifically, within the academy.

For this reason, in part, I reference casual academic work throughout the dissertation as a point of reflexivity about the conditions under which academic research is produced. Precarious employment within academia is also a useful illustration of damaging working conditions for both graduate student workers and adjuncts. Using academia as both a platform and pivotal example in my research, I aim to draw attention within scholarly literature to the embodied experiences of other precariously employed workers as well.

## **2.2 Critical Research Methods**

My research provides a platform, however limited, for the articulation and emotional expression of people who have been confronted by mental health issues within everyday work and life. Here, theoretical analysis brings attention to the structural oppression experienced by people living in precarity as well as its socio-historical and ideological underpinnings. Additionally, first-hand narratives provide a space for the vocalization of feelings and perceptions of distress and to examine issues of power and control in daily life. Oliver (1992) also discusses the emancipatory potential of critical methodology to not only confront and challenge systems of oppression, but also enable the exploration of alternative relations and “a politics of the possible” (111).

Although this project is not ethnography per se, I draw on the principles of critical ethnography. As such this project's underlying foundation is in political economy and the interrogation of current capitalist society. As a researcher, I interrogate points of oppression and the ways in which they affect people's lives and wellbeing. Like a critical ethnographer, I too seek an understanding of the ways in which individuals make sense of their lives in relation to everyday activities and feelings. As Madison (2011) elaborates:

The critical ethnographer also takes us beneath surface appearances, disrupts the *status quo*, and unsettles both neutrality and taken-for-granted assumptions by bringing to light underlying and obscure operations of power and control. Therefore, the critical ethnographer resists domestication and moves from "what is" to "what could be" (5).

Critical ethnography respects the right to self-determination and seeks to make audible voices that have in some way been restrained, talked-over, or silenced (Madison, 2011).

I am also interested in the relationship between the mind, body, and society. As a researcher I reject positivist, Cartesian ways of knowing based on a mind/body binary in which rationality, abstraction, and intellect are privileged over the sensations, passions, and furies of the body. I do not conceive of the body as something to be reined in and controlled by the will of the mind and submitted to the superior power of reason. Such a view associates the body with unpredictability, unruliness, and irrationality. In short, bodily sensations become associated with senselessness. This false dichotomy reinforces patriarchal and misogynistic associations between the irrational, emotive female/woman and the rational, logical male/man keeping "the mind/body, reason/emotion, objective/subjective, as well as masculine/feminine hierarchies stable" (Conquergood, 1991:180). It also reinforces a false gender binary, therefore excluding a myriad of gender identities, and privileges cis-gender heteronormativity.

One way I hope to resist this outmoded and oppressive mindset is to dismantle the bifurcation between mind and body by privileging the body as a “site of knowing,” or what Conquergood (1991) refers to as “embodied research practice” (180). Following Goffman’s (1989) writing on the corporeal nature of doing anthropological fieldwork, this is one aspect of a critical approach to research that is particularly central to this dissertation. Knowing is then perceived as a sensuous process; we know through feeling and our feelings communicate knowledge. The fact that I, as a researcher, am precariously employed with a history of antidepressant use, and am living the same social and economic conditions that I am also researching is not an obstacle. It actually allows me to approach my research from a standpoint already immersed in the culture surrounding antidepressant use and the medicalization of the productive body. In line with feminist researchers such as Dorothy Smith (1999; 1987), my analysis is situated in knowledge of the world that is acquired through actual everyday lived experiences. Therefore, I consider this research as not only based on existing theory and the discovery of growing trends within health and labour, but on my own life and my stories. This research, for me, is not only about refining theory but also reconciling myself with my scholarship.

### *Reflexivity*

Generally speaking, engaging in reflexive practice forces the researcher to acknowledge their intimate connection and integration into their research. However, critical reflexivity expands beyond tracking the factors influencing decision-making or evaluating levels of objectivity. It involves the deconstruction of the social and political context in which the research is taking place and underscores the existence of a diversity of representations in which the research is located. To quote Cannella & Lincoln (2011),

“If societal structures, institutions and oppressions become the subject of research (rather than human beings) perhaps we can avoid further creation and subjectification of an, or the, Other” (88). I take this to mean that by focusing on broader social structures and our location within them, as researchers, we lessen the tendency to perceive of participants as somehow external to our own social context; thus creating a marginalized “Other” or reinforcing the existence of “the Other.” Instead we recognize individuals and social groups as interconnected within social and economic institutions. As a researcher, I am interested in highlighting the broader social structures that inform personal experience. In doing so, it is not my intention to analyse individual workers, but to understand how broader structures of oppression, exploitation, and medicalization shape their lived experiences. The subject of my research therefore is a social problem, not a personal issue belonging to individuals. This is in line with the writing of C. Wright Mills (1959):

...[p]erhaps the most fruitful distinction with which the sociological imagination works is between 'the personal troubles of milieu' and 'the public issues of social structure' (8).

By keeping focus on the structural, research takes away from the spectacle and objectification of the pathologized “Other.”

This project is rooted in sociological and political economy theory. However, it engages with personal narrative as well – located at that place where armchair musings meet real-life happenings. Adopting an emic perspective in this research springs, in part, from the tenets of “rhetorical reflexivity.” As such I must reflect on the implications of using both theory and real-life narrative as inspiration for the research, and the dangers of misinterpretation when participants’ lived accounts are taken out of context and put into scholarly text. This can be understood through the lens of anthropological research as

“Being There/Being Here.” Geertz (1988) outlined this problem in his insightful writings on his ethnographic research in Polynesia; however, I believe the point he makes is applicable to social research well beyond his time and discipline. He explains, “This rhetorical reflexivity has helped politicize ethnography. The gap between engaging others where they are and representing them where they aren’t, always immense but not much noticed, has become visible. What once seemed only technically difficult, getting ‘their’ lives into ‘our’ works, has turned morally, politically, even epistemologically, delicate” (130). I hold these words to heart, especially as I consider interview excerpts.

### *Validity*

It is important to my research that my interpretations, theoretical explanations, and representations of participants’ narratives, as well as my own, are a consistent view of the social world and accurate in what the research is intended to describe. Validity, as it is applied here, refers to the “correctness” of my research findings and credibility of my theoretical arguments (Ritchie et al, 2014). I must also consider my research design including the characteristics of the sample population, the effectiveness of interview questions, the relevance of topics and themes, and strength of my analysis.

One way of validating my analysis is a justified reflection of the social structures through triangulation. Triangulation of sources is the process whereby information gathered through different and complementary methods are considered for the purpose of constructing a more complete picture (Ritchie et al, 2014). As such I have used theoretical health and labour scholarship complemented by personal narratives collected through interviews and autoethnographic accounts. The use of varying sources allows for not only more information, but also a deeper understanding through diverse perspectives.

Furthermore, by disseminating copies of the completed research to interviewees in the interest of transparency, I am engaging in respondent validation (Ritchie et al, 2014) and providing interviewees with the opportunities to provide additional insight, confirm the interpretations and descriptions where they are involved, and point out any possible corrections for future publications.

### **2.3 Theoretical Analysis**

My primary method for this research is a theoretical analysis. I utilize sociological and political economy literature exploring the recent upsurge of precarious employment conditions, its impact on the mental health of individual workers, and the ways in which mental health issues are managed. Although my theoretical methodology is not strictly grounded theory, I borrow from its principles in the development of theoretical insight and emerging concepts (Bryman, Bell, and Teevan, 2012; Strauss & Corbin, 1994).

My theoretical analytic approach can be broadly characterized as a critical research method and is rooted in a materialist perspective. Materialism acknowledges both the existence of 1) external, material conditions, comprising the capacity of a social group or individual to accumulate economic and social capital, and 2) social constructions that are shared collectively and expressed through culture, attitudes, beliefs, and values. In short, I believe that it is the combination of our material conditions as well as the social meaning that we place on them that shape our lived reality. This position is in line with a Marxist critical social science that seeks to, in part, raise consciousness of the contradictory social relations that are hidden within taken-for-granted understandings of everyday life.

My analysis offers a critique of the ideologies that inform oppressive social and economic practices. To quote Comstock (1982), “Critiques of advanced capitalism must

similarly combine structural analyses with critiques of the ideologies that command contemporary thought” (379). The implications for my research being that I want to connect social structures that inform institutional political and economic practice to the thoughts, behaviours and, most of all, to the illness experiences of workers. This will illustrate that illness is not just a subjective experience reducible to individual bodily functions, but it is also a constructed experience shaped by dominant discourses of mental health under capital. It is through a discussion of particular ideologies – namely, medical and neoliberal ideologies – that my research gains theoretical ground upon which to examine the (instrumental) rationality behind specific social and economic practices and policies, such as the restructuring of work and fiscal austerity.

In terms of the locality of these practices and policies, I most often refer to the province of Ontario as an illustration. Ontario provides an appropriate context in which to frame the extent to which neoliberal policy and fiscal austerity have altered the social and economic landscape for municipalities and the province as a whole, particularly under former Premier Mike Harris’ Progressive Conservative government.<sup>2</sup> As will be discussed in subsequent chapters, neoliberal policy in Ontario has spurred major restructuring of both work and healthcare in recent decades. However, these practices can also be understood in a global context (as my later discussion of temporary foreign worker programs in chapter 5 demonstrates).

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<sup>2</sup> For explicit discussion of cuts to Ontario’s provincial funding by the federal government and the resulting offloading of social service provision onto municipalities see Fanelli, 2014. Keil (2002) examines neoliberal restructuring in direct relation to urban everyday life in Toronto, Ontario. Additionally, for a more focused discussion on the gendered aspects of poverty and neoliberal restructuring in Ontario see Coulter, 2009.

### *A Structural Analysis of Health*

The main thread running through my research is that the development of mental illness, particularly in precariously employed workers and the unemployed poor, must be understood *and treated* in relation to structural issues. This means addressing damaging social and economic conditions as a way of improving population health. If we maintain that mental health is a standard by which “normality in functioning” is measured, then functional health can be understood as a set of prescribed behaviours that are based on an ideology reflecting the dominant values of a society located at a particular time and place. Therefore, conceptions of mental health and its impact on our lives are formulated not only by medical standards, but social standards as well.

The social construction of certain aspects of human experience is a major tenet of sociology. It is fairly commonly accepted that there are elements of society that are shared in terms of values, norms, beliefs, and the meaning that we place on them. Human behaviour is understood, at least to an extent, as socially shaped. However, there is also a tendency to apply a biological component to human variation (for instance, in explaining differences in gender, race, or sexuality) in an effort to understand not only how society works, but how individual bodies do as well. Indeed, such theories have contributed to the marginalization and oppression of certain social groups and led scientific research, especially medical research, down some extremely regrettable paths. Medical sociology, as a field of study, provides an opportunity to examine the historical trajectory and interplay between the (subjective) social and the (objective) biological in people’s understanding of society. Particularly important for my research is an examination of how society understands health and illness as influenced by both biological and broader social structural

variants. Equally important are the ways in which mental health and illness are experienced at both the biological (disease) and social (illness) levels (Olafsdottir, 2013).

Defining mental health as either a social construction or an independent reality would be creating a false dichotomy. Rather, the point of my research is to examine the ways in which Western understandings of mental health have developed out of both (Karp & Birk, 2013). In keeping with this framework, scientific gains in medicine as well as approaches to health are reflective, not of a purely medical understanding of the body and its functions, but of social and political processes, which have been shaped and informed by the structural conditions of capitalism (White, 1991).

As such, my research applies a structural approach to mental health. I examine the social constructions of mental health and illness and the way these concepts are negotiated and reproduced in everyday social relations. I draw from literature exploring the evolution of diagnostic boundaries around mental health, particularly depressive and anxiety disorders. My work is in line with scholarship that explores connections between trends in mental health and trends in broader social and economic conditions, specifically precarious employment and neoliberal policy (Lewchuk, Clarke, and de Wolff, 2011; Lewchuk, de Wolff, King, and Polanyi, 2003).

### *The Social Production of Medical Knowledge and Technologies*

My analysis of medical knowledge production is in line with the materialist principles set out by Boris Hessen (1971 [1931]). Although Hessen was not referring specifically to medicine in his analysis, Hessen aimed to incorporate a Marxist interpretation of historical processes in his attempt to locate scientific knowledge within socio-economic structures along three main guidelines – 1) that the historical evaluation of

science can be expressed as a “dialectical movement” flowing back and forth between the economic foundation and the ideological framework of a society; 2) there must be a distinction made between the theoretical significance of scientific discovery and the social empirical conditions that stimulate it; and 3) emphasis must be given to the social and political context of science. This is useful to my analysis as I take into account the ways in which medical knowledge production has developed in terms of its political economy.

Expanding from this, I also agree with Appbaum’s (2010) notion that advances in science under capitalism are motivated and guided by interactions between the contradictory and socially productive forces of capital accumulation and labour. I understand this to mean that the production of scientific knowledge is always negotiating contradictions between human need and profit generation – the needs of workers with the needs of capital.

#### *The Use of Antidepressants in Mental Health Management*

I explore the use of antidepressants, as well as the pharmaceutical industry in general, from a critical perspective and as primarily market-driven (particularly in line with Appbaum, 2010; Conrad, 2007; and Moynihan & Cassels, 2005). To be clear, I do not deny the successes of pharmaceutical medication in improving functioning, decreasing suffering, and extending life expectancy. However, there seems to be a consistent reliance on antidepressant medication in managing mental health issues, such as depression. This reliance does nothing to challenge documented underlying social and economic factors in mental health. Also, as demonstrated by participant stories in subsequent chapters, experiences of antidepressant use vary from person to person in significant ways, raising questions regarding their efficacy. Therefore, along with its successes, it is crucial to also

acknowledge the ways in which antidepressants have the potential to worsen illness and actually do harm. Furthermore, a firm understanding of the proliferation of such pharmaceuticals requires an examination of the social processes through which they are produced and distributed. As such I discuss the evolution of medical knowledge production and how medical research falls in line with a capitalist focus on profitability and market expansion. I demonstrate that the primary value of medicine from an industry perspective is in its potential for commodification and consumption.

I discuss the role of pharmaceuticals using two general frameworks. One is a public health framework, in which pharmaceutical treatments, like antidepressants, are generally considered successful if they decrease symptomatic suffering and improve chances of survival, thereby decreasing mortality rates among the population (Lichtenberg, 2003). The other is an occupational health framework where pharmaceutical treatments are seen as a way of addressing illnesses that are not, from a managerial perspective, considered a direct result of the workplace. Mental health issues and emotional/psychological illness experiences commonly fall into the “non-workplace” category. Because certain health complaints, such as depression, are often not interpreted as a workplace issue, they are instead seen as a problem within the individual worker. Therefore, from an occupational health perspective, the primary role of pharmaceuticals is to produce a healthier workforce. Pharmaceuticals then, particularly antidepressants, are promoted to employers as a tool for improving productivity and decreasing worker absenteeism due to mental illness. Here, Woo et al. (2011) provide us with a good example. Their research concludes that the productivity of workers diagnosed with major depressive disorder (MDD) can be significantly increased in as little as eight weeks with antidepressants.

It should also be noted that there is a trend forming in occupational health research since the early 2000s that suggests economic inequality is a crucial indicator of worker performance. This research (for example, McCunney, 2001) draws attention to the relationship between income and employee health, thereby making connections between mental health and working conditions. However, even though there is an acknowledgement of structural issues at play, the end goal remains to increase productivity. Again, the economic viability of the company is prioritized over the overall mental health and personal fulfillment of workers.

#### **2.4 Theoretical Overview & Location in the Literature**

My research highlights the relationship between mental health and labour, and the compatibility of neoliberal ideology with medicalization and individualist approaches to health – the combination of which conceals structural issues and treats illness experiences as medical, thereby enabling the continuation of damaging social policies. Framing the mental health of poor people and precariously employed workers through the lens of medicalization serves to depoliticize and isolate their circumstances and equates health with individual functionality and the technical ability to perform job duties. I argue that neoliberal ideology is used by capital as a reassertion of the necessity of precarious labour and disciplines workers to endure a chronic state of stress and insecurity. Enduring such a situation makes workers vulnerable to mental illness, while individual approaches to work and health downloads the responsibility of maintaining health onto workers.

##### *Medicalization*

My analysis begins with a look at the production, and privileging, of medical knowledge in an effort to situate it within medicine *as an industry*. I draw from theorists

examining the commodification of medicine and medical knowledge as reinforcing, and in turn reinforced by, the ruling ideologies and class interests of contemporary capitalism (Applbaum, 2010; Freidson, 2007, 1988; Abraham, 1995; White, 1991; Navarro, 1977; Renaud, 1975). I also refer to the Marxist conception of infrastructure (or base) and superstructure – comparable to Gramsci's (2011) *hegemony* or Althusser's (2006) *ideological state apparatuses* – to frame how dominant philosophical beliefs and values inform ideologies that then shape material, structural realities in society (Engels, 1972 [1890]; Marx, 1971 [1894]).

I examine the ideological and structural development of Western medicine as compatible with capitalism in terms of the quantification of daily life. This prepares the foundation for my further analysis of medicalization literature discussing the depoliticization of social problems by framing them as medical disorders (Conrad & Slodden, 2013; Conrad, 2007; Horwitz & Wakefield, 2007; Crosby, 1997; and Conrad, 1992). The importance of this for my dissertation is that it illustrates the way in which the concept of mental health is disconnected from its social, cultural, or economic context – a perspective that I discuss in relation to its rich scholarship (Arewasikporn, Davis, and Zautra, 2013; Warr, 2005; Waitzkin, 1986; Helman, 1981; and Haines, 1979).

Marxist theory is a major thread running through my analysis. I turn to Marx's (1972 [1867]) description of the value held by commodities, particularly use-value and exchange-value as the basis for monetary equivalents. I relate this to the social and economic value that can be placed on mental health under capitalism. This leads me to engage with scholars who raise bioethical concerns around the profitability of disease, the acceptance of medical knowledge as fact, and the influence of industry on the development

of medical/pharmaceutical technologies (Latour, 1986; Rose & Rose, 1972). In this context I describe how medical knowledge production serves both economic and ideological functions through two brief examples – 1) the University of Toronto’s termination of Dr. David Healy’s contract following his criticisms of pharmaceutical giant Eli Lilly, and 2) the appointment of Dr. Bernard Prigent, the Vice-President and Medical Director of Pfizer Canada, another major pharmaceutical company, to the governing board of the Canadian Institute of Health Research.

### *Neoliberal Ideology and Health*

My analysis considers medical ideology as it informs medical authority and the role of the medical expert (Brase, 2005; Abraham & Sheppard, 1997). Included in this discussion is the doctor/patient relationship (Mallia, 2013; Kleinman, 1988; Foucault, 1982, 1979). The work of Braverman (1974) is important here in theoretically situating the role of the doctor within the monopolization of technical knowledge (of the body). Because my research is more focused on mental health, bringing in literature around the socio-historical development of the field of psychiatry and the treatment of mental illness is appropriate (Karp & Birk, 2013; Withers & Epstein, 2010; Tremain, 2005; Whitaker, 2002; Rose, 1999; Foucault, 1973; Rothman, 1971; Rush, 1812). Reflecting on this history calls attention to psychiatry’s medicalizing force with regard to mental health and to the way it, as a medical profession, has been called upon to pathologize and regulate unruly minds and bodies, thereby enforcing social norms and prejudices (Frankenberg, 1980; Ehrenreich & Ehrenreich, 1974; see also Illich, 1976; Foucault, 1973; Sasz, 1961; and Fanon, 1952).

In my analysis, a comparison can be made between medical and neoliberal ideologies as they inform individual approaches to mental health and resilience, as well as

the sovereign worker. Taken together, an examination of a neoliberal conception of health and medicine opens my discussion of “healthism” as a form of medicalization that reinforces depoliticized approaches to health that focus on the regulation, and stigmatization, of individual behaviours (Kirkland & Metzl, 2010; Rose, 1999; Crawford, 1980, 1977; Goffman, 1963). I consider pharmaceuticals as a way people regulate and manage their mental health, particularly illustrated by recent trends indicating a reliance on antidepressant medication in the management of anxiety and depression. This is situated in scholarship critical of the pharmaceutical industry’s neoliberal push for the deregulation of the prescription drug market, including patent restrictions and drug approval processes, that would increase the global trade of non-generic medication (Shan, 2006; Petryna, 2005; Rajan, 2003). Gaining access to new markets also requires increased medicalization of everyday life and the broadening of diagnostic boundaries to include more illness experiences under the disease, or mental disorder, category. This necessitates a discussion of the way private interest, specifically pharmaceutical companies, influences the creation of disease categories in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Cosgrove & Krinsky, 2012; Silverman, 2009; Horwitz & Wakefield, 2007; Conrad, 2007).

Here, the reintroduction of medicalized issues to society, or the socialization of disease, is important. Frankenberg’s (1980) account of the three dimensions of the illness experience – disease, illness, sickness – contributes to my research in my extension of it to the creation and proliferation of mental disorders by the medical community and pharmaceutical industry through awareness-raising campaigns. I use the example of social anxiety disorder (SAD) as it became included in the DSM and led to the success of the

drug Paxil (Kramer, 2006, 1994; Elliott, 2003). The purpose of this discussion is to highlight that the distress experienced by a portion of people diagnosed with disorders such as SAD may be rooted in social and economic conditions rather than just brain chemistry. Furthermore, this distress may serve a biological and social function indicating when living conditions are unsustainable.

### *Precarious Employment*

I make use of research linking precarious employment to declines in mental and physical health to support my argument (Lewchuk et al, 2013; Lewchuk, Clarke, and de Wolff, 2011; Lewchuk, de Wolff, King, and Polanyi, 2003; Thomas and Hersen, 2002). Chronic stress, job strain, financial hardship, and overwork can all result in experiences of mental illness (Perrewé et al, 2012; Burgard et al, 2009; de Witte, 2005). To pathologize these responses undermines the importance of their implications and inflates the market for certain drug treatments. This would indicate that relying on pharmaceutical technologies, such as antidepressants, is not sufficient in addressing the social and economic factors at play and results in the further depoliticization and normalizing of capitalist exploitation.

This leads to a discussion of the harm produced by precarious employment and neoliberal restructuring. My analysis is located in the extensive body of literature on the neoliberal restructuring of work<sup>3</sup> arrangements since the 1970s, resulting in an upsurge of

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<sup>3</sup> The concept of work provides somewhat of a theoretical challenge in academic literature (Deranty, 2009) in that it can be conceived of as ‘employment,’ in which case personal freedom is curtailed in the employer/employee relationship and what this means for the legal rights of workers. It can also be spoken of in terms of ‘labour.’ The prevailing Marxist definition of labour being an activity that humans do with intention and forethought. Labour can be understood as a liberating force and something that provides the labourer with personal gratification, given the worker has control over the means of production. Then, there is ‘work’ in its capitalist context, synonymous with toil or drudgery, and clearly delineated from leisure. Work is the thing that people have to do,

precarious employment. Key areas of this work focus on rising levels of vulnerability, precarity, as well as the dismantling of job security, workplace safety, and benefits on a global scale (Sennett, 2006; Beck, 2000). I turn to the literature on precarious employment to illustrate how neoliberal restructuring has resulted in the downloading of risk, cost, and responsibility onto workers, thereby individuating labour issues (Noack & Vosko, 2011; Vosko, 2010; Kalleberg, 2009; Tompa, et al, 2007; Castells, 2000; Peters and Marshall, 1996). This refers to what Marx (1984 [1894]) described as “savings in labour conditions at the expense of the labourers” (Chapter 5, section 2). Locating the rise of precarious employment within its socio-historical context provides more in-depth clarity of capital’s reliance on neoliberal ideology to inform policy and assert the necessity for the increasing casualization of labour.

I draw on the significant trends in which employers are demanding more flexibility from their employees with a growing discrepancy between rises in productivity and decreases in real wages as discussed by labour scholars (Shalla, 2011; Shalla & Clement, 2007; Head, 2007; Broad & Antony, 2006; Stiroh, 1999; Shepard, 1997). Central to my analysis is Wilson & Ebert’s (2013) work around the “precarious work-society,” which stresses the way individual experiences of precarious employment can be woven back into a conception of the structural organization of work. I relate this back to Marx’s (1972 [1867]) conception of the reserve army of labour on both a local and global scale. Here, I discuss intensely exploitative temporary foreign worker programs (TFWPs) as an example of global labour trends and capital’s reliance on the mutability and availability of an

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but may not want to; and leisure being what people want to do, but can only engage in after work. I use these words interchangeably in my research.

appropriate labour power to be disciplined and exploited (Albo, 2012; Walia, 2010; Carchedi, 1979). Arrangements such as these draw particular attention to the imperialist and neo-colonial aspects of the global labour market and the Canadian federal government's opportunistic grab for an international community of impoverished workers.

The restructuring of work includes the application of fiscal austerity to social services. Fiscal austerity measures have targeted social security and replaced welfare systems with workfare programs, unemployment insurance with employment insurance, and enabled the propagation of stigma regarding people trying to access social assistance and disability benefits (Karim, 2011; Chunn & Gavigan, 2004). Using the SARS outbreak in Toronto as an example of the possible consequences of cuts to healthcare, I also illustrate the way in which the health of workers, such as nurses, has been framed within such a damaging system.

Instruments such as the Work Ability Index illustrate how functional health in contemporary capitalism is framed as the ability to perform work duties (Tengland, 2011; Goedhard & Goedhard, 2005). This is reflective of neoliberal ideology around individual responsibility and self-interest, as well as individual resilience and stoicism (Arewasikporn et al, 2013). The threat of unemployment and deepening poverty has also created what Ciulla (2000:25) has dubbed "the work ethic of fear" where workers are disciplined to perform work duties regardless of deteriorating working conditions or deteriorating mental health. I use the example of precarious academic employment to illustrate the neoliberal restructuring of work in a setting traditionally associated with job security and highly skilled labour. This example also highlights the damaging effects of precarious employment on mental health and the internalization of individual resilience within a

culture of acceptance of mental health issues (Field et al, 2013; Maldonado, Wiggers, and Arnold, 2013; Shantz & Vance, 2013; Gulli, 2009; Churchman & King, 2009; Muzzin & Shahjahan, 2005; Rajagpal, 2002; Huberman-Arnold, 1999).

I argue that this work ethic of fear and culture of acceptance of mental illness in the workplace result in the increased reliance on the use of pharmaceutical technologies to manage the damaging effects of a precarious work-society. Antidepressants in particular are marketed for treatment for illness experiences that are related to the chronic stress and anxieties surrounding precarious employment.

## **2.5 Narrative Analysis**

The narrative analysis portion of my research is a case study primarily concerned with exploring personal experiences of mental health issues, and specifically antidepressant use, within the context of everyday life as depicted and understood by interviewees. I also use narratives taken from research conducted by others (for example, Waitzkin, 1979) that privilege the stories of those seeking help with issues of mental health or, what I will often refer to as “distress.”<sup>4</sup> The objective is to complement existing theoretical analyses by situating individual experiences within an understanding of broader social and economic structures. Additionally, this project is very much rooted in my own

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<sup>4</sup> The concept of distress has been traditionally used as a measure of population and individual mental health, and is one of the terms most used in mental health literature, either from a clinical or social perspective. I favour the term “distress” as an alternative to the language of a psychiatric diagnostic categories and medical symptomology. Gadalla (2009), borrowing from Sellick & Edwardson (2007), defines distress as “an unpleasant emotional state of psychological or social nature that affects the individual’s ability to cope with a particular set of circumstances.” Distress is triggered by a “relationship between the person and environment that is appraised by the person as taxing or exceeding [their] resources and endangering [their] wellbeing” (Lazarus & Folkman, 1984:19).

lived experience. Therefore, it is important for me to include my stories, as they are really where this project began.

Interviews, as well as autoethnographic accounts, consist of people telling stories:

- stories about things that happened (their experiences being on antidepressants, particular workplace situations, being diagnosed with a mental disorder...);
- stories about interacting with other people (conversations with their doctor, with their family, with their academic supervisor, or with their employer...); and
- stories about themselves in relation to dominant social discourse (health, work, education, gender...).

Embedded in these stories is the construction of meaning as people express and articulate the emotion and impact of these happenings and interactions making connections within their own lives and the bigger picture.

Narrative analysis is interested in the ways we construct “versions” (132) of our experiences and ourselves situated within social context through the telling of stories (Silverman, 2014). My analysis pays particular attention to situating narratives in two ways – 1) within the construction of illness and work narratives presented in interviews and autoethnographic accounts; and 2) within broader systems of oppression that are enabled by and fed through capitalism; for instance, the role of gender in the identification of symptoms and/or diagnosis of certain mental disorders such as general anxiety disorder (GAD), panic disorder (PD), and depressive episodes (Thomas and Hersen, 2002; Currie, 2005). Therefore, paying attention to gender relations and the way in which emotions are expressed and given meaning under patriarchy makes sense within my analytic framework. As such the interview sample is weighted heavily towards women.

My analysis will focus primarily on narratives around three main subthemes in terms of experiences and attached meaning:

- Health and illness
  - Descriptions of personal experiences (chronic stress, anxiety, depression...), meanings and interpretations attached to health and illness, etc.
- Structural stressors
  - Employment, interactions with state institutions (such as social assistance, healthcare system...), financial insecurity, social stigma around mental health issues, oppressive social relations (gender, class), etc.
- Antidepressant use
  - How they were prescribed, the role antidepressants play in everyday life, side effects, etc.

As a starting point, I began my analysis of each narrative by asking the following questions (Riessman, 2005; Cortazzi, 2001):

- What is the content of this story? Who are the main characters?
- What is the story's function? What is the story's context (social/personal)?
- Where is the narrator in the story? Where is the narrator positioned in relation to other characters?
- How is the story told? What claims are being made?

Again, although I give recognition to the physiological aspect of mental health, I am particularly interested in the way issues of mental health are experienced, interpreted, and managed through the lens of social context. This leads me to a more social constructionist perspective in the sense that my analysis will resist reification (Weinberg,

2008) at either the macro- (conditions of capitalism) or micro- (individual mental health) level. Instead I will place emphasis on social relations, which weave the fabric of our experiences and construct our realities.

Most of the original data used for this research is memory-based. The interviews are a collection of some of the participants' memories of their experiences. Participants told me their stories retrospectively, after the fact. Readers of this research, unless the researcher explicitly does so, cannot separate memory from actuality. This can be compared to what the ethnographer remembers about the field (first impressions, physical environment, social mapping, etc.), referred to as "headnotes" (Coffey, 1999, cited in Wall, 2008). My fieldwork is situated in my own lived history. Although I use journal entries whenever possible, most of my autoethnography comes from what I remember. My stories are lived memories.

Interpretation of the narratives meant parsing the more substantive content in terms of context, expressed meaning, contradictions in the narratives, and anything that was part of the participant's point of view. I also looked for conceptual meaning and abstract associations or comments made by participants relating to broader social phenomena, as well as how those connections fit together. In doing so, I focus not only on the similarities between narratives, but also on their differences in order to expand current understanding by way of exception. I also seek to map the breadth of the topics explored in the narratives in terms of generality, diversity, and depth. For example, many interviewees spoke of mental health as a continuum or in terms of degree of functionality suggesting that people perceived mental health as something that is never really 100%. They were also clear on

not equating health with normality, but rather including illness experiences as part of normal life.

### *Autoethnography*

Autoethnographies can be defined as autobiographical accounts written by the author/researcher about their lived experiences and personal narrative in relation to the research topic with the aim of advancing sociological understanding (Sparkes, 2000). The actual term can be broken into its three components – *auto*, meaning self; *ethno*, meaning culture; and *graphy*, meaning field of study. In other words, autoethnography enables sociocultural connections to be made through the application of the self to the research process (Wall, 2008). This research method first caught my attention because of its potential for authenticity and richness. Quite often, when writing research papers, I have felt as though I present myself as writing about the lives of others when in actuality my own lived experiences is what draws me to write about the topic. As a researcher, I did not want to hide behind participants; I wanted to contribute my own narrative along side them. My intention is to disrupt the lines between formal and informal ways of knowing and reject the notion of the academic research professional, unexposed and totally together while I asked participants to share their personal, and at times painful, stories. This was not true. The doctoral process is complex, stressful, and emotionally demanding as I swing from confident keener to shameful imposter and back again.

I am careful to connect themes in my narrative to social theory, as I did with any other participant. Just as the interview is not a counselling session, although it may feel therapeutic to talk about past experiences, the autoethnographic portion of this project is not about healing from past transgressions or seeking closure (although that has been part

of it). That said, due to the intimacy and vulnerability involved in autoethnography, I have found that treating my own stories exactly like any other is not actually possible. Applying the same methodological rigour to my own personal narrative is much more challenging. This does mean that I am trying to employ some sort of detachment, as a researcher, from myself as the author of the autoethnography. It seems that one function of objectivity in research is to make it so neither the researcher nor the reader needs to deal with the emotionality of human lives (Muncey, 2005). My epistemological approach to research embraces personal insight and a certain level of subjectivity. The story resulting from autoethnography invites readers to share in, not just an account of what happened, but also in the personal thoughts and emotions of what happened in order to capture the experience in all its richness and meaning (Ellis, 1999). In this way, the data retains a human quality.

My autoethnographic accounts appear in the final two chapters of the dissertation. Each story organized conceptually, exploring a different element of the larger discursive picture and appearing alongside the participants' excerpts. It is because of the insight gained through sharing one's experiences with others that I could not invite others to tell their stories without telling my own also. This meeting place between the personal and the social provides me with a unique perspective from which to conduct this research (Wall, 2008). As Laslett (1999) explains, "Personal narratives can address several key theoretical debates in contemporary sociology: macro/micro linkages; structure, agency, and their interaction; [and] social reproduction and social change" (392).

There is a rather deep sense of lasting exposure and vulnerability that derives from writing oneself into one's research. There is a sense of permanency and a loss of control in that what you have put into print cannot be unsaid and a sense that readers are free to

critique and interpret your life (Ellis, 1999). Autoethnography is an approach to social inquiry that requires a level of self-disclosure that can provoke anxiety and self-consciousness. Wall (2008) shares her experience writing an autoethnography about her involvement in international adoption, “I wanted to present an authentic self, but I was also aware that brutal honesty might reinforce misconceptions and stigma about adoption, and I was afraid what my readers would think of me if they knew what I ‘really’ thought” (41). I share her concerns. I fear that outing myself as someone who has struggled with anxiety and taken antidepressants in the past will somehow damage my academic reputation because I will be seen as damaged or unable to cope. I also fear that my stories will be seen as an opportunity to voyeuristically peer into my personal life (Ellis & Bochner, 2000) instead of receiving my accounts in the context of sociological scholarship. Although these fears are real, they do not negate the conviction that people cannot be separated from their social context, nor can I, as me, be separated from I as researcher. It makes sense then, for me and for my project, that my personal experience be considered a viable and justified vehicle for the advancement of sociological understanding (Wall, 2008).

### *The Interviews*

The point of interviewing is to gain an interpreted understanding of the social world through the eyes of the participants and their account of how things are (Berg, 2001). This is achieved through the telling and re-telling of stories. The importance of the interview component in my research is two-fold – 1) it is meant to provide a case study that complements existing theoretical scholarship regarding labour, alienation, and health under capitalism with articulations of everyday lived realities, and 2) to compare illness narratives to the pathologizing discourse of medical communities, including the pharmaceutical

industry, contributing to the overall medicalization and depoliticization of personal distress and social dis-ease.

Participants were encouraged to talk about what was important to them and to reflect on their beliefs and behaviours. The point of this was to provide a space for an insightful recounting of their experiences. I approached the interviews from three main entry points – 1) the medicalization of distress as pathology, 2) the proliferation of antidepressants as a treatment for everyday distress, and 3) “work ability” as a definition of functional health. The main objective here was to encourage participants to reflect on their experiences and what they had been told about them from authority figures in their lives (doctors, psychiatrists, employers, academic supervisors, etc.). The interviews also explored personal experiences of antidepressant use, overall attitudes regarding antidepressant medication, general perceptions of mental health in current society, and everyday life stress as a contributing factor to mental health issues.

My approach to interviewing is semi-structured, allowing space for participant responses to prompt the interview to take on shape or direction (Kvale, 1996). Participants were encouraged to lead the discussion within the general boundaries laid out in a topic guide, which was offered to participants beforehand. The topic guide is necessarily broad to include a spectrum of possible questions and lists them in a progressive fashion to limit jumping around and possibly throwing off the participants (see Appendix A for the full Interview Guide). Given its flexibility, my approach allowed for questions to evolve, to inform, and be informed by participant responses over the course of the interview process (Arthur & Nazroo, 2003). I did make a point of beginning each interview with the same general, demographic-type questions that were easy to answer, such as:

- Where do you live?
- How old are you?
- What do you do for a living?
- Describe a typical day for you.

The purpose here was to create some sort of baseline for the interviews as well as get the participants comfortable with answering questions. The interviews consisted of mostly open-ended questions and probes. Prompts were used as a way of introducing new topics and leading questions were avoided entirely. I remained cognizant of the fact that participants bring their own preconceptions, motivations, and agendas to the interview and that the topics I wanted to discuss may be reinterpreted, reframed, and possibly outright resisted. I wanted the interviews to have enough structure as to ensure the opportunity to cover appropriate topics, whether planned or unexpected, but flexible enough to allow the interviewee the space to fully explore their answers. For me, part of remaining flexible as a researcher is to clarify my meaning only when asked to do so and learning to control my compulsion to over-explain questions according to my own understanding. None of the participants refused to answer any of my questions.

I consider the participants experts about their own lives, thoughts, and experiences by virtue of the very fact that they live them everyday. Ritchie et al. (2014) define an interpretivist approach as privileging ways of knowing outside of the empirical realm of direct observation. This offers the possibility for varying points of view, each one of them real, and builds and refines our understanding of the social world through an inductive process that grounds theory in identified patterns, narratives, discourses, and associations of everyday life. Regarding my interactions with participants, I acknowledge the unequal power differential in the researcher/participant relationship. Furthermore, I do not consider myself an authority, nor do I perceive my role as researcher to analyse participants

themselves as if I know more about them and their circumstances than they know about themselves.

There were eight individual interviews in total. Participants chose their own pseudonym that would represent them in the dissertation. Three interviews took place in coffee shops, two in my home, two in the participant's home, and one over Skype. Regardless of the physical location, I assured participants that the interview space should feel safe and free from judgement or shame. Each interview was about two hours long. Establishing rapport early on was especially important considering the possibility that some interviewees may be talking about certain experiences for the first time and making connections that might not be obvious in the day-to-day (Ritchie et al, 2014). In all of the interviews, there was only one moment where the interviewee, remembering past crises and experiences of poverty, exhibited clear signs of distress (pausing, tearing up, looking down) and expressed difficulty:

Rina: "When I have been in crisis it's to the point where I can't pay rent... food... It's hard talking about that." [...]

Although it was not standard information that I shared with all participants, I did mention my own history with antidepressant medication, or other stories, if it came up organically during the interview and felt appropriate.

### *The Interviewees*

The recruitment of interviewees followed a convenience sampling method. The data generated by the interviews is not meant to be generalized to a broader population therefore convenience sampling was a viable option (Bryman, Bell, and Teevan, 2012). Although I did know all of the interviewees beforehand, they were a part of my extended community and all participants were pulled from existing local social networks here in

Ottawa. Four were recruited online in response to social media posts; two participants responded to a callout in The Icarus Project newsletter (a non-profit, radical peer-based group devoted to mental wellness education and support) circulated in Ottawa; and two participants were recruited through targeted letters of invitation sent by email.

Of my eight interviewees there were six women and two men, ranging from 21 to 36 years of age, including two people of colour with the remaining participants white. The majority of the interviewees had a university education at some level. Again, the participants represent a convenience sample that is therefore limited and unrepresentative of larger society. The stories collected reflect distinct experiences that cannot readily be generalized to a broader population. All participants, at the time of the interview, were living in the Ottawa region with the exception of one interviewee in British Columbia. They were asked at the start of the interview to state their age, where they lived, and what they did for a living.

The following provides a breakdown of the names of interview participants as they requested to be identified throughout chapters:

Participant (pseudonym)	Age (yrs)	Occupation	Formal education status	Gender category	Racial category
Anna Murray	21	student union worker	part-time university student	woman	white
Ankur	24	unemployed	former university student	man	person of colour
Stella Martin	24	unemployed	graduate student on leave	woman	white
Kitty	32	unemployed	doctoral student	woman	white
Sarah Tony	32	fulltime worker with accommodation needs	n/a	woman	white
Rina	33	house painter	undergraduate student	woman	person of colour

Joanne Lewis	34	childcare worker	n/a	woman	white
Mark	36	ODSP recipient	n/a	man	white

As reflected in the sample, recruitment prioritized self-identified women as disproportionately affected by diagnoses of mental illness (mainly anxiety and depressive disorders) and antidepressant consumption, as very well documented in the literature (McKnight-Eily et al, 2009; Hyde, Mezulis, and Abramson, 2008; Currie, 2005). Given the small sample size, the sample was limited in racial and occupational diversity.

Three participants were enrolled as university students; two had past experience as university students. As will be discussed in subsequent chapters, participants tended to speak of their current or past university experiences as involving ableism,<sup>5</sup> acute stress, and financial insecurity – not unlike trends within precarious labour. Four participants were unemployed, including one interviewee receiving ODSP benefits. With the exception of one participant who described their situation as financially “comfortable,” participants were living in relatively lower socio-economic conditions and spoke of either current or past financial strain. Four participants described themselves as living in poverty and, at times, struggling to keep up with living expenses. Two participants expressed distress at having to borrow money from family in order to live. All participants were taking antidepressants at the time of the interviews and most had been taking antidepressants for several years. At least three participants had an extensive history with antidepressant

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<sup>5</sup> Ableism in this context occurs when mental health issues are perceived as incompetence. This affects women, people of colour, and disabled people predominantly (Vest, 2013). For scholarly writings on this topic see Price, 2011 and Ryan-Flood & Gill, 2010. As will be discussed in this dissertation, various first-hand accounts also exist online written by adjunct professors and doctoral students (as well as graduate students in general) describing experiences of distress. Many speak of the expectation to endure situations of chronic stress and scrutiny, and recount mental health issues being silenced and dismissed within the university.

medications since childhood. All participants acknowledged having faced mental health issues to varying degrees of diagnosis and treatment; however, not all participants identified as disabled.

Recall that the two main objectives of this research are to 1) explore the depths of individual circumstances of participants in relation to broader social structures and processes related to mental health and labour, and 2) complement larger trends and theoretical analyses of health and labour with the experiential accounts of how people's lives and wellbeing are affected. I am not aiming to reach any point of data saturation; rather, my interest lies in the details of the narratives, not in replicating them or generalizing them beyond the participants or myself. Instead narratives, including autoethnographic accounts, along with theoretical analyses offer multiple perspectives in scope and scale. Therefore, such a small sample was appropriate and provided detailed accounts sufficient for the exploratory and descriptive purposes of the narratives in my research.

As was my intention, the sample was fairly homogenous with most participants having several years of experience managing mental health and negotiating institutional settings, as well as employment. All participants were articulate and had accumulated impressive theoretical knowledge and understanding of mental health discourse and social relations either through a combination of formal, independent, and/or experiential learning. This was a great advantage to the research project as interviewees presented critical insight, reflection, and a capacity to situate their experience within broader social structures. In this way data collection and analysis occurred somewhat simultaneously in some instances as a conversation between interviewee and me, as researcher. Finally, all participants are referred to by use of the pronoun "they." This was my decision in order to protect

confidentiality, and because I did not want to assume the preferred pronoun for each participant as this was not established beforehand.

### *Ethical Considerations*

In my opinion, ethical behaviour means treating participants with dignity and respect all around. I tried to be transparent and open regarding my research objectives. Informed consent was obtained before proceeding with participation. Here, informed consent implies full understanding of what is being agreed to and is therefore meaningful as it reflects an informed decision. This meant directly communicating my research objectives, what the interview process would look like, topics to be discussed, what would be done with the interview data, and reaffirming confidentiality (Ritchie et al, 2014). It also meant remaining open to any questions the participants may have had at any point in the research process. Also, I always asked permission before audio recording and made it clear that participation was indeed voluntary.

The issue of including the memory of other people (e.g.: family members, friends, doctors) in the recounting of both the participant's personal experiences, as well as my own, must be acknowledged. There needed to be a certain amount of control over how other people would be represented in the narratives. As such, any identifying information (for example, "doctor at clinic X in Ottawa") was excluded from the narratives. This was especially important for the autoethnographic accounts as my identity is known and descriptions of my relationships to certain people could easily breach their anonymity.

Finally, since I was dealing with what the Research Ethics Board (REB) considered a sensitive population I was expected to demonstrate an appropriate level of reflection and care for the wellbeing of the participants according to the policies and requirements of the

REB. After a successful application, my project cleared formal ethics approval by the REB at Carleton University on December 18<sup>th</sup> 2013. The primary potential harm to participants was in remembering painful or triggering experiences, and perhaps sharing it for the first time or in a context outside of their emotional support system (Ritchie et al, 2014). No one was expected to talk about something they did not want to talk about. I avoided asking for excessive detail not needed for the purposes of my research, and tried to be as clear and direct as possible in my questioning to avoid ambiguity or misdirection. None of the participants required it, although I did have the contact information for available counselling.

## **2.6 Conclusion**

Here, I have offered an overview of my methodological and theoretical frameworks. In following the structural progression of the dissertation, I begin by developing my primary objective, which is presenting a theoretical analysis of mental health as situated in broader social and economic conditions, including the neoliberal restructuring of work and health. I also provide an analysis of the medicalization of mental health and the reliance on pharmaceutical technologies in the management of mental health issues. In line with a phenomenological approach my theoretical analysis brings to the surface those underlying, taken-for-granted perceptions of work and mental health in current capitalist society. Here, mental health becomes connected to the ideologies that inform social, political, and economic policies and practices. In this way, I am engaging in a structural analysis of mental health.

I have also outlined my understanding of medical research and the development of medical technologies as a social process. Here, I point to the ways in which medical

knowledge must negotiate the contradictions between functional health (according to needs of capital) and genuine health (according to the fulfilment of human needs). My theoretical approach to the pharmaceutical industry is critical as I discuss medicine as an industry, which I understand as primarily profit-driven.

I also gave mention to my methodological leaning toward grounded theory. I develop more theoretical insight from the comparison and interrogation of theoretical research literature. As the dissertation progresses, my theoretical analysis becomes more specific as I work through broader concepts and socio-historical processes to more specific contexts, such as particular sectors of employment, and, finally, to individual personal accounts.

### **Chapter 3: Medicine Under Capital**

### 3.1 Introduction

Western medicine<sup>6</sup> and its current ideological conception of health have developed within a capitalist system. I understand Western medicine as shaped by scientific research taking place within capitalist mode of production infused with commodification, alienation, and exploitation. As such, areas of scientific research are influenced by the beliefs and values of the dominant class – the owners of the means of production (Abraham, 1995). I base my analysis on a Marxist critique of capitalist science and am informed by the notion that medical research cannot be divorced from its historical and social trajectory.

This chapter also examines the role of medical authority and situates the social construction of disease within broader structures of domination. Here, I examine the micro-level interactions between patient and doctor. The doctor-patient relationship can be a space in which dominant normative medical discourse around the individual maintenance of mental health is transmitted and reinforced by medical authority. I also include a brief account of the historical trajectory of mental health as a field of medicine, as it relates to the focus of this chapter. I refer specifically to the production of medical knowledge through research, and the commodification of such knowledge through the sale of medical technologies, namely pharmaceuticals.

Drawing from Renaud (1975), I argue that technologically based means of achieving and/or maintaining functional health buttresses a capitalist economy by equating

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<sup>6</sup> Although it is beyond the scope of my research, it should be noted that there is a broad literature examining medical systems in non-capitalist economies. For example, see Brotherton (2012), Brotherton (2008), and Waitzkin, Iriart, Estrada, and Lamadrid (2001).

medicine and treatment with the consumption of commodities. In this way mental health under capital, influenced by corporate interest, becomes focused on the needs and values of capital, not the needs of people. In line with Farmer (2003), I consider class disparity and the unequal distribution of wealth as key features in creating the conditions for the growth of disease through structural economic imbalance. As such I argue that capitalism is at once the purveyor of ill health and its supposed remedy.

### **3.2 Medical Ideology and Capitalism**

One way society can be divided according to Marxist theory is into two broad levels – the infrastructure (or base) and the superstructure (Marx, 1977 [1859]). The infrastructure serves as society's economic base and consists of, among other things, the organization of work. It also delineates social groups into class categories based on their control, or lack thereof, over the means of production. The superstructure is comprised of social institutions – such as governmental, medical, educational, religious, and judicial – that are governed by prevailing ideologies of the time. In his correspondence to Bloch in Königsberg, Engels (1972 [1890]) wrote:

The economic situation is the basis, but the various elements of the superstructure – political forms of the class struggle and its results, to wit: constitutions established by the victorious class after a successful battle, etc., juridical forms, and even the reflexes of all these actual struggles in the brains of the participants, political, juristic, philosophical theories, religious views and their further development into systems of dogma – also exercise their influence upon the course of the historical struggles and in many cases preponderate in determining their form (para 1).

Howard Waitzkin (1979), professor emeritus at the University of New Mexico and primary care practitioner, explains that these ideologies are informed by dominant philosophical beliefs and values regarding politics, beauty, and ethics. His work also points out that the ideology of science is somewhat unique in that it quite intentionally separates

the scientific from the ideological by firmly asserting that, at its foundation resides a scientific method that values objectivity above all else. It was here that political, economic, and social issues were methodologically folded into the sciences and were construed as problems that only legitimate, official experts could handle. Waitzkin's extensive research on the political, economic, and psychosocial aspects of practicing medicine has been widely referenced in the medical sociology literature since the 1970s and is still relevant today. Waitzkin (2011) most recent work highlights the importance of collective struggle against neoliberalism in the move towards public health.

In line with a structural approach, exploring medical ideology in relation to mental health requires a cultural critique of the ruling paradigm. This cultural critique of medical ideology questions the belief that medicine is intrinsically good and situates it as a product of a distinct set of ideological assumptions about the human body and condition (Wright, 1980). Informed by medical ideology, these assumptions are foundational to the prevailing Western model, or what Davis-Floyd and St. John have termed the "technomedical model." I now turn to the research of Davis-Floyd and St. John (2001:16) and the twelve precepts of the technomedical model, which they have outlined. These precepts provide a clearer understanding of how medical ideology shapes medicine as a practice:

- 1) Mind/body separation
- 2) The body as machine
- 3) The patient as object
- 4) Alienation of practitioner from patient
- 5) Diagnosis and treatment from outside in (curing disease, repairing dysfunction)
- 6) Hierarchical organization and standardization of care
- 7) Authority and responsibility inherent within practitioner, not patient
- 8) Supervaluation of science and technology
- 9) Aggressive intervention with emphasis on short-term results
- 10) Death as defeat
- 11) A profit-driven system
- 12) Intolerance of other modalities

The authors developed these precepts based on the observations and experiences of doctors they interviewed. Doctors were asked to share their views and critiques of the ways in which medicine is practiced. These points draw attention to the underlying principles of Western medicine, which are reflective of medical ideology and capitalist values regarding objective authority and profitability. According to their research, the technomedical model consists of hierarchically organized bureaucracies rooted in technological progress. Medicine then, revolves around technical expertise and prescriptive behaviours put forth by a detached authority.

Of course, it should be noted that these twelve precepts present a theoretical picture. Actual medical practice may vary depending on the people involved. My analysis is in line with all of these principles with the exception of number 7. I argue that neoliberal ideology places responsibility of the attainment and maintenance of mental health, in part, on the individual. I also argue that the constitution of the neoliberal sovereign worker exacerbates this responsibility in order to retain work ability. Tied to the concept of functional health, work ability is defined quite explicitly as a worker's physical and emotional capacity to perform work tasks and sustain wage labour. This point will be discussed in greater length in the next chapter.

Unpacking medical ideology works to locate it as a product of the prevailing political and economic order (Navarro, 1977). Medical ideology contributes to the reproduction of capitalist relations and the stratification of social groups. In doing so it also

protects the interests of the capitalist class (those in control of the means of production).<sup>7</sup> As medical practice, psychiatry shares similar traits and has been criticized by scholars (such as Caplan & Cosgrove, 2004) and by the anti-psychiatry movement (see Cooper, 1967) for maintaining the subordination and death rates of women, people of colour, non-heterosexual communities, and the poor in general (Navarro, 1977). Such critiques focus on the ways in which the institutional authority of medicine, incorporating the roles of both the expert and the sick, has disciplined “deviant” minds and bodies and subsumed an increasing amount of everyday life into medical jurisdiction (Waitzkin, 1979). At its root medical ideology reduces public health issues to a malfunction of individual physiological machinery. Following this reductionism, any relation of ill health to capital becomes circumstantial (Navarro, 1977).

Keeping with this framework, an important ideological function of the medical expert is to separate the “layperson” (or “nonexpert”) from medical research, and the decision-making power that lays therein, thereby producing technocratic rule over medical knowledge production (Brase, 2005). This phenomenon has produced a call from both experts and nonexperts to seek a more democratic and socially accountable research process (Abraham & Sheppard, 1997). Another point of separation is economic class. The social status and compensation awarded to the medical professional work to bring their interests in line with those of the capitalist class (Freidson, 2007; Navarro, 1977). To quote medical sociologist Eliot Freidson (1988):

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<sup>7</sup> The topic of medicine as a tool of social control has been a topic of robust critique. For more discussion see Horwitz, 2002, 1990, 1982; Conrad, 1992; Illich, 1976; Ehrenreich & Ehrenreich, 1974; and Zola, 1972.

A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society, which has been persuaded that there is some special value in its work (72).

Furthermore, there is an ideological claim that medical interventions and medicines are based in an objective scientific method. This enables the voice of the expert to transmit politically charged messages, which are based on a particular set of values, to their patients under the pretext of impartial authority.

### *Doctors as Medical Authority*

Doctors, like the public, are not immune to stigmatizing notions regarding persons living with mental health issues. While I agree that mental health experiences require interpretation and can be quite difficult to make sense of, psychiatry's insistence on prioritizing the biochemical context exacerbates the tendency to overlook or consider personal, firsthand accounts as lacking relevant meaning (Hornstein, 2013). An examination of the doctor (as medical expert)/patient (as lay) relationship helps put into perspective the way in which these interactions reinforce class division and capitalist structures of power, as well as the subordination of workers and the unemployed poor (Waitzkin, 1979).

When doctors sit down with patients they come with an entire culturally mandated, medical industry behind them. Doctors are construed as, if not always moral, at the very least of rational mind, which is of particular importance to mental health. They are focused on disturbances to biological functioning, whereas the patient is usually more concerned with disturbances to social, daily functioning. This duality is reconciled through interactions between the two; however, the unequal distribution of power remains constant (Frankenberg, 1980). Ehrenreich & Ehrenreich (1974) have outlined three main ways that

doctors communicate ideological messages to their patients under the guise of scientific expertise, albeit perhaps at times unintentionally. The first is through comments regarding the health problem that have no scientific validity; the second is through the overuse of technical jargon, alienating the patient from their own health experience; and the third is through statements made regarding technical aspects of the health problem that may have underlying social implications.

It must be made clear that patients are active, although typically less powerful, participants in their interactions with doctors and the medical system. In the context of Western medicine, seeking out a medical evaluation and diagnosis is an ideologically and culturally sanctioned way of expressing distress (Horwitz, 2013). Making the decision of whether or not to go to the doctor is illustrative of several intersecting cultural cues regarding class, gender, race, etc.<sup>8</sup>

### *The Doctor/Patient Relationship*

Doctors, like employers, are an important point of contact between the capitalist and working class. The doctor/patient relationship reproduces the employer/employee relationship in several ways (Waitzkin, 1979). Although historical shifts in labour will be discussed more fully in later chapters, it is important to note that doctors uphold a capitalist organization of labour, specifically in terms of scientific management and the monopolization of knowledge. This perpetuation sustains what Braverman (1974) referred

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<sup>8</sup> For example, the “Movember” campaign was created to raise awareness of (cis) men’s health issues, specifically prostate and testicular cancer (movember.com). Campaigns such as this seek to shift prevailing cultural attitudes towards medical examinations and masculinity regarding virility and homophobic sentiments around rectal exams. Also, see Bell company’s “Let’s Talk” initiative to raise awareness of the stigma around mental illness with the goal of “fighting stigma with facts” (letstalk.bell.ca).

to as the division between “conception” (mental labour) and “execution” (manual labour). Patients are not expected to be creative when it comes to medicine; they are expected to comply with the doctor’s orders. Treatment is usually made up of repetitive tasks, such as taking a pill or performing an exercise, as prescribed by the doctor. Doctors are also bureaucratic gatekeepers to social and material compensation, such as access to sick leave or insurance claims. A doctor’s approval is required for a person to be considered officially sick. Finally, the patient is dehumanized and objectified as the sum of their moving parts, much like the machinery on a factory floor. This attitude is in line with the scientific management of workers (Taylor, 1911). However, unlike the employer/employee relationship, the doctor/patient relationship within the practice of medicine is, generally speaking, much more intimate regarding personal detail and invasive of one’s body and/or mind (Waitzkin, 1979).

Neoliberal conceptions of individual resilience can also be reproduced in the doctor’s office, replicating oppressive class relationships. Because issues of social inequity and labour exploitation fall beyond the purview of medicine, rationalizing statements can be passed on from doctor to patient that ultimately locate health and illness within the individual. Even when social and economic conditions, such as job insecurity and alienation, are acknowledged, care is distributed on a case-by-case basis, and therefore not threatening to the current social order (Waitzkin, 1979). Also, care is often limited to biomedical treatments, such as prescription medication, which is more likely to be covered by employee health insurance benefits (for those workers with health benefits).

### *Doctors as Medical Expert*

Not only does the doctor/patient relationship reinforce and replicate oppressive relationships within contemporary capitalism, it also reinforces the dominant social positioning and control of medical research as the only legitimate source of knowledge regarding disease and sickness. The doctor/patient relationship also reinforces the influence that medical research exerts in everyday life. The doctor's office is a medicalized space and therefore is not typically welcoming of the presence of approaches to illness and treatment that challenge a medical approach. Doctors will often correct patients, disregard, or simply ignore questions or alternative explanations put forth by them. Also, doctors have been taught a medical discourse that they use to speak of the body and health. The use of medical jargon, or "mystification," serves to maintain the doctor's authority within social stratification as the holder of expert knowledge that is inaccessible to the patient (Waitzkin, 1979).

The massive influx of health information available to people via the Internet has tapered this inaccessibility to an extent, presenting medical experts with a more informed patient population capable, more or less, of gathering information on their own away from the doctor's office. Here, the role of the medical expert is somewhat challenged as patients expect the opportunity to contribute to decision-making with their doctors around their own treatment and care. This can contribute to heightened tensions in the doctor/patient relationship with practitioners who resist this shift in power. For patients, the volumes of information available online can be overwhelming and the capacity to interpret it may require training that the average patient may not possess due to educational or cultural barriers. Also, access to information is tied to class privilege, varies by age group, and

enables companies to market their products to patient-consumers in search of guidance. Furthermore, the degree to which doctors may be willing to listen to the treatment suggestions of patients may also be dependent on the patient's educational background and ability to use medical jargon to articulate their point. Still, although much of the health-related information and support found online can be very useful, the medical community continues to be relied on for access to treatment and the verification of potentially bogus online search findings (Kronstadt, et al, 2009).

Furthermore, doctors remain the primary gatekeepers to legitimate access to prescription medication. Therefore, medical professionals continue to be the only sources of official information and understanding about the workings of the body. Yet, individual approaches to treatment provide more room for autonomy as patients are ultimately free to make their own medical decisions, including acting against medical advice or demanding a particular treatment. In this way, patients are related to as consumers, particularly by the pharmaceutical industry. Here, individual responsibility falls on both doctor and patient.<sup>9</sup> The doctor, as the medical expert, carries the responsibility to provide relief from symptoms and restore "normal functioning," typically through the use of medication. Although the patient, as the medical consumer, may have an opinion on what drug would be appropriate to try it is ultimately the doctor's prerogative to choose and prescribe

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<sup>99</sup> Recall the twelve precepts of the technomedical model and my point of contention with number 7 – "Authority and responsibility inherent within practitioner, not patient." Here, I am explaining how my theoretical analysis is not in line with the original notion that all the responsibility of treatment falls on the doctor. I am arguing that, with the advent of individual responsibility regarding one's own health, responsibility falls, to some extent, on both doctor and patient.

medication, while the patient's primary responsibility is compliance to the prescribed treatment and drug regimen.

Building on this last point, the role of the doctor then has the effect of preserving social order and pacifying discontent through the management of distressed people (Waitzkin, 1979). The doctor/patient relationship and the dismissive silencing of patients within that relationship have been important points of critical discussion among authors and scholars concerned with primary care (Mallia, 2013; Frank, 1997; Lorde, 1980). As a result, some sociologists have privileged the stories of patients and consider sharing these stories a liberating act of resistance (Karp & Birk, 2013; Kleinman, 1988). Indeed, I agree that listening to patients' stories can be considered a moral act with radical implications for how medicine is practiced. Listening to these stories can provide much needed insight into the ways in which people experience distress, alienation, and illness within current social relations. As Frank (1995) notes, "[In] listening for the other, we listen for ourselves. The moment of witness to the story crystalizes a mutuality of need, when each is for the other" (25).

Often the stories that are collected represent a diverse range of experiences. Some patients have expressed outrage, confusion, and exasperation toward the medical community as they bounce around from doctor to doctor, therapist to therapist, in search of help and relief from distress (Karp & Birk, 2013). The authority and decision-making power of the medical expert results in patients experiencing a significant lack of control over their own health (both mental and physical). The doctor-patient relationship also degrades and dismisses patient knowledge or insight by preventing them from contributing

in ways that feel meaningful. Instead, the lived experiences of patients culminate into medical diagnosis.

### **3.3 Medicalization**

Here, I enter into a theoretical discussion of socio-historical conceptions of scientific knowledge production leading up to an account of medical research framed under capitalism as empirical and detached from broader social structures. In doing so I also provide a brief account of society's emphasis on quantification and positivism resulting in the privileging of medical knowledge above shared lived experience. I then discuss the process of medicalization, which "literally means 'to make medical'" (Conrad, 1992:210), as an individualizing force central in the expansion of the medical industry. Here, framing illness experiences as purely medical – thereby removing social, political, and economic factors from consideration – extends medical jurisdiction.

It must be recognized that the process of medicalization is not all bad. It would be wrong to deny that inclusion into medicalized mental health categories have helped many gain access to treatments that have improved their quality of life. Indeed, medical explanations can be a comfort to those who are suffering and may even alleviate social stigma and personal blame around certain conditions (see Pescosolido, 2013). In this way, the development of disease is perceived as a physiological dysfunction beyond individual control. However, it would be equally irresponsible to overlook the possibility that medicalization also depoliticizes illness experiences related to socio-economic inequity by framing health as an individual responsibility, which enables the downloading of social costs onto patients. Furthermore, note that the alleviation of blame and stigma only applies to certain conditions or certain lifestyles. I discuss this more in the next chapter.

The take-away point here is that diseases that are located in the individual – as opposed to the social – are predominately treated at the individual level. Individual treatments are typically commodity-based, produced by private industry, and exchanged on the market, thus fulfilling the “commodity production as sickness / commodity production as cure” cycle. This creates a reliance on expert knowledge and medical technologies as a remedial response to individualized illness experiences, constituting the technomedical model of healthcare.

### *The Quantification of Health*

The predominance of Western medicine has flourished under capital. The development of Western medicine would not have been possible were it not for centuries of increasing economic focus on monetary trade and the quantification of daily life. The advent of price setting and placing a money value on commodities is reinforced with a Western obsession with measurement and the development of private property leading up to the scientific revolution of the sixteenth and seventeenth centuries (Crosby, 1997). Western medicine has grown alongside capitalism as the basis for monetary trade and the determination of value. Not only has the value of health come to be quantified in relation to capital, but also quantified are the diagnostic boundaries that separate health and disease.

Quantification remains as the basis of contemporary medicine. Much of medical research is based on quantitative inquiry and testing to define, understand, and develop treatments. Health is based on measurements and levels of functioning that fall within a generalized “normal” range. Disease is therefore seen as the deviation from this normal range of functioning and the severity of the disease can be measured based on the size of that deviation. In keeping with disease boundaries as quantifiably measurable, a return to

health is then interpreted as a return to a normal range and level of functioning (for example, white blood cell counts, thyroid activity, production of insulin, or serotonin levels in the brain). This quantification of health informs an understanding of health and disease that is disconnected from its social, cultural, or economic context (Helman, 1981).

Scientific gains in medicine as well as approaches to disease and treatment are reflective, not of a purely biophysical understanding of the body and its functions, but of social and political perceptions of health. Scientific fact making occurs within a particular economic system, a system that is driven by wealth accumulation and market expansion. In this way the concept of legitimacy gets confounded with profitability. It is at this point that health may be defined as functional and reduced to the productivity of workers/consumers. Therefore, I argue that capitalist commodity production should be central to an analysis of health.

A consideration of the tensions between the use-value and exchange-value attached to medical knowledge sheds additional light on its production. Marx (1972 [1867]) described use-value as tied to a commodity's capacity for the fulfillment of a want or a need – in other words, its usefulness:

The utility of a thing makes it a use-value. But this utility is not a thing of air. Being limited by the physical properties of the commodity, it has no existence apart from that commodity. A commodity, such as iron, corn, or a diamond, is therefore, so far as it is a material thing, a use-value, something useful (Chapter 1, section 1, para 4).

Therefore, a commodity only contains use-value if its physical properties are useful to the consumer. Use-value is the qualitative aspect of the value attached to a commodity. For example, pharmaceutical medication only contains use-value if – 1) the medication is designed to treat an illness that exists and affects consumers, and 2) the medication is

effective as treatment. Exchange-value, on the other hand, represents the monetary worth, or quantitative value, of a commodity – its price on the market. A commodity’s market worth is expressed by a “universal equivalent” that determines one commodity’s value compared to another’s. Under capital, exchange-value is deceptive as it is the monetary equivalent that determines the worth of a commodity, not its labour time. The amount of labour that is required in the production of commodities is hidden and disproportionate to its overall exchange-value. However, what sets medical technology and pharmaceuticals apart from other commodities is that their commodification involves the speculation of disease profitability and placing a monetary value on health.

*“To Make Medical”*

The broadening of diagnostic boundaries and widespread marketing of medical treatment has included a growing number of individuals into the “sick” category. Medicalization studies focus on the creation and expansion of the malleable disease categories as an increasing level of life events and experiences are redefined to fit diagnostic criteria (Conrad, 2007). For example, the inclusion of grief following the death of a loved one as a symptom of clinical depression as defined by the 5<sup>th</sup> edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), to be discussed further in Chapter 4. The study of medicalization, and subsequently psychiatrization, requires an examination of not only the process of how different aspects of human life become medicalized, but also of their consequences for the genuine health of society (Conrad & Slodden, 2013). Recall that medicalization is a process, which “literally means ‘to make medical’” (Conrad, 1992:210), and results in a reductive concept of health and illness. It is first important to understand that medicalization can occur at varying intensities and levels

of public acceptance. For instance, depression has become highly medicalized in recent decades, especially with the proliferation of antidepressant medication, whereas conditions such as “sex addiction,” have not received equal attention (Conrad & Slodden, 2013). Attempts to medicalize what people generally think of as personality traits, such as shyness or nervousness, have been met with considerable scepticism, as have attempts to bring what could be considered “natural” reactions to a life event – such as the death of a loved one (life event) and grief (reaction to life event) (Horwitz & Wakefield, 2007).

When instances of dysfunction are explained as pathological they fall under the authority and domain of medicine (Warr, 2005). Although this understanding of health is disconnected from its social, cultural, or economic context (Helman, 1981), the authority granted to medical experts allows them to exert a strong influence over segments of an individual’s work and social life (Waitzkin, 1986). Under the current paradigm of the technomedical model (recall the previous discussion of the increasing quantification of society), bodies are compartmentalized and quantified; they are divided into points of specialization and bits of computer imagery. This understanding of health at once assumes a universal approach to treatment while maintaining an individualistic method of assessment, which is carried out and reinforced through expert or ‘official knowledges’ (Haines, 1979). Following this process, for any dysfunction (social or otherwise) to be treated it must first fall within the realm of medicine at some level.

Defining a problem as medical requires the weight of those possessing the greatest power and authority – be they the medical expert, the corporation, the consumer, or the state. To be clear, it is not so much whether the problem can be treated medically that concerns medical sociology; it is the ways in which they come to be diagnosed. Before a

problem can be recognized as medical it must be redefined to fit a medical framework. Therefore medicalization cannot take place without society's ability to define and redefine its problems. This is a social process of transformation (Conrad, 2007). It highlights the ways in which the construction of health narratives is informed by social and cultural context (Arewasikporn, Davis, and Zautra, 2013).

What is defined as a medical issue is often contested within the medical community itself. However, because experiential discomfort and distress that cannot be directly observed in the body can be considered psychosomatic, or somehow not real, medicalization also legitimates individual concerns and identifies ways individuals can manage their symptoms under the guidance of the medical expert. Therefore, in certain instances medicalization is made possible by the organized efforts of patients, such as with advocacy groups, even when met with resistance from the medical community. Diagnosis can be a source of great comfort. Having illness confirmed by medical authority validates patients' feelings of distress and provides hope that effective treatment exists. Also, an official diagnosis may be required for access to certain social and economic benefits and services.

Part of the appeal of medicalization is its potential capacity to combat social stigma. Instead of attributing dysfunction to faulty character and labeling people with derogatory terms such as 'bad' or 'crazy,' blame is placed on genetic weaknesses in the body, leaving the self more or less intact. Here, it is the body that needs to be corrected, disciplined, punished, and picked apart, not the person. The danger here is that the more people are complicit with the medicalization of distress, the less they will challenge broader social and economic conditions that perpetuate distress in people. Furthermore, medicalization is

limited in eliminating social stigma from mental illness. In fact, it can even instigate it. This can be illustrated by an exploration of “healthism,” which extends the medicalization of everyday life to the concept of individual responsibility and serves to place blame back on the individual for being the cause of their illness.

### *Healthism and Conformity*

Crawford (1980) defines healthism as a form of medicalization that informs popular conceptions of health behaviours and reinforces a depoliticized, individualistic view of health. It is an arena in which to compare our self to others in terms of performance, stamina, resilience, strength, beauty, and morality. Healthism places blame onto the individual for illnesses that can be connected to the personal regulation of lifestyle – the undeserving sick (undeserving of care). Those who are perceived to have followed the socially prescribed health behaviours are then considered to have become sick through no fault of their own – the deserving sick (deserving of care).<sup>10</sup> For example, medical sociologists and practitioners have written about the development of a cancer hierarchy that delineates levels of social compassion and shaming that occur with various types of cancer experiences (Gray, 2010). Lung cancer is among the most stigmatized because of its association with an individual moral failing – smoking (Gonzalez & Jacobsen, 2010). In contrast, an entire morally positive survivor culture has grown up around breast cancer creating what Bell (2014) refers to as the “pink envy” effect. Here, breast cancer is framed

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<sup>10</sup> The language of the “deserving” and “undeserving” sick was originally used in a seminar discussion around the unequal distribution of healthcare services, such as the case for refugees in Canada (see Audrey Macklin’s 2014 event entitled “The Deserving and Undeserving Sick: Withholding Public Care From Refugees” <http://nsbs.org/event/2014/01/deserving-and-undeserving-sick-withholding-public-health-care-refugees-jan10>). However, I am using it differently here as an indication of stigmatization and blame around certain illness experiences.

as occurring through no moral failing on the part of the patient, and surviving the illness, or even battling it at all, is construed as an act of bravery and a point of admiration.

Good health is awarded to those who act in accordance with social order. They do not smoke, they eat certain foods, they follow the law, they take their meds, they go to work, they contribute to the economy, and they are productive citizens. In contrast, those who do not do these things suffer ill health and are considered negligent, reckless, thoughtless, selfish, lazy, and perhaps even beyond help. Rose (1999; cited in Bell, Salmon, and McNaughton, 2012) makes this point well in describing healthism: “The state does not need to *make* people be healthy, as the citizens of course *want* to be healthy, partly as a condition of living in a society that profoundly marginalizes those who ‘opt out’ of health” [emphasis in original] (42). This process can serve to stifle public debate and limit social change by at once removing people’s agency to address the problem and placing responsibility on individuals to seek treatment according to the expectations of the “sick role” (Parsons, 1951).

In this way medicalization serves to not only separate the broader social structures from individual circumstances, but also reinforces the mind/body separation by reducing health, and mental health, to physiological functioning. Health then becomes an outcome of the individual choices made between conformity to lifestyle advice and treatment plans set out by medical authorities; or non-conformity, which is then considered as personal risk taking and perhaps even irresponsible. The boundaries around desirable and allowable ways of behaving, thinking, and being are also prescribed. Control, surveillance, discipline, and conformity are all part of this process. This is the power of medicalization, which, at

its most basic, stems from the authority to set boundaries, thereby determining how people perceive, interpret, and respond to illness (Conrad, 2007, 13).

### **3.4 Medical Scientific Knowledge Production**

Here, I will take a closer look at the production, and privileging, of medical knowledge in an effort to situate it within medicine *as an industry*. The production of medical knowledge takes place within a capitalist economic structure and therefore cannot be understood or discussed without an accompanying analysis of capitalism (White, 1991). In order to gain a deeper understanding of the mechanisms by which contemporary medical knowledge is produced under a capitalist framework, an exploration of the ideologies that inform both the material conditions and social relations within capitalist production is required. In this way, the connection between medical research and greater social and political influences informing it attains analytic clarity.

I also examine the influence of private interest over medical research conducted primarily to maintain profit. Focusing on antidepressants, I argue that profit generation is the driving force behind the production of new pharmaceutical technologies. This raises serious concerns regarding medical research and the development of technologies in a context where major multinational corporations, such as in the pharmaceutical industry, hold influence over the direction of medical knowledge production. Through the use of illustrative examples, I discuss the conflicts of interest that have arisen within the medical and academic communities regarding the control of private interest over the development and marketing of new drugs. I also discuss the actions of industry when such concerns threaten the profitability of certain medications.

### *Social Forces and Medical Research*

It is important to interrogate the relationship between the selection, accumulation, and classification of medical research findings and the structural constraints guiding the construction of interpretive theoretical explanations of the epistemology and treatment of disease. This relationship is not a neutral one in that the prioritization of which research questions are pursued along with the conclusions and discoveries derived as a result of such questions is influenced by both the logic of the scientific method and dominant ideological social forces (Rose & Rose, 1972). Conceptualizing medical knowledge requires placing it within its social context and material conditions so that we may begin to flesh out the extent to which the interests of political and industrial institutions, such as private corporations, control its production. To be clear, my intention here is not to say that all scientific knowledge is simply fabrication, or that the role of the researcher is to pander to the demands of social super-powers. I am arguing for the prioritization of human need within scientific inquiry and greater reflexivity within the research process regarding economic motivations and who stands to benefit the most as a result.

Another interesting point of analysis is Bruno Latour's (1986) "fact making" in scientific research. As the basis of his analysis Latour (1986) looks at the production of scientific knowledge carried out in a laboratory setting. His main focus is the construction of scientific fact and how these constructions become accepted as knowledge. This process involves a myriad of actors and social relations, some controversial or even contradictory, involved in various stages from research proposals to funding to securing lab space to participant recruitment to the producing academic papers. Each of these stages requires a strategic network and access to the scientific communities in order to build legitimacy and

recognition. The acceptance of the constructed fact by the scientific community then propagates its acceptance within the broader public. Although compatible in approach, Latour did not take his analysis beyond fact acceptance. However, this analysis could be considered in the context of medical knowledge and the pharmaceutical industry in order to relate scientific fact construction to profit generation.

While it is beyond the scope of this chapter to provide an exhaustive account of the critiques of the modernist concept of scientific objectivity, we may consider Thomas Kuhn's (1962) thoughts on science and Ludwik Fleck's (1979 [1935]) notion of the "thought collective" as illustrations. Fleck developed the idea of thought collectives to signify different schools of thought, or camps, to which researchers belonged and through which they perceived the world. In this way, scientific knowledge is a product of its time, place, and camp within which it is developed. According to Fleck, achieving objective truth is not possible as all knowledge is tied to social, political, and economic forces that give it shape. Inspired by Fleck, Kuhnian tradition also challenged the acceptance of positivist science in that scientific knowledge production is not considered objective (as in free from bias), but relative to social forces by which it is largely influenced. Furthermore, there was no distinction made between unbiased or "pure" science and contaminated or "false" science that had been polluted by external interests.

Kuhn's (1962) view indicated that scientific research was subject to structural incentives that determined the acceptance of any given theory according to prevailing social perceptions of the order of things. This is an important distinction in that, with two essential features, Kuhn's view turned the thinking at the time regarding the ways scientific discoveries are made on its head. First, any theory can be proven according to results as

long as the researchers are willing to adjust their preconceived theoretical beliefs accordingly. Second, interpretation of results is done through the lens of already prevailing theories, thus the gathering of evidence regarded as significant or relevant is largely dependent on the theory that is being tested. This presents a rather circular process that does not necessarily challenge dominant organizational and ideological structures or paradigms. However, shifts in paradigms can occur, not as a result of the discovery of “Truth,” but due to social transformation and the deconstruction of previous ideological structures. This indicates that knowledge production, along with the basic assumptions of scientific thought, is fluid and can be revolutionized through political change for better or worse.

From this viewpoint, the design of scientific theory is congruent with the beliefs and values of collective social groups and championed by individuals who constitute them. It follows, then, that particular groups will reinforce scientific research representing their interests. Furthermore, the implementation of technical idealism within scientific discourse is an important factor in sustaining oppressive class differences on a local and global scale. An effect of scientific knowledge is a legitimizing of these beliefs and values backed by evidence. This leads to certain preferred theories being chosen over others, not through intellectual autonomy or as a result of methodological rigour, but determined by the interests of a dominant social group and the level of power and influence this group can enforce. Scientific knowledge can therefore be understood as a social product and subject to political and economic conditions and the social relations they encompass. The problems that science is charged with solving are relative to the goals of dominant groups within a particular social order. Within capitalism, knowledge production takes on a competitive

aspect and becomes focused on problem solving through laboratory studies (Abraham, 1995).

### *Corporate Interest*

The role of industry and government, particularly under a capitalist order, in the production of medical knowledge cannot be ignored in terms of funding and the selection of what research problems receive attention, as well as indeed the need for scientists to earn a wage for their labour. The notion that scientific inquiry occurs in an ideal space free from political intrusion fails to reflect its complex material conditions. Let us, for instance, consider pharmaceutical industry funding for medical research.

The Canadian Medical Association (CMA) has developed policy around conflicts of interest regarding physician interaction with industry money and collaborating in research efforts funded by industry. The underlying principle is that physicians are expected to behave in ways that prioritize the best interests of the health of Canadians at all times. Also, all research projects are expected to go through formal ethics approval from the appropriate body and inform all involved, including participants and medical journals, of the source of funding. Principle #7 states: “A prerequisite for physician participation in all research activities is that these activities are ethically defensible, socially responsible and scientifically valid. The physician’s primary responsibility is the wellbeing of the patient” (CMA, 2007:2). However, the approval of medical research in the academic setting is left to the institution’s Research Ethics Board (REB). Article 11.10 of the CMA’s guidelines for research involving human participants states the following regarding industry funded research:

Researchers and REBs should be aware of and consider the possibility of financial conflicts of interest. They should ensure that clinical trials are designed

to meet appropriate standards of participant safety in accordance with the core principles of this Policy. Financial considerations shall not affect these standards or the scientific validity and transparency of trial procedures... Researchers should not benefit financially from pharmaceutical or biotechnology companies, or other types of sponsors. Financial incentives have the potential to distort researchers' judgment in ensuring the design and conduct of the trial is ethical. Some clinical trials are conducted under contract with companies that have a profit motive in order to secure marketing approval for the drug, device or product being tested. Because these companies operate on a profit-based model, the financial benefits of demonstrating efficacy and safety in a novel therapy may have the effect of compromising standards of participant protection and scientific validity (see Chapter 7). Financial conflicts of interest are not a feature of all sponsored research. However, REBs shall consider the potential for conflicts of interest in clinical trials because it has been empirically established as a risk of some sponsored research and can undermine the ethical conduct of research (163).

Medical research within the academic setting representing some of the largest research institutions in Canada has come to rely on funding from both government agencies – such as the Tri-council funding agencies, including the Canadian Institute for Health Research (CIHR) – as well as the private sector, whose chief executives often sit on a university's board of governors.<sup>11</sup> Of course, simply because members of a university's board of governors have ties to the pharmaceutical does not necessarily imply the presence of financial or ethical conflicts of interest when it comes to the transparency of medical research. However, there certainly have been examples of serious conflicts in the past where pharmaceutical companies sway scientific debates in the academic setting (Shafer,

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<sup>11</sup> Recent examples include Sanofi Pasteur Limited President and Chair of Canada's Research-Based Pharmaceutical Companies (Rx&D), a pharma trade association, Mark Lievonen, at York University ([sanofipasteur.ca](http://sanofipasteur.ca)); and General Counsel for Lilly Diabetes of Eli Lilly and Company and former Vice President, Legal and General Counsel to Pfizer Canada, Dr. John Rudolph, at McMaster University ([mcmasterinnovationpark.ca](http://mcmasterinnovationpark.ca)).

2004). One particular incident occurred at the University of Toronto (U of T), causing a media storm.<sup>12</sup>

In 2000 Dr. David Healy, a leading scientist from Wales and internationally recognized expert in antidepressants, had been offered a high-ranking job with the U of T's Centre for Addiction and Mental Health (CAMH). Right before Dr. Healy was set to arrive in Canada and begin work, he gave a lecture on Eli Lilly's drug Prozac. Dr. Healy spoke of research findings that concluded the drug induces suicidal ideation in some patients and may not be appropriate for certain demographics, particularly young adults and adolescents. Shortly after presenting this research, the U of T senior administration terminated the contract – a contract that was nearly two years in the making. Dr. Healy recalls that he had been warned by a fellow scholar, Dr. Nemeroff from Emory University, who was critical of his work that “presenting research of this kind was unlikely to be helpful to my career, as pharmaceutical companies roll over people who are awkward to them” (Healy, 2008:109).<sup>13</sup>

The story hit the media in April 2001 once it had been revealed that, not long before Healy's talk, Eli Lilly had donated \$1.5 million to the CAMH and provided funding for the construction of a new hospital wing at the teaching university. The public grand opening

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<sup>12</sup> CBC's *The National* (MacIntyre, 2001) aired a documentary on the case. A full transcript can be accessed here - <http://www.pharmapolitics.com/cbcnational.html>

<sup>13</sup> It is also of interest that, six months prior, Dr. Healy also wrote a paper critical of antidepressants appearing in the Spring 2000 issue of a prominent bioethics journal, the *Hastings Centre Report*. The publication receives sizable financial support from the private sector. One of its supporters at the time included Eli Lilly, who promptly withdrew its contributions after the release of the issue stating that the journal had “published articles that Lilly felt contained information that was biased and scientifically unfounded and that may have led to significant misinformation to readers, patients and the community” (Elliot, 2004).

of the new wing was scheduled to occur after the commencement of Dr. Healy's contract. Direct communications from the drug company ordering the U of T to terminate Dr. Healy's contract were never found. It is also unclear how the senior administration arrived at that course of action. When asked, the administration made rather vague statements regarding "clinical concerns" and that Dr. Healy was a "bad fit" for the university (Shafer, 2004). What is certain is that this case, and others like it,<sup>14</sup> raise serious concerns around conflicts of interest in medical research, specifically academic freedom, academic stalking, financial disclosure, and the influence of industry over the workings of academic research (Shnier & Lexchin, 2013; Lemmens & Luther, 2008; Sismondo, 2007; Shafer, 2003).

In addition, in order to secure government funding and job security, researchers must write grant proposals that are convincing as to the scientific value of their research and their ability to advance the needs of society, lending to an industry model in research. Proposals that are seen as controversial or running counter to dominant political values or interests of industry may find this process more challenging (Greenberg, 2007). This encourages congruence between the knowledge that is produced on these campuses with industrial demand, resulting in the commercialization of medical research, ethical concerns, and conflicts of interest. A recent example of this is the appointment of Dr. Bernard Prigent, the Vice-President and Medical Director of Pfizer Canada, a major pharmaceutical company, to the CIHR, which sparked public controversy within the academic, medical, and patient advocacy communities. Some called for his immediate

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<sup>14</sup> See also the case of Dr. Nancy Olivieri at the University of Toronto's Hospital for Sick Children. When Dr. Olivieri's research discovered risks associated with a drug produced by Apotex, the corporate sponsor for the clinical trial, the company shut down the trial and gagged Dr. Olivieri with threats of legal action (Shuchman, 2005; Baylis, 2004; Shafer, 2004; CAUT Bulletin, 2001).

removal from the governing council and charged the appointment as highly inappropriate (Lewis, 2010; Gibson, 2010; Silversides, 2010, 2009). Jocelyn Downie, Canada Research Chair in Health Law and Policy at Dalhousie University, was quoted in the media as saying, "My primary concern is that a senior executive from a pharmaceutical company has been given a seat at the highest governance table for the national health research funding agency. This person is in an intractable conflict of interest — on the one hand, he has an obligation to serve the shareholders of his company [as an executive at Pfizer], and on the other hand he would have an obligation to serve the public interest [as a member of the CIHR governing council]. Given the divergence of interests between the shareholders and the public, he cannot serve these two masters" (Sharratt, 2009). Others commended the appointment (see Sharma, 2009) stating that criticisms were "based on innuendo rather than fact" and that the appointment did not violate the mission of the CIHR's governing council (Williams & Morin, 2010).

Major apprehension regarding Dr. Prigent's appointment stemmed from Pfizer's dubious ethical history in medical research and the unsafe distribution of products. It is reported that the company paid out more than \$2.3 billion for violating ethical and legal regulations regarding the marketing of drugs (\$1.3 billion was paid in order to settle criminal charges) (Gibson, 2010). Additionally, Pfizer Inc., Pfizer Canada's parent company, paid \$75 million in an out of court settlement to the government of Nigeria after a 15-year legal battle as settlement for a 1996 clinical trial disaster. In this trial, the testing of the experimental meningitis drug Trovan on human subjects resulted in the death of 11 children and left dozens disabled (bbc.com, 2011; Silversides, 2009; Petryna, 2006; Coleman, 2001). Scholars continued to join the opposing voice including Abby Lippman,

professor of epidemiology, biostatistics and occupational health at McGill University and Patricia Baird, university distinguished professor with the department of medical genetics at the University of British Columbia (Siversides, 2009).

The debate resulted in an online petition containing 4400 signatures protesting the appointment presented by Dr. Downie and other Dalhousie scholars, including Françoise Baylis,<sup>15</sup> Canada Research Chair in Bioethics and Philosophy, to both the CIHR and the House of Commons. The House of Commons conducted two hearings on the issue, which ended with the motion to remove Dr. Prigent from CIHR's governing council being defeated in a split vote (Lewis, 2010). Dr. Prigent served his first term from October 1, 2009 to September 30, 2012 and was reappointed on November 22, 2012 for a second term that continues until November 21, 2015 (cihr-irsc.gc.ca).

This example demonstrates that, in the context of medical research, knowledge production serves both economic and ideological functions within capitalism. It secures capital accumulation through the commodification and consumption of medical treatments, such as pharmaceuticals, as well as providing investment opportunities in the research and development of such technologies, which in turn preserves the organization of the labour force and the extraction of surplus value from health care workers. Medical research under capital also reinforces and legitimizes the current social order through the individualization

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<sup>15</sup> Original letter by Dr. Baylis to Dr. Harvey Chochinov, Chair of the CIHR Standing Committee on Ethics:  
[http://www.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/Letter\\_to\\_Chochinov\\_December\\_01.pdf](http://www.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/Letter_to_Chochinov_December_01.pdf)  
Dr. Chochinov's response letter:  
[http://www.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/Chochinov\\_memo.pdf](http://www.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/Chochinov_memo.pdf)  
Dr. Chochinov's memo to CIHR's Standing Committee on Ethics addressing the matter:  
[http://www.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/Chochinov\\_response.pdf](http://www.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/Chochinov_response.pdf)

and the delivery, however uneven, of innovative cures and medications, thereby maintaining the status quo.

Reducing medicine to industry models of research and individual consumptive patterns minimizes the role of social relationships with regards to mental health. This reductionism parses social relations from the causality and treatment of disease. This type of research and development also preserves a capitalist mode of production of medical commodities. In this way, medical research becomes a capitalist pursuit; it cannot be removed from a capitalist mode of production because it reproduces a capitalist mode of production. Within this structure, as White (1991) points out, scientific knowledge is woven into the interests of the capitalist class and the perpetuation of class relations.

### **3.5 The Commodification of Medicine**

I now turn my attention to the pharmaceutical industry, as a profit-driven industry, and the way in which medical knowledge is transformed into a commodity to be marketed and sold. I also consider the lobbying efforts of pharmaceutical companies at the government level to influence the deregulation of the approval and sale of medications, raising questions around drug safety and overall trust in the pharmaceutical industry (Hernández, 2015; Light, Lexchin, and Darrow, (2013); Liu, 2012).

In line with Busfield's (2006) criticisms, I question the reliance on pharmaceutical technologies in the maintenance of mental health. I ask whether this reliance could in fact create harm. This harm comes from not only the deregulation of pharmaceutical products, as in marketing and sales, but in the activities the industry puts forward as scientific knowledge, including drug development and evaluation. These practices often stem from deep conflicts of interest – namely the prioritizing of profit over human need and/or

effectiveness. My intention is not to delegitimize the use of medical interventions as treatment of mental health problems. The purpose of this chapter is to call attention to the silencing of broader social and economic concerns, perhaps even voiced by patients in relation to their health, by interpreting distress as a predominantly medical issue. I also want to establish that the driving forces of capitalism – namely productivity, profitability, and economic expansion (Rinehart, 2001; Marx, 1972 [1867]) – also drive medical technologies and research.<sup>16</sup>

### *The Pharmaceutical Industry*

The extent to which medical knowledge is coveted by industry is the extent to which it can be reinvented to reconstitute its value over and over again by turning into as many different profitable commodities as possible, however subtle the differences between them. Medical knowledge that is produced by private industry soon becomes part of legal struggles to retain ownership and withhold innovation from competitors as well as keep it from falling into the public domain where the information retains none of its original market exchange-value. For example, there are several strategies within the pharmaceutical industry that can be employed to avoid losing monopoly power over a particular pharmaceutical product, such as releasing a generic alternative of their own a month or two before the patent expires. Alternatively, a company may also choose to re-patent a slightly different version by altering one of its ingredients, changing the strength, form (gel,

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<sup>16</sup> I would like to be clear that putting forward a critique of science in no way invalidates the discovery of effective treatments and cures. My issue is not with the healing potential of medicine; it is with the harmful effects of a capitalist medical science. I do believe that medicine applied equitably to public health in a more socialist-anarcho-feminist oriented, community-based way is possible and indeed preferable (for more discussion on this see Davis-Floyd & St. John, 2001; and Waitzkin, 1978).

capsule, ointment, etc.), or, as in the case of AstraZeneca's anaesthetic Diprivan,<sup>17</sup> even adding an additional ingredient that is patented in its own right such as a preservative (Pearce II, 2008).

Patent protection restricts the research process in that once one company has invented a drug, no other company can immediately profit from it. A company's ability to secure exclusive access to innovation as private intellectual property serves as an incentive to streamline the efficiency of the research process and increase the rate of circulation. The speed at which medical knowledge is produced is of particular importance in the realm of pharmaceuticals where blockbuster drugs generate millions of dollars for the company. Time is of commercial essence when delays in the development or market placement of a product could mean huge losses in daily profit. Also, speediness and efficacy in problem solving lends legitimacy to the research process as being on the 'cutting edge' and responsive to the changing needs of the field (Rajan, 2003). This has resulted in private corporations controlling much of the capital needed for the production of medical knowledge. The purpose of medical research then becomes to buttress capitalist expansion of medical solutions. This includes the promulgation of manufactured market interests as perceived social need through the technomedical model as well as notions of modern innovation and professional authority.

The influence of the medical professional and the pharmaceutical industry in the medicalization of social problems cannot be overstated. Since the 1980s, pharmaceutical companies, patient advocacy groups embracing the disease model, and health insurance

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<sup>17</sup> Diprivan is the brand name drug to the generic version Propofol, to be discussed in more depth later on in this chapter.

providers have gained significant control. To a large extent, the medical expert has been demoted from all-knowing healer to prescription gatekeeper. This shift can be illustrated by the now familiar tagline in pharmaceutical advertisements, “Ask your doctor if [said drug] is right for you” (Conrad, 2005).

The mainstay of the pharmaceutical industry’s power and authority is in part due to the successes of medicine against infectious disease. Indeed, medical research has resulted in drugs, vaccines, and interventions that have benefitted humans in the treatment of infectious disease. However, pharmaceutical approaches that were appropriate for infectious and microbial diseases may not be appropriate or sufficient for all illnesses. Moreover, they may even create further damage. Nonetheless, this medical approach has remained the primary method for the treatment and management of mental health issues under the purview of medical practice. This stems from the disease model, based on the premise that treatable diseases are caused by a physical pathogen that can be observed, isolated, and targeted at the biochemical level or through other invasive treatment, such as removal or replacement (Cockerham, 2013).

The speed at which medical knowledge is produced is of particular importance in the realm of pharmaceuticals where blockbuster drugs generate millions of dollars for the company. The primary purpose, then, of medical research in relation to pharmaceutical development is to maintain a healthy *economy*. This language can be seen in Pfizer Canada’s message to consumers on its webpage entitled “Advancing Medicine”:

In order to discover and develop innovative medicines, find new ways to provide access to research-based medicines for Canadians, and contribute to Canada's knowledge-based economy, at Pfizer Canada, we believe that we need to be more than just partners. The science community, all levels of government, patients and industry need to be "co-creators." Moving beyond the execution of a project, co-creators take partnerships one step further by

playing an active role in the creation of value and new knowledge that translates into improved quality of life, healthier outcomes, innovations, accessibility for patients and a prosperous and productive economy (<http://www.pfizer.ca>).

Here, the focus is on accessing medications and participation in the economy. Even in such a short blurb the emphasis consistently returns to marketing buzzwords like “innovation,” “research-based,” and “the creation of value.”

The same language is routinely used in a neoliberal construction of commodified knowledge, such as with the corporate restructuring of universities, and the potential for profit in the “knowledge-based economy.” Where “healthier outcomes” and an “improved quality of life” are mentioned, they appear as less important, sandwiched between repeated statements about innovation and a “productive economy.” Patients’ contributions and concerns seem to play a secondary role (at best) when it comes to the “co-creation” and advancement of medicine. Also, the message equates making advances in medicine with “the execution of a project” and implies that aiming to improve the quality of people’s lives is actually taking medicine “one step further.” This implies that quality of life is not the primary motivation in the development of pharmaceutical medications.

### *Expansion vs Need*

Concurrently, the pharmaceutical industry consistently points to its own empirical evidence and holds firm a positivist view of science in its defence, which serves as a shield from accusations of corrupting ethical boundaries around research and development, as well as marketing and advertising (Petryna, 2005). Furthermore, the pharmaceutical industry’s positivist stance acts to isolate medical knowledge production as the untainted pursuit of “Truth” separated from the vast inequalities and power differentials in which this

work is engulfed. In so doing, this justification masks the political and social interests that influence and direct medical research. However, this emphasis on detached objectivity can be seen as contradictory as it also throws into question the supposed underlying ethical foundation of medical research as communal and serving the wellbeing of humanity, where all human life is considered intrinsically valuable (Abraham, 1995).

This contradiction serves to point out that the commodification of medical knowledge is not a natural, flowing process within capitalism. It is rife with contradiction and complexity. In order to accumulate symbolic (social) capital, the pharmaceutical industry strategically conveys itself as made up of compassionate corporate entities and ethical subjects (Rajan, 2003). Indeed, it is in the pharmaceutical industry's best interest to promote their products as life-saving technologies. A recent example to illustrate this point is Denmark's H. Lundbeck A/S and Fresenius Kabi's refusal to sell the generic anaesthetic Propofol to Texas prisons for use in state executions (Biospace, 2012). This decision was followed by Teva Pharmaceutical Industries one year later, with manufacturing based in Italy, who also refused to sell Propofol for this purpose. Their reason was that using the drug in executions runs counter to its approved usage by the Food and Drug Administration. Also, the pharmaceutical companies stated that they want their products to be associated with prolonging life, not ending it (Prison Legal News, 2015).

However, negotiating between ethical boundaries and economic restraint can be a source of contestation as the imposition of regulatory and competitive restriction encumbers the transformation of knowledge into commodity. Despite claims of humanitarian intent, the pharmaceutical industry is indicative of capitalist social relations in its reproduction of imperialism, and in the ways in which already existing class

disparities are exploited in order to further capitalist class interests. For example, pro-industry institutions (for example, the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use) work to convince nation-states that lowering standards regarding the testing and registration of pharmaceutical medication will accelerate the flow of medication into the country (Shan, 2006). This heightened flow of trade also allows pharmaceutical companies to gain access to possible new markets.

The importance of revenue from both international sales and domestic employment to the home countries' national economies cannot be overstated (Busfield, 2006). Canadian sales of patented prescription pharmaceuticals hit \$13.6 billion in 2013 (a \$2.6 billion growth since 2004). Included in the leading top ten drugs sold in Canada were two antidepressant drugs – Cipralex (an SSRI) in 5<sup>th</sup> place and Cymbalta (an SNRI) in 7<sup>th</sup> place (Canadian Institute for Health Information, 2013). These numbers seem rather modest when taken into consideration with US pharmaceutical sales. With a bottom line of US\$339 billion in 2013, which grew to US\$365 billion in 2014, pharmaceutical sales in the US outpace the gross national product for entire countries. The US also remains the most profitable market, representing 39% of global pharmaceutical revenue in 2013 (China is the second most profitable and surpasses Japan as currently the fastest growing market). The bulk of global pharmaceutical sales continue to profit Western countries where most head offices are located. The US houses five of the top ten most lucrative pharmaceutical companies, with the remaining four in the UK, Switzerland, and France (pharmaceutical-technology, 2014).

### **3.6 Conclusion**

In this chapter I have discussed medicine's compatibility with capitalism and the ways in which medicine is shaped by dominant ideological social forces. The historical development of medicine has occurred along with an increasing focus on quantified measurements of value and monetary trade. This evolution has resulted in quantification as the foundation of medicine. Here, disease is defined as the deviation from a measurable "normal" range of functioning, thereby separating health from its social, cultural, or economic context. It is here that dysfunction (read: processes falling outside of the normal range of measurement) is located in the body and becomes the domain of medicine.

The doctor/patient relationship reflects relations of power and domination relating to the monopolization of expert medical knowledge. This can result in patient voices and personal accounts of lived experience being dominated or dismissed by the medical expert. This does not necessarily remove all agency from patients, who may advocate for their perceived interests. Patient advocacy, for instance among sufferers of depression have done much good in reducing the stigmatization of certain illness experiences. However, the domination of expert knowledge accepted as medical fact serves to isolate the illness experience and individualize the healing process. Consequently, patient education has never been so important, not only in terms of how the body functions, but also how society functions; or more pertinently, its dysfunctions. The doctor in this scenario remains the gatekeeper to medical treatment and, in this way, maintains authority. Ultimately, the responsibility of health is split between doctors and individual patients who are expected to conform to the direction of medical authority, both in regards to disease and everyday health behaviours. This does little to challenge broader social structures.

The quantification of health underlies the process of medicalization. The reliance on scientific research and medical technologies is reflective of the ruling technocratic paradigm in medicine based on a set of assumptions about the body. Framing the body as machine, medicine as a practice is then based on technical expertise and emotional detachment between the doctor as medical authority and patient. In doing so, the technomedical model also reinforces the depoliticization of illness experiences by focusing on immediate symptoms and locating dysfunction within the body. This technomedical approach objectifies the body, alienates the patient from the healing process, and enables the commodification of medicine. By theoretically removing the ideological from the scientific, social structural issues that influence mental health are cloaked in objectivity and relegated to the medical expert. The medical profession is awarded social and economic privilege separating the legitimate expert from the layperson in potentially two ways - knowledge and class. This expert knowledge and professional status also grants medical authority with the freedom to determine what constitutes a medical diagnosis.

Medicalization also shapes health narratives and the individualizing way people understand illness experiences. Medical authority reinforces the medicalization of aspects of everyday life that may be attributable to broader social conditions. Medicalization is often contested and renegotiated between the medical and patient communities. A medical diagnosis can either be a source of blame, shame, and stigma or it can serve to alleviate blame by reinforcing a mind/body separation and locating causality as a physiological dysfunction independent of personal characteristics (Goffman, 1963). A medical diagnosis can also legitimize illness experience as more real, not just in one's mind, which can provide comfort and even empowerment to individuals. Indeed, there are communities that

are formed based on the internalization of disease identification. However, it is important to remember that medicalization also locates mental health issues squarely in the bodies of individuals at the expense of pursuing more radical social change that would contribute to genuine health.

Medicalization illustrates a deep contradiction – on the one hand, by locating illness in the body, moral judgment is alleviated; on the other hand, medicalization falls in line with notions of individual responsibility around self-care<sup>18</sup> and self-help (Silva, 2013).<sup>19</sup> I interpret this to mean that self-care/self-help culture has placed the responsibility of maintaining the functional body back onto the individual. Failure to do so results in disease, in which case the diseased body then becomes the purview of medicine. This focus on individual behaviour reinforces a depoliticized technomedical approach. Focusing on individual responsibility also reinforces the distinction between the deserving and undeserving sick based on lifestyle, which is tied to socio-economic class. In this way, blame is then (re)placed on the working and unemployed poor for developing illnesses that are perceived to be preventable given a higher quality of life. This type of social disciplining of mental health behaviour has evolved into healthism – a highly commercial, competitive, and individualistic form of health promotion.

Healthism also benefits the pharmaceutical companies as a platform upon which to promote their products for more mild complaints or preventative purposes (for example,

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<sup>18</sup> Please note that I am using the idea of self-care as a privatized and individualized expectation that isolates embodied illness experiences from collective understanding. This is very different from, for example, Audre Lorde's (1988) articulation of self-care as anti-racist, feminist resistance in *Burst of Light*.

<sup>19</sup> For more detailed discussion of self-help culture and neoliberal individualism see Peck, 2008.

daily aspirin therapy). The maintenance of a prosperous health economy is the main priority of the pharmaceutical industry. As an authoritative voice in the medical community, pharmaceutical companies influence social policy around drug approval and regulation. The industry also reinforces a medical approach to mental health and the disease model that relies on pharmaceuticals as treatment.

The prevalence of medicine *as an industry* is maintained through the privileging of medical knowledge and rejecting (or coopting) other approaches to health and healing. Medical knowledge production serves both economic and ideological functions within capitalism. This results in an approach to mental health that is legitimized by its position in the market. In this way, medical discovery becomes confounded with profitability, and health becomes defined as functional and confounded with worker productivity. Medical research provides investment opportunities for industry. The knowledge and technologies that are produced secure capital accumulation through the commodification and consumption. Medical knowledge then, is very much a product of economic and social relations and represents, in large part, the interests of dominant social groups. In fact, the influence of private industry over medical research has led to serious conflicts and the suppression of findings that jeopardize profitability, often superseding public interest.

By framing medicine as an industry, corporate players seek out expansion and profitability, which results in the privileging of market needs over the genuine health needs of people. However, this produces a contradiction – as the growth of the medical industry requires an increase in the demand for the medical intervention of disease, which is the very thing it is meant to eliminate. The sustainability of sickness requires that disease must be contained to the extent that it does not compromise the integrity of the capitalist mode

of production and workers' ability to perform labour. In fact, I argue that maintaining workers' ability to work is a primary function of medicine.

As will be discussed in more detail in subsequent chapters, capitalist commodity production creates working/living conditions that are incompatible with the fulfilment of human needs. This results in experiences of distress and illness, particularly in vulnerable workers and poor communities. For capital, sickness needs to exist if medicine as an industry is going to continue to expand. The commodification of medicine requires both the elimination of disease and dysfunction that would threaten the integrity of capitalism (i.e.: wipe out the labour force), and the sustainability of sickness profitability. It is in this instrumental rationality, where “[t]he violent [disabling] of growth coincides with the imperative of growth without limits” (Appelbaum, 2010:61), that the external cost of capitalist expansion becomes apparent. On the one hand, capitalist innovation in medicine promises the extension of life with the development of new technologies. On the other, ensuring unlimited growth potential requires the ongoing expansion of diagnostic boundaries around disease in order to secure market demand.

## **Chapter 4: Mental Health and the Disease Model**

## 4.1 Introduction

As outlined in the previous chapter, Western medicine is rooted in social and economic processes. I argue that, in order to develop a structural approach to mental health, these processes need to be taken seriously and distress must be situated within its broader structural context. However, illness is currently predominantly treated at the individual level by medical experts and focused on measurements of biological functioning. In order to obtain a clearer understanding of medicine in relation to mental health, this chapter focuses on the development of the disease model, as well as the historical trajectory of psychiatry as a field of medicine.

As a profession, psychology has met with dismissal from medical communities, prompting a paradigm shift that has increasingly medicalized the practice. I argue that an individualist approach to mental health falls very much in line with the concept of functional health. Here, workers are considered sovereign and objectified entities maintaining their ability to participate in the capitalist market through individual resilience and commodity consumption. This is also the case with health in general, not only mental health. I use the SARS outbreak in Toronto to illustrate the far-reaching and detrimental effects of neoliberal restructuring to healthcare services on the overall health of healthcare workers, patients, and the general public.

I end the chapter by offering a more concrete conceptualization of how mental health in general is perceived in contemporary capitalism, according to the needs of capital. Functional health is conceived of as the ability to perform work tasks, what I refer to “work ability.” I argue that framing mental health in this way is actually damaging to people. For precariously employed workers especially, the inability to work due to illness often results

in the loss of employment. This communicates to workers that they cannot “be sick,” and that falling ill and the need to convalesce may result in ruin. Therefore, workers may feel a need to remain functional, or “work able,” even though they may be experiencing illness, out of fear of unemployment. This opens the market for pharmaceutical products that are promoted to maintain work ability and productivity. This also influences the practice of medicine, including psychiatry, in that a primary goal of medicine is to bring patients back to a level of functionality – i.e. work ability.

#### **4.2 The Medicalization of Mental Health**

Although notions of “madness” or “insanity” can be found documented throughout history beginning in Greece and Rome (Rosen, 1968), Western medical interventions did not surface until the early 1800’s (Conrad & Slodden, 2013). It is important to note early on that doctors, although there were no accepted explanations or treatments at the time, were initially given the responsibility over those deemed mentally ill. Their primary duty was to hold them in exile, keeping them away from general society (Foucault, 1973). Drawing from these beginnings the role of doctors was as guardians of the “disturbed.” In the context of mental health and psychiatry, disease is mainly located in the brain and disease symptomology. However, the credence awarded to psychiatry as legitimate knowledge is located in particular cultural values and beliefs that have their own distinct historical trajectory (Horwitz, 2013). The power relations between patient and medical expert are particularly important to this trajectory and are a good place to begin in examining it.

Some maintain that whatever legitimacy psychiatry may have secured in the past is now being jeopardized by a corporate stronghold over the development and proliferation

of medical treatment. This can be seen in the recent criticisms of changes made in the 5<sup>th</sup> edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). As will be discussed in more detail, financial ties to industry have been called into question in relation to the diagnostic criteria of certain mental disorders. Some view these criteria as corporate attempts to expand the market under the guise of medical expertise and call these disorders bogus “discoveries,” pointing to a lack of clear evidence and tenuous links between symptoms, diagnoses, and treatment effects (Horwitz & Wakefield, 2007; Healy, 2002).

### *Psychiatry and “Diseases of the Mind”*

Psychiatry’s primary role in society has been to delineate between “normal” and “disordered” thoughts, emotional states, and behaviours. As such it has been instrumental in framing mental illness as disease (Conrad & Slodden, 2013). It is beyond the scope of my research to outline this in detail, but it should be mentioned that, as a profession, psychiatry has been criticized as a tool of governmentality (Tremain, 2005; Rose, 1999; Foucault, 1973). That said, psychiatry’s tendency toward medicalization can be better understood given some historical context.

The first asylums were established in the early 1800s. They were initially created as spaces whose function it was to segregate “the insane” from the general population. Doctors were employed as guardians whose main duty it was, not to heal or cure, but to control and contain. This is not to say that there was no treatment; however, treatments were often experimental and amounted to little more than torture (Whitaker, 2002). The notion of mental illness was formulated and first articulated by Benjamin Rush (1812) who authored *Medical Inquiries and Observations upon Diseases of the Mind* maintaining that “madness” was, in effect, a disease located in the brain and should be treated medically by

physicians (cited in Deutsch, 1949). It is this biological disease model that I am citing here. This particular line of thinking continued into the 1900s where early attempts at cures included the establishment of discipline and routine through institutionalisation in a hospital-like setting.

It should be noted that, even in its beginning, the disease model of mental illness was not devoid of social analysis. At this time mental illness was thought to be biological, but triggered by social forces (a theory that remains to this day). For example, in his reflections on the work of Rush, Deutsch (1949) does take into account the social conditions of poverty in relation to mental illness:

Unemployment, overwork, congestion of population, child labour, and the hundred economic factors which increase the stress of living for the poor are often contributing factors in the production of mental disease. Weaknesses in constitutional makeup are discovered under the stress of such conditions, that might have remained undiscovered under happier circumstances... Everything which makes for the betterment of those upon whom the stress of living falls heaviest will save many from mental disease (33).

The best treatment then was thought to be the removal of these social factors through isolation. However, the success of this approach was quite limited as mental wards began to overflow with permanent in-patients (Rothman, 1971). This cast a shadow over psychiatry's ability to treat mental illness as well as the validity of its so-called scientific advancements (Conrad & Slodden, 2013). The profession was in need of new theories of mental illness.

Sigmund Freud's psychoanalysis had a revolutionary effect on psychiatry at the beginning of the twentieth century (Karp & Birk, 2013). Psychoanalytic theory was applied to even the most severe mental illnesses, not by Freud himself, but by his followers. From a Freudian perspective mental illness stems from conflicts having to do with biological

drives (such as sex) and defensive psychological mechanisms (such as repression). The development of mental illness resulted when these internal functions clashed with external sociocultural elements. Although psychoanalysis prioritized intrapsychic phenomena, Freud's model did delineate categories of mental illness and so-called "deviant" behaviours such as homosexuality and female hysteria<sup>20</sup> (Conrad & Slodden, 2013). Oppressive disease labels such as these, ongoing theoretical divides amongst practitioners, and controversies surrounding repressed memories (Loftus, 1994) resulted in talk-centered psychotherapies, such as psychoanalysis, coming under fire as "pseudoscience" and psychiatrists were ridiculed as "shrinks" and "quacks." By the 1970s, psychiatry was yet again searching for renewed legitimization as a medical science (Karp & Birk, 2013).

Popular perceptions of psychiatry today still maintain a fascination with psychoanalysis; however, the profession has undergone a paradigm shift due to scientific advances in medical technology. Major tranquilizers were the first prescription pills to be widely distributed by psychiatrists to their patients in the 1950s (Karp & Birk, 2013). The pills' immediate effectiveness, and addictive qualities, resulted in their increasing use (Shorter, 2008). With the approach of the 1980s, prescription pills were very much embraced by the profession as the norm for psychiatric treatment (Karp & Birk, 2013). Pharmaceutical medication was also seen as a theory-neutral treatment that could be

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<sup>20</sup> Homosexuality was designated a mental illness until 1973 when it was finally removed from the 3rd edition of the Diagnostic and Statistical Manual of Psychological Disorders (American Psychiatric Association, 1980). Female hysteria was also removed at this time (Tasca, Rapetti, Carta, and Fadda, 2012). Female hysteria is a misogynistic notion dating back to ancient Greece beginning with the concept of the "wandering womb." It was defined by the psychiatric community as a nervous disorder with a wide range of symptoms from faintness to insomnia to irritability (Morantz & Zschoche, 1980). Treatments included vibration, institutionalization, and hysterectomy (Maines, 1998).

applied to any therapeutic context at the time, creating greater consensus amongst practitioners. Furthermore, the general public could debate all they wanted about which popular theories best explained what mental illness, but the highly medicalized issues based on human biochemistry were much less disputable and restricted to niche expert dialogue (Horwitz & Wakefield, 2013).

With the weight of the pharmaceutical industry behind it, psychiatry had entered a new era. The union between the two has been overwhelmingly profitable as psychiatry continues to mould the boundaries of normality and disease, ever increasing the number of people falling into the disease category. Meanwhile, private pharmaceutical research develops and advertises treatment to a growing market (Horwitz & Wakefield, 2007). This is not to say that psychiatrists are simply pawns of “Big Pharma.” However, the symbiotic relationship between the two has been undeniable regardless of any altruistic intentions. A common message communicated by psychiatrists and other supporting groups in the medical community has been that individuals with mental health issues can be successfully treated with prescribed medication just like any other disease or condition (Karp & Birk, 2013). Quite often disease categories can be a relief to patients who are in need of help, but it can also shut down conversations about other things that may be contributing to the problem.

#### *Anti-Psychiatry and Survivor Backlash*

This explicit dismissal of lived experience has resulted in a tenacious “anti-psychiatry” movement, a term coined by Cooper (1967). Additionally, others such as Fanon (1952), Sasz (1961), Foucault (1973), and Illich (1976) have all called attention to psychiatry’s retention of oppressive religious morals and social prejudices. Authors have

questioned psychiatry as a tool of governance for keeping social order and controlling, or at least restricting, unruly bodies and minds. This movement not only consists of theoretical critics, but psychiatric survivors as well who have created their own survivor movement, sometimes referred to as the “mad” movement.

The anti-psychiatry movement took form in Canada and the US in the 1960s and 70s. Former patients at this time came forward with horrible stories about painful and traumatic therapies, such as electro-shock, and the anguish of being ostracized and denigrated by the medical professionals who were meant to help them (Neigh, 2012; Burstow & Weitz, 1988). Anti-psychiatry is rooted in the notion that distress does not exist only in one’s mind. It begins from the assertion that the distress people feel is real and need to be addressed as such (Neigh, 2012). Criticisms of psychiatric practices have developed alongside psychiatry’s journey to medical legitimacy and continue today (Withers & Epstein, 2010).<sup>21</sup> This has led to a rich literature containing the observations and analyses of scholars and survivors alike.<sup>22</sup>

The movement criticizes psychiatry for undermining and outright disregarding the experiences, stories, and knowledge of people living with mental health issues. At the least, the movement seeks to 1) deconstruct the autonomous authority of the psychiatric expert, 2) place more emphasis on the social context in which symptoms emerge, thereby removing medical reductionism, and 3) focus on effective and integrated healing processes.

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<sup>21</sup> For instance, Mad Pride organizing in Canada refers to madness as a “political and social identity” that actively challenges shame and stigma attached to mental illness categories. Instead, there is a focus in “collective strength” and support in navigating the medical community ([www.madprideto.com/about.php](http://www.madprideto.com/about.php)).

<sup>22</sup> For authors who write about the history of psychiatry and current debates see LeFrançois, Menzies, and Reaume, 2013; Eghigian, 2009; Healy, 2002; Valenstein, 1998.

At the most, the movement questions the very existence of psychiatry and calls for its complete dismantling. There are also organizations rooted in communal care and social justice principles that incorporate a more structural and experience-based approach to mental health. For instance, The Icarus Project ([www.theicarusproject.net](http://www.theicarusproject.net)) includes as part of their vision statement the self-determination of people who have been diagnosed with a mental illness to develop their own idea of what constitutes genuine health:

We honor the language people use for understanding their experiences and we respect how people choose to navigate their distress. We embrace diversity, harm-reduction and self-determination. Everyone is welcome, whether they support the use of psychiatric drugs or not, and whether they identify with diagnostic categories or not (“About us” section).

Furthermore, psychiatry has more recently been charged with increasing suffering by misdirecting attention away from broader structural indicators of mental health, such as poverty and job insecurity, and labeling seemingly normal responses to increasing levels of life stressors as pathological (Karp & Birk, 2013). Sociological inquiry into the variable and unequal social relations within psychiatry – as well as its relationship with other profit-driven, medical industries – can be useful in shifting attention toward the lives and stories of people in distress and developing a more comprehensive and inclusive understanding of mental health.

### *Disease, Illness, and Social Sickness*

I have discussed how medicalization is the process whereby social issues are made medical; however, it is equally important to understand *social sickness* as the re-introduction of medical issues into society. In other words, it is to take a disease and make it social. Just as medicalization is important for the proliferation of medical ideology within capitalism, the socialization of disease, or *social sickness*, serves a similar purpose. To

explore this further, I focus on Frankenberg's (1980) account of three main dimensions of the illness experience – disease, illness, and sickness.

*Disease* occurs at the biological level and refers to an underlying problem within the physical body regardless of whether the individual patient or the medical community are aware of its existence. For example, it is possible for a person to have a disease and not know they have it. Diseases are framed by the medical community as supported by empirical evidence and located in the body. A disease may be discovered through routine or chance testing and is medical in nature. Another way a disease may be discovered may be through individual illness. *Illness* is a subjective discomfort or disturbance experience by the individual and is usually what prompts the socially appropriate response of going to the doctor's office in search of a disease confirmation. The patient may have their own opinions about what is wrong, but in order for their illness to be considered a medical issue it must be diagnosed and accepted for treatment by a medical expert.

Recall that the central point of this chapter is to examine the congruence between the dominance of the medical authority over the body of the patient. This includes the power of the medical expert in determining the legitimacy of embodied experiences. It is important to keep in mind that an illness experience may not constitute the presence of a disease. For example, I argue that distress experienced in reaction to the chronic stress of unemployment may very well have a physiological component, but it does not necessarily signify physiological dysfunction. Distress (as an illness experience) may be considered an appropriate reaction to life circumstances or events.

The doctor/patient dynamic is crucial to the socialization of disease and is most often where tensions or disagreements occur. However, with the weight of the medical

institution behind them, more power lies with the doctor who is in a much better position to impose their view. Additionally, these power dynamics are intensified by the potentially life-or-death situation of the patient. Going to the doctor and assuming the sick role<sup>23</sup> reflects conformity to social and cultural conventions of what to do when one feels ill. These behaviours transform an isolated illness experience limited to the individual into a social expression of sickness that is externalized and shared with others, thereby connecting all three dimensions – *having* a disease, *feeling* ill, and *being* sick (Frankenberg, 1980).

The socialization of disease can also be achieved through disease promotion or “awareness raising” (Frankenberg, 1980). Disease promotion serves to relay information directly to the public regarding the morbidity of a particular disease and its symptoms, prompting them to seek medical confirmation. This is insufficient when we consider that some experiences of illness, as is the case with distress resulting from job strain and insecurity, have significant underlying social and economic triggers. This results in the medicalization of illness experiences that are largely indicative of social problems, which are then treated medically. This is illustrated in examples such as the development of social anxiety disorder (SAD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM) discussed in the next section.

The medicalization of social problems also redirects conflict that could bring potential change to the current social order (Frankenberg, 1980). By containing this conflict within the control of medical authority – an authority invested in existing class relations – political conflicts become pathologized and reframed as disease. People are then described

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<sup>23</sup> The sick role (Burnham, 2014; Shilling, 2002; Parsons, 1951), although highly contested in sociology, is still a popular concept and therefore useful for our purposes here.

as “sick” instead of overworked, exploited, alienated, or oppressed. Again, the boundaries around mental health and diseases of the brain are much more difficult to establish than other parts of the body and, therefore, more open to interpretation. This opens up the possibilities of what can be construed as a legitimate sickness or diagnosable disease. Diagnostic boundaries are determined by medical experts, as described in the DSM, which serves to reinforce medical authority and the depoliticization of illness experiences.

### **4.3 Diagnostic Boundaries and Mental “Disorders”**

The acceptance of the treatment of mental health issues into the medical domain carries significant implications for the way feelings of distress, anxiety, and depression have been interpreted. I discuss the social processes involved in the integration of illness experiences into the disease model and ultimately, public awareness. Part of the process requires the creation of diagnostic boundaries and the inclusion of new classifications of disease in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This is not always a smooth process and raises many questions around what should and should not be considered a mental disorder, and therefore medicalized, as well as the influence and involvement of private industry in decision-making and treatment.

In theory the disease model would imply that only scientifically valid and medically relevant information is taken into consideration when establishing diagnostic boundaries. However, in practice there are various extraneous variables that also influence what gets labeled as disease. This is especially true with mental illness, when assessment is not as clear and when the problem is said to be located in the brain, which is perhaps the most complex and least understood organ of the body. Diagnostic debates within the medical community have led many to question the disease model and its susceptibility to be

corrupted by economic and social influences that lie well beyond its purview (Brown, 1995). As Szasz (2001) argues, just because doctors diagnose and treat something like a disease, does not make it so. For example, distress experienced by workers may interfere with their functioning, but this should not necessarily imply that what they are suffering from is a disease.

Although Western psychiatry locates mental illness within the individual, being sick is also experienced socially and elicits a social response. One of sociology's important contributions to the discussion of mental health under capital is to ascertain that socialization is a primary factor in the occurrence and development of mental illness categories. Furthermore, this socialization also informs culturally appropriate expressions of those illness categories, thereby shaping people's personal experience of mental illness. There are social norms around what is acceptable and what is "abnormal" in terms of thoughts, feelings, and behaviours (Horwitz, 2013). These norms also indicate how those thoughts, feelings, and behaviours are interpreted, acknowledged, and treated not only by the individual experiencing illness, but also by the medical community, and society in general.

The dialectical relationship between the social superstructure and its economic base is regulated through various institutions including medicine. This relationship is governed by the ruling values and ideologies of society that then reinforce capitalism as the overarching economic structure, as well as the unequal, day-to-day material conditions between classes (Waitzkin, 1979). Given the dominant medical ideology as the official lens through which we see mental health, medical authority is required in order to confirm an illness. This is usually done using the disease model to identify dysfunction within the

body. However, due to a lack of medical understanding of the brain, as well as the intrapsychic nature of mental illness, mental illness often cannot be directly observed. Medical authority then becomes especially important in distinguishing between “normal” functioning and pathology when the fuzziness of mental illness categories make them ambiguous to confirm through strictly empirical methods.

*The Diagnostic and Statistical Manual of Mental Disorders*

The development of psychological disorders recognised by the medical community is negotiated between various interests within the institutions of medicine (hospitals administrators, practitioners, researchers), corporate industry (the pharmaceutical industry, health insurance companies), and patients (advocacy and awareness groups) (Kutchins & Kirk, 2003; Conrad, 2007). These influences can be observed by looking at the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and how the diagnostic criteria of certain psychological disorders have changed over time in tandem with broader social change. The history of the DSM is also rife with controversy and the parties involved have been criticized as using spurious empirical correlations in order to conflate mental disorders with arguably healthy and adaptive responses to major stressors (such as job insecurity, social isolation, or loss of a loved one). This widening of diagnostic boundaries further medicalizes distress and removes it from social context; quite literally, manufacturing disease.

The DSM, published by the American Psychological Association (APA), found its beginning in 1952, heavily steeped in the dominant psychoanalytic perspective of the time. Although international versions exist, the DSM is especially used in the US and Canada and is considered the psychiatric “bible” for diagnosing mental disorders and

distinguishing “normal” functioning from pathology. Since the 1980s it has incorporated a medical approach and has become more focused on biochemical explanations for feelings of prolonged distress (Conrad & Slodden, 2013). The number of new disorders and brain diseases that have been developed throughout the evolution of the DSM is staggering and could lead us to believe that we are truly a sick society. Between 1953 and 1969 the number of diagnosable disorders doubled from 60 to 120 respectively; the number of disorders then reached 200 in 1987. The dramatic increase has led many to question exactly what kinds of evidence are being considered in the development of new categories of disorders (Karp & Birk, 2013).

The DSM has also undergone several major revisions that can be seen as a direct reflection of social change driven by feminist and civil rights movements; for example, the removal of homosexuality as a mental disorder in the DSM-III (APA, 1980). However, with the growing use of the disease model, diagnostic boundaries speak to individual symptomology, which are removed from their greater social context (for example, precarious working conditions). Also, the number of mental disorders listed in the DSM has grown, steadily widening the range of behaviours included in the disease category. The revised version of the DSM-IV-TR (APA, 2000) contains 297 distinct disorders (Conrad & Slodden, 2013) with over 350 diagnosable conditions (Karp & Birk, 2013) in its 886 pages. The DSM-V-TR’s new dimensional approach to disorder, combined with its already existing categorical approach, is designed specifically to blur the lines between normal functioning and pathology. The APA (2013) describes this as beneficial as it “allows the clinician more latitude to assess the severity of a condition” (para 1). This has enabled the widening of the diagnostic net, medicalizing behaviours that, by themselves, previously

would not have fallen into a stand-alone diagnostic category. Now, they are categorized as cutting across disorders and can be diagnosed as “shadow disorders.” The most recent DSM-V (APA, 2013a), at 991 pages, has broadened the boundaries around several existing disorders, including social anxiety disorder (SAD) and depressive disorders. The DSM-V also specifies new disorders, such as “premenstrual dysphoric disorder” (PMDD), a severe variation of premenstrual syndrome (PMS) (Conrad & Slodden, 2013).

While the labeling of any human thoughts or behaviours as disordered may stir controversy, the DSM is seen as a source of official medical knowledge on the subject and, as Conrad & Slodden (2013) put it, represents a “diagnostic repository of legitimated psychiatric conditions” (64). However, this legitimacy has been increasingly called into question. While there have always been outside critics of the DSM, the latest DSM-V has been the subject of intense scrutiny among doctors, psychiatrists, and psychologists alike. The Society for Humanistic Psychology, a division of the APA, has created the Coalition for DSM-5 Reform and written an open letter to the APA and the DSM-V Task Force, made up of “160 world-renowned clinicians and researchers,”<sup>24</sup> demanding an independent review of the DSM-V:

...we are concerned about the lowering of diagnostic thresholds for multiple disorder categories, about the introduction of disorders that may lead to inappropriate medical treatment of vulnerable populations, and about specific proposals that appear to lack empirical grounding. In addition, we question proposed changes to the definition(s) of mental disorder that deemphasize sociocultural variation while placing more emphasis on biological theory. In light of the growing empirical evidence that neurobiology does not fully account for the emergence of mental distress, as well as new longitudinal studies revealing long-term hazards of standard neurobiological (psychotropic) treatment, we believe that these changes pose substantial risks to patients/clients,

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<sup>24</sup> <http://www.dsm5.org/about/pages/faq.aspx>

practitioners, and the mental health professions in general (para 2, Open Letter to the DSM-5).<sup>25</sup>

Open letters critiquing the DSM-V have also been written by the International Society for Ethical Psychology and Psychiatry stating, “The evolving editions of the DSM have been remarkable in expanding psychiatric labels for alleged ‘mental illnesses’ with no scientifically substantiated biological etiologies” (para 1, ISEPP Statement on the DSM-V).<sup>26</sup> The Association of Black Psychologists also expressed concern with the lack of consideration for social context or structural oppression as factors contributing to distress:

We share a concern about the apparent change to the definition of mental disorder. As written, it would diminish the role of socio-cultural factors in mental distress, and users of the manual would be charged with determining whether mental disorder is the primary or secondary result of deviance or social conflicts. The possibility that socio-political deviance could be labeled as a mental disorder would have clearly negative consequences for African Americans specifically, given our history of activism and resistance to oppression, discrimination, and prejudice. In addition, many in the nation are currently engaging in political action related to the nation’s economic system; these individuals would be at risk for inappropriate diagnosis according to the revised definition of mental disorder (para 3, Potential Changes to the DSM-5: A Response from the ABPsi).<sup>27</sup>

Third parties cannot take part in the DSM Task Force or have a direct influence on revisions to the DSM. However, many scholars have written about the financial connections between clinicians and researchers who do take part in the DSM Task Force while also working as spokespeople, consultants for pharmaceutical companies, or who have received research grants from the industry (Cosgrove & Krinsky, 2012; Horwitz & Wakefield, 2007; Conrad, 2007).

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<sup>25</sup> The full petition can be seen here - <http://www.ipetitions.com/petition/dsm5/>

<sup>26</sup> The full letter can be see here - [http://www.psychintegrity.org/isepp\\_statement\\_on\\_the\\_dsm5.php](http://www.psychintegrity.org/isepp_statement_on_the_dsm5.php)

<sup>27</sup> The full letter can be seen here - <http://dsm5reform.com/wpcontent/uploads/2012/05/DSM5CommentaryABPsi-copy.pdf>

*When Dis-ease Becomes Disease – Depression and Anxiety*

The diagnostic criteria around both depressive and anxiety disorders have changed dramatically throughout the evolution of the DSM from a theory-based perspective to one of symptom identification. The successful marketing of anti-depressant medications, especially throughout the 1990s, has also influenced popular and professional consciousness of these disorders, such as with selective serotonin reuptake inhibitors (SSRIs) and selective norepinephrine reuptake inhibitors (SNRIs), contributing to increases in the rate of diagnosis. However, many have criticized a purely medical view of depression. It is beyond the scope of this chapter to review the extensive body of writing on depression, particularly in feminist literature (Ussher, 2011; LaFrance, 2009; Walters & Denton, 2008; Horwitz & Wakefield, 2007; Lewis, 1995); however, many understand depression as a product of social, cultural, and political forces.

A large portion of the most recent controversy around the DSM-V can be attributed to exclusion of the bereavement clause from major depressive disorder (MDD), which had previously framed grief as a non-disordered (and therefore considered functional) response to death. As a result, someone suffering sadness in the first few months following a loved one's death can now be classified as *clinically depressed* – a mental disorder – rather than simply “grieving,” which can arguably be considered a normal human response. This is, of course, not to diminish the occurrence of clinical depression and the profound effects it can have on people's lives. My point is that sadness, as a triggered psychological response, may have basic value in terms of biological and social functioning, and therefore serves an emotionally healing purpose (Horwitz & Wakefield, 2007). To pathologize these kinds of

responses is to undermine their value and immediately inflate the market for psychoactive pharmaceuticals (Silverman, 2009).

MDD is on the cusp of becoming the second leading cause of disability in the world (WHO, 2011) with annual expenditures in the US reaching \$43 billion dollars in lost productivity and treatment. Social anxiety disorder (SAD) has been pegged as the third most commonly diagnosed psychological disorder (Lane, 2008). The creation of SAD as a disease category has also been a source of controversy. SAD is described as a substantial and continual fear of being negatively perceived by others. SAD, previously social phobia, was relatively unknown before GlaxoSmithKline (GSK), a leading pharmaceutical company, began an aggressive marketing campaign to raise public awareness of the new condition (Conrad, 2005). Some argue that, not only are more emotions and behaviours being targeted for medicalization, but also whole personalities. The mental health of shy, introverted people in general is thrown into question as pharmaceutical ads strongly imply that in order to function well in today's society they need to be more outgoing, competitive, positive, and assertive – traits that are in-line with dominant Western conceptions of masculinity, white privilege, and capitalist free market ideology. This phenomenon has received harsh criticism as amounting to little more than “psychopharmacological plastic surgery” (Kramer, 2006, 1994; Elliott, 2003).

The commodification of medicine inherently involves the marketing of a medicalized illness; put simply, supply requires demand. Pharmaceutical companies employ public relations firms to assist them in demand creation, which typically takes the form of campaigns to promote the public awareness of a particular health condition that would necessitate the consumption of their product. This marketing tactic has been very

successful, especially with antidepressant medication. For example, SmithKline Beecham's – now GlaxoSmithKline (GSK) – drug Paxil is a “blockbuster” drug thanks to a campaign headed by Cohn and Wolfe, a public relations firm based out of New York. To clarify, by recent standards a drug is considered a “blockbuster” when it rakes in over one billion dollars yearly (Leventhal, 2006). The firm took SAD, rarely diagnosed at the time, and began to publicize directly to consumers<sup>28</sup> the disorder as something that basically anyone could develop – a practice referred to as “condition branding” (Conrad & Slodden, 2013). The campaign encouraged people to reflect if they have ever felt anxious at a social event or during a job interview, and consider if these were potentially symptomatic of SAD. As awareness around SAD increased, the mental health of people who previously may have been considered introverted, nervous, or shy around others was thrown into question (Conrad & Slodden, 2013).

Paxil soon became the first and only pill to be approved to treat SAD. Of interest, many people typically diagnosed with SAD are also underemployed relative to their education and skill levels (Thomas and Hersen, 2002). Part of the public awareness campaign was making available a self-assessment at [www.Paxil.com](http://www.Paxil.com) so that members of the public could use it to determine the likelihood that they suffer from SAD (Conrad, 2005). All of the questions asked on the self-test are concerned with feelings of personal

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<sup>28</sup> Direct to consumer (DTC) marketing was approved in the US in 1997 (the second country to be approved following New Zealand). In the US, spending on DTC marketing grew 330% between 1997 and 2005 averaging out at a yearly increase of 20%. The number of people prescribed antidepressant medication rose from 17 to 27 million in the same time period (Conrad & Slodden, 2013). While DTC marketing of pharmaceutical medication is prohibited in Canada (Gardner, Mintzes, Ostry, 2003), consumers are still reached via online marketing, television, magazines, and other ad materials sold in Canada.

distress (isolation, anxiety, etc.) and the bodily sensations that accompany them. If the results suggest the individual “may be experiencing symptoms” of this disorder, the site encouraged them to make an appointment with a “healthcare provider” and suggested that the “client” provide their doctor with a printed copy of the assessment (GlaxoSmithKline, 2008). The drug Effexor was introduced in 1998 for treatment of depression as well as SAD. Shortly after in 2002, the total prescriptions for the drug grew more than any other prescription drug in Canada with an increase in sales of 42.4% (Currie, 2005).

The success of SAD for the GSK would not have been possible without the public demand created by what Moynihan (2002) has termed “fear-mongering” around having a mental disorder without knowing it, and perhaps needing medical attention. Also crucial was the reinforcement of SAD by medical authorities as a legitimate mental disorder by 1) including the disorder in the DSM to begin with, 2) following through on recognizing the disorder in their patients, and 3) prescribing pharmaceutical treatment. The role of medical authority must not be overlooked as a reinforcing agent of the medical knowledge created by industry for the purposes of sales of commodified medicine. Of course, this is not to say that there are not patients who do benefit from medication, or that medical authorities unquestioningly follow the directives of industry, or that there are not disputes within the medical community over such matters.

### *It's a Brave New World – Antidepressants and Condition Branding*

Included in the most popular class of antidepressants in recent decades are selective serotonin reuptake inhibitors (SSRIs), particularly Prozac, Zoloft, Paxil, and Celexa; as well as serotonin-norepinephrine reuptake inhibitors (SNRIs) such as Effexor (Conrad & Leiter, 2004). SSRIs and SNRIs are designed to affect brain chemistry through the

transmission of neurotransmitters, namely serotonin and norepinephrine, between nerve cells. Reuptake inhibitors prevent the reabsorption of neurotransmitters back into nerve cells, allowing for a higher volume to remain in the brain. This is based on the premise that the cause of certain mental disorders, such as a major depressive disorder (MDD), is connected to the level of neurotransmitters in the brain being too low (Royal College of Psychiatrists, 2015). The popularity of SSRIs and SNRIs today can be traced back to the minor tranquilizers of the 1950s and 70s in particular.

An interesting shift in the public's perception and use of prescription pills occurred with the introduction of meprobamate in May 1955. Up until that time patients had only taken prescription medicine to cure infectious diseases, such as with antibiotics. However, meprobamate, sold in North America as Miltown and Equanil, was the first to be promoted to physicians as a "lifestyle drug." The market for these pills opened up and people were beginning to decide that it was quite acceptable to visit their doctors for a prescription for something that would make everyday life easier to manage. In fact, one magazine commented on the story of a 36 year-old man on meprobamate as a great "American success story." Apparently, the man complained of feelings of acute distress related to his sales position. His experiences of anxiety, insomnia, and tremors forced him to leave his job and seek medical help. After being evaluated by a psychiatrist he was prescribed meprobamate. Soon after starting on the medication, the salesman's symptoms had all but disappeared. He then cancelled any future appointments with the psychiatrist, deeming them unnecessary, and went back to work – "with a little pharmaceutical help, the neurotic unemployed had once again become a productive breadwinner" (cited in Tone, 2007:165).

Miltown's success had never before been seen by pharmaceutical executives with sales of \$200 million in the US. In their day, minor tranquilizers such as Miltown were seen as both the cutting edge of medicine and as a tool to maintain a conservative cultural climate. They reinforced the moral fabric of society by keeping levels of anxiety among the general public in check. Tranquilizer success continued on with benzodiazepines, commercially known as Valium and Librium, until sales began to slow down in the 1970s when they came under public and political scrutiny for creating dependence in their users. However, this slump proved to be short lived due to the establishment "panic disorder" in the DSM. The condition was branded as treatable with the short-acting tranquilizer Xanax, introduced in 1981. The pharmaceutical industry soon took advantage of the decline of benzodiazepines to launch a new class of drug touted as non-addictive - SSRI antidepressants and among them, Prozac.

SSRIs and SNRIs were positioned as useful for treatment of mental disorders, as well as general "anti-anxiety" medications by the end of the 1990s. Miltown had cleared the path for future products such as Prozac, Viagra, and Ritalin by being marketed as a "lifestyle" drug. Miltown redefined the social and medical utility of pharmaceuticals (Tone, 2007). More than sixty years after its introduction, psychopharmaceuticals are a multi-billion dollar industry.

#### *Medicalization and Market Expansion*

For pharmaceutical companies to go the enormous expense of putting a new drug on the market, as with any commodity, they require a promising outlook on their return of investment and a belief that the drug will tap into the previously unmet need of a large population (Greider, 2003). Condition branding has been heavily criticized, particularly by

scholars such as Moynihan and Cassels (2005) by coining of the phrase “disease-mongering” referring to “doctors and drug companies unnecessarily widening the boundaries of illness in order to see more patients and sell more drugs” (xvii). The aim is always to instil a link between a condition/illness and their product (medication) in the minds of affected people to induce them to ask for it by name and increase sales.

It is not at all unusual for a pharmaceutical company to sink 60% or more of its annual spending into promoting potential blockbusters, which represent only a fraction of their thousands of available products (Greider, 2003). In fact, the US takes an impressive lead in money spent on promotion and sales in general representing 43% of the world’s overall pharmaceutical drug market. In 2004, leading pharmaceutical companies, compared to \$31.5 billion for research and development, spent a combined estimate of \$57.5 billion on promotion, which led to total domestic sales of \$235.4 billion (Gagnon and Lexchin, 2008). In 2003, SSRI and SNRI antidepressant medications such as Paxil, Zoloft, Remeron, Effexor, Celexa, Luvox, and Prozac were the third top selling type of drug in the US, reeling in \$10.9 billion (Conrad, 2005). In a market survey published in 2003, 50% of respondents identified Paxil by name (Greider, 2003).

It is important to include the extensive research of Elliott Valenstein (2006, 1998) in my discussion of antidepressants. Dr. Valenstein is professor emeritus at the University of Michigan and has been writing in the field of psychology and neuroscience since the 1970s. Of particular relevance is his work tracing the development of the antidepressant in the US and how this class of medication grew in popularity and usage. Here, his work is helpful in order to gain an idea of how antidepressant medications have become capable of such high sales. The potential profitability of a medication increases with the number of

illnesses it can be prescribed to treat. To this end, pharmaceutical companies offer doctors and psychiatrists promotional materials regarding the versatility of antidepressant medication for a variety of mental health issues, including anxiety and depression. For instance, SSRIs such as Prozac are prescribed for an impressive list of illness complaints including, but not limited to, “obsessive-compulsive disorders, panic disorders, various food-related problems (including both anorexia and bulimia), premenstrual dysphoric syndrome (PMS), attention deficit/hyperactivity disorder (ADHD), borderline personality disorder, drug and alcohol addiction, migraine headaches, social phobia, arthritis, autism, and behavioural and emotional problems in children” (105). However, the proven effectiveness of antidepressant medication in medical research has been controversial. This raises concerns over the effectiveness of the medication for such wide usage, as well as the strength of the research backing the industry’s promotional efforts.

Eli Lilly, the makers of Prozac, has described depression as “caused by a deficiency of serotonin” and that SSRIs are designed specifically to restore balance by “blocking the reuptake of serotonin in the brain” (180). What Eli Lilly does not include in that description is that, even though the association between mental health issues and serotonin levels in the brain people is popularly accepted, it cannot be stated with certainty. There are no clear laboratory tests that measure serotonin levels in the brain, nor are there blood tests that can reveal a neurochemical imbalance, such as with glucose. The reasons why certain psychopharmaceuticals, such as antidepressants, affect individuals in different ways remain a bit of a mystery (Valenstein, 2006).

Much pharmaceutical research and development is based out of the US. There, pharmaceutical companies have opportunity to lobby for favourable legislative

deregulation and influence the direction of research through the financial support of studies that shed a favourable light on their medication. According to Valenstein (1998) this particular funnelling of funds began during the Reagan administration in the early 1980s, which allowed the pharmaceutical industry to provide research grants for clinical drug evaluations. Since then at least 29 antidepressant medications have been introduced to the market. In a landmark 1989 study, sponsored by the National Institute of Mental Health, antidepressant medication, in the absence of any other form of treatment such as psychotherapy, was found effective only with more severe cases of major depressive disorder. However, antidepressants did not prove to be any more beneficial than placebo in milder cases. This suggests that antidepressant treatment is perhaps not appropriate for these milder cases or that the problem may not be biochemical in nature.

A key shift in the marketing of antidepressant medication in the US was the approval of the Food and Drug Administration (FDA) Modernization Act of 1997. In addition to the promotion directed at doctors already, such as medical journals and drug detailing, the Act permitted direct to consumer marketing, chiefly television advertising, and the loosening of regulations to allow for broader off-label drug usage, in which a drug is prescribed for a purpose not approved by the FDA (Conrad, 2005). In 1997 alone, medical information given by 1080 US patients indicated that 56% of SSRI consumers were using them for off-label purposes (Law, 2006). A 2005 study found that physicians wrote significantly more prescriptions when a patient mentioned a television ad for an antidepressant even if their symptoms did not call for it (Kravitz et al, 2005). In the US, \$3 billion worth of direct to consumer advertising is produced each year, which translates into \$10 million every day (Moynihan and Cassels, 2005).

The approval of direct to consumer pharmaceutical marketing in Canada has been debated by Health Canada since the 1990s. Although not approved, some argue that the fact that drug ads have become culturally commonplace in the materials and broadcasts coming into Canada, coupled with a lack of regulatory enforcement, has amounted to “permission by default” (Gardner, Mintzes, and Ostry, 2003). Regardless of the legality of direct to consumer marketing, the consumption of antidepressants in both the US and Canada has become routine (Conrad and Leiter, 2004). Furthermore, the growing reliance on antidepressant medication in the management of mental health issues, particularly feelings of depression and anxiety, do very little to challenge, or even acknowledge, damaging social structures. The increasing reliance on antidepressants also reinforces an understanding of mental health issues as primarily biochemical, within the realm of medicine, and treated with commodity-based interventions. Furthermore, a medical understanding locates the issues in the patient, thus reinforcing an individualist approach to mental health.

#### **4.4 Medicalization and Neoliberal Individualism**

The individualizing quality of medicalization can be related to neoliberal ideology, which prioritizes self-interest and individual resilience. This connection is crucial as it shapes work practices and social relations with implications for personhood and identity (du Gay, 2004). In neoliberal market terms, the labour force is made up of “free agents” who are individually responsible for their own success or failure. Here, the impact of illness experiences is compounded by a predominantly individualist approach to mental health that fails to address structural issues as contributing factors. Neoliberal ideology also informs policy and austerity measures that cut funding to healthcare and social services.

Limited access to these services deepens precarity, job strain, and a lack of agency, control, or meaningfulness with regards to one's circumstances.

Neoliberal ideology emphasizes individual sovereignty in place of social cohesion. Peters and Marshall (1996) provide a very specific account of what the neoliberal mindset entails, "The most fundamental and unifying premise of neoliberalism is a belief in individualism which, under the influence of neoclassical liberal economics, is postulated in terms of 'homo economicus,' a universalist conception based upon three main assumptions: of individuality, of rationality, and of *the maximization of self-interest*" [emphasis added] (63). The emphasis is added to draw attention to the nature of neoliberalism in its focus on the individual at the expense of any notion of communal care or the interdependency of social relations.

We can use this definition of neoliberalism to understand current conceptions of mental health and work as made up of individual behaviours performed by sovereign patients and workers. There are similarities between trends in the mental health issues and illness experiences among precariously employed workers and unemployed poor, and the health message and targeted symptomology promoted by pharmaceutical companies in relation to antidepressant treatment.<sup>29</sup> There is also a clear positive correlation between the

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<sup>29</sup> It should be noted that my critique here is with the idea that pharmaceutical companies are exploiting the deteriorating effects of structural inequities. I am questioning the relationship between functional health and the ability to perform work tasks (work ability), and conceptions of genuine health. That said, I fully acknowledge antidepressant medication as helpful, and even life saving, to some people with mental health issues. I value the stories participants in this research have shared about finding the right medication in the right dose and appreciate the struggles involved with treatment management. I also acknowledge that antidepressants hold the potential for great harm and can, in certain people, be life threatening, which speaks to the need for more extensive clinical testing and tighter regulations.

increase in antidepressant use and the upsurge in precarious work arrangements. Critical mental health professionals recognize this relationship by drawing attention to the detrimental effects of precarious employment and mental health (PAA, 2015). Fundamental globalizing shifts in capitalism have led to neoliberal restructuring of labour and healthcare in Canada that have had substantial health consequences over the last forty years. The underlying tenets of these widespread changes have been market deregulation and individual responsibility (McGregor, 2001).

### *Social Disintegration and Individual Resilience*

A good indication of structural precarity is the level of poverty experienced within a given society. Wilson & Ebert (2013) highlight that social precarity can lead to the internalization of exploitation as a fact of life. This defeatist attitude lends to a general cynicism or hopelessness regarding the possibilities of positive social change and collective action. I would add that this sense of hopelessness also stunts people's capacity to imagine what radical changes to society would even look like, let alone how they could be achieved. Also, even at times when social change does seem possible, political participation can require time and energy that many people do not have. This results in a cycle of survival, in which people are simply managing day-to-day living (Ehrenreich, 2001).

This decline in social integration aggravates the individualist mindset as workers may feel as though the only solution available to them is what they can do for themselves, which is limited given the instability and insecurity of their livelihood. The consequence is social *disintegration*, which is manifested in feelings of depression and anxiety, and the depoliticization of labour (Ehrenberg, 2012). This withdrawal from collective forms of resistance leaves workers with a sense of social isolation and lack of agency that, for many,

develops into negative coping methods (Wilson & Ebert, 2013) with the goal of escape, distraction, and/or numbing.

The idea of individual resilience demonstrates a perception of mental health that is reduced to health promoting behaviours and biological predispositions. Although social and economic factors may be difficult to deny as contributing to mental health, they are treated as a taken-for-granted constant. Indeed, social factors play an important role in mental health, yet they play a supporting role at best in terms of treatment. This is reflective of not only neoliberal individualism within contemporary capitalist society, but of the prevalence of the technomedical model as a mainstay in the treatment of disease (Cockerham, 2014).

When we deconstruct the concept of individual resilience in the context of mental health, we begin to see its connections to what it is to be a neoliberal subject within capitalism. For instance, Arewasikporn et al. (2013) break individual resilience down into three main aspects – 1) the ability to recover in the face of adversity and stress; 2) the capacity to sustain a level of positivity while enduring negative stress; and 3) the ability to grow and perceive hardship as a learning experience with the goal of increasing capacity to endure more negative stress and recover more quickly in future. Notice how none of these points call societal structures into question, yet all of them demand a stoic absorption and internalization of distress.

The importance placed on individual resilience can also be seen in the ways in which the individual is defined and in the responsibilities tied to them. Attitudes around what it means to be healthy also speak to what it takes to combat disease, often located within individual bodies and behaviours. Survivors of disease are conveyed as resilient in

both the strength of their body and the courage of their will. Those who succumb to disease are conveyed as pitiful and weakened. They may even be blamed for their illness and seen as lacking in fight as their body can't take it, *they* can't take it. The individual is singled out as unable to cope and failing to conform to functional health and productivity. Regardless of whether social factors are taken into consideration regarding the development of disease, the struggle to return to functional health is waged by the individual.

On the ground, individual resilience paired with neoliberal austerity decreases public access to health services, and reinforces the notion that individuals must provide for themselves whatever the cost to the genuine health of society as a collective.

#### *Neoliberal Dysfunction and Cuts to Medicare*

Neoliberal reforms have also produced major cuts to provincial healthcare. This has resulted in an increasing strain being placed upon healthcare service providers and front line health workers, not to mention the patients that are in need of care. Not only is the healthcare system unable to provide essential and routine services, but it also has very little capacity to respond in the event of an actual public health emergency, such as a viral outbreak (Shantz, 2004). Let us consider the degradation of Ontario's healthcare system for a glimpse at the profoundly negative consequences of neoliberal restructuring to overall health.

Medicare in Canada is made up of a relationship between the federal and provincial governments. Although much of the funding allocated for healthcare is provided federally, provincial governments are responsible for how that money gets spent to meet the needs of the province. In 1993, the majority Liberal government introduced massive cuts to federal

funding, which accumulated over three consecutive terms. Additionally, in 1995 the Liberals deregulated the funding structure that ensured federal funding actually went directly to healthcare services for the province. As a result the Ontario government at the time chose instead to apply the \$987 million they received to hydroelectric costs that had run over budget (Diebel, 2003). Between 1995 and 1999, Ontario saw a total cut of \$6 billion from federal healthcare funding that it was to receive from the Liberal government at the time (Shantz, 2004).

However, the deepest cuts to Ontario's healthcare have been at the provincial level at hands of the (Progressive) Conservative government. When former Premier Mike Harris' government took office in 1995, they set about implementing neoliberal policy in the form of corporate tax breaks and cut \$1.3 billion in public spending slated for hospitals in order to enable the establishment of a second private sector tier of superior health services affordable only to the rich (Diebel, 2003). The Harris government also laid off thousands of nurses and cut 25,000 positions in hospitals across the province between 1995 and 1999, parallel to the ongoing federal cutbacks. In 1998, the Ontario government decided to download healthcare responsibilities onto underfunded municipalities, which only exacerbated the steady decline in services. It was also at this time that the nursing profession experienced massive casualization, leaving about 50% of nurses precariously employed and working contracts at several hospitals simultaneously to make ends meet (Shantz, 2004). In 2002, the provincial government of Ontario terminated the employment of five infectious disease scientists working as part of a laboratory unit in Toronto. In an unfortunate turn, an outbreak of Severe Acute Respiratory Syndrome (SARS) hit the city eighteen months later. Healthcare providers scrambled to bring in healthcare workers from

other towns to help manage the crisis, which left 43 Toronto residents dead and thousands of workers close to exhaustion with no overtime compensation (Toronto Star, 2003). Astonishingly, some hospitals actually laid off nurses who had been sent home or quarantined due to infection and could not work (Boyle & Mallan, 2003).

The deaths resulting from SARS could, in large part, have been avoided and the spread contained had there been adequate healthcare resources in place. Even after the outbreak subsided, in 2004, funding was not reinstated. Unable to cope with the costs of healthcare, Toronto's public health department continued to operate sixty-five workers short of full capacity, leaving service delivery stretched very thin and many wealthier Torontonians opting out in favour of private health clinics. However, to say that the rich have access to better health and the poor do not, while true in many ways, is overly simplistic (Metzl, 2010) in that it accepts health in its current commodified conception – a good or service to attain, possess, and accumulate.

Problems in healthcare cannot be entirely corrected with more funding alone. While a redistribution of resources is urgently needed, it is not the whole solution. Funding for healthcare may make it possible to increase the delivery of services to individual patients, but it still does not address underlying social and political factors that lead to sick people in the first place. This requires the integration of a structural analysis that would challenge the medicalization of mental health. An examination of these factors, specifically the organization of labour, can provide insight into the ways in which healthcare can be improved both for patients and workers trying to navigate a dysfunctional system. Also, a structural approach would reconnect mental health with more socially and politically oriented solutions to illness instead of relying solely on commodity-based treatment.

#### **4.5 The Depoliticization of Work and Health**

Depoliticization refers to an increased sense of marginalization and political detachment. It represents the flattening of political discourse and the reification of the status quo, in this case having to do with contesting norms and values regarding the organization of labour. This flattening of discourse takes away from workers' ability to imagine alternative ways of working or engage politically in the workplace. This depoliticizing effect serves to increase managerial control and render workers as powerless as possible and undermine their voice (Wilson & Ebert, 2013). Managerial control is then concretized with threats of a highly competitive market filled with a reserve army of labour. Issues such as job insecurity and low wages are thus sadly accepted as inevitable outcomes of economic downturns, instead of resulting from the self-preservation strategies of managers/employers.

The depoliticization of the workplace typically occurs when workers internalize the message that they do not have the ability to defend themselves against exploitation. Under precarious work arrangements absolute managerial control reinforces this message and leaves workers vulnerable to exploitation, intimidation, and abuse. Research indicates that managerial authority in the absence of worker protections, such as rules around unfair dismissal, carries a significant impact on the mental health of workers (Vives et al, 2013). Lines of defence can be formal as in the exercise of legal rights, or informal such as direct action. However, the restructuring of labour has been quite intentional about widening the gap between workers and management by removing these defensive strategies from workers through both the deregulation of legislation and through attacks on organized labour (Ross & Savage, 2012).

Thus the central point here is that *functional* health is, in effect, defined according to the needs of capital – namely productivity and profitability. As such a significant aspect of mental health under capital basically revolves around the ability to perform work tasks – to be productive. I refer to this as one’s “work ability.” This occupational framing of health as functional is exemplified by employment policies around employee sickness and intolerance of the occurrence of sickness, particularly among precariously employed workers. Furthermore, the precarious living and working conditions experienced by workers creates a “work ethic of fear.” Workers in consistent fear of unemployment are especially vulnerable to exploitation. With nothing to fall back on, precariously employed workers are disciplined to tolerate their illness experiences for prolonged periods of time. This becomes evident when examining worker complaints around chronic stress and feelings of intense anxiety, as well as depression. As such a capitalist conception of functional health is not in line with *genuine* health, which I conceive of as rooted in the fulfillment of human need. I discuss this alternate definition of health in more detail in the next chapter.

#### *Functional Health as Work Ability*

In the context of precarious labour and mental health, treating individual symptomology without changes to social and economic conditions of contemporary capitalism results in superficial responses to illness and a culture of work ability. The conception of functional health in this context has resulted in the development of occupational evaluations of individual workers’ ability to perform job tasks. For instance, the Work Ability Index (WAI) is an assessment used for sickness certification and carried out by doctors in order to determine an individual’s capacity for performing work duties

(Goedhard & Goedhard, 2005), predicated on the common-sense rationale that functionally healthy people should be able to work.

The WAI measures traits such as competence, skill, and motivation “assuming that the work tasks are reasonable and that the work environment is acceptable” (Tengland, 2011:275), which, given current working conditions, is a fairly huge assumption. The assessment tool also conveniently leaves out any examination of working conditions such as levels of autonomy, social isolation, job insecurity, or any other factor that research has shown to actually affects the mental health of workers. Instead, health is defined as having developed the “basic abilities” typical of society. Furthermore, the logic of the WAI freely admits that, although work typically requires a certain level of physical and mental functionality, “full” (read: genuine) health is not necessary for work ability (Tengland, 2011).

The anxieties produced by the focus on work ability coupled with the restructuring of the workplace as increasingly precarious are felt unevenly throughout the working class. However, there is a mounting feeling expressed among workers of what Ciulla (2000) has dubbed “the work ethic of fear.” Workers are disciplined to perform work duties as their responsibility as productive citizens, regardless of deteriorating working conditions. This is reinforced by the threat of unemployment and desolation. Thus, the illness experiences of distressed workers are simultaneously acknowledged through medical diagnosis and treatment, and denied due to a cultural expectation, compounded by their own financial need, to push through their distress and keep working. Indeed, many precarious workplaces leave little space for the mental health needs of workers and may even demand that workers continue to work despite feeling ill.

Here, the social complexities contributing to illness are not only medicalized, but also reframed in line with corporate values and directed through human resource management (Yuill, 2011). The language of occupational mental health becomes steeped in notions of “stress management,” “absenteeism,” “flex-time,” and developing a “work/life balance” (Wainwright & Calnan, 2002). Managerial responses to workers’ inability to work usually include the requirement of disease confirmation by a medical expert, therefore creating a “sick” or disabled worker. Lacking in social protections and with no alternative but to maintain work ability or face possible dismissal, the only available treatment for workers without extended health benefits is often pharmaceutical medication (Leventhal, 2006).

#### *Boosting Worker Productivity with Antidepressants*

Pharmaceutical companies have promoted claims that antidepressants are vital to a mentally healthy workforce through research publications. These publications have been used to influence companies to encourage antidepressant treatment for employees identified as “depressed” in order to increase their productivity.

Russell, Patterson, and Baker (1998) suggest that productivity in depressed workers increases by an average of 30% in twelve weeks with the use of antidepressants and that the profits gained from the increased productivity “far outweighs” the cost of the pills. The authors emphasize that “since the effectiveness of antidepressant treatment is very high and the disease is often unrecognized and/or under-treated, the productive capacity of a company could be increased substantially if greater efforts were directed toward the detection and appropriate treatment of depression” (138). The “appropriate treatment” refers to antidepressant medication. The authors also call for “proactive employer initiated

programmes to diagnose depression” (138) although the details of such programmes are not discussed. This particular research was funded by Pfizer, the maker of the SSRI antidepressant Zoloft, in the form of an “unrestricted educational grant.”

This example provides an excellent illustration of the way in which functional health and work ability is reinforced by various interrelated social actors and processes. It illustrates the way in which the medicalization of mental health enables the expanded use of antidepressant medication not only for individual workers seeking to maintain work ability, but also for employers seeking to increase worker productivity in the workplace. The expanded use of antidepressants is, in large part, the result of marketing by the pharmaceutical industry through research funding, condition branding, and product promotion, which reinforces the commodification of medicine and prioritizes its profit-making potential. The promotion of a commodity-based, medical treatment for worker distress then contributes to the depoliticization of the workplace by locating mental health in the brain chemistry of individual workers. Here, functional health according to the needs of capital becomes the only conception of mental health that is addressed in relation to labour.

#### **4.6 Conclusion**

Through an account of the socio-historical development of psychiatry, we see the eventual medicalization of mental health as legitimizing for the profession. Pharmaceutical technologies have remained one of the main treatment tools in psychiatry. Pharmaceutical companies also rely, in part, on the voice of the medical expert to confirm and distribute their products to patients in distress. Psychiatry has been criticized for conveying messages to patients in line with ruling ideologies and reinforcing oppressive norms and prejudices.

This is a problem especially considering that medical authority is relied on by society to delineate normal functioning from pathology and establish diagnostic boundaries around disease categories.

A dimension of medicalization that is important to consider is the socialization of disease, in essence the proliferation of disease categories. I have discussed the example of SAD as it has been developed in the DSM. This example, and others like it, raises concerns around the strength of evidence supporting the inclusion of such illness experiences as actual medical disorders. It also leads to discussions of the influence of private interest, specifically financial ties to the pharmaceutical industry, and their influence on what constitutes a mental disorder.

The increasing medicalization of everyday feelings of distress deserves pause to consider the possible constructive purpose of distress and how it reflects upon the social and economic condition in which we live. I argue that distress needs to be situated within the broader social context in order to determine where the dysfunction actually lies. To pathologize distress associated with oppressive social conditions is to undermine the purpose of distress as an internal warning system akin to a canary in a mine. That said, hope remains due to the fact that medicalization can be seen to work both ways to move with shifting social and political terrains. The demedicalization of homosexuality and female hysteria in the DSM, as well as developments around SAD and MDD, suggest that the social construction of mental health is malleable and therefore subject to change.

Neoliberal ideology and social policy place emphasis on the sovereign worker and the productive citizen based on the assumptions of individuality, rationality, and self-interest. This notion of self-interest and individualism strengthen divisions amongst

workers by denying them meaningful relationships with either their fellow workers or their own labour. This can lead to an internalization of exploitation and the further socialization as workers begin to perceive their social and economic conditions as a given. Even when change is considered a possibility, it comes at great effort. Precariously employed workers and the unemployed poor often do not have the time or energy to invest in political work. This lack of social cohesion deepens individualism and serves to further depoliticize working conditions, alienating workers from their broader social context. This can be understood as social disintegration, which can lead to deepening distress within the population. At this point, it is important to understand that illness experiences perceived as individual are actually shared by a growing number of working class people. From a structural analytical standpoint, an important shift that must take place is the rejection of individual and purely medical approaches to mental health in favour of one that takes into consideration the damaging effects of neoliberal restructuring and fiscal austerity.

Public services have experienced the blow of austerity, which has resulted in the rise of precarious employment in these sectors and destabilized service delivery. This can have serious consequences for individual workers as well as whole communities. This would indicate that fiscal austerity results in dysfunction at both the social and institutional level. In Toronto, at the time of the SARS outbreak, the provincial government advised workers that if they were symptomatic to stay home because of the risk of spreading infection. However, workers were also informed that there would be no wage compensations offered for workers who didn't go to work. Symptomatic workers who could not afford a cut in wages, including nurses, then rode public transport and went to work anyway (Shantz, 2004). For me, this anecdote is a poignant example of functional

health as work ability. It details the way in which workers, trained in providing health services and who are experiencing disease symptomology, are forced to work due financial insecurity.

In this chapter I have offered a more concrete conceptualization of how mental health is perceived in contemporary capitalism as functional. I propose that functional health is informed by a capitalist perspective and is, in effect, defined as the ability to perform labour and participate in the economy. Here, functional health is put into economic terms. What it is to be a healthy worker basically revolves around the ability to perform work tasks, or one's "work ability." Recall that this is tied to the neoliberal rationale that people must be available to work and participate in the capitalist market as a productive body. Work ability allows this mentality to be enforced in the workplace through individual measures of employee competence and "reasonableness" of work tasks, such as with WAIs. This enables the continuation of precarious employment as well as imposes a view of mental health that centres on the productivity of individual workers instead of their subjective illness experiences or the actual needs of the work force.

Functional health as work ability ignores how problematic it is that, even during a health emergency, cost saving by the institution is prioritized over the workplace health and safety of hospital staff and patients. It also ignores the extent public health services have been defunded to the point of dysfunction. Recall that I posit that the conception of functional health is a reflection of the dysfunction that exists in current social and economic conditions. In fact, I argue that mental health issues have come to be expected in many workplaces – so much so, that pharmaceutical companies have funded occupational health studies that demonstrate the prevalence of depression among underproductive employees.

Of course, the findings of studies such as these overwhelmingly indicate that depressed workers treated with antidepressant medication show an increase in productivity in a matter of weeks. This would indicate that the pharmaceutical industry holds some influence over the medical community, over patients through direct-to-consumer marketing and condition branding, and over employers and human resource management.

Finally, we see how the conception of functional health serves the interests of capital as worker productivity is increased through the use of antidepressants. The broadening of diagnostic categories of mental disorders and the individualization of distress enables the prescription of antidepressant medication in this context. Therefore, the medicalization of worker distress and the commodification of medicine supports the interests of capital at the levels of employer, psychiatry as a profession, and the pharmaceutical industry, which are all mutually reinforcing.

## **Chapter 5: Precarious Labour**

## 5.1 Introduction

The previous chapter outlined a notion of functional health framed according to the needs and values of capital. This conceptualization revolves around people's ability to engage in wage labour and meet the demands of the workplace. I argue that this focus on work ability is actually damaging to the mental health of workers living in precarity. I also offer a definition of what I describe as *genuine* health, following Kelman's (1975) notion of "experiential health." Genuine health, as it is presented here, is positioned in direct opposition to capitalist exploitation and alienation. Building on this central point, it is important to gain a clearer understanding of precarious working conditions and how capitalist labour is entrenched in deepening exploitation and insecurity.

In this chapter, I outline the defining characteristics of precarious labour that construct workers as disposable, replaceable, and desperate. I argue that precarity is a fundamental aspect of a capitalist mode of production. This chapter seeks to explore precarious employment in terms of scale, from an articulation of its impact on individual

workplace experiences to broader global shifts in the labour market. In doing so, the purpose of this chapter is to demonstrate the connections between the precariously employed, distressed worker and the neoliberal restructuring of work – where the personal meets the political. Here, I discuss precarious labour in terms of scale in order to map out inequitable work conditions.

As a backdrop to current conditions, I explore the historical development of precarious employment and the casualization of labour. I focus particularly on the failed promises of the “new economy” as a part of the major integration of, at the time, new information technologies into the workplace. I argue that the surge in the use of information technology in and out of the workplace has reinforced a technomedical approach to health as well as Western society’s reliance on new technologies to resolve everyday problems.

I end the chapter with a description of precarious employment in Canada. Here, I emphasize scarcity, deregulation, and labour market competition as resulting in increasing job insecurity, overwork, and poverty wages. I also highlight the gendered aspect of precarious employment and note that the deepening of precarity and alienation is worsened by the performance of emotional labour expected from a large number of workers, such as those in the caring or service industries.

## **5.2 Defining Precarious Labour**

In essence, precarious labour can be traced back to the beginnings of the capitalist mode of production and the enclosure of the commons. The sale of the commons as private property and the separation of the peasantry from the means of subsistence “freed” workers to participate in a capitalist economy. As Marx (1972 [1867]) explains in *Capital vol. 1*:

The advance made by the 18th century shows itself in this, that the law itself becomes now the instrument of the theft of the people’s land, although the large

farmers make use of their little independent methods as well. The parliamentary form of the robbery is that of Acts for enclosures of Commons, in other words, decrees by which the landlords grant themselves the people's land as private property, decrees of expropriation of the people (Chapter 27, Expropriation of the Agricultural Population from the Land section, para 8).

According to Marx, the enclosure of the commons was a violent process akin to “reckless terrorism” and robbery. It also represented a significant shift in social relations as land was converted into capital and a newly created proletariat sold their labour power for a wage. For capital, the goal is wealth accumulation through the extraction of as much surplus value from workers as possible, therefore reducing production costs and increasing profit. The cheaper the wages, the more profit there is to be had by the owners of the means of production (whom I can also refer to as the capitalist class).<sup>30</sup> Marx goes on to describe the lowering of wages as an essential component of disciplining the proletariat:

In the ordinary run of things, the labourer can be left to the “natural laws of production,” *i.e.*, to his dependence on capital, a dependence springing from, and guaranteed in perpetuity by, the conditions of production themselves. It is otherwise during the historic genesis of capitalist production. The bourgeoisie, at its rise, wants and uses the power of the state to “regulate” wages, *i.e.*, to force them within the limits suitable for surplus-value making, to lengthen the working-day and to keep the labourer himself in the normal degree of dependence. This is an essential element of the so-called primitive accumulation (Chapter 28, Forcing Down of Wages section, para 6).

The maximization of profit, in large part, requires a working class that is in a perpetual state of precarity and dependent on wages to survive. Survival in a capitalist economy requires the consumption of commodities (food, rent, clothing, etc.). Without these commodities, and with no capacity for labour to sell, workers would be left to the streets with nothing. Knowing this, workers are compelled to sell their labour power for a

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<sup>30</sup> Recent literature examining precarious working conditions will reveal facts such as current wages have fallen well below the Low Income Cut Off (LICO) in most cities in Canada (for example, see Lewchuk, De Wolff, and King, 2007).

meagre wage. Workers must be cut off from the means of subsistence to enable the commodification of labour. The more workers are forced to depend on selling their labour power as a source of survival, the less they are able to resist exploitation.

The only thing that could prevent this from happening is a social safety net to catch those who, for whatever reason, cannot gain a wage. For capital, enough social security could jeopardize the integrity of capitalism if workers were guaranteed a living regardless of whether they took on wage labour or not. What incentive would people have to voluntarily participate in the drudgery of paid labour if they no longer needed to for survival? It is in the best interest of capital to keep workers in a state of insecurity and ready to take on any job out of necessity. It is this insecurity that has been intensified with current working conditions of precarious employment.

#### *Precarious Labour Today*

A variety of terminology can be found in the academic literature to describe current trends in labour and industrial relations. These trends all reflect various political orientations regarding the organization of work and evoking different perspectives, and values, on work and health (Tompa, et al, 2007). Terms that imply a more accepting tone include “alternative work” (Ronen, 1984), “flexicurity” (Auer, 2010), and “non-standard work” (Krahn, 1991); whereas more critical scholars take a harsher tone, offering labels for this form of work such as “flexploitation” (Bourdieu, 1998), “marginal work” (Hodson & Sullivan, 2011), and “precarious employment” (Vosko, 2010; 2000). This comparison illustrates how politically charged these terms can be. On the one hand, proponents of the flexibilization of work maintain that flexible work arrangements allow for an increased work-life balance and enable the social interaction of workers who cannot commit to

fulltime schedules, such as students and working mothers. On the other hand, a more critical perspective would argue that flexibilization has been used to dismantle job security, remove employee benefits and pension packages, and increase worker alienation. Wilson & Ebert (2013) argue that this restructuring of work reflects a managerial effort to download labour costs and social responsibility onto the backs of individual workers.

Particular terms have also been criticized for their lack of political analysis. For example, the term “non-standard work” has been criticized for erasing systems of oppression – namely, structural racism, sexism, and heteronormativity – that privilege the hiring of white, cis-men in fulltime, permanent, well-paid positions (both in wages and benefits) with a single employer and considering this the “standard” rule by which to measure employment (Tompa, et al, 2007). This fails to acknowledge that women and people of colour have always been shut out of so-called standard work and forced into marginal work arrangements (hooks, 2000). Acknowledging this, it is also important to remember that, when reading literature around labour market regulation and conditions, the notion of a “standard employment relationship” is often referred to and used as the basic model of employment. The word “standard” implies that fulltime, permanent employment is typical and expected. However, an increasing number of jobs no longer resemble this model, if they ever did, rendering occupational legislation and policies moot for a large proportion of actual workers. Legislative restructuring may even exacerbate the economic instability and vulnerability felt by oppressed groups who are overrepresented in precarious employment situations (Noack & Vosko, 2011).

Keeping these issues in mind, I will refer to “precarious labour / work / employment” interchangeably and consider it “employment that is uncertain,

unpredictable, and risky from the point of view of the worker” (Kalleberg, 2009:2). I prefer to keep to a relatively broad definition of precarious employment because I perceive the term as referring to more of a political process than a classification of the employer/employee relationship. As such, precarious employment not only impacts work, but also education, social reproduction, citizenship and immigration, corporate mobility, and is itself an important part of capitalist globalization (Standing, 2014, 2012, 2011). I consider job insecurity and contingency to be one of the most prominent features of precarious labour, along with low wages, and lack of social protections. Polivka (1996) writes that job insecurity, or contingent work, is identified as a work arrangement in which there is no direct or indirect indication of whether the employment contract will continue, and where the number of hours available for work can change without notice.

Further discussion requires a clear definition of what is meant by the term “contingent,” as it has different connotations for labour and capital. For capital, contingency refers to the flexibility of the workforce as disposable labour with no entitlement to permanent employment. Because contingency, in this sense, gives control to the institution, which can then use workers on a malleable rather than fixed budget line, the institution considers it a positive value. As Marx (1959 [1844]) explains, the “supply and demand” business model is not only applied to the production of commodities, but to actual workers as well as a commodification of labour:

Should supply greatly exceed demand, a section of the workers sinks into beggary or starvation. The worker’s existence is thus brought under the same condition as the existence of every other commodity. The worker has become a commodity, and it is a bit of luck for [them] if [they] can find a buyer. And the demand on which the life of the worker depends, depends on the whim of the rich and the capitalists. Should supply exceed demand, then one of the constituent parts of the price – profit, rent or wages – is paid below its *rate*, [a part of these] factors is therefore withdrawn from this application, and thus the

market price gravitates [towards the] natural price as the centre-point. But 1) where there is considerable division of labour it is most difficult for the worker to direct [their] labour into other channels; 2) because of [their] subordinate relation to the capitalist, [they are] the first to suffer (Wages of Labour section, para 3).

For labour, contingency is not just a fiscal strategy. It reaches far beyond economic categories and substantially disrupts workers' goals and plans for the future. It is running from contract to contract. Contingency represents both material and existential hardship as it takes away choice, constrains potential, and threatens the possibility of genuine health and a good life. Workers then, live in a perpetual state of immediacy and temporariness. The insecurity contingent work arrangements bring annihilates the future and disregards the past. The past accomplishments of workers, the building of experience, and development of skill are minimized when there is only a slim chance of successful advancement and, in fact, a likelihood of dismissal (Gulli, 2009).

Again, there are potentially liberating aspects to part-time or contract work for the privileged permanently employed, well-paid worker – for example, a worker wanting to cut back on work hours to pursue other interests or home responsibilities. This is not precarious employment or contingency as I mean it. The type of contingency that I critique is a situation where workers would take fulltime employment at a living wage if given the opportunity, but are denied that possibility. Furthermore, the work that contingent workers do often fulfills a permanent need of the employing institution, yet specific positions are not recognized as permanent. For example, adjunct professors perform essential teaching services for universities and are hired for courses that are offered on an ongoing basis, yet their jobs are temporary. In this case workers are contingent in status only. Gulli (2009) connects the denial of, for example, fulltime faculty positions and the construction of

adjuncts as interchangeable and readily available to a type of involuntary labour used to maintain a reserve army of cheap labour. This conception of contingency draws on Marx's (1972 [1867]) explication of the reserve army of labour, which is created when the available labour source exceeds the labour needed to power the means of production:

If the means of production, as they increase in extent and effective power, become to a less extent means of employment of labourers, this state of things is again modified by the fact that in proportion as the productiveness of labour increases, capital increases its supply of labour more quickly than its demand for labourers. The overwork of the employed part of the working class swells the ranks of the reserve, whilst conversely the greater pressure that the latter by its competition exerts on the former, forces these to submit to overwork and to subjugation under the dictates of capital. The condemnation of one part of the working class to enforced idleness by the overwork of the other part, and the converse, becomes a means of enriching the individual capitalists, and accelerates at the same time the production of the industrial reserve army on a scale corresponding with the advance of social accumulation (Chapter 25, section 3, para 8).

Additionally, contingent labour is also a heavy source of surplus-value for the employing institution since casual workers are typically paid less than fulltime workers, yet expected to maintain a comparable quality of service:

Labour power is sold today [sic], not with a view of satisfying, by its service or by its product, the personal needs of the buyer. [Their] aim is augmentation of [their] capital, production of commodities containing more labour than [they pay] for, containing therefore a portion of value that costs [them] nothing, and that is nevertheless realised when the commodities are sold. Production of surplus-value is the absolute law of this mode of production. Labour power is only saleable so far as it preserves the means of production in their capacity of capital, reproduces its own value as capital, and yields in unpaid labour a source of additional capital. The conditions of its sale, whether more or less favourable to the labourer, include therefore the necessity of its constant re-selling, and the constantly extended reproduction of all wealth in the shape of capital (Marx, 1972 [1867], Chapter 25, section 1, para 7).

Precarity must be understood as something that is not only created by labour market conditions, but also as the embodied experience of precariously employed workers and the unemployed poor. There is a perception of precarious labour that runs deeper than textbook

understandings of it. It is also a feeling, a state of insecurity. Here, the work of Ebert and Wilson (2013) is central to my analysis of precarious labour in that a more subjective consideration of precarity implies that there is a clear social element affecting the prevalence of precarious work that may be expressed and interpreted differently by different social groups with varying levels of support and resources. Following this, I follow the principles of the “precarious work-society,” a concept developed by Ebert (2011) as a translation of the German *Arbeitsgesellschaft* (Offe, 1984; cited in Ebert and Wilson, 2013). The concept of the precarious work-society is in line with this dissertation in that it “invites us to consider how fragmented individual experiences of precarious work are organized into a structured and organized whole” (Wilson & Ebert, 2013:264). Wilson and Ebert espouse an understanding of labour as an organized system, not a self-regulating free market. Instead, labour is deregulated and re-regulated by a shifting political landscape.

### **5.3 Precarious Employment and Alienation**

Another damaging characteristic of capitalist labour is alienation. Through a discussion of Marx’s (1959 [1844], 1972 [1867]) alienation theory<sup>31</sup>, I outline the ways in which workers are alienated from their labour, the products of their labour, and from each other. Alienation reflects the dehumanizing and oppressive force of capital in preventing workers from realizing their human potential. My discussion of alienation revolves around the main assertion that as much as working conditions have changed, the basic exploitative nature of capitalist labour has remained the same. This also points to the structural

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<sup>31</sup> It should be noted that in later writings Marx did not refer to alienation theory. However, humanist tones can still be felt even in his more economic writings such as “The Working Day” in *Capital, Volume 1* (1972 [1867]), Ch. 10).

component of worker distress and isolation. For Marx, alienation was not an individual psychological condition; it is rooted in social relations and in the basic organization of capitalist labour. Following his analysis leads to the conclusion that structural changes are needed in response to alienation.

According to Marx's (1959 [1844], 1972 [1867]) theory of alienation, exploitation and dehumanization are inherent to capitalist commodity production.<sup>32</sup> An exploration of how the basic structure of capitalist labour is organized allows for a more profound analysis of its inherently alienating qualities, which are damaging for the mental health of workers. Yuill's (2011) summary of four main characteristics of capitalist labour are helpful in understanding the breadth of alienation – 1) it is representative of social conditions that should not exist, 2) people experience a sense of loss regarding relationships with the self and/or others, 3) some aspect of human development central to personal fulfillment as an individual and social agent is fundamentally disturbed and deteriorated, and 4) the underlying cause is located in broader social and historical processes.

As a “cog in the machine,” the interests and actual feelings of workers are denied in order to meet the demands of paid labour and maintain basic levels of survival. This places the needs of the capitalist market in direct odds with human need. This is true for all capitalist labour. I argue that the working conditions of precarious labour result in experiences of alienation that are intensified by the massive insecurity brought about by the neoliberal casualization of labour and cuts to social services. The perpetual state of temporariness of precarious labour generates chronic stress and anxiety for workers,

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<sup>32</sup> For other theoretical discussion of Marx's alienation theory, see the interpretations of Kalekin-Fishman (2006) and Kanungo (1982).

intensified by the alienation inherent to wage work under conditions of capitalism. Not only are precariously employed workers estranged from their labour (their “being”) and the product of the labour, they are denied their own place and position within the institution as a recognized employee. In this way, precariously employed workers are not even recognized as cogs in a machine, but become merely placeholders for cogs.

Furthermore, related feelings of dis-ease are perceived as illness experiences within a pathologizing paradigm. Medicalization serves to depoliticize distress in workers by removing it from its political and social context. Imposing a disease category implies that the dysfunction lay with individual workers, not in an inherently damaging system. This also implies that the expressed dysfunction is an abnormal response in need of corrective treatment, regardless of its prevalence. The medicalization of such illness experiences enables alienation and structural dysfunction to hide in plain sight, as it were.

### *Alienation Theory*

My conception of alienation in current society is located in increasing precarity, individualism, and the way in which resilience and functionality are tied to work ability. I understand precarious labour as the deepening of capitalist exploitation and the devaluing of labour through the creation of a global surplus. My intention here is to apply alienation theory to an understanding of mental health under capitalism. The study of alienation theory within the field of medical sociology presents us with a valuable opportunity to understand social and economic capitalist relations not only in abstraction, but also as an embodied experience. In this way, the detrimental health effects of capitalism can be discussed in their social context. In my discussion I acknowledge systems of oppression and unearned privilege as contributing to alienation and distress, particularly for workers

of colour and other marginalized groups. It must be noted that I also consider the unemployed poor as alienated in that they are excluded from full participation in community life.

Alienation is a result of capitalist commodity production and the deterioration of fundamental social relations inherent within it. Marx understood labour as an essential component of “being,” of one’s essence; labour is an expression of one’s self. Therefore, workers should be able to recognize themselves in the product of their labour, as their own creation. However, a capitalist mode of production separates workers from the expression of self through labour and disconnects the worker from the product of their labour. Through the commodification of labour, the product of labour ceases to be the creation of the worker and becomes the property of the capitalist.

The commodification of labour transforms labour into a dehumanizing force and diminishes the quality of human life. In the *Economic and Philosophic Manuscripts of 1844*, Marx (1959 [1844]) describes alienation resulting from workers being estranged from the product of their labour. Capitalist commodity production has as its goal the objectification of labour into a material object. The objectification of labour inhibits the realisation of human potential. Capitalist labour then can be understood as denying workers their own humanity:

The *devaluation* of the world of [humans] is in direct proportion to the *increasing value* of the world of things. Labour produces not only commodities; it produces itself and the worker as a *commodity* – and this at the same rate at which it produces commodities in general. This fact expresses merely that the object which labour produces – labour’s product – confronts it as *something alien*, as a *power independent* of the producer. The product of labour is labour, which has been embodied in an object, which has become material: it is the *objectification* of labour. Labour’s realization is its objectification. Under these economic conditions this realization of labour appears as *loss of realization* for the workers;

objectification as *loss of the object and bondage to it*; appropriation as *estrangement*, as *alienation* (Estranged Labour section, para 6).

Marx argued further that creativity is intimately tied to labour and an essential component to human development. Labour is considered a creative process through which workers contribute their labour and in doing so imbue a part of themselves into the product of their labour, which can be seen as an extension of its creator. Not only does capitalist labour separate workers from the labour process, but it also destroys the connection between workers and the work they perform. Labour is then something that workers do, but something that exists only outside of them, outside of their control. Post-production commodities are then sold on the market as seemingly discrete units, concealing the social relations integral to their production. Workers then use wages to purchase the products of labour back as alien objects through commodity consumption. The world is then experienced passively, as such alienation can be said to be the cognitive manifestation of subordination:

The *alienation* of the worker in [their] product means not only that [their] labour becomes an object, an *external* existence, but that it exists *outside [them]*, independently, as something alien to [them], and that it becomes a power on its own confronting [them]. It means that the life, which [they have] conferred on the object confronts [them] as something hostile and alien (Alienation section, para 2).

Marx referred to this phenomenon as commodity fetishism where the relationships within capitalist production are perceived as the relationship between things, not people. To quote Marx (1972 [1867]):

This I call the Fetishism which attaches itself to the products of labour, so soon as they are produced as commodities, and which is therefore inseparable from the production of commodities. This Fetishism of commodities has its origin, as the foregoing analysis has already shown, in the peculiar social character of the labour that produces them (Chapter 1, section 4, para 4).

Commodity fetishism speaks to the reification of capitalism as somehow removed from the human agency as natural law. Commodity fetishism reflects the way that capitalist commodity production not only prevents worker control over the labour process, but also limits the way that workers relate to each other. As individual cogs, each worker is concentrated on their own task and is prevented from seeing the overall chain of production. This compartmentalization breaks down worker solidarity and disempowers workers as a collective through isolation. This lack of cohesion takes away agency and depoliticizes the workplace leading to the internalization of this lack of agency into everyday life circumstances.

This denial of genuine relationships, self-estrangement, lack of meaning, and social isolation due to alienation can be extremely damaging to the mental health of workers. In this way, capitalist labour degrades the mind – what Marx referred to as “consciousness” – and the body (Langman & Kalekin-Fishman, 2006).

#### *Alienation and Distress*

In his critique of the intensification of labour by piecework in manufacturing, Marx (1972 [1867]) highlights the distress caused to workers by capitalist production. He uses the term “industrial pathology” stating that the “[disabling] of body and mind is inseparable even from the division of labour in society as a whole” (Chapter 14, section 5, para 4). Seeman (1959) found there are several correlated factors involved in worker alienation that contribute to distress, including:

- powerlessness to overcome identifiable problems,
- failure to consider one’s actions as meaningful or leading to a predictable outcome,

- the inability to make sense of the norms governing behaviours by which goals are achieved,
- self-estrangement through the denial of one's own needs or interests, and
- social isolation or lack of community.

Other studies have found similar results. For instance, Horwitz (2007) argues that the stressful environment of the workplace, along with the way an individual copes with these circumstances, greatly influences mental health. He relates this to Marx, Weber, and Durkheim respectively in outlining three primary social contexts within which workers suffer prolonged personal distress – 1) ‘chronic subordination,’ in which one feels powerless to improve upon or justify one’s current position, 2) social impotence, in which one feels incapable of achieving meaningful goals, and 3) individual isolation in the absence of community cohesiveness.

A lack of control recurs as a central component in alienation (Seeman, 1975). Sennett (2007) speaks to the importance of control in his apt description of the transient and precarious nature of the contemporary workplace by comparing it to a train station where workers come and go, always moving from one place to another. This frequent turnover seriously impedes the formation of lasting relationships or worker solidarity and locates control squarely in the hands of the managerial core that directs workers through hiring and firing power. The absence of control in the lives of workers is reflected in the fact that insecurity and instability are the only predictable constants in life.

Feeling a sense of mastery and personal autonomy over work acts to diffuse the alienating effects of performing capitalist labour and mitigates the impact of daily stressors, such as financial insecurity (Goosby, 2007). In other words, people experience fewer

feelings of depression when they feel they have a higher level of control over their lives; this seems to be especially prevalent among women (Gadalla, 2009). Not having decision-making power in the workplace or input into when and how to perform regular tasks can increase psychological distress and put workers at risk of physical disease, particularly chronic back pain and problems with cardiovascular functioning.

Developed in the 1980s, the demand/control/support model (Karasek & Theorell, 1990) is useful for assessing working conditions along three axes – 1) the intensity of job demands placed on workers, 2) the level of autonomy experienced by workers and their perceived level of control over working conditions, and 3) the amount of social support workers receive in the workplace (inclusive of both managerial and collegial support) (Kristensen, 2006). Following the demand/control/support model, the risk for psychological distress is compounded in workplaces that offer little control or creative input into how work duties are performed, yet have high demands of performance and productivity (WHO, 2003). This “low control/high performance” work environment is also a strong indicator of mental health as it can be damaging for workers’ capacity to cope with independent, and potentially unpredictable, stressors (Tausig, 2013). Furthermore, the perceived ability to acquire social support is related to one’s sense of mastery. Workers who do not feel in control of their working lives often experience alienation and isolation outside of work as well (Karasek & Theorell, 1990).

#### *Alienation and Antidepressants – A Fix, But Not a Solution*

The capitalist mode of production, at its very foundation, impedes the attainment of genuine health. We can understand alienation as the embodied expression of workers’ incapacity to achieve genuine fulfillment through capitalist labour. Based on his

interpretation of Marx's alienation theory, Yuill (2005) identifies three main conditions that must be met in order for humans to find fulfillment through labour – 1) labour is self-governed, 2) labour provides stimulation and pleasure, and 3) labour enables the cooperation and participation in community. None of these conditions are a priority for capital. In fact, worker control over the labour process actually runs counter to the capitalist mode of production where the ultimate decision-making power lies with the owners of the means of production. This would indicate that the solution to alienation and the distress related to it is in the dismantling of the capitalist mode of production, at least to the extent that the three main conditions of fulfilling labour can be met. There have been many advances in this regard due to the efforts of organized labour and unions. However, as will be discussed in the next chapter, these gains are not easily won or maintained. Many workers experience the full brunt of alienation and distress.

Workers who struggle with illness experiences related to the alienating conditions of capital may seek medical help. When this is the case, alienation is not what is addressed or perhaps even acknowledged as the source of the problem. Recall that it is the role of the medical expert to confirm the existence of disease within the individual patient. Upon confirmation that an experience fits into the established medical classification of disease, treatment is prescribed, often in the form of pharmaceuticals. In this way, the purpose of treatment is to alter the biochemical functioning of the individual to cope with the expectations and responsibilities of everyday life.

Again, this does little to challenge broader social structures that may be incompatible with achieving lasting, genuine health. I hold *genuine* health in opposition to a conceptualization of health based on the needs of capital. I understand genuine health as

based on the fulfillment of human needs and the absence of alienation. Considering that capitalist commodity production is inherently alienating and exploitative, it is difficult to imagine the achievement of genuine health on a broad scale unless major social and economic structural changes occur.

Antidepressant medication, in this context, may only be a temporary fix to a major structural problem. Here, the alleviation of distress via pharmaceuticals serves to enable individuals to cope with damaging social and economic conditions from which they cannot fully escape. To be clear, I am not implying that antidepressant use is a sinister manipulation by the capitalist class to sedate workers. People are prescribed antidepressants for various reasons, and the prescription of pharmaceuticals may very well be a necessary treatment. My point is that the treatment of individual symptoms only, without a consideration of broader social conditions as a contributing factor of distress, is a mistake. This narrow focus in the treatment of mental health issues leads to treatment plans that locates dysfunction physiologically and burdens the individual with the responsibility of conforming to society as is, thus perpetuating harm.

In writing about Prozac, Elliott (2000) reconstructs alienation as “an incongruity between the self and external structures of meaning – a lack of fit between the way you are and the way you are expected to be, say, or a mismatch between the way you are living a life and the structures of meaning that tell you how to live a life” (7). Elliott’s departure from Marx to the more existential is lacks a discussion of exploitation and a labour/class analysis. However, I believe that Elliott’s point is useful in that it points to the incompatibility as an underlying issue and suggests that Prozac, in this case, is a superficial treatment for a much deeper structural problem. Also, Elliott goes on to write that

alienation may be considered an *appropriate* response to social conditions and perhaps not in need of treatment.

Kramer (2000) takes Elliott's argument further by saying that if alienation indicates an incompatibility between the subject and their environment, and if alienation is the appropriate response to this incompatibility, perhaps treating the distress is not the answer. Antidepressants such as Prozac may be seen as a means to achieve an artificial, inauthentic sense of fulfillment. A better response to alienation would be to make changes to the underlying social structures, including a return of the commons and the decommodification of labour.

Technological advancement and globalizing shifts in labour have resulted in increased precarity and exploitation for workers in recent decades. The growth of capitalist globalization reflects the ongoing separation of workers from the means of subsistence and deepening of their dependency on capitalist production for survival.

#### **5.4 Precarious Labour and the Global Market**

In order to appreciate the enormity of current international labour struggles, changes within the labour process and social forms of contemporary capitalism, as well as the state's role as political interceder, need to be explored in terms of how these transformations have led to an intensification of exploitation and greater inequality in the labour force. My analysis focuses more on global political and economic forces that have shaped current work arrangements in Canada, as well as the role of the nation-state in creating antagonism and breaking solidarity between foreign and domestic workers. Contemporary trends in the global labour market point to shifts in the locus of extraction

of surplus-value from labour, work organization, and the vicissitudes of the labour process in keeping with the changing requirements of the forces of production (Albo, 2012).

One way capitalist expansion works is through the reinvestment of capital into the procurement of the means of production and labour power necessary in order to produce profit. This accumulation involves the constant development of new forms of labour relations, class conflict, and commodification. This transformative process also implies a reliance on the mutability and availability of an appropriate labour power to be disciplined and exploited, which includes factors such as skill-level, mobility, state regulation, and social reproductive capacity. The successful constitution of labour power, as well as the demand for it, shapes the characteristics of wage labour (for example, the driving down of wages).

Economic inequality within the labour force in Canada is shaped by contemporary capitalism's mode of production, or what Mandel (1975) referred to as "late capitalism." I begin with an acceptance that there has been an emergence of a new form of capitalist expression that can be distinguished from preceding historical characteristics and class conflict (Albo, 2012). For example, Carchedi (1979) places this period as generally located post-World War II. However, pinpointing a precise moment when the shift occurred is not the point. Of main concern here is an understanding of the changes in the means and mode of production in response to the evolution and reinvention of capitalism. This involves a consideration of a more global picture of major international trends within the labour market and relationships between nation states.

Here, my focus is on the transformation of migratory demands upon labour and the super-exploitative constraints placed upon temporary foreign workers. According to

Citizenship and Immigration Canada, the temporary foreign worker program “allows Canadian employers to hire foreign nationals to fill temporary labour and skill shortages when qualified Canadian citizens or permanent residents are not available” (Government of Canada, 2012). A necessary point of discussion around this program is the tensions between foreign workers and citizen workers, as well as the oppression and violence generated within the terms of foreign worker programs. For this purpose, I pull mostly from the work of Carchedi (1979) and his articulation of the US state’s relationship with foreign workers. I refer back to Carchedi’s historical analysis as it still holds relevance today and is cited in more recent works on migrant labour.<sup>33</sup> Generally speaking foreign workers can be categorized as either relatively permanent or following a continuous cycle of acceptance and expulsion by the state. I also highlight Walia’s (2010) writing on the colonial and oppressive nature of this relationship considering the rationalization and non-citizen “othering” of this group of workers. Walia’s work also pulls the discussion into a specifically Canadian context.

I refer to international labour arrangements as sites of “super-exploitation” and an outcome of neo-colonialism and capitalist globalization. I then discuss Canada’s<sup>34</sup> role in the inequitable working conditions of temporary foreign workers. Although there are certainly significant differences in the severity of precarity, exploitation, and violence experienced by foreign workers compared to citizen workers, I also want to draw attention

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<sup>33</sup> For example, see Sharma’s (2006) linking of Carchedi’s 1979 analysis to current conditions regarding migrant labour in Canada.

<sup>34</sup> It should be noted that “Canada” as a sovereign country is disturbed by the fact that the nation-state has been established on unceded indigenous territory. Here, Canada’s colonial history of genocide and continual assimilation efforts are acknowledged, as are the ongoing repression of indigenous self-determination and the federal government’s failure to respect treaty rights.

to some important similarities in the ways that shifts in global capitalism disciplines both foreign and domestic (citizen) workers and shapes their experiences.

*The Push and Pull of International Labour Power*

The internationalization of labour mobility and temporariness characterizes a significant portion of labour within contemporary capitalism in the West (Carchedi, 1979). Globalization has altered the economic and social dynamics of labour and the accumulation of capital (Albo, 2012; Standing, 2011). Richer countries have come to increasingly depend on foreign labour as a cheap surplus to make up for particular labour shortages. Carchedi, (1979) classifies this as an imperialist relationship that requires an “international centralization” (39). However, this relationship has gone from permanent settlement to a typically temporary, cyclical acquisition of labour power that flows from peripheral countries into the centre and is sent back out again. Capitalist globalization requires a flexible labour force that is readily available on the market at a low cost, but which disappears – first from the workplace and then altogether back to the country of origin – when no longer needed (Carchedi, 1979). This phenomenon is comparable to Bauman’s (2000) concept of the mobility of capital. The dismantling of regulatory barriers serves to increase the geographical mobility of foreign labour, while restricting the positional mobility that characterizes the international circulation of labour power.

Carchedi (1979) points out an important aspect of the contemporary acquisition of foreign labour power is that its temporariness is set prior to migration and, upon arrival, workers are already subsumed into a predetermined position within the division of labour. The continual “attraction and expulsion” of foreign labour necessitates coordinated effort and strategy on the part of the host state in the interest of capital. Insourcing temporary

foreign labour makes possible the intensification of exploitation (Carchedi, 1979). Walia (2010) provides us with further insight here in that a crucial requirement is a sufficient level of poverty in peripheral countries, as well as the structural violence it entails. This is then coupled with a demand for foreign labour<sup>35</sup> in the receiving country, creating the “economic refugee.” Brickner & Staehle (2010) point out that temporary foreign worker programs are also mechanisms for immigration policy makers to limit permanent access to the country. Therefore, I conclude that they are not only a mechanism to regulate the structural and economic demands of capital over time, but they bring the option of cheap foreign labour to the doors of industry on domestic soil without limiting capitalist expansion.

#### *The Super-Exploitation of Temporary Foreign Workers*

Workers recruited under temporary foreign worker programs are classified as “unskilled” (Gross & Schmitt, 2012) and the designation as “temporary” allows the state to withhold rights and privileges, including access to health services. This is further enabled through bilateral trade agreements that aim to ease the flow of labour power across borders (Carchedi, 1979) and maintain the constant disciplinary threat of deportation (Walia, 2010). Temporary foreign worker entry into Canada grew by 63.6% from 101,000 in 1993 to 165,200 in 2007 (Gross & Schmitt, 2012). However, even in light of this growth, due to demands from wealthy Canadian employers and local governments for more immediate access to foreign labour power, the federal government increased efforts to alleviate

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<sup>35</sup> Canada has acquired foreign labour power for the purposes of indentured servitude since its making as a nation beginning with the servants who accompanied European settlers through to the Black and Indigenous people who were used for slave labour (Walia, 2010).

backlogs in applications handled by Citizenship and Immigration Canada (CIC) (Brickner & Staehle, 2010). Walia (2010) emphasizes that the push for foreign labour by industry and the state is a highly racist practice with a history of slavery:

The relationship between *exploitable* and *disposable* labour in Canada has developed over the past century. Up until the eighteenth and nineteenth centuries, indentured servants working off debt bondages from England accompanied White settlers. The enslavement of Indigenous and Black people soon replaced indentured servitude as a preferred form of permanent bonded labour. With the growing abolition sentiment, transient servitude as a profitable form of labour began to develop. Transient servitude, especially in the form of (im)migrant labour, had many of the advantages of slave labour, as employers maintained control of both the labour *as well as* the labourer (73).

Walia is referring to control over the labour of foreign workers, as working conditions are often not regulated, and control over the labourer under threat of deportation through the denial of citizenship. Threat is compounded by the simultaneous deployment of enforcement agencies such as police, border control, and immigration officials to intimidate and harass, or conversely neglect and ignore, certain groups of temporary foreign workers.

This is reflective of Carchedi's (1979) account of the intense gaze of the state on racialized workers and caution around the potential for labour disruption. Furthermore, the precariousness of their legal status leaves many foreign workers feeling forced to endure the indignities of exploitation (Walia, 2010). This is a situation in which employers are assuming "implicit permission" (Brickner & Staehle, 2010:315) to violate labour agreements. It is certainly not helpful that the CIC does not accept any responsibility regarding the enforcement of individual employment contracts. Due to their economic vulnerability and the precarity of temporary status, migrant labourers represent the ideal source of exploitable labour power (Walia, 2010).

Not only do temporary foreign worker programs contribute to inequalities and hierarchical divides between nations, but also along a horizontal axis among privileged and marginalized workers in the labour force (Fuller, 2011). Temporary foreign labour is priced overwhelmingly low when compared to the wages of Canadian labour. Employers have little motivation to seek out workers from high unemployment sectors in Canada before turning to foreign labour (Gross & Schmitt, 2012). In fact, more and more employers are continuously recruiting temporary foreign workers to fill permanent positions (Nakache, 2013). Serving as a disciplinary force for the citizen worker, this construct frames temporary foreign workers as “capital’s weapon” against the resistance of domestic labour and their demands for improved working conditions (Carchedi, 1979), thus deepening precarity for both domestic and foreign workers.

### **5.5 The Upsurge of Precarious Employment**

The organization of labour is reflective of a society’s values and institutions of power, referred to as ‘superstructure’ by Marx (1977 [1859]). This ideological social structure, entrenched in culture, morality, and politics, also provides the basis for socio-economic relations and the (de)formation of community. As such, the superstructure also houses systems of oppression and various institutions (for example, legal and penal, medicine, marriage, schooling, etc.). Other theorists have described similar social structures. For instance, Veblen simply used the term “institutions,” while Gramsci (2011 [1937]) wrote of “ideological hegemony.” Here, it was not so much the institutions and systems that were the actual problem. For Gramsci, it was the process of socialization that lay at the root of the perpetuation of oppression. In order to overcome an oppressive hegemony, a counter-hegemony replacement would need to be forged (Dowd, 2002). In

other words, for genuine social change to occur there needs to be a viable alternative in existence. It is precisely this revolutionary mentality that is being stomped on when, for example, Conservative Prime Minister Margaret Thatcher announced to Britain in the 1980s, “There is No Alternative” (or simply TINA in economics and political circles) (Harvey, 2005). Gramsci’s conception of counter-hegemony helps us understand how social paradigm shifts occur between contesting political and economic ideologies.

Emerging out of the late 1990’s, the working conditions of the new economy were meant to liberate workers from their desk and the tyranny of fulltime work. However, what was meant to be flexibility that would grant workers more freedom and control over their workweek actually developed into the casualization of labour and precarity. Control was taken away from workers and technological advancement enabled the neoliberal restructuring of labour. Here, permanent positions were converted into part-time or contract work, and many positions were eliminated altogether either through robotics or computer software and the outsourcing of production overseas.

#### *Technophilia and the “New Economy”*

Locating working conditions within their historical context offers deeper insight into who is being most affected by current employment trends and how this shift is powered by recent neoliberal policy development. The contradictions of industrial capitalism remain evident in what was dubbed at the time, a “new economy.” The new economy is described as the third wave of the industrial revolution coming out of the information technology (IT) revolution of the 1980s (Broad & Antony, 2006). Quoting Stiroh (1999), “the defining characteristic for a new economy viewpoint is a focus on increasing globalization and expanding information technology as the underlying causes of an evolving economy” (87).

The new economy of the late 1990s was also considered an incredible time of economic growth.

Ironically, the conditions of the new economy were not so new, given that the same economic trends of increased production quality and decreased production time have happened before the IT revolution; for instance, in the automotive industry (for discussion of this see DeLong, 1997). Furthermore, the new economy seemed to be more of a return to earlier industrial models of labour management. Indeed, the new economy is illustrative of one of the main contradictions of the organization of capitalist labour – in order to produce goods and services that hold market value, employers need workers that possess the skills and knowledge necessary for such production. However, one of the failures of the new economy was the application of a factory model onto a knowledge-based economy. As discussed by Canadian political economists (such as Shalla & Clement (2007); as well as Broad & Antony (2006)) what has happened is that, in order to increase profit, employers are faced with the need to reduce production costs, which is achieved through the de-skilling of labour, downsizing, and the denial of benefits and/or an equitable wage.

Technological innovations in the domain of information and communications have dramatically affected the production and transportation of goods and services. This has revolutionized the capitalist economy by allowing for an unprecedented free flow of capital. This mobility is the engine that fuels global capitalism and has made it possible for multinational corporate interests to transcend spatial and temporal confines crossing over international borders, which results in the sidestepping of trade regulations. Globalization has provided employers of major companies with the opportunity to exploit the option of outsourcing and off-shoring techniques in their search of cheap unregulated labour. Many

jobs that were once available to domestic workers have been moved overseas where the more extreme forms of worker exploitation and deprivation are still possible. Another consequence has been the restructuring of fulltime positions into casual labour (Broad and Antony, 2006).

Early proponents of the new economy envisioned a “post-industrial,” high-tech future (see Friedman, 2000; Mandel, 1998, 1997; Lester, 1998; Kelly, 1997; and Bell, 1973). In the US, *Business Week* published enthusiastic articles on the new economy celebrating it as a signal for long-term growth with limited inflation (Shepard, 1997). Proponents also speculated as to what working conditions would look like in this era of wealth accumulation, increased productivity, and expansion (for example Brynjolfsson and Yang, 1996). Broad & Antony (2006) summarize these fascinations as envisioning a time of maximized leisure in which the separation of social classes would be minimal, if not eradicated completely. Workers were to enjoy much higher levels of autonomy due to the job market being flooded with newly created, well paid jobs that allowed for custom schedules to meet their personal needs.

One of the selling points of the new economy was the idea that it would create white-collar, high-tech, middle class IT jobs that would make up for the massive layoffs experienced in the industrial sector. Another selling point was that workers in the new economy would be valued individuals with creative input and control over their work. Unfortunately, this is not the reality. In fact, overwork and exploitation have increased in the IT industry, as well as other sectors. For example, Amman et al. (2007) discuss the possibility that the blurring of spatial boundaries by the use of wireless communication

may have cut the chains that once tied workers to a workstation. However, they argue that this has not freed the worker; it has freed the workstation.

Instead of thriving in the new economy, many workers are occupied with simply surviving. In fact, the information-technology revolution has actually rejuvenated exploitative industrial work practices, such as Fordism<sup>36</sup> and Taylor's scientific management.<sup>37</sup> The Fordist model of speed is a characteristic that has been carried over from manufacturing to information technology in the new economy. By segmenting work into individual minor tasks (for example, data entry), greater control is attained over labour practices. The increased use of computer technology in the work place has resulted in downsizing and reorganization of labour. Jobs where the tasks required are often mundane, quick to learn, and repetitive, render workers replaceable, which radically reduces their bargaining power. Much of the skill needed to perform tasks has been written into software programs and as a result workers are further removed from the meaning of their labour contribution (Amman et al, 2007).

Originally, the Fordist model called for paternalism on the part of the capitalist class to take care of workers to ensure high productivity. However, the 1980s experienced economic downturns in which neoliberalism gained traction. The economic shift toward fiscal austerity in the new economy resulted in workers being expected to work more efficiently as production demands increase, yet they were rewarded with benefit cuts and

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<sup>36</sup> Fordism refers to the mass production of huge quantities of goods in as little time as possible. A practice perfected by Henry Ford, the primary focus is on "power, speed, accuracy, economy, system, continuity and speed" (Head, 2007:47).

<sup>37</sup> Scientific management, credited to Frederick Winslow Taylor (1911), is a strategy used to manage mass production and projects the Fordist ideals of 'speed and standardization' to the actual workers and to the labour process itself.

even job loss. Furthermore, as the casualization of work grew, the “deskilling” of a variety of jobs allowed for the employment of cheaper, non-union workers who quickly replaced the more costly and organized craft workers. Even though there were 25 million US jobs created in the 1990s, a mere 18% of them paid above the national average. The past three decades have actually resulted in a decrease in wages for some workers (Head, 2007). In fact, nearly three million employees were laid off between 1993 and 1998 (Clement, 2007). The threat of downsizing remains a powerful managerial tool.

Clement (2007) argues that the new economy actually represents an era of ‘reindustrialization,’ which has renewed the search for an underemployed labour force to fill casual job positions. These positions offer little to no job security or chance of union representation. The result has brought real wages to a virtual standstill for many workers for decades and a growing discrepancy between the intensification of worker productivity and the compensation that follows.

### *Emotional Labour*

With the growth of the service industries and caring professions, more attention has been awarded to emotional labour as part of capitalist production and therefore, alienation. The commodification of emotional labour carries implications for the mental health of workers who perform such labour, and raises the issue of ownership of emotional expression in the workplace. Here, Hochschild’s (1983) articulation of emotional labour in the service industry is useful in formulating a clearer understanding. Emotional labour adds an additional layer to the internalization of alienation as workers are estranged from their own feelings and emotions. This can be especially disturbing for mental health.

The crux of this work is the commodification of labour extending to the regulation of workers' emotion in job performance. Here, alienation becomes increasingly invasive as workers' expression of emotions is controlled by the demands of the workplace. Emotional labour involves "the management of feeling to create a publicly observable facial and bodily display" (Hochschild, 1983:7). Workers are expected to manage and display particular emotions as part of their job duties. For example, expectations to "take care" of clients or make customers happy are all reflections of the emotional labour process. Emotional signifiers, such as a smile, are considered a product and part of a commodified service package to be consumed. In this way, the employer assumes ownership of the worker's smile, at least in part. The emotional expression is considered part of the production process as a believable, and ideally internalized, performance of particular emotional cues. These cues are included as part of work duties to be replicated potentially hundreds of times throughout a single shift.

The main concern around emotional labour is its effect on subordinated workers. The danger being that the performance of emotional labour results in the prolonged denial of genuine emotion and of the self. This forced affect may create internal dissonance by disturbing the authenticity of emotional expression and resulting in intensified alienation, particularly self-estrangement, and feelings of depression in all kinds of workers (Tausig, 2013). This is particularly true of the service industry where phrases such as "service with a smile" and "the customer is always right" are still applied. This managerial attitude can leave often low-paid workers vulnerable to customer harassment.<sup>38</sup> Furthermore, gender

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<sup>38</sup> See Watt's (2007) research on the emotional labour and managerial policies in the Toronto's hospitality industry for more discussion. Watt concludes that while many workers (front desk staff, for example) said they enjoyed interacting with guests, workers

role expectations can erase the emotional labour of women, leading to increased exploitation. Friendly and caring emotional expressions are naturalized in women and have come to be expected as part of being a woman. This expectation is due to dominant conceptions of femininity, which still hold women as more submissive, emotionally available, and as natural caretakers (Rosenfield & Mouzon, 2013).

### *Neoliberal Restructuring of Labour*

Neoliberal ideology maintains that private industry is more efficient than the state in the provision of goods and services to society (McGregor, 2001). In favour of the deregulation of the market, “protectionist trade barriers” are seen to prevent economic growth, and are thus detrimental to the economy. The dismantling of labour regulations within contemporary capitalism results in the deterioration of standard employment relationships and increasingly precarious work arrangements (Wilson & Ebert, 2013). The driving force behind deregulation has been neoliberal political and economic reform. Kalleberg (2009) defines neoliberal reform as a global process “emphasizing the centrality of markets and market-driven solutions, privatization of government resources, and removal of governmental protections” (3). As Levin (2007) noted, “Neoliberal ideology and its related practices are antithetical to justice for the disadvantaged populations” (193).

As will be discussed in more detail in the next chapter, deregulation has affected workers in that they have witnessed the dismantling of whatever social safety net once existed. Cuts to the budget usually translate into cuts in social benefits, leaving individuals to “exercise their autonomy” and provide for themselves. This attitude of “standing on your

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found the need to emotionally detach when having to continuously maintain a pleasant exterior, especially when faced with irate customers. The research also showed that, for some workers, the ability to detach eroded over time and led to employee turnover.

own two feet” does not leave many choices but to take whatever work they can find in order to support themselves and their families (Broad & Antony, 2006). The promise of the new economy’s well-paying knowledge-based work has turned into poorly paid manufacturing and service jobs (Herod, 2007). Furthermore, due to the push for individual responsibility, precariously employed workers are being forced to provide themselves with private health insurance, plan for their own retirement, and take on more “initiative” in terms of (unpaid) job training as “self starters” (Amman et al, 2007).

The implementation of pro-market policies combined with the dismantling of legislative protections for workers have enabled employers to rely more on precarious employment practices, which include increased productivity, work intensification, and a decrease in worker input over the labour process (Tompa, et al, 2007). Casual labour and precarious working conditions have become the norm in strategies to reduce labour costs (Warskett, 2007). This strategy marks a return to what Marx (1984 [1894]) identified in *Capital, vol III* as “savings in labour conditions at the expense of the labourers” (Chapter 5, section 2). Here, Marx articulates the damage presented to workers through cost-saving measures that lend to the restructuring of work:

Capitalist production, when considered in isolation from the process of circulation and the excesses of competition, is very economical with the materialised labour incorporated in commodities. Yet, more than any other mode of production, it squanders human lives, or living-labour, and not only blood and flesh, but also nerve and brain. Indeed, it is only by dint of the most extravagant waste of individual development that the development of the human race is at all safeguarded and maintained in the epoch of history immediately preceding the conscious reorganisation of society. Since all of the economising here discussed arises from the social nature of labour, it is indeed just this directly social nature of labour which causes the waste of life and health (Chapter 5, section 2, para 3).

In his time, Marx made reference to the conditions of factory work and agriculture as detrimental to human (and I would add non-human animal) life. I argue that the working conditions found in precarious employment also produce harm for workers. The neoliberal restructuring of work as flexible, casual, and low-paid is compounded with the constitution of the sovereign worker – *homo economicus* – responsible for their own survival.

From the employer's point of view, precarious work arrangements, such as contract or temporary employment, provide reduction of risk by allowing positions to be eliminated, created, or adjusted to meet the shifting market demands. Labour is made flexible by rendering the boundaries that define work times and responsibilities malleable. The negotiation of such boundaries results in “task-oriented” piecemeal work on a temporary basis (Castells, 2000). Contract and temporary labour arrangements also cut costs since benefits, pensions, or fixed wages are not offered. Nor are employers obligated to pay out laid off workers, provide cause for dismissal, or give notice before reducing hours or pay. Even in cases where these contract positions provide reliable and necessary work for the institution, workers are still underpaid and denied any kind of job security (Noack & Vosko, 2011). Compliance to market demands, as well as the damage resulting from them, has been downloaded onto workers (Lewchuk et al, 2013; Lewchuk, et al, 2011; Mazières-Vaysse, 2011).

### *Precarious Employment in Canada*

In recent decades there has been a sharp increase in contract work, part-time work, and casual labour, particularly affecting academia, the service and retail industries, manufacturing, agriculture, and office work. Locally and globally workers have to deal with rising levels of vulnerability, precariousness, and the dismantling of job security,

stability, safety, remuneration, and benefits. Employers are demanding more productivity and flexibility from their employees with little offered in return. Even though workers across this spectrum occupy a diversity of positions, their experiences are often quite similar in many ways, including the effect their work is having on their health and their capacity to sustain a good quality of life.

In Canada, the increased exploitation and risk involved in precarious employment takes a toll reaching far beyond the workplace. It is important to bear in mind the cost of unsafe and intensely stressful labour conditions to healthcare. According to current provincial and federal law concerning employment standards, precariously employed workers are not entitled to a minimum number of paid sick days; casual staff can be laid off without notice and employers are not obligated to consult with staff regarding changes in job duties (deWolff, Lewchuk, and Clarke, 2007). In some cases, such as contingent academic labour, workers are forced to continuously re-apply for their position without automatic renewal. These workers also have little to no say in how their job performance is evaluated, which may affect future employment.

Many workers complain of being pressured by their employer to take on more tasks than can be effectively performed within a regular eight-hour workday, which results in unpaid overtime (Cropanzano et al., 2005). Totterdell (2005) defines work overload as “too much work, time pressures and deadlines, and a lack of personal resources needed to fulfill duties, commitments, and responsibilities” (13). In fact, the average workweek consists of 51 to 55 hours and many workers supplement this by working through vacation time and holding more than a single employment. Furthermore, this type of labour is both highly

gendered and racialized, predominantly filled by women of color. The men who do work these jobs are younger and are often post-secondary students (Vosko, 2007).

In Ontario the gender wage gap in fulltime, year-round employment was measured as men making an average of 26% more than women in 2011 (Statistics Canada, 2012). This is compounded by the domestic and reproductive labour that women are expected to perform. In heteronormative cohabitation, even when both partners are employed, women do twice the amount of chores in the home (Rosenfield & Mouzon, 2013). Also, 25% of fulltime self-employed workers, and 16% of workers in permanent fulltime positions, took home an annual income of less than \$20,000. There are almost twice as many women who fall below the low-income cut off (LICO) than men (Vosko, 2007). Women in general occupy lower level positions with less opportunities for advancement, work jobs that are more often not unionized, and are charged with less decision-making power as employees (Rosenfield & Mouzon, 2013).

Women, people of colour, migrant labourers, and new immigrants, have disproportionately carried out precarious work arrangements since the ending of WWII, so much so that the recent surge in precarious labour has been dubbed a “feminization” of the market (Tompa, et al, 2007). The advent of women entering the paid work force has resulted in an increased demand for childcare. Undocumented or temporary foreign workers, who are not eligible for official state protections and who are overwhelmingly women, are often relied upon to provide private childcare services (Warskett, 2007). The difficulty women and people of colour face in the workplace reflect broader systems of oppression, which also reflect global trends through discriminatory policies and trade

agreements. With the decentralisation and the fragmentation of employment, individual workers are subject to the global labour market forces of capitalist commodity production.

## **5.6 Conclusion**

One of the aims of sociological analysis is to connect social structures to individual circumstances. Therefore, an examination of precarious employment requires a consideration of the overarching structural shifts that drive changes to working conditions. Workers face continual emotional and physical damage as a consequence of neoliberal restructuring and the casualization of work, as well as individualizing ideologies around durability and resilience. As a result, workers are expected to endure all the variations of oppression and exploitation doled out by the conditions of capitalism and yet push through in order to survive. The medicalization of social issues has created a lack of political education needed to address underlying social structures in relation to mental health, such as job security and a living wage. When the demands of precarious work arrangements manifest as psychological or physical distress that become too much to manage on their own, workers often turn to a medical expert for relief. This has resulted in the concretizing of the role of medical professionals, not only as managers of the collateral damage produced by current economic and working conditions, but also as the gatekeepers of profit for the pharmaceutical industry.

From its very beginning with the enclosure of the commons, it is important to understand that capitalism has developed out of social processes rooted in a history of exploitation, colonialism, and oppression. Workers were separated from the means of subsistence and forced to depend on capitalist production by selling their labour power for survival. Capitalist production has always involved precarity, low wages, and a lack of

social protections. Capitalist commodity production prioritizes the maximization of profit by driving down wages through the intensification of work and the creation of precarious working and living conditions. Capitalist commodity production requires the creation of a precarious labour force that is at once available and restricted, attracted and rejected. Growing conditions of precarity ensure that workers have no other option than to engage in the capitalist market, or risk total ruin.

Marx's alienation theory demonstrates how capitalist commodity production is fundamentally dehumanizing, objectifying, and incompatible with the genuine health of workers. Workers are alienated from their being, from the labour process, from the product of their labour, and from each other. All of these things are instead presented to workers as external and alien. Capitalist labour prevents workers from realising their human potential, resulting in feelings of social isolation, meaninglessness, and subordination. Commodity fetishism describes the way reification of capitalist production and the erasure of social relations in the labour process. The focus on commodity exchange in the market presents only the surface of a much deeper process. By keeping the focus on relationships between objects and end products, workers are inhibited from their own social context and relationship with each other within broader structures. This leads to a breakdown of social cohesion and depoliticizes labour as a political and social process.

Alienation and precarious employment can be extremely stressful and damaging. Distress and feelings of anxiety and depression related to such estrangement are often medicalized and treated with pharmaceuticals, such as antidepressants, thus removing them from a more structural analysis. This fails to consider the possible social factors contributing to illness experiences and enables harmful conditions to continue. By only

treating individual symptoms and locating dysfunction within the individual, broader social structures are taken for granted and it is the workers responsibility to conform to society as is. In this way, there is an expectation for distressed workers to remain functional in an economic system of production that is incompatible with the genuine fulfillment of their needs. Instead, functionality is measured by workers ability to continue their role as subordinated workers. It is therefore important to articulate a notion of genuine health that rejects work ability as a primary focus and pays attention to detrimental social structures as related to distress. I put forward that the notion of genuine health centers on the fulfillment of human need as well as a reconnection to meaningful labour.

An examination of the current conditions of precarious employment is required in order to more fully understand the ways in which broader social structures, such as the organization of work, can be detrimental as a system. Precarious employment can be defined as labour that is unpredictable, risky, and uncertain from the point of view of the worker. Employers and the state have downloaded risk, cost, and responsibility onto individual workers and already vulnerable poor communities. Often, the labour precariously employed workers do is a permanent aspect of the workplace. This leaves workers in a perpetual state of insecurity as their labour is essential, but they, as workers, are regarded as disposable and interchangeable. In this way, precarious work arrangements are an organized system that contributes to a reserve army of available cheap labour.

The deterioration of employment amidst capitalist crises is quite clearly reflected globally. The outsourcing and importing of labour through colonial and imperialist international development and labour programs have had devastating effects on local economies and livelihoods. The extent to which precarious employment represents

economic, social, and geographical mobility, or the exclusion from it, reflects the ways in which contemporary capitalism shapes the broader inequalities of the labour market on a local and global scale. The developments, however uneven, in contemporary capitalism discussed here are indicative of the ongoing evolution of globalized capitalist expansion and restructuring. All of which create conditions of increased exploitation where any advantage gained by capital is paid for by labour.

Key to market expansion and the acquisition of cheap labour, the transnational neo-colonialism of today has created a reserve army of subjugated migrant workers. Their existence is valued only in as much as it supplies labour shortages in receiving countries. Regardless of its transitory nature, the structural need for foreign labour has become a permanent feature of contemporary capitalism. This implies that the exclusionary conditions of foreign labour are designed as alienating and to keep foreign workers on a rotational basis, effectively barring them from becoming integrated members of social and political life. While the denial of citizenship paints foreign workers as needed, they are not wanted.

Racist and nationalist policies inherent to temporary foreign worker programs serve to discipline migrant workers, while the growing reliance of capital on the creation of precarious work arrangements serves to discipline domestic-citizen workers and break solidarity between the two. Furthermore, the disciplining effect of temporary foreign worker programs can lead to the perception of foreign workers not only as outsiders to the Canadian labour force, but also as actively working against the interests and labour rights of Canadian workers. This tension exacerbates the competitiveness of the neoliberal labour market and reinforces self-serving individualism amongst workers.

Neoliberal ideology is used by capital to reassert the need for precarious work arrangements and to socialize workers to accept precarious conditions as inevitable. This socialization process has taken place over decades throughout shifts in the political and economic landscape. A brief examination of the conditions of the new economy reveals an era of reindustrialization marked by global market competition and the casualization of labour. The resulting deregulation and cost-saving measures of neoliberalism come at the expense of workers. Precarity is not only experienced as the technical circumstances of their employment, it is also an embodied experience. The working conditions of precariously employed people also translate to their living conditions as neoliberal ideology informs both the stripping of employment security and fiscal austerity targeting social services. This leaves precariously employed workers and the unemployed poor in dire straits in relation to mental health management and self-care. As will be examined in the next chapter, structural conditions of social and economic precarity carry seriously detrimental effects on mental health.

## **Chapter 6: Precarity and Mental Health**

## **6.1 Introduction**

Thus far I have emphasized the damaging characteristics of capitalist commodity production and discussed current precarious working conditions. Through a consideration of primitive accumulation and alienation theory I have argued that deepening precarity and exploitation are essential components of capitalism, which places capitalist labour as fundamentally incompatible with human fulfillment and genuine health in workers. I have also argued that damaging structural issues must be taken into consideration as contributing to mental health issues in precariously employed workers. Antidepressants have been marketed by the pharmaceutical industry as appropriate treatment for underproductive workers experiencing mental health issues. However, without addressing the more structural issues at play, treatments such as antidepressants may only offer a short-term superficial solution. At best, this allows workers to survive. At worst, this forces workers to endure higher levels of distress and does nothing to challenge damaging working conditions. Of course, this is assuming that workers can tolerate the medication. For many, adverse reactions to antidepressants constitute a health crisis of their own.

Continuing from this discussion, the purpose of this chapter is to examine precisely where individual illness experiences are situated within structural forces. An important part of this is a discussion of how experiences of precarious employment conditions manifest as distress leading to workers to seek medical help. I argue that, given declines in the mental health of precariously employed workers, current working conditions are not sustainable. This chapter highlights the way in which participants understand and interpret their own feelings of alienation and precarity. Here, I use excerpts from my interviews with participants and autoethnographic entries to signal the weaving together of theoretical

economic and political philosophy with lived realities. In doing so I illustrate how precarious labour conditions, and neoliberal restructuring, have profound negative effects on people's health.

## **6.2 Precarious Employment and Dysfunction**

Neoliberal restructuring has dismantled social security and the rights gained by the labour movement and made workplace conditions significantly less safe for workers. Tompa, et al. (2007) argue that increasing precarious conditions in employment and social security may have long-term, negative effects. Workers experience increasing disempowerment, within and across social groups, in material ways such as poverty and economic exclusion, as well as non-material ways such as occupational stress. Both can be linked to deteriorations in mental health (Vives et al, 2013). Clear links have been established between precarious job strain and declines in mental and physical health (Lewchuk et al, 2013; Lewchuk, Clarke, and de Wolff, 2011; Lewchuk, de Wolff, King, and Polanyi, 2003). Enforced flexibility, financial hardship, and overwork are all associated with feelings of hopelessness, anxiety, worry, and exhaustion in workers (Thomas and Hersen, 2002).

For precariously employed workers social isolation and low wages create an environment that leaves them especially vulnerable to adverse health effects. In the absence of structural solutions, such as proper labour regulations and social welfare policies, the ways people cope with workplace stressors depend to a great extent on limited resources.

### *The Stress of Insecurity*

There is a growing literature<sup>39</sup> exploring the impact of precarious employment on workers.<sup>40</sup> Job insecurity and the threat of unemployment can lead to disease and high levels of personal distress, which can lead to longer-term health issues such as heart disease, depression, anxiety, and shorter life expectancy (World Health Organization, 2003). Greenhalgh & Rosenblatt (1984) defined job insecurity as “the perceived powerlessness to maintain desired continuity in a threatened job situation” (438). The belief and expectation that your job will exist next month, in four months, in one year, and so on is an important indicator of mental health.

Precarious labour not only presents workers with an elevated level of work stress, but also contributes to overall stress in workers in quite tangible ways through inadequate wages, poor diet, and lack of access to health services (Tompa, et al, 2007). Taking all of this into consideration, mental health issues are an expected outcome of precarious employment and places workers at high risk. In fact, “job insecurity and temporary employment are most consistently and significantly associated with mental ill health” (Vives et al, 2013:3).

Workers tend to feel a certain underlying and ongoing sense of anxiety about losing their job regardless of the permanency of their position or the economic climate. However, with the onslaught of neoliberal restructuring to both employment and healthcare services

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<sup>39</sup> International literature includes books and journals, as well as academic and industry conferences, all dedicated to examining the damaging physiological and psychological effects of workplace stress (for instance, Vives et al, 2012; Gagné & Bhave, 2011; Rossi, Perrewe, and Sauter, 2006).

<sup>40</sup> The health implications of this are especially important for research given Canada’s aging workforce.

in recent decades, the resulting cognitive threat of job loss, vulnerability, and economic stress have workers experiencing severe drops in their mental health (for more evidence, see Perrewé, Halbesleben, and Rosen, 2012; Burgard, Brand, and House, 2009; de Witte, 2005). Furthermore, the health risks associated with unemployment are positively correlated with the prevalence of unemployment in a particular geographical region, even taking into account other factors (WHO, 2003). In other words, the more people in your community who are unemployed the greater impact unemployment will have on your health.

There are three main ways that stress can have detrimental physical and psychological effects. First, one may trigger the other. Physical health problems, such as work-related injury or illness, may lead to psychological issues, such as depression. Conversely, continued psychological distress can contribute to physiological problems in the long run (Tompa, et al, 2007). For example, heightened levels of glucocorticoids in the blood, one product of stress, can lead to heart disease, stroke, or other ailments (Sapolsky, 2004). Second, stress can adversely affect other variables related to health, such as job satisfaction or social inclusion. Third, prolonged stress can lead to the development of alcohol/substance abuse and other negative coping habits (Tompa, et al, 2007).

Keep in mind the point of my discussion here is to point to the physiological and psychological damage related to precarious employment. Such damage indicates that the deepening precarity and alienation inherent to capitalist labour contribute to personal distress and illness experiences in workers in very tangible ways. The prevalence and intensity of these illness experiences, coupled with the medicalization of mental health, often results in the detrimental effects of precarity to be treated medically. However, the

argument remains that underlying, structural problems are not being addressed here, thereby limiting the possibility for genuine health.

### *Symptoms of Precarity*

Prolonged conditions of precarity produce chronic stress in people. Dr. Bruce McEwen (cited in Adler & Ostrove, 2006) developed the term “allostatic load” to describe the physiological effects of chronically elevated cortisol levels in the body resulting from continued stress. With the body’s “fight-or-flight” stress response stuck in a permanent state of low-level activation, allostatic load can be manifested through a variety of recurrent, unpleasant emotions and feelings such as anger, frustration, worry, exhaustion, and defeat. Current diagnostic boundaries outlined in the DSM classify the feelings associated with chronic stress over long periods of time (for example, longer than six months) as a mental disorder such as major depressive disorder (MDD) or general anxiety disorder (GAD). This illustrates the way in which working conditions that produce chronic stress can be diagnosed in individual workers as a mental disorder.

According to the DSM-V, people diagnosed with GAD worry excessively “more often than not” for at least a six-month period. This worrying interferes with professional and personal functioning and at least three of the following symptoms must be present – restlessness, fatigue, concentration difficulties, irritability, soreness of muscles, or sleep disturbance (APA, 2013). It is important to note that this symptomology closely resembles common illness experiences in precariously employed workers. Reports indicate that the total prescriptions for Effexor, introduced in 1998 for treatment of depression as well as GAD, grew more than any other prescription drug in Canada in 2002, with an increase in sales of 42.4%. Canadian physicians wrote over 15 million prescriptions for

antidepressants in 2003 alone. This translated into sales of over \$15 billion, which marks an increase of 14.5% from 2002 and sales continue to grow (Currie, 2005).

Gender-based<sup>41</sup> differences are important to take into consideration because they can skew perceptions of mental health in the population. The same underlying social conditions can be expressed as different illness experiences based on learned gendered reactions to external stressors, coping strategies, and manifestations of distress (Horwitz, 2013). Epidemiological research indicates that women have a higher rate of diagnosis of mood and anxiety disorders than men. Although this gap seems to be narrowing in recent years (Seedat, Scott, Angermeyer, et al, 2009), women remain twice as likely to be diagnosed with MDD. In fact, MDD is the primary cause of disability among women (Wilhelm, Parker, Geerligs, and Wedgwood, 2008; Noble, 2005). Interestingly, even though the rate of antidepressant prescriptions is uneven between women than men, rates of antidepressant use continue to rise for both. Furthermore, once prescribed there is no significant difference between the length of time men and women remain on antidepressants (Pratt, Brody, and Gu, 2011).

In regards to mental and physical health, generally speaking, it is better to be employed than to be unemployed. However, taking into account both physical and psychological hazards, working conditions have great bearing on health in workers, including feelings of anxiety and depression. Detrimental working conditions can lead to experiences of severe illness and even premature death (WHO, 2003). Studies point to several key indicators in the development of physical and mental health issues in workers

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<sup>41</sup> It must be noted that most existing psychological research on gender differences in mental health assume a cis-binary gender orientation between male/man and female/woman.

associated to issues of job insecurity and job quality, in particular economic and work-related stress (Schwartz, 2004), lack of autonomy (Tausig, 2013), and social isolation (Gadalla, 2009).

### *Perceptions of Workplace Distress*

Through a consideration of firsthand accounts it becomes evident that workers experience and cope with their work in diverse ways. Here, I draw from the impressive body of research on health and labour that has found precarious employment conditions to be tremendously stressful and damaging to workers. Workers are exposed to a range of working conditions and have access to varying levels of support. The restructuring of labour and upsurge of precarious employment can be regarded as levelling the playing field as more permanent positions are replaced with casual labour. This increases the vulnerability of all workers to structural oppression and exacerbates distress.

As I not turn to my interview material, two questions are important to consider are:

- What do workers need for work to be more sustainable?
- What are their actual experiences and expectations?

Participants' workplace experiences ranged from fulltime, permanent positions in the public and private sectors, to part-time, contract work, to unemployment. Everyone I interviewed had experiences of precarious employment, even if their situation was currently more stable. Three interviewees were unemployed, one of whom is a recipient of provincial disability benefits. None of what participants said they needed to be able to live and work well is being offered by current precarious working conditions. In their interviews, participants told me they considered living conditions that revolved around stability and security to be conducive to mental health. The unpredictability of precarious

employment makes establishing any kind of routine very difficult, and almost impossible to plan for the future.

For people already living with mental health issues, precarious employment presents a significant barrier to survival. Workplace benefits and accommodations such as sick days, stress leave, and health insurance can make the difference between being able to work and support one's self, or constantly fearing unemployment and falling deeper into poverty. For workers like Anna Murray, a 21-year-old part-time student and student union worker, working fulltime can be challenging due to issues of periodic, incapacitating pain that can occur without warning, as well as days when feelings of depression are more difficult to manage:

Being able to maintain a routine is huge. For me, being able to predict how you're going to feel from one day to the next is huge in terms of physical pain and mental state. I feel like I need this sense of stability and reliability... [Anna Murray]

Anna Murray's experience points to an aspect of precarious employment that often goes unnoticed. The conditions of precarious employment are often variable and unpredictable making it much more difficult to make plans or manage life outside of work.

The reliability of a permanent position provides workers with more resources and opportunities to manage stress and illness. However, for workers with access to benefits and accommodations, making use of these protections can be a source of stress and stigma. Interviewees spoke of management pressuring workers to push through without taking time off, or even making it more difficult for workers to access benefits. Recall that the main priority of functional health for capital is to increase the productivity of workers, including those experiencing difficulties due to illness. Also, diagnosed mental

disorders are often considered an existing condition, the development of which is not perceived as related to the workplace. For these workers, a diagnosis is often required to gain access to disability accommodations. Sarah Tony, a 32-year-old fulltime worker with accommodation needs, recounts times when management questioned their use of accommodations:

With my job I have a disability accommodation, but sometimes management... Like, if I take too many days off work they don't take into consideration that accommodation, and they come down on me. It's stressful. [Sarah Tony]

They explain that the bureaucratic process required for the approval of accommodation happens through a central office. This process is removed from the immediate workplace. The lack of communication between departments leaves management to make negative assumptions resulting in increased stress and tension.

When asked to consider further what conditions they would need in order to make work more sustainable, many interviewees pointed to the importance of recognition and meaningfulness. Participants expressed a need to be recognized in their work and to have their efforts acknowledged as contributing to an overall project. This echoes Marx's point about capitalist commodity production in which workers are alienated from their labour as an extension of themselves. Part of this recognition is fair compensation reflective of the value of their labour. Here, it is important to keep in mind that wages in a capitalist system are never a direct reflection of the value of labour due to the extraction of surplus value in order to turn a profit. Consequently, workers can expect to be objects of exploitation even in the "fairest" of conditions.

Precarious employment typically involves a focus on individual tasks, or in some cases piecework, which obscures the broader picture. Also, precariously employed

workers often do not feel visible in the workplace “community” as a respected member of the organization due to their temporariness. At the very least, workers expressed the need to find meaning in what they do. Meaningfulness may lead to some sort of work satisfaction. However, this is also very difficult to achieve given their alienation from the labour process.

Joanne Lewis, a 34-year-old childcare worker, illustrates their need for meaningfulness using their own work in childcare as an example. Keeping to a regular schedule of long days taking care of young children, Joanne is able to exercise some autonomy regarding the activities of the workday. They emphasize the importance of this type of meaningfulness in paid work. Joanne expands on this point:

I think people need to feel that what they’re doing is meaningful. I think that people need to feel appreciated by people around them, and the tasks that they’re doing are not useless tasks. Those are important things, but especially people need to feel compensated and respected for what they do. [Joanne Lewis]

They also say they feel a sense of satisfaction knowing that they are contributing to the development of the children.

This is not to romanticise the incredible energy needed to perform caring or emotional labour. Workers engaged in emotional labour are often judged, not on the quality of their task performance, but on the believability of their emotional expression as friendly or happy. Again, Joanne Lewis elaborates on this topic:

...If your cashier isn’t happy that’s worthy enough to write a complaint card. “The cashier wasn’t happy” – not the cashier smashed my eggs or, you know, triple charged me for something; it’s, “my cashier wasn’t very happy today.” It’s the same in daily interactions, especially women are sort of held to the standard of we should always have a smile on our faces. Like, it’s this tired trope of, “Smile, you should smile.” [Joanne Lewis, a 34-year-old childcare worker]

Joanne's account makes an important point regarding how hegemonic gender roles<sup>42</sup> not only influence the ways in which people cope with the negative effects of work, but also shape divisions of labour and the type of work a person is likely to be expected to perform. Dominant notions around femininity consider women to be natural caregivers and mothers. Childcare, eldercare, and customer care are all jobs that carry gendered expectations regarding the performance of feminine attributes such as pleasantness, cheerfulness, friendliness, and a desire to nurture and please. These taken-for-granted expectations make invisible the exhausting efforts that go into emotional labour that often go uncompensated and unrecognized. Kitty, a 32-year-old doctoral student, sums this up well and goes on to point out that these expectations are not imposed in the workplace, but in everyday life too:

And then this idea in sexism that women's labour, especially emotional labour doesn't count as anything. If you're raising up the community that's what you're meant to do, that doesn't count. It's just taken for granted that you would be doing that kind of work and that you would do that plus whatever pays the bills. It is super oppressive. [Kitty]

Women are expected to perform unpaid reproductive labour in their families and community as well as paid labour. As Kitty mentions, these gendered expectations leave many women exhausted as their efforts go largely unacknowledged.

Engaging in wage labour is a means to an end for many workers. There seems to be an understanding that workers sell their labour in order to be able to provide for themselves and enjoy some kind of leisure time. To some extent, this can be considered an offset to the inherently exploitative and alienating conditions of capitalist labour.

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<sup>42</sup> Hegemonic gender roles assume a binary approach to gender, as will be reflected here. However, research also exists that focuses on the experiences of a spectrum of gender identities and sexual orientations regarding work and health. For example, Smith, Wright, Reilly, and Esposito, 2008; James, 2009; Sabat, Lindsey, and King, 2014.

Many workers now do not expect wage labour to be anything but drudgery. In talking about their search for future employment, Ankur, a 24-year-old unemployed former student, speaks of work in this way:

My expectations right now are that I won't find satisfaction in employment. But, at the end of the day you have to spend money to provide for yourself and take care of yourself, it'll allow me to provide for myself. And that, hopefully, will more or less balance the mundaneness of whatever I end up doing. [Ankur]

Here, Ankur describes what can be perceived as a kind of deal between workers and wage labour where a lack of fulfillment and meaning is compensated for by a living wage. In this way, workers are expected to tolerate the alienating conditions of capitalist labour, but in return workers are able to purchase commodities and provide for their needs and, to some extent, wants. Precarious employment breaks this deal.

In current social and economic conditions, workers still perform the mundane tasks of wage labour, but without the security of being able to fully provide for themselves. This increased precarity heightens the desperation of workers in search of a living wage, which drives down wages and makes it challenging for workers to demand more. Joanne describes their work as a union activist and points out that when workers do fight back it is often an arduous and emotional battle:

A lot of the time people come to us with problems where they haven't been paid appropriately in their workplace. I would say the main thing is either they've lost their job and haven't been given termination pay or vacation pay, that's really common. Other areas are not paid properly for overtime too, and sometimes wrongful dismissal... It's really devastating to them. They think, "Everything I did was this job. I put so much effort and energy into this job and now, here I am. I have no way to support myself." [Joanne Lewis, a 34-year-old childcare worker]

Workers are not only outraged by the injustice of the organization of work broadly speaking, they are also hurt and angry about being taken advantage of so explicitly.

Clawbacks to the gains won by the labour movement in recent decades have meant losses in protections (for unionized workers who had protections). Of course, non-unionized workers never enjoyed these protections in the first place, and are finding the struggle for labour rights extremely difficult in light of increased attacks on labour. The casualization of labour creates conditions where workers are expected to perform efficient, high-energy, high-productivity labour, while at the same time clawing back wages, employment benefits, and job security. These losses contribute to a workplace that is highly exploitative and intolerant, even abusive, reinforcing a work ethic of fear where workers are disciplined to endure stressful and damaging conditions under the threat of unemployment.

Precarious employment conditions enable the occurrence of intimidation, harassment, and inadequate health and safety protocols in the workplace. Many workers face unsafe and oppressive conditions without support, which results in acute distress and illness. In cases such as these, the workplace has become so intolerable that the mistreatment of workers leads to the deterioration of work ability. This is reflective of the capitalist notion that workers are disposable and if one can no longer work they are simply replaced from a pool of surplus labour. Sarah Tony shares the story of an overworked colleague:

One older woman, well, in her forties, she took eight weeks off and now she's only back part-time because the stress just got to her. Another one, they were just really unfair with her for this specific thing, and she ended up taking a month off, and it was mental health. She was depressed and, even now, she has trouble. She's like, "I'm on the verge having a nervous breakdown." So, it's really sad. Another girl took a week off just to sit in her chair and look out the window. That's what she told me, she said, "I just sat in the chair in front of the window all day and time just went by." And that was from stress, from work. [Sarah Tony, a 32-year-old fulltime worker with accommodation needs]

Overwork and a lack of support can result in the development of major illness experiences, including total burnout. Burnout is also a real threat in workers experiencing chronic stress and precarity as they are pushed to a breaking point.

Workers who are unwell often seek out medical help in order to regain work ability or access time off. The voice of the medical authority is important to notice here. Also, employers and insurance providers will often require workers to be examined by “company doctors” or third-party representatives. Joanne speaks of the distress they experienced being harassed and bullied in a former workplace to point of illness:

I ended up having a panic attack in the workplace and after that I went to see my doctor. I said, you know, this is what’s been happening for a long time. I was going in and coping with it anyway, but now I can’t show up without panicking. I’m getting sick in the mornings, I’m not sleeping... And she said, “Yeah, you can’t go back. You need to take a stress leave. [...] Then they made me see a company doctor, which was a much less friendly visit. The company doctor said, “You should take a week, you’re exhausted. But then you should go back to work. [Joanne Lewis, a 34-year-old childcare worker]

When finally trying to access stress leave, a health benefit available through the employer, the extent and legitimacy of their illness experience was questioned with the burden of proof falling on the worker.

Workers confronted by unsafe, precarious, and violent workplaces are left to cope on their own. The responsibility of managing mental and physical health lands squarely on the individual worker. Joanne goes on to describe the ways in which their former employer would evade responsibility in protecting the safety of workers and how individual workers are blamed for illness experiences and injuries that are clearly work related:

I think in most areas it’s 100% on the individual. Certainly my previous employer, even when the job was causing the injuries – there’s a lot of repetitive stress – they would go to great lengths to try and distance themselves from any

responsibility. They would dig up records for training and claim, “No, this person was supposed to be doing this job in this particular way.” What they don’t add is the fact that if you do this job in a safe way you don’t meet your quota of what you’re supposed to do, and then you’re penalized for that. If somebody was injured they’d come up with a modified work protocol and then they just wouldn’t provide any support in the workplace to allow for that. There’d be a lot of negative talk about it like, “This person is obviously faking this to get out of work.” If people would try to call in sick they would say, “Oh, you’re faking it; it’s not a legitimate sickness.” There was no space for anything other than this health or faked health. So, energy drinks; people would drink the energy drinks all the time, that kind of thing. People would come in sick and just medicate to deal with that... The rare person would actually take a stand and say, “No, I’m too sick to work” and cope with the harassment that would come with that. [Joanne Lewis, a 34-year-old childcare worker]

Again, it is the integrity of the worker and not workplace conditions that are the focus of scrutiny. In this way, not only are workers expected to care for themselves, but they are also expected to deny themselves care in order to maintain work ability.

### **6.3 “Our Hands Are Tied” – Precarious Labour as Necessity**

Neoliberal restructuring and cuts to public funding – particularly in public sector industries, such as healthcare and education – have resulted in the methodical dismantling of fulltime, permanent employment. These positions have been allowed to atrophy and have been replaced by the integration of an increasing number of precarious, casual positions into the workplace. The post-secondary education sector is a salient example of this growing insecurity.

The example of precarious employment in academia provides an excellent example of neoliberal restructuring of work. A popular conception of academia is that it houses financially secure staff and faculty with high levels of education. Academics are seen as a privileged group of workers due to the social status accorded to those in higher education (i.e. professors and researchers). However, this is no longer the case as can be illustrated by the growing casualization of academic work and the creation of the academic precariat.

This example also demonstrates the diversity of precariously employed workers as inclusive of manual labour, caring professions, office work, service industry work, and intellectual labour. Here, the experiences of interview participants in academia, as well as my own as an adjunct, are highlighted.

I use the example of contingent academic workers, or adjuncts, to demonstrate several points. First, this example illustrates the ways in which employers point to neoliberal policy and austerity measures to justify the suppression of wages and monetary gains for workers. Cuts to public funding in the university sector is routinely presented at the bargaining table as the reason for which senior administrations cannot offer wage increases, increases in health benefits, longer term contracts, or even regulate class sizes. This results in an employer reasserting increasingly precarious working conditions as a necessity, claiming their hands are tied to do otherwise. Second, this example demonstrates the pervasiveness of precarious employment. Academia has traditionally been considered a privileged workplace consisting of tenured professors and permanent workers who are highly educated and well paid. This is not the case. The university sector has been experiencing increasing precarity since the 1970s. Senior administrations have systematically dismantled fulltime, permanent positions resulting in an increased reliance on devalued adjunct labour.

Third, this example illustrates quite well how damaging precarious employment can be for workers. The lived realities of contingent academic labour have received increasing attention in Canada as well as internationally. Existing UK research identifies occupational stress in higher education employment as an issue of serious concern with workers reporting that mental health has declined steadily since 2008 and female workers

reporting the lowest levels of “wellbeing” on average (Kinman & Wray, 2013). There is also a culture within academia that places importance on individual performance, competitiveness, and the ability to tolerate ongoing critique and pressure. This results in workers feeling stigmatized and considered failures for having mental health issues. Even so, mental health issues have come to be accepted as a normal part of academic work and are therefore overlooked as part of the landscape. Finally, many of the workers interviewed for my research have experience working in academia as both an adjunct or graduate student and can offer firsthand accounts. My autoethographic selections also speak to the variety of experiences of precarity in academia.

### *The Neoliberal University*

The casualization of academic labour has been central to the development of the corporate university (Shantz & Vance, 2013). Numerous scholars coming out of Canada, as well as the US, UK, and Australia have written about what has been termed *the neoliberal university*.<sup>43</sup> Here, emphasis is put on the ways in which privatization and cuts to post-secondary education have resulted in the increased casualization of academic labour. University senior administrations in Canada have systematically decreased the hiring of fulltime permanent faculty from 79.4% in 1999 to 65% in 2010; and increased casual, part-time contracts from 6.9% in 1999 to a more than double 15.2% in 2010 (CAUT, 2013). Highly exploitable, low-paid, temporary academic positions are now firmly embedded within the structure of the neoliberal university and are quickly becoming the norm (Gulli, 2009; Rajagpal, 2002). This has resulted in an academic workplace where

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<sup>43</sup> For a deconstruction of this term and a full examination of its implications, see Heath & Burdon, 2013; Morgan, Wood, and Nelligan, 2013; Donaghue, 2009; Bousquet, 2008; Brown, Goodman, and Yasukawa, 2006; and Slaughter & Rhodes, 2004.

contingent faculty and the work that they do are increasingly marginalized and devalued yet increasingly relied upon.

This trend comes out of the post-WWII doubling of university enrolment, which culminated into the 1960s “academic revolution,” but unfortunately resulted in massive underemployment in graduates in the 1970s (Moffat, 1980). This was worsened by a financial crisis leading into the 1980s and the intensified rollout of funding cuts that quickly followed, prompting university faculties to take a defensive position in order to guard against further losses (Neatby, 1985). For example, between 1983-84 the provinces of Ontario, Nova Scotia, and PEI experienced cuts of 32%, 36%, and an overwhelming 60% respectively (Smallman, 2006). It was then that the differences in compensation and status between tenured and non-tenured academics really grew (Rajagpal, 2002) and the use of precarious academic labour became significantly entrenched in the workings of the university.<sup>44</sup> This is reflective of capital using neoliberal restructuring and cuts to public funding as a reassertion for the need of precarious employment.

Employers often use neoliberal rhetoric regarding fiscal restraint to their advantage to justify further cuts while displacing blame by claiming, “our hands are tied.” In this way, provincial cuts to public funding have been downloaded onto precariously employed workers. For contingent academic labour, this downloading takes the form of the intensification of work (for example, increasing class sizes), monetary concessions and cuts to real wages, brinkmanship bargaining, and tuition hikes affecting student-workers. Furthermore, cuts in public funding also result in increased privatization of education. To

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<sup>44</sup> For a full analysis of trends in the progression towards precarious academic employment see Heath & Burdon, 2013; Ross, 2009; Bousquet, 2008; Smallman, 2006; Davies & Bansel, 2005; Tuckman & Pickerill, 1988; and Warne & Lundy, 1988.

compensate for the loss in funding, university administrations again claim to have no choice but to seek money from the private sector.

In order to appeal to private industry as a source of external funding, new marketing strategies have been rolled out over several decades to change the perception of a university as a place of “higher learning” or dedicated to the intrinsic “pursuit of knowledge above all else” (Dollery, Murray, and Crase, 2006). For example, promotional materials now incorporate the use of more competitive language such as “innovation” and “research excellence.”<sup>45</sup> This shift in rhetoric reinforces a broader neoliberal shift in university culture.

#### *Demanding Work – The Precarious Labour of Adjuncts*

Here, I will focus on adjunct professors (also known as sessionals, part-time faculty, or contract instructors, depending on the institution). Adjuncts are at once disregarded by university administrations and sent to occupy the front lines of providing education services for the university. They are simultaneously a necessary component of the corporate university and excluded from the academic community because of their temporariness (Gulli, 2009).

In Canada graduate student enrolment increased by 53% between 2002 and 2013, outpacing the hiring of tenure-track faculty (Field et al, 2013). The hiring of adjuncts has also grown to pick up the slack on larger class sizes. For example, York University saw a 135% rise in adjuncts from 2002 to 2013 compared to a 20% increase in tenure stream faculty. Representing a cheaper and more flexible workforce, up to 55% of undergraduate

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<sup>45</sup> See the Ontario Research Fund – Research Excellence, ([ontario.ca/business-and-economy/ontario-research-fund-research-excellence](http://ontario.ca/business-and-economy/ontario-research-fund-research-excellence)).

courses are taught by adjuncts in Ontario (Maldonado, Wiggers, and Arnold, 2013). Adjuncts are often paid a basic stipend per course that is not reflective of the actual responsibilities of the job or labour hours required in the design and execution of a course. Because adjuncts are often hired on a course-by-course basis, it is extremely difficult to piece together enough contracts to substantiate fulltime wages. Also, some collective agreements stipulate a cap as to how many courses a single adjunct can take on. For example, at Carleton University adjuncts cannot teach more than 3 full credits per year (CUPE 4600, 2013). With remuneration ranging from \$5584 (Nipissing University) to \$7665 (York University) per course, many adjuncts live below the after-tax Low Income Cut-Off (CAUT, 2013).<sup>46</sup>

Adjuncts represent some of the most precariously employed workers in academia. Typically, adjuncts are forced to reapply for their position every four to eight months. Workers have no reliable way of knowing beforehand what course will become available. Some courses may be offered with as little as two weeks to prepare for the term. There are adjuncts who become “freeway fliers,” forced to teach at more than one institution simultaneously in order to make ends meet, traveling between jobs (Muzzin & Shahjahan, 2005). Adjuncts are further alienated by their low social status within the academic community topped by tenured faculty. Also, contingent academic staff are greatly impacted by, but have little input into, the decisions made by the university administration. Research

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<sup>46</sup> Adjuncts may also be senior doctoral students who begin teaching in order to support themselves financially and compensate for inadequate funding. Graduate student adjuncts provide the university with an especially vulnerable pool of precarious workers. While teaching is a good way to develop professional skills, adjuncts who are also pursuing fulltime studies get caught up in the vicious cycle of double precarity as they depend on teaching to live *and* pay fulltime tuition. As a result, graduate student adjuncts drag out their time to completion due to the demands of teaching.

funding, technological training, professional development, and other resources that could be provided by the institution are limited, if offered at all (Rajagpal & Farr, 1989). Furthermore, research indicates that women are more likely to be precariously employed within academia (Field et al, 2014; Khosla, 2014; Vosko, MacDonald, and Campbell, 2009).

This denial of recognition and support can result in adjuncts feeling insignificant and invisible (Smallman, 2006), yet adjuncts are expected to carry themselves with professionalism despite their nonprofessional status (Gulli, 2009). The emotional labour required to do this can be significant. Furthermore, this overwork leaves little time to perform the research activities – such as conference presentations, publishing, and collaborating on academic projects – all of which are needed in order to be an attractive candidate for tenure-track positions. The insecurity and degradation that adjuncts endure can be draining. Many push themselves to work even harder to deliver quality teaching that truly reflects their talent in the hopes of advancement to a more permanent position (Bousquet, 2008).

There is growing evidence that adjuncts are suffering not just professionally, but psychologically and physically as well. Research shows that the degraded social status of adjuncts within the academic community, combined with income insecurity, underemployment, overwork, and high levels of work stress (Churchman & King, 2009), can result in serious consequences for their wellbeing. As Gulli (2009) comments, “[M]any promising scholars (after years of abnegation and study) will reach a point when they have to renounce (or realize that they have already renounced) their aspirations – for lack of time, energy, resources. The time comes when it is no longer possible to catch up. What

the institution does is consume their lives, destroy their dreams and concrete possibilities” (20). The responses to mental health issues in academia for both adjuncts and graduate students have been sorely inadequate.<sup>47</sup> In fact, the acceptance, and even expectation, of mental health issues have now become part the culture of academia.

### *Academia’s “Culture of Acceptance” of Mental Health Issues*

Discussions of mental health within academia are on the rise and some have articulated what they refer to as a “culture of acceptance” of mental illness in academia (Anonymous Academic, 2014), which is tied to taken-for-granted perceptions of stress and overwork as a normalized part of academic life given the competitiveness of the job market (Fullick, 2011; Turner, 2014). This internalization results in imposing expectations of perfectionism, intense scrutiny, and an exhausting work ethic onto precarious academic employment, which makes workers especially vulnerable and susceptible to psychological distress.

Personal accounts of adjuncts and graduate students in several online articles and blog entries emphasize their experiences of subordination due to their casual status within the academic institution and feelings of immense pressure to develop a recognized professional name (Muller, 2014; Shaw & Ward, 2014; Shaw, 2014). Based on these accounts as well as my own experience, I identify five major problems around precarious academic labour - 1) difficulties in achieving work-life balance; 2) the stress of having to withstand intense and continued scrutiny from supervisors, colleagues, and student

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<sup>47</sup> The exploitation of adjuncts is further complicated by the popular perception that academic work is a grooming process as opposed to an employment relationship with the university. This perception of working in higher education as a privileged position relative to other professions works to silence the concerns of adjuncts and erase their experiences of marginalization within broader society and even the labour movement.

evaluations; 3) increasing workloads and feelings of social isolation; 4) the stress of conflicting roles and unreasonable job demands; and 5) high levels of stigma around mental health issues that imply sufferers are unable to successfully compete within academia.

One recent doctoral graduate and researcher, writing under the nom de plume “Anonymous Academic” (2014), describes their experience in academia as such:

I have experienced the effects on my mental health, and I have witnessed the culture of acceptance surrounding this issue. Among the people I do know who have done PhDs, I have seen depression, sleep issues, eating disorders, alcoholism, self-harming, and suicide attempts. I have seen how issues with mental health can go on to affect physical health. During my PhD I noticed changes to my skin, and changes in my menstrual cycle, which persist to this day. Let us not forget that in the majority of cases, all this comes at a time when you are likely to be suffering from financial instability, or are forced to make uncomfortable changes to your personal circumstances to accommodate your studies (para 13).

It is clear by this description that the working conditions and normative expectations within academia can be quite damaging to the mental health of students and workers in positions of precarity and subordination. When mental health issues arise counselling services are typically understaffed and inadequate, and there is often an expectation of sustained ability through times of increased distress even at the expense of overall health.

Kitty describes their previous academic supervisor’s reaction to limitations around work ability resulting from mental health issues:

What I would get a lot of from my previous advisor is, “Why can’t you set a schedule for yourself?” I had known this particular prof. from my 2<sup>nd</sup> year undergrad all the way up to my PhD, and I was so successful in those years it was kind of like, “I don’t understand. You were able to do it before. Why aren’t you capable now?” And I remember saying, “Well, I have anxiety and mental health problems,” and he’s like, “Well, we’re all a little mentally ill.” [Kitty, a 32-year-old doctoral student]

This dialogue illustrates a few assumptions around work ability and distress in academia. First, there seems to be an assumption that if someone has demonstrated consistent work

ability in the past, they should be consistently work able moving forward. This assumption of ongoing work ability may lead to questioning the nature and legitimacy of illness experiences, as well as victim blaming. Second, the assumption that work ability will be maintained even when experiencing mental health issues and distress serves to minimize the illness experience. There is also a, perhaps unintentional, shaming involved in implying that illness experiences are under the control of the individual and therefore should not be allowed to interfere with work ability. Third, and particularly interesting, is the assumption that everyone is “a little mentally ill.” I put forth that the idea that every person has mental health issues is reflective of a dysfunctional society. On the one hand, it makes sense that a harmful and dysfunctional system would act as a barrier to a person’s ability to function. This would suggest that a structural focus is needed instead of simply examining individual circumstances. On the other hand, and to the advantage of capital, the assumption that everyone is a little mentally ill insinuates the idea that mental illness is so common as to cease to be of importance. It also reinforces the healthism-related stigmatization of people who have difficulty managing their own health issues.

The expectations placed on adjuncts are compounded by their low-level ranking on the academic hierarchy, which results in a double standard in the way adjuncts and tenured faculty are treated by the university administration. Huberman-Arnold (1999) describes the double standard by which adjuncts are treated as highly damaging to workers:

No one asks us what we have done during the past year, nor what we plan to do in the future. This may be because it is taken for granted that we do not do anything that matters during the year, or that no one cares whether we do or not. The university gets the benefit and credit for our professional activities, while we get no credit or benefit at all (1).

To be clear, tenured faculty also face immense pressures and scrutiny in their job. However,

they also tend to have stronger collective agreements, job security, superior employment benefits, and cultural capital. The disconnection felt by precariously employed workers due to their casual status is deeply isolating. This alienation prevents many from creating bonds with co-workers or developing any sense of belonging within the employing institution.

Intentionally or not, tenured faculty can disregard or be dismissive of the work adjuncts actually do. I remarked on one such instance when I encountered one of my undergraduate students in the hall looking for my office and they told me the following:

I was having a hard time finding your office so I asked a prof. They asked me your name and they said, “Oh, she must be a contract instructor [adjunct]. Their offices are all down there.” [gesturing down the hall] I just thought that was disrespectful. [Journal entry, March 2014]

I recorded in my journal that I responded to the student with, “Yes. Yes, it was.” However, my reaction as I reflected later was “What could I say?” I felt that this particular prof had been thoughtless, and I took it as a slight. Not against me personally, but against the fact that I was an adjunct. Taken by itself this singular gesture is not important, nor does it affect my life; however, this one instance reflects an entire academic hierarchy that routinely mistreats adjuncts while expecting excellence in return, and *that* bothered me.

The culture of acceptance of mental health issues in academia reflects the damaging effects of precarious employment. Academia represents a kind of workplace that prides itself on rigour and drive. The expectation is that people engaged with academia are busy and under stress. Even though mental health issues are clearly acknowledged as a common occurrence, academic workers and students are expected to carry on and even flourish. This falls perfectly in line with the characteristics of individual resilience in that individuals are expected to absorb damage and remain a competitive participant in the capitalist market. Following this logic, functional health is the only conception of health considered.

Regardless of one's illness experiences, and even in the case of confirmed disease, one is excluded from "being" sick as long as job functioning remains. The measure of health then, is the ability to carry on with your work.

#### **6.4 Precarity and the Cycle of Survival**

Cuts to social assistance results in greater precarity for workers who have no option but to take whatever job they can get. The removal of social security and alternate means of survival outside of wage labour is crucial for capital to ensure the disempowerment and compliance of workers. For capital, the goal is to make it so the only way people can survive – pay rent, receive healthcare services, eat, etc. – is by way of the capitalist market and commodity consumption. Again, just as with health behaviour, there is a moralizing tone surrounding people's duty to contribute to the capitalist economy as productive workers. The creation of a two-tiered social assistance program separating workers<sup>48</sup> unable to work from those who are able, but are not working, creates another stigmatizing dichotomy between the deserving and undeserving poor. This results in marginalized communities, who either have more difficulty finding work or who cannot work, as left uncared for and perceived as unworthy of help.

There are major difficulties and discrimination around gaining access to programs, such as the Ontario Disability Support Program (ODSP). Here, I again turn to interview excerpts and autoethnographic accounts to provide personal experience with navigating

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<sup>48</sup> It should be noted that many people who are unable to work do not identify as workers. I often use 'workers' as a blanket term in my research incorporating a broad definition of the working class. Here, the working class includes any person who does not accumulate wealth off the backs of workers (for example, the owners of the means of production). However, out of respect for those who do not self-identify as workers, I also refer to the 'unemployed poor.'

such a system. Part of this conversation includes the decision to not engage with social assistance programs because of feelings of shame or due to the additional stress and humiliation involved in trying to get access to state support. Interviewees in this situation talk about turning to their parents for financial support in order to live, which is also a point of shame. Again, this type of scenario captures quite well the expectations around individual resilience.

The expectations around individual resilience can be quite devastating. Marginalized groups, suffering from prejudice and discrimination, are particularly affected. Joanne Lewis speaks of a former workplace as an illustration of typical employment equity and workplace issues experienced by women:

...the positions that had almost no chance to move up in the company were largely given to women; most of the cashiers were women or young men who were still school aged. Adult men were given jobs that there would be a potential for advancement. Yet, most women wouldn't, they'd have to start in this role and sort of have to fight their way into another job; whereas men got to start a step higher. Even if everyone was paid the same amount, it was just the time you'd have to spend to advance and basically, who's voice... At the time I rose up to an assistant store manager level, out of twelve roles in the city there were three women and nine men, which didn't represent the demographics in the workforce at all. In fact, areas around some of the things that people would be asked to do, there was real imbalance because women had caregiver roles at home. People with children were excluded from opportunities because they couldn't work sixteen hours straight. There was just this sexism all over in the workplace, as well as sexual harassment, which was epidemic, basically, a constant from customers and co-workers. [Joanne Lewis, a 34-year-old childcare worker]

This is compounded by restrictions around access to social assistance, or any state protections. The inadequacy of institutional responses and lack of support leaves oppressed people in continual survival mode. Individual resilience then, constructs health as the ability to endure constant crisis. Kitty reflects on this:

I just think of people I know that are structurally and systematically shit on constantly. Sex workers, for example – literally, it’s okay to murder you; or it’s easily justifiable to murder you or to assault you because you failed in all of these ways. And that’s shitty to internalize. There’s a lot of shame and stigma around that. It definitely kills people’s spirits, that’s what it’s intended to do. But at the same time it’s so contradictory. It’s like – I want to kill your spirit and wound you, but I also expect you to be able to deal with that and pick yourself back up; you can’t do it because you’re horrible and weak, but you should do it and you need to do it, and if you don’t do it we’re going to continue to impose upon you. And that’s hard to deal with. I think, a lot of the other institutions like, medical or even the child-welfare systems and stuff like that, their existence is not health. Even health organizations, I feel like when you get down to it, healthy people is not necessarily the outcome. It’s particular types of people doing particular types of things and fitting certain definitions of what’s healthy. Even around so much fat-phobia... like, “wellness” is if you’re fat then that’s the end of the fucking world, and you need to blah-blah-blah and you’re all these things. That is not helpful and the people always get the blame shifted right back on them for the conditions they can’t at all control. [Kitty, a 32-year-old doctoral student]

Mental health issues, stress, and adversity come to be expected as outcomes of work and life.

### *Social Insecurity and the Dismantling of Care*

Cuts to social assistance programs threaten people’s ability to survive. Without these protections people are expected to engage in paid labour as the only way to survive in the capitalist market. This is reflective of capitalism’s reliance on the capacity of people to commodify their labour. Capitalism, by its design, cannot function without human labour to perform the tasks required to produce goods and services. The structural violence inherent in capitalism disciplines people who do not fulfill their enforced obligation to participate in the market. They experience social isolation and shame, and are prevented from meeting their basic needs. In such a system the inability to work is a terrifying prospect. The anxiety experienced in response to this threat is profoundly affected by the amount of social protections in place to compensate and accommodate for a limited capacity to work (be it short or long term). The capacity to survive without having to rely

on the market to make a living reflects a *decommodification* of labour, which is a major offset for the damaging effects of precarious employment (Vives et al, 2013). The effectiveness which a welfare program addresses the basic needs of the population is a direct indication of its decommodifying potential. In essence, the total decommodification of labour would eliminate the need for people to participate in a capitalist market (Panitch, 2011).

Motivated by “[t]he unfairness of a society that neglected the contribution of the working class while disproportionately rewarding the idle rich...” (Jackson, 2005:141) welfare state policies are ideally created as a way of redistributing wealth. A strong welfare state can offer workers protection in times of underemployment, unemployment, and overall job insecurity. Social assistance can keep workers from falling into poverty during work interruptions for health or disability reasons, or when fulltime and/or permanent work is not available.

However, the current reality is that due to the deregulation of labour and the dismantling of social protections, quite often precarious workers are trapped in cycles of financial insecurity for years. This insecurity leaves many with the bare minimum of state allowances to retire with or fall back on in case of work interruptions (Gulli, 2009). That said, it would be problematic to compare current social and economic conditions to some Keynesian “golden era” in which social rights stood at the forefront. As part of an effort following World War II (WWII) to legitimate federalism, resources were redistributed through the state. In this way, the post-WWII Canadian welfare state<sup>49</sup> was built upon

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<sup>49</sup> For a more complete history of welfare and workfare public policy see Hunter & Miazdyck-Shield, 2006.

providing basic benefits to its citizens as a pacification tool and to keep the population, and importantly labour, on side. In other words, the welfare system is more indicative of strategic state manoeuvring than of the valuing of social or human rights. State provided benefits have since been progressively dismantled by a post-Keynesian neoliberal backlash (Siltanen, 2007).

The dismantling of the welfare state has shifted the implicit containment and pacification responsibilities of managing people in distress to the medical profession. Again, gaining access to benefits typically involves the authority of a medical expert to provide consent and classify recipients as “sick.” Where medical authority is not required as part of the process, social assistance is significantly less and stigmatization is more intense due an assumed ability to work. Mark, a 36-year-old ODSP recipient, explains how this has created two classes of poor – the deserving and undeserving:

I wish I knew more about the history of it all, but welfare was instituted during the Depression. It came partly out of a lot organizing and resistance from unemployed workers and unemployed people. And I’m sure that Disability is tied to that. It was both a victory and is something that the government could do to calm people down. So, with Disability and welfare, it’s like, deserving and undeserving poor. Disabled people are the good poor people who really can’t work. People on welfare you know, “they really could work.” And that’s why they get \$560 a month, which is in Ottawa not even vaguely enough to survive, and people on Disability get \$1100 a month. You get twice as much money for being the good poor people. [Mark]

Here, the development of social assistance and welfare seemed to have been created as a way of diffusing resistance on behalf of a desperate working class. Over time attitudes towards people receiving benefits have become increasingly stigmatized and untrusting.

This notion of the undeserving poor has made it very difficult for unemployed people in crisis to gain access to assistance. People in general seeking welfare benefits are often treated with unwarranted suspicion thanks to actions such as former Premier Mike

Harris' very public campaign against welfare fraud in Ontario. The strategic underlying message being that welfare *is* fraud, thereby making the association that people on welfare are immoral, criminal, and undeserving (Chunn & Gavigan, 2004). Social assistance recipients are often blamed for their own state of poverty through the propagation of inaccurate and stigmatizing notions of "the poor as lazy; they don't want to work; I did it why can't they" (Karim, 2011:2). As Sarah Tony observed about this:

Right now, a lot of people are really hard on people with disabilities or who are on welfare. And you know, there's a reason why; they're not lazy. Some people just can't. Like, they don't have skills or... It's not reasonable for you to expect everybody to be on top of everything and sometimes you need help and it's not always there. [Sarah Tony, a 32-year-old fulltime worker with accommodation needs]

Sadly, access to support is often an invasive and dehumanizing process. Mark elaborates on the frustrations and stigma involved:

I interact almost not at all with ODSP. I can probably get more money. I can probably do things, I don't know, but it's such a negative experience pretty much any time that I interact with anybody that I just avoid it. I fill out my forms and I hand it in. And there is stigma. I don't tend to think of stigma, but it definitely exists. It's a real thing. People get judged. I remember when I was looking for apartments and I say that I'm on ODSP for a while all my landlords were asking me if I was a drug addict. They'd be like, "Are you a drug addict?" I'm not sure what that has to do with anything. Some people judge poor people; judge people on welfare, and they judge people on Disability too. Usually less harshly, but again, people are seen as kind of broken. Disability is so helpful and necessary. I don't know what I'd do without it. I'd have a fucking problem. And they make it so dehumanizing, frustrating, that people don't get access to services that they deserve. Even the services that they could access, they don't know about them. It's designed to keep people getting as little money as possible to just kind of, keep eking by. [Mark, a 36-year-old ODSP recipient]

The stigma Mark refers to here seems to be applied to anyone who is unable to work for any reason.

The increased casualization of labour places workers in increasingly precarious financial situations. Contingent and contract workers often cannot reliably predict when

they will be able to find work. It is quite easy to imagine that precariously employed workers may find themselves on social assistance once their employment insurance benefits run out. Also, without access to health benefits precariously employed workers are in danger of falling into crisis if they experience temporary illness or get injured and have to convalesce. I found myself in a similar situation after experiencing a brief illness. I was on social assistance for three months before feeling able to begin a new job. My first encounter with the welfare office was an emotional experience and left me with the resolution that ever going through that process again would truly be my last resort:

I went to the welfare office today in Magog. I have never been so mad or humiliated. This woman started talking to me while I waited to be called in. She was telling me how she wouldn't cash her cheques at the bank close to where she lives. She drives to Sherbrooke [a town 20 minutes away] instead because she doesn't want anyone to know she's on welfare. I thought, "No kidding." I remember [my friend's] dad talk about how he doesn't want his taxes going to people who don't want to work. Ugh, I'd like to see him raise a kid with no help. Finally got called in and this woman hands me a paper and tells me to write down my monthly expenses. Of course, this is all happening in French. I notice there's a box of Kleenex on her desk. I don't know why but I'm about to find out. I write down everything – food, tobacco, rent, gas, bills, cat food... She looks at it and says, "That's way over budget. How are you going to pay all this with what you'll get from us?" [\$575 at the time] I'm like, you tell me!! I don't know! I tell her I'll cut some stuff if I have to. "Like what?" I don't know... "I'll quit smoking." Whatever, just get me out of here. She starts laughing!! She's like, "Yeah, right. People on welfare never quit smoking." I could not believe it. What are they even asking me this for?! I started feeling a lump in my throat and I'd rather die than start crying. "Is this what you do?! You trick people into filling this out so you can accuse them of getting money on the side?" "No. We just need to know how you're planning to pay for all this." She pushes the Kleenex box my way. I'll just use my sleeve, thanks. Keep your fucking Kleenex. So, I'm supposed to get a cheque. I thought for sure I wouldn't get anything. Who the hell are they to evaluate me? NEVER AGAIN. [Journal entry, June 2002]

I remember feeling shame, embarrassment, and so much anger. I was made to feel as though I was expecting money that I had no right to ask for, even though financial aid was what social assistance was supposed to provide.

I wrote the above journal entry upon returning home after the appointment. I was apprehensive about applying for assistance in the first place because of the stigma and negative assumptions expressed by people around me. This was made worse by the shocking attitudes of the people who actually provide these services. However, the real struggle was trying to figure out how to survive on what little I did receive. As Mark mentioned earlier, social assistance and support services are currently insufficient to address the needs of the poor and precariously employed of Canada. This has not gone entirely unnoticed. In 2008, the international anti-poverty group Avaaz listed Canada as one of the three top nations actively contributing to world poverty (Avaaz, 2008). The way social benefits are rolled out can actually contribute to poverty and social isolation. Joanne Lewis articulates this problem and identifies that the unemployed poor are not only alienated from participating fully in their communities due to poverty, but also from the normative experiences of paid labour:

We know people who aren't working right now for various reasons and some are for health reasons and they end up in an enforced poverty because any sort of benefit is very low. You can barely cover housing with it. And they tend to get isolated too because so many other things focus around work like, a lot of people they socialized with as co-workers, they form families centered around the experience of working. Somebody who isn't working gets isolated in two ways – partially just from the poverty, and partially from not having access to that experience that is supposed to be the experience that people are having. [Joanne Lewis, a 34-year-old childcare worker]

Cuts to public spending have resulted in the gutting of employment programs, as well as welfare (or now, Ontario Works) and ODSP, with rates far below the cost of living forcing some workers to accept precarious minimum wage jobs (Clarke, 2014).

Similar to foreign work programs, current social assistance programs hold people in poverty, which leads to desperation and disciplines workers into complying with working conditions that would otherwise be unacceptable. Mark offers insight:

If somebody had the alternative of working 40 hours a week at \$8 an hour minus taxes in this terrible job, some terrible service industry job or Walmart, or working at... Minimum is what, \$10 an hour now? So, we'll say \$10. That's \$400 a week, \$1600 a month minus taxes is like, \$1300 a month. Well, Disability's \$1100. So, we could maybe get by on Disability. Welfare is \$560. You can't. So, you'll have to work in these terrible conditions. People are that much more constrained, they have less options, less alternatives. They need to hold on to that job because there's no alternative, which means don't cause a fuss, don't start unionizing, don't stick up for yourself, take less risks, take any job. Whatever job you can get is the one you'll take because you need something. [Mark, a 36-year-old ODSP recipient]

In workfare systems, taking on this kind of employment is a condition of receiving assistance. Exploitation is embedded in conditions of social insecurity resulting from the dismantling of social assistance. Here, the unemployed poor provide cheap labour to employers and increase the generation of profit.

Using social assistance as a pool for cheap labour is only possible in so far as recipients are able to work. Those who are not, or those who refuse for any reason, are often threatened with the removal of support and sent deeper into crisis. Removing access to the resources needed in order to participate in the life activities of their communities isolates and erases people. The unemployed and those deemed by the state as unable to work are rendered near voiceless on the political stage, save in their resistance. Concurrently, poverty and issues of economic justice are deemphasized in the public eye in order to bolster positive claims regarding economic prosperity entrenched in neoliberal ideology.

## **6.5 Conclusion**

Chronic stress, insecurity, financial hardship, and overwork are all components of precarious employment and associated with declines in mental health, carrying long-term negative effects. This association indicates that broader social and economic factors must not be overlooked when considering the mental health workers. The restructuring of labour has systematically chipped away at the gains won by the labour movement, making the workplace increasingly unsafe and damaging. Precariously employed workers are especially vulnerable to distress and the development of illness. When combined with a lack of autonomy on the job and a sense of social isolation, the chronic stress caused by precarious employment puts the mental health of workers in real jeopardy. Medical help, often through technologies such as pharmaceuticals, can be more or less effective at alleviating symptoms of distress. However, this type of response is limited in that the alleviation of individual symptoms does not address the structural dysfunction present in precarious work arrangements. A reliance on medicine, in this case, to treat damage that is already done is not an avenue to genuine health.

Health studies indicate that job insecurity and the threat of unemployment can result in chronic stress and contribute to serious drops in physical and psychological wellbeing. In addition to causing damage, prolonged distress can also exacerbate existing conditions making them more difficult to manage, and lead to further damage through the adoption of negative coping habits, such as self-medicating and substance abuse. Due to the medicalization of mental health, distressed workers seek medical help. The effects of prolonged precarity and chronic stress on the body commonly lead to the diagnosis of a mental disorder such as major depressive disorder or general anxiety disorder, both of

which are treated with antidepressants. This has resulted in a significant pathologizing of workers, especially women. Not only is the diagnosis of mental disorders gendered, work expectations around emotional labour are as well. Normative assumptions regarding the performance of femininity renders the exhausting efforts of emotional labour invisible as taken-for-granted feminine characteristics.

Firsthand accounts of the conditions of precarious employment provide further insight. Here, I presented a series of excerpts from interviews I conducted with participants. The excerpts illustrate the various ways that workers understand, experience, and cope with their working conditions. Workers identified several key factors that they considered important to the maintenance of health and contribute to the sustainability of workplace conditions; among them were stability, predictability, meaningfulness, and access to accommodations. It would seem that all of these are contrary to the conditions of precarious employment, thereby reiterating its potential for harm. The upsurge in precarious employment has resulted in disillusionment with the trade-off of wage labour. Workers often consider a job as a means to an end, not necessarily their passion. The expectation being that, in exchange for labour, workers are provided with the means to live. This is no longer the case, as precarious employment does not guarantee a living.

A central point here is that, even in work arrangements that offer all of the qualities identified by the interviewees, genuine health can still not be attained due to the inherently exploitative and alienating nature of capitalist commodity production. The priority for capital is the extraction of surplus-value from workers and the generation of profit. Often management will protect those interests by pressuring workers to push through illness and distress to maintain work ability. Again, the responsibility to maintain functional health

and work ability is placed on the individual worker. This tactic is reflective of the initial goal of the capitalist system, which is to remove all other means of subsistence from workers and make them totally dependant on wages and commodities for survival. This goal is also reflected in the neoliberal restructuring of labour.

The expansion of precarious employment in a diversity of sectors and professions has begun to shatter the illusion of the “upwardly mobile worker” and have disturbed the idea that highly educated, highly skilled workers will be rewarded with highly paid (or at least permanent and fulltime) positions. This is illustrated by the example of contingent academic labour. The creation of the neoliberal university is indicative of broader changes to political and economic landscape. Cuts to public funding in the post-secondary education sector have resulted in the increasing privatization of university campuses and the dismantling of permanent, fulltime academic positions. The advent of neoliberal policy and fiscal austerity has been used by university senior administrations as a justification for increasing conditions of employment precarity under the guise of necessity.

Adjuncts represent a cheap and flexible labour source for universities, resulting in the increased reliance on adjuncts to perform essential education services. This is typical in precarious employment in that often workers are contingent in status only as the work adjuncts do is a permanent component of the institution, even if their position is not. Even though adjuncts are highly skilled workers, they are also highly replaceable. There is also the danger that the deregulation and restructuring of employment will continue to erode conditions for all workers. Employers will often aggravate relations between more privileged workers and the more precarious. Whether they are tensions between tenured faculty and adjuncts, the employed and the unemployed, or Canadian workers and foreign

labour, capital benefits the most from the lack of worker solidarity. This scarcity contributes to an increased competition, exploitation, and desperation among workers pursuing limited career opportunities.

Academia can be an environment of chronic stress, continued scrutiny, unreasonable job demands, and expectations of excellence. Workplaces such as these place a high emphasis on flourishing under pressure and individual reliance. Even though levels of distress are evident in academia, mental health issues that interfere with work ability are stigmatized and individuals are considered incapable or unable to compete and achieve success. It is common for the individual to be questioned or blamed for their issues, or for their distress to be minimized as a normalized part of being an academic. Consequently, academia has been criticized as cultivating a culture of acceptance of mental health issues. This culture of acceptance recognizes the prevalence of mental health issues and reinforces silence around them through their dismissal.

Capitalism relies on the commodification of labour in order to function. In order to trap workers in a cycle of precarity, all other options to make a living must be cut off. This includes the dismantling of social assistance programs that may provide workers with an alternative, if only temporarily, and represents a slight decommodification of labour. Not only are workers expected to participate in the capitalist market, they are expected to want to participate. Perceived workers are stigmatised as “lazy” or “undeserving” if this duty is not actively pursued. Just as with healthism and the division between the deserving and undeserving sick (the undeserving sick being those who are considered to be to blame for their own sickness by not conforming to socially sanctioned health behaviours), a duty to work creates the division between the “deserving” and “undeserving” poor. The deserving

poor are people who are not able to work. In other words, they do not possess work ability and are therefore entitled to social support, however begrudgingly it is awarded. The undeserving poor are those who are perceived as possessing work ability, but for whatever reason, still do not participate in paid labour. To capital and the neoliberal mentality, this is unacceptable and should be punished.

In this way, barriers to social assistance and cuts to social services, such as Medicare, threaten people's survival, particularly for members of marginalized communities. Social insecurity reinforces and work ethic of fear and forces the unemployed poor to take low-paying, high-stress precarious employment or face abject poverty. This insecurity also contributes to a reserve army of cheap labour, drives down workplace standards, and disempowers labour. Workers are disciplined to endure distress and damaging working conditions with an emphasis on the resilience of individual workers, which enables further damage.

All of this illustrates the structural violence inherent in the capitalist system and its compulsion to destroy the very resources, in this case human labour, that it relies on to exist. It is therefore interesting and important to explore the ways in which workers and unemployed persons articulate their own individual experiences and understand them within the social context of broader structures.



## **Chapter 7: Precarious Conditions / Precarious Treatment**

## **7.1 Introduction**

As outlined in the previous chapter, workers and the unemployed poor experience, understand, and cope with distress in various ways. The observations of those who struggle with survival in a system of precarity are important to any discussion of work and health. Therefore, the purpose of this chapter is to continue to explore the personal narratives of interviewees and the connections they make between their individual circumstances and broader social structures. This chapter focuses on participants' reflections around 1) the different ways mental health is perceived in society and what is required for people to maintain functionality, 2) medical and social responses to mental health issues, 3) lived experiences navigating the medical community, and 4) the meaning and expectations attached to antidepressants as a response to personal distress, as well as the ways in which the use of antidepressant medication can affect everyday life.

I end the chapter with interviewees' reflections on what is required in order to achieve genuine health. I discuss what aspects of their lives they highlight as currently fostering genuine health in ways that do not rely on commodity consumption, and therefore present an alternative to capitalist notions of functional health tied to productivity and profitability.

## **7.2 Beyond Individual Pathology – Situating Structural Dysfunction**

Efforts to address mental health issues in precariously employed workers and the unemployed poor require a close examination of the broader social and economic conditions of contemporary capitalism. As such, issues of structural oppression and socioeconomic inequality must be taken seriously within mental health discourse. For this to happen, distributions of mental health across populations must be understood as firmly

rooted in social processes (for example, see Fenwick & Tausig, 2007). Throughout this dissertation I have spoken of “personal distress” as in fact a reflection of the conditions of capitalism. Here, individual “dysfunction” can be reframed as one’s inability to adapt to dysfunctional social and economic conditions. If capitalism, as a social and economic system, is understood as incompatible with genuine health, then perhaps becoming unwell in a capitalist system is to be expected.

Interviewees generally perceived mental, and to a great extent physical, health in two main ways – 1) as a health discourse framed within the context of the demands and expectations of capital and the institutions that reinforce them, namely the state, and 2) as a more genuine sense of health tied to the fulfillment of the actual emotional and physical needs of humans. This is perfectly in line with the distinction between conceptions of functional vs. genuine health. All of the interviewees identified aspects of current society as stressful, overwhelming, and contributing to psychological harm. Many specifically named capitalism as an exploitative system and pointed to the ways in which it also aggravates social conflict and prejudice. They explained this as dehumanizing to marginalised communities, who are treated as a source of cheap and disposable labour on a global scale.

One recurring theme was the belief that genuine health was not possible due to the trauma to both mind and body caused by work stress, poverty, and structural oppression. As remarked by Mark, “We live in a dysfunctional society and the simplest way to function in a dysfunctional society is to be dysfunctional.” Kitty takes this point further and implies that the idea of being able to function in an oppressive system without experiencing feelings of distress is a disturbing concept:

I don't think it's really even possible to be perfectly healthy because society is super duper unhealthy. I feel like if people adapt well to these conditions that's a sad thing. If you can totally adapt to capitalism and colonialism and sexism, and you're doing fine, then that freaks me out a little. [Kitty, a 32-year-old doctoral student]

In this way, distress can be understood as the appropriate response to deepening precarity, insecurity, and exploitation. The expectation that people should be able to function without issue in such an environment is actually what should be considered dysfunctional.

*"Everyone Has Mental Health Issues"*

Another major theme coming out of the interviews was the notion that everyone, at some point, will experience mental health issues. The quantification of society has led to health, medically speaking, often defined according to measurements of normal functioning in the body. The notion that health, to some extent, is synonymous with normalcy feeds into the perception of "health as normal" and "illness as abnormal." This perception of health and illness reinforces the idea that illness experiences are a result of the body not working properly. Some interviewees picked up on this perception. They explained that mental illness cannot and should not be assumed to be a sign of abnormality. They argued that, given the trauma and stress caused by current working and living conditions, mental illness is actually a healthy response and a sign that the body is in fact functioning properly.

The link between health and normalcy also speaks to the stigmatization of mental health issues still occurring today. For instance, Mark speaks to this and to the moralizing connotations of categorizing people with mental illness as separate from the rest of society:

...the way your body and mind cope with trauma is not disordered. It's doing its best. We're doing our best. I'm doing my best and there's nothing disordered about it. There's nothing wrong or abnormal about people with mental health issues. Everybody has mental health. Almost everybody will experience some sort of acute

or serious mental health problem over their lifetime. Some people have experienced far more than others. There's no order and disorder. There's no normal and abnormal. There's no good and bad. [Mark, a 36-year-old ODSP recipient]

I have argued that the destigmatizing effects of the medicalization of mental illness are limited. By locating dysfunction in the body and not in the character of the person, the classification of illness as a disease removes personal blame and judgment. However, medicalization also depoliticizes illness experiences by separating them from contributing factors rooted in broader social structures. This also serves to individualize mental health and place the responsibility of maintenance and recovery on individual patients under the direction of a medical expert.

Furthermore, it is important to remember that the alleviation of stigma is not true for all disease categories. Healthism, as discussed above, reinstates personal blame for disease categories popularly perceived to be linked to individual lifestyle choices and, therefore, considered irresponsible behaviour. Recall that, in this way, healthism delineates a negative distinction between the “undeserving” sick, who are at fault and therefore undeserving of care, and the not at fault “deserving” sick. Here, the “undeserving” sick are considered an unnecessary burden on the economy due to their non-productivity and need for healthcare services. Again, the priority is the maintenance of a healthy *economy*. Also, the so-called irresponsible behaviours of the “undeserving” sick may be perceived as endangering the integrity of labour by compromising their own work ability, or that of other workers through the spread of contagion.<sup>50</sup>

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<sup>50</sup> This is also rooted in moralizing and prejudicial attitudes around health behaviours as reflective of the good and ethical citizen, such as with second-hand smoke or the contracting of HIV.

Similarly, another aspect of personal blame and stigma, as previously discussed in the context of academia, is the notion of the duty of the market-citizen to maintain productivity and contribute to the capitalist market through commodity consumption. This expectation is compounded by the neoliberal principles of free-market competition and individual resilience. Here, mental health issues are considered acceptable as long as they do not pose a barrier to work ability. Workers who disengage from wage labour as a result of mental illness are stigmatized as weak and unable to compete on the market, or are suspected of exaggerating their distress in order to escape their responsibility to work.

For those who are unable to work, the burden of proof rests on the individual to convince the state of the genuineness of their disability. This is reflective of the socially constructed bifurcation between the “deserving” poor, those who are officially designated disabled, and the “undeserving” poor, those who are resented by capital as wilfully refusing to work. For capital, those who are unable to work possess no value. Mark goes on to explain that the stigmatization, or even demonization, of the unemployed poor is a reflection of the threat that their existence poses to capital:

Everybody experiences mental illness. Those of us who have chronic or consistent mental health problems definitely get lumped into this category of not being really human. Not being productive. They don't really matter. To capitalism, we don't matter because we can't work. We can't function in a capitalist economy. There's more to it. Also, I think it's really threatening. If people were really mentally healthy I think that's profoundly threatening to capitalism and colonialism. I think there's a huge challenge from disabled people, I'm thinking specifically of people with mental health issues, in terms of what it would mean for all human beings to be able to be physically and mentally healthy and the way our society would have to change. [Mark, a 36-year-old ODSP recipient]

Here, the unemployed poor's inability to function sheds light on the ways in which capitalism is dysfunctional.

When definitions of mental health and normal functioning are constructed according to the values of capital, conceptualizations of healing and recovery then revolve around a return to economic productivity and profitability. In this way, measurements of emotional health revolve around people's capacity to internalize, or at least conform to, the capitalist prioritization of wealth accumulation and commodity consumption. Moreover, the emphasis on neoliberal ideology in contemporary capitalism also serves to individualize and isolate the needs of workers and unemployed people. People are regarded as responsible for their own health, their own survival. The internalization of notions around individual reliance also has a dehumanizing effect on workers, which serves to further alienate workers from each other and from the communities around them.

However, while the internalization of individual reliance may weaken the potential for collective action en masse, the everyday efforts of workers and the unemployed poor to survive alienating and oppressive conditions must not be dismissed as unimportant. As Kitty explains, the ways in which people survive can be perceived as points of resistance and should be considered a form of activism in itself:

The structures are so disabling. They're doing exactly what they're intended to do, which is disable people and keep them not fighting for sovereignty, and not demanding whatever... Not burning shit down. But, I feel like people who are "surviving"... They are resurging, they are resisting. The fact that they are still, like... I try not to totalize the oppression. I just want to make sure that there's room for people's everyday stuff that's not always considered activism, or that's not necessarily considered productive work – that it is progressive. [Kitty, a 32-year-old doctoral student]

Kitty's account here is optimistic in that there seems to be a conceptualization of the survival strategies of oppressed people as a form of resistance and resurgence, which provides hope for the possibility of change.

*“Serotonin Depleting Times”*

Michael Norden (1997), a psychiatrist from the University of Washington, once remarked on the living conditions of the past 100 years as “serotonin depleting times” (11). Norden was referring to the hectic lifestyle and pressures of contemporary society. His recommendation for improving the overall mental health of society was the widespread use of antidepressant medication. I think this quote is useful in demonstrating the acknowledgement of social conditions as a source of distress, even in the psychiatric community. Taking a structural approach to mental health is not particularly controversial. As reflected by the interviewees, the perception of mental health issues as rooted, at least to some degree, in the social and economic conditions is fairly common. Participants were quite vocal about the damaging aspects of everyday life and how they relate back to overarching social, political, and economic institutions.

The narratives presented by participants concur with research presented in previous chapters, and with my own personal observations, regarding contemporary capitalism as detrimental to genuine health. Participants mentioned several characteristics of what they considered necessary conditions for genuine health (as opposed to functional health based on the needs of capital), predominately:

- the opportunity to form meaningful relationships
- being surrounded by a good social support network
- feeling hopeful about the future
- having the ability to set boundaries around work
- stability and financial security

In speaking of mainstream capitalist accounts of functional health, Stella Martin, a 24-year-old graduate student on leave of absence, describes expectations around individual resilience and the reliance on individualist approaches:

[Society] expects people to pull themselves up by their bootstraps and will themselves out of feelings of depression. And even if it's not necessarily in a mean way, like with self-help books or the happiness project, and stuff like that. It's all pushing us to say that we should be happy most of the time, but there are no supports to make everyone so. [Stella Martin]

Stella raises an excellent point around self-care and the social expectation to perform wellness. Other interviewees mentioned this as well. Some described it as cultural etiquette, that when someone asks you how you are the polite response is to tell them you are "fine." This is reflective of capitalist values of the busy and productive citizen that, even in times of personal crisis or illness, people feel compelled to feign health and ability. Revealing that they might be struggling would expose them to the stigma of being regarded as unable to cope. Indeed, an entire industry has been built around ways that individuals are expected to perform self-care and self-help, allowing their issues to remain invisible.

Interviewees also reflected on the ways in which functional health in capitalist society is framed in relation to productivity. There is an expectation for workers to be able to maintain work ability and perform under the pressures of a fast moving economy. Some spoke of the maintenance of health as requiring the ability to absorb stress and anxiety or, even better, use that energy to push themselves to be even more productive. For many workers, the ability to harness energy in this way is not sustainable and can leave them feeling overwhelmed and exhausted over time. Kitty describes their experience:

I've been like, the super anxious type person. I just remember having anxiety since I was probably 11 or 12. My brain runs pretty fast a lot of the time. And I was always very high achieving and had a lot of responsibility and kept shit together. I always felt a lot of stress, but it was more positive stress. I was contributing in some way.

Not that I don't feel like that now, but I just feel more overwhelmed. [Kitty, a 32-year-old doctoral student]

In speaking of their own illness experiences, Anna Murray relates the ability to push oneself to neoliberal rhetoric around excellence and innovation in the work world. They tie this to an entitlement more privileged workers feel around the ability to succeed:

I see the root of most of my ill health as this drive for perfection and pushing myself too hard. But even that is a result of my privilege as a middle-class, white girl who believes and whose parents have encouraged them to believe that they can do anything they want. That's just not a reality for most people. [Anna Murray, a 21-year-old part-time student and student union worker]

Not only are more privileged workers far more likely to be upwardly mobile, they also benefit from unearned social and economic privilege due to structural oppression that inhibits workers of colour and people in poverty from advancing in the work world.

Recall that marginalized groups are hit the hardest by conditions of precarity. This vulnerability to precarity removes any opportunity for upward mobility and traps many workers and unemployed people in a cycle of survival where the goal is to simply survive day-to-day. For instance, most socially prescribed health-seeking behaviours are reflective of class privilege. For more impoverished workers these behaviours (for example, going to the gym, eating organic foods, etc.) may be out of reach and simply represent more stress and responsibility. These behaviours also feed into neoliberal, capitalist values of competitiveness, busyness, and achievement for which many do not have the capacity or resources.

Some interviewees also expressed a certain frustration or sadness in grappling with their dependence on wages and the necessity of participating in the capitalist production. All of the workers I interviewed had an understanding of capitalist social relations as exploitative. This seemed to present an additional challenge for them in that not only were

they struggling to minimize harm caused to themselves, but they were also conscious of how their participation in a capitalist economy may cause harm to others. Ankur expresses this concern in regards to their search for employment:

I need to reconcile to the fact that if I'm making a living for myself, or if I'm being supported by someone else, that's always going to end up in exploitation somewhere. There's going to have to be some profit at some point, from which I use to live my life, or with which I'm supported by someone. I need to reconcile myself to that, and to the limited ways in which you can work against that. [Ankur, a 24-year-old unemployed former student]

One participant in particular, Mark, spoke of how people come to internalize the instrumental rationality of capital, which seeks the most efficient way to maximize profit regardless of the human cost. The internalization of this type of ruthlessness, and the violence involved, results in social disintegration. This enables the perpetuation of not only the harm done to workers and unemployed people, but the harm they do to each other as well. This is not to say that individuals should not be held accountable for their actions. However, their actions must be understood as a replication of the “destructive and self-destructive dynamics” of capitalist society and the systemic violence that workers and poor people endure.

### **7.3 Perceptions of Health**

#### *Mental Health and Normalcy as Indicators of Economic Success*

Interviewees had a definite sense that part of functional health requires a certain level of productivity and that being employed was an indicator of successful functioning. This perception is in line with capitalist values and the idea that citizens have a duty to actively participate in the economy. Recall that I refer to the ability to engage in wage labour as “work ability,” which basically means one’s capacity to sell their labour power. For instance, Anna Murray speaks of work ability as also tied to the accessibility of

resources that requires a certain amount of privilege in terms of social and economic security:

Privilege is a huge part of health, and be able to get what you need to function at a level that you want to function at. And probably, for me at least, at a level that society deems acceptable. Like, I feel healthy now because I'm actually able to work fulltime. I didn't think I'd be able to do that the past few years. I was always kind of afraid that working fulltime would be this dream that I would never be able to obtain, but I don't even want to work fulltime necessarily. The fact that I can now is a huge indicator of health for me and I realize, now that I'm saying it, that this is a very societal, capitalist idea of what health looks like. [Anna Murray, a 21-year-old part-time student and student union worker]

Of course, a functional conception of health excludes people without this privilege and who, for whatever reason, are unable to maintain employment and shamed for apparently not contributing to capitalist society. Interviewees also reflected on work ability as not only the ability to maintain employment, but also as the ability to tolerate the damaging effects of precarious social and economic conditions. This indicates that individual resilience requires a certain level of class privilege. The ability to access social and economic resources makes a difference in supporting workers in conditions of chronic stress, which is key to work ability.

I asked interviewees to reflect on how they have been socialized to perceive health as well as the ways in which health has been presented to them as a goal to achieve. It is interesting to note that, for some of the interviewees, health messages included more than simply the ability to work, but that functionality was associated with popular perceptions of what it is to be successful in society. This is tied into capitalist values of wealth accumulation and material gain. However, it is not enough to consume an abundance of commodities. One can imagine that a person can be both rich and unhealthy. Therefore, it

seemed that my interviewees understood that an essential component to healthy functioning and success is happiness.

Several interviewees made the observation that notions of health and happiness were intimately connected and, therefore, this meant that sadness was perceived in society as some kind of failure. As Sarah Tony explains:

I think [sadness] is considered a failure because everyone expects you to be happy, or not so much happy, but on top of everything. No. I think happy; they expect you to be happy all the time or able to function properly and be at your best all the time. And when you're not, or if you're sad, it's kind of like a failure. [Sarah Tony, a 32-year-old fulltime worker with accommodation needs]

Equating sadness with failure carries important connotations for the way mental health is framed in current society. Mainly, it implies that negative affect – such as sadness, anger, worry, and anxiety – are associated with illness and may be treated medically. Recall the expansion of the diagnostic boundaries around depression and anxiety disorders in the DSM.

It would seem that health according to capital is conflated with not only work ability and functionality, but also with wealth and happiness under current social and economic conditions. For example, Stella Martin refers to this apparent definition of health:

Health, from what I hear, is having a fulltime job, having a good support network around you, having energy, having enthusiasm. [Stella Martin, a 24-year-old graduate student on leave of absence]

Again, notice this conception of functional health not only requires work ability, but also access to social and economic resources. Stella points out that continued positive affect, namely enthusiasm, is also an indicator of health. Additionally, the mention of energy can be interpreted to suggest a high level of productivity. This reflects a previous point made

by Anna about how pushing one's self to the brink of exhaustion is normalized in capitalist society, which for them has been as major source of distress.

Another aspect of health and normalcy was, as Ankur put it, “the kind of narrative of middle-class lives.” In this way, normal functioning implies the pursuit of not only socially prescribed goals, but also of a particular life path:

Have a day job with some kind of vacation. Okay, your job is not satisfying, but you can go to cool places on your vacation. Get into a relationship – married, kids, and raise them. Have your friends and go out with them, and go traveling with your family. [Ankur, a 24-year-old unemployed former student]

It was interesting to compare concepts of functional health that followed this narrative of middle-class lives with the realities of workers living in conditions of deepened precarity. Here, social norms around striving for success and happiness are muted by the day-to-day struggle to survive. That is not to say that workers and the unemployed poor do not want to be successful or happy. Regardless, it could be argued that more basic human needs must first be met.

At the very basic level, the maintenance of work ability, from a genuine health perspective, can be considered a very “bare minimum,” limited perception of mental health. However, according to capitalist values of profitability and productivity, work ability is greatly emphasized as the primary component of functional health. To illustrate this point, Mark describes what is required to be able to work:

I guess for me, essentially is as long as you can keep it together for 8 hours, that's all that matters. The rest of your life can be a fucking shambles. You could be a total alcoholic, you could be somebody who's a shut-in and the only thing they do is go out to work and then they go and watch TV all day and just try and cope with their issues. You could be somebody whose physical health problems are so bad that... Your back is so bad that after an 8 hours shift all you can do is lay on your back the rest of the day. That's all that matters. [...] Emotionally, the ability to dissociate for 8 hours... The ability to shut down emotionally, I would say, for 8 hours or more. That's how I think of it. [Mark, a 36-year-old ODSP recipient]

A central point here is that maintaining work ability through the repression of pain and distress is not sustainable. Time spent outside of work is focused on recuperating for the next shift. At some point, repressing or delaying the effects distress is no longer possible and the ability to work is then jeopardized.

Of course, people's opinions around what constitutes health, success, and happiness will vary. Keep in mind that the picture I am presenting here are the interviewees' thoughts around how these terms are framed in society. Workers are pressured to conform to these expectations regardless. Recall that functional health in this context becomes a status symbol reflective of a successful, "sports and leisure" lifestyle. Also, that the opposite is true as well – that unhappiness and illness resulting in the inability to work may be perceived as personal failure.

#### *Mental Illness as Failure*

Maintaining health as a reflection of power, capital, privilege, and social position can be better understood through an examination of healthism. Recall that healthism, a form of medicalization, can be described as a governing tool for the self and a platform upon which to judge the character and behaviours of others (Metzl, 2010). The internalization of the individualizing and moralizing ideology of healthism contributes to the public shaming of those who are perceived as shirking their social and economic duty to engage in health-seeking habits and productivity (Rose, 1999).

Here, those who have internalized healthism-related assumptions, including the medical community, broader society, and even concerned loved ones, judge individuals' character and behaviours. Mental health issues that interfere with worker productivity are

attributed to personal defect; that the worker, as a source of commodified labour, is somehow defective. Mark elaborates:

As a broad generalization, people are told that their mental health problems are their problems to deal with themselves and it's something wrong with them. That's everyone. People who become symptomatic or dysfunctional in terms of capitalism – not being able to work, not being good parents – are judged. Judged as faulty, as broken, as damaged and they need to be returned to productivity. [Mark, a 36-year-old ODSP recipient]

This would indicate that, regardless of medicalization as a destigmatizing force, shame and judgement for those unable to meet the normative expectations of capitalist society is ongoing. Stella Martin recalls a conversation with their father that reflects this:

My dad has never really gotten it, probably won't any time soon. It's funny, about a month and a half ago, we went for dinner and he asked me, "So, do you even want to be part of productive society?" And what was I going to say? "No, no. I want to be dependent and not part of society and not contribute anything. Thank you very much. That's my goal here. I'm really having a great time in this place." I know that he loves me, and all that, but he doesn't understand why I can't just be... He's like, "You're smart. Why can't you do this?" That was especially in relation to [my] medication consistency. He just can't understand why someone who, you know, understands things can't manage to get everything together... My mom, she's a little more understanding, but very similar. She will often mention things that I should be doing or that I'm doing wrong. You know, "If you do that, you'll feel better." When I'm in a more extreme depressed state I hardly feel able to do anything, so criticizing me for not doing something is not helpful. [Stella Martin, a 24-year-old graduate student on leave of absence]

As illustrated here, the expectation is to "do" and the blame of being unable to "do" is placed on the individual – "Why can't you do this?" Keep in mind that Kitty was faced with the same question from their academic supervisor when asked about not being able to sustain an expected level of perceived success and productivity.

Participants especially remarked on being labeled a failure for lacking work ability. Unemployed people on disability programs may still, to some extent be expected to work in some way as a contribution to society. However, in order to be recognized as disabled

by society and the state, this requires official confirmation from a medical authority. This approval may alleviate some of the blame involved in being unable to work. However, people officially designated as disabled and therefore unable to work are instead perceived as a burden on the system. Kitty observes this relationship and elaborates on the structural dimensions of ableism:

This idea that every single person has the same capacity as an able-bodied, usually a male-identified... All those intersections of privilege and power... This idea that if you don't achieve you fail; you're weak. And in capitalism if you're unproductive, you're a burden and you're a waste. Your value comes from what you can produce for other people and if you're not producing anything, you suck hard. [Kitty, a 32-year-old doctoral student]

Again, this is reflective of the view that people have a moral and civic responsibility to be productive and engage in the capitalist market. Not only are people expected to remain work able, there is very little compassion or consideration of broader structures of oppression when people's capacity to work becomes limited.

Kitty's point about people's productivity as an indication of value and worth is reflective of ideological justification for the dismantling of social welfare programs. This reflects the social distinction between the "deserving" and "undeserving" poor, where the "undeserving" poor on social assistance are perceived as possessing the ability to work but not the will. The perceived unwillingness to work is perceived as personal failure, laziness, and immorality. Recall that one of the primary objects for capital is to cut people off from the means of subsistence, leaving workers with no other way of surviving other than by selling their labour power for wages. Wages are then used to purchase back the commodities that workers produce and need in order to live. People who are unable to tolerate the distress and alienation created by capitalist commodity production need to either find support through other means or face ruin. Therefore, cuts to social welfare

programs threaten people's survival and drive them into desperation. Mark offers the following insight:

You just got to suck it up and do your job because if you don't you won't have money to pay the bills. And when people aren't able to do that that's when they go "crazy" and then they can't work. If they're lucky they get put into a disability program; if they're not lucky they get out into a welfare program where they get some money. And people end up homeless, people end up killing themselves. Killing other people. End up institutionalized; they end up in prison. All those institutions exist to deal with our total failure as a society to address people's emotional needs, their human needs. [Mark, a 36-year-old ODSP recipient]

Mark raises an interesting point regarding the criminalization of poverty and the social segregation of people who do not maintain work ability.

A link can be made here between the institutionalization of the unemployed poor and the initial purpose of psychiatry, which was to segregate people with mental illness away from the rest of society under the guardianship of doctors. Today, it would appear that the primary duty of the doctor/psychiatrist is not to segregate, but to reintegrate potential workers back into the workplace. In this way, the purpose of medical care and medicine is to regain work ability.

#### **7.4 Functional Health, Work Ability, and Antidepressants**

Society's shift to medicalize distress and illness experiences stems from pervasive neoliberal ideological assertions around individual resilience and self-care. It also stems from the reinforcement of medical authority in the confirmation of disease and disability. Interviewees noted that medical authority is needed for access to several resources including disability benefits, insurance coverage, and treatment. As Stella Martin remarked, "You don't get certain services if you don't have a diagnosis." Under the dominant model, seeking help from the medical community and following the advice of a

medical expert is the normative response to individual illness experience. However, it is important to disrupt the assumption that medicine leads to genuine health.

I have argued that medicalization and the erasure of social problems actually contribute to the perpetuation of harm. Through an exploration of current conceptions of health and so-called normal functioning it becomes evident that the priority for capital is maintaining wealth accumulation and increasing worker productivity, not the actual fulfillment of human need. Interviewees often commented on the harmful aspects of capitalist society and the return to productivity as the central focus of treatment. For instance, Mark commented:

We live in a society that creates mental illness or mental health problems, that creates trauma. It's a traumatic society and people get hurt, of course, and psychiatry exists to patch them up and get them back on the playing field again... working, being functional. [Mark, a 36-year-old ODSP recipient]

Stella Martin's discussion of how productivity connects with distress elaborates this point:

We don't live in a society that promotes wellness, or at least mental wellbeing. It seems as though it's just how productive we can be and how you adjust to this very fast-paced, very driven... You know, how well we can work. How much you produce. I think there's so many reasons that people would feel distress, but the only way that they can get validation for those feeling being real is for them to go and see a doctor and have the stamp of approval, and get medications. [Stella Martin, a 24-year-old graduate student on leave of absence]

Here, Stella underscores the point that distress requires medical confirmation in order to validate the illness experience as a medical condition. Because doctors are the gatekeepers to pharmaceutical medication such as antidepressants, people have little alternative but to consult a doctor for legitimate access to medication.

### *Seeking Medical Help*

Interviewees shared their experiences navigating the medical community and offered their perspectives on the doctor/patient relationship. They mentioned many issues

such as feeling a lack of control, not having important information properly explained to them, and sensing an absence of genuine care on the part of their doctor. With the availability of medical information available to patients, there is an expectation to be included in treatment decisions and for the doctor/patient relationship to take on more of a partnership in healthcare. However, based on the experiences of the participants, it would seem that patients continue to be, for the most part, excluded from the treatment process because they are considered to lack the technical expertise and medical training to be fully included. In this way, they are subordinated to the medical expert and are expected to follow a set of prescribed tasks.

Some interviewees remarked that they felt very little control over the information that gets included in their medical dossier and how that information affects them. Quite often patients feel as though going to the doctor does not adequately respond to their health concerns or experiences of illness at all, which may deepen the sense of crisis for people who rely the medical community as their only available option for help. Others, for instance Kitty, mention not having a “real connection” with doctors. When asked why that is, they go on to talk about their interactions with the medical community:

I just feel like it's so rushed. I always feel like I have about ten things to say, but I can only pick my top one or something. And I find it difficult, I'm not good at asserting myself in the context of certain kinds of relationships, so I'm not a good advocate for myself a lot of the time. I usually just want to get out of there. Even with counsellors, I never really cared for them. I never really found them helpful. Most of the time I felt counselling sessions really triggering, and even doctors; you spend the first time puking out all the information, and they usually want to know history, so you ramble that off or whatever, and then they either make a determination like, “Ok, I'll just give you this medication.” Or then, they're like, “Oh, that's very important, but our time is up.” I would usually end up leaving way more stressed out than when I'd get there. [Kitty, a 32-year-old doctoral student]

Interactions are described as empty question-and-answer sessions that can actually create more distress through the expectation of difficult personal disclosure without offering the necessary care and support.

Kitty's story illustrates the limitations of the medical community and its reliance on medication as a solution to illness. These feelings of detachment reflect positivist, scientific principles around "objective" distance and give the impression of cold sterility. Detachment may also be reflective of the constraints of the healthcare system as underfunded and overworked. Indeed, doctors are also subject to the intensification of labour resulting from lack of public funding to healthcare. This results in primary care providers who may only be able to devote a limited amount of time to each patient in order to deal with the increased patient volume. Treatment that is time and cost effective often takes the form of a prescription to alleviate symptoms. In this way, treatment becomes less about genuine health or actually resolving the source of distress, and more about what is required to function under existing circumstances.

Another recurring theme in the interviews was a perception of psychiatrists as uncaring and unconcerned with the needs of patients. Interviewees noted that the psychiatrist would dominate sessions and participants were not even given a chance to speak, thus creating a space where the medical expert was the centre of attention and importance. Participants also expressed that they felt exploited and that their distress was considered first and foremost a source of profit for psychiatrists. Many interviewees felt as though their interactions revolved around a monetary transaction. Sarah Tony recounts their experience with one psychiatrist as highly technical and profit-driven:

I just felt a lot of the time that I was a paycheque for them. Because a lot of the time I was just in and out: I was in - I got my medication - I was out. They didn't

want to hear about... Like, the psychiatrist that was treating me from the hospital, she didn't really ever talk to me. It was just like, "Oh, what are your symptoms? How do you feel?" She would check my blood pressure and that kind of thing; like, medical stuff. It wasn't ever talking, and she was a psychiatrist. She kind of just acted like a medical doctor or a researcher... I found that insulting because every time they see you they get paid by OHIP or whatever, and I kind of felt like she was just seeing me because I was just another paycheque for her. [Sarah Tony, a 32-year-old fulltime worker with accommodation needs]

Furthermore, the focus on profit in the medical profession can potentially corrupt some practitioners, which may result in unnecessary diagnoses and expensive treatments. Joanne Lewis shares their story:

I didn't agree with the personality disorder [diagnosis] at all. It was based on a forty-five minute interview where basically [the psychiatrist] spoke the whole time. He didn't let me talk. I was not comfortable with the situation... Basically, with this personality disorder he was saying that I should stop taking any medications I was taking and enter into psychoanalysis and, it turns out, his wife is a psychoanalyst... I know, Internet reviews can be pretty unreliable, but this guy had a lot of reviews. Basically, every person was told they needed to go into psychoanalysis. [Joanne Lewis, a 34-year-old childcare worker]

These types of experiences can devastate people's trust in mental health professionals leaving them perhaps at a bit of a loss as to their options for help.

To be clear, I am not arguing that the entire psychiatric profession is unethical. However, stories such as these point to real problems in the delivery of care to people in distress. Patients are alienated from the treatment process by the medical expert as the only legitimate source of knowledge about the body and disease. Also, due to patients being treated at the individual level through pharmaceutical medication, patients are also alienated from each other and from collective expressions of shared distress.

However, people are not ignorant of the social and economic context of distress. Interviewees presented quite critical opinions of the reliance on pharmaceutical treatments of distress. All interviewees had experience with antidepressants and had

much to say on the topic of being prescribed antidepressants as well as the meaning attached to their use.

### *The Reliance on Antidepressant Treatment*

The notion that feelings of distress are located in the brain's biochemistry and can be controlled with medication can be of great comfort to people who are struggling. For example, I remember when my family doctor first prescribed me antidepressant medication:

When I was sixteen, which would have been in 1994, my doctor said to me that taking antidepressants was the same as someone with a heart condition taking heart medication. When he said this I remember feeling a sense of great relief. It made me feel normal and reassured me that, as long as I had my meds, life was manageable. Taking these pills was just a thing I had to do. No big deal. I never questioned what being on this medication, at the time a mix of Buspar and Imipramine, would actually be like. [Headnotes, January 2015]

I had originally gone to my doctor because I was experiencing heart palpitations, shortness of breath, and tingling, all of which were terrifying me. I was actually quite desperate for anything that could make those feelings disappear. Medical treatment took away my capacity to understand the source of my distress as this was the purview of medicine and I was not knowledgeable in that. By focusing on a medical response to physiological symptoms, this interaction with my doctor did very little to illuminate *why* this was happening or what the underlying issues were, just they were happening and a prescription could stop it. This defused my sense of urgency around the terrifying feelings I was experiencing, which felt both soothing – because these feelings were apparently nothing serious – and confusing – because they felt very serious and I did not know why.

I argue that the focus on the alleviation of symptoms oversimplifies distress and serves to depoliticize illness experiences as related to broader social and economic

conditions of precarity, alienation, and exploitation. This is not to say that biological components to health are not important, or that medication such as antidepressants are not useful to people. The point here is that there is a need for a more integrated, structural approach in order to strive for the genuine health of society.

Participants acknowledged a physiological component in mental health and necessity of medical treatment, which can be life saving and key to survival. However, participants also recognized the dominance of medical authority in the validation of illness experiences. As such they expressed scepticism and doubt around such a heavy focus on biological processes and medical responses. Stella Martin questions the helpfulness of locating dysfunction in individual brains:

For me, I do see all the stuff that goes on in your brain as a biological process. And, obviously, there's a lot of distress... There is this thing where we need something to be an illness for you to validate distress. And I'm not really sure how I feel about that. At one point you want to have these be taken really seriously because it's [depression] a huge public health problem, and it can so easily be dismissed. We're trying to move away from the stigma of it being a personal failure or that sort of thing, but I don't think stepping into the whole, "you're brain isn't working properly" area is particularly beneficial either. [Stella Martin, a 24-year-old graduate student on leave of absence]

Stella raises a salient point. Locating dysfunction in the brain reinforces the notion of the defective worker. Recall that medicalization serves to remove stigma from mental illness by disconnecting it from a person's character, but not completely. People experiencing distress may feel more open to talking about it due to their inclusion into a disease category. However, stigma and judgement is still applied to people who cannot regain their ability to work. For capital, people who do not possess sellable labour power are perceived as burdens to the system.

The rise of antidepressant prescription in recent decades is reflective of more openness around mental disorders, as well as condition branding put forward by the pharmaceutical industry. Recall that condition branding is a marketing strategy to raise awareness about a particular mental disorder and associate a particular brand of medication as its treatment. This encourages patients to evaluate themselves as fitting particular symptomologies and to ask doctors for medications by name. Anna Murray makes the excellent point that the issue is not that people are being prescribed medications that they do not need, but that purely medical treatment is not inclusive of all that is in need of attention:

I think it's because mental illness has risen dramatically. I think we're under, not necessarily a lot more, but different kinds of stress. And I think people are talking about it and admitting they need help more. I wouldn't know enough to say that people are prescribing antidepressants to people who don't need them. I think it's pretty likely that people need them or want them and are just admitting it. I think it speaks more to the culture of... For example, as you said, antidepressants are the most prescribed drugs on campuses pretty much across the country. I think that's a result of university culture, which is very much that white supremacy culture of, "Go, go! You will be the best or you'll drop out and lose money!" [Anna Murray, a 21-year-old part-time student and student union worker]

Here, Anna is suggesting that a cultural shift is also needed in order to address the kinds of stress that people in precarity are experiencing – a central and recurring point in this dissertation.

Precariously employed workers often do not have access to additional or alternative treatments because of constraints around time and money. Medication seems like a viable solution, at least in the short-term, for maintaining work ability and avoiding crisis. Here, antidepressants take on a more instrumental purpose. They are a convenient way of increasing one's tolerance for stressful working and living conditions. For instance, Joanne

Lewis explains how antidepressants alleviate some of the strain of a demanding work schedule in the absence of other sources of fulfillment:

I have an ambivalent relationship with it. Like, I do like the idea that I can feel better in a quicker way. Right now, my job is 50 hours a week plus travel time. I don't really have a lot of time to devote, most days, to other personally fulfilling activities. But the barrier is cost. I can't afford any sort of gym membership or yoga or anything like that, *and* I also can't afford the antidepressants. It's not really accessible at the moment. [Joanne Lewis, a 34-year-old childcare worker]

However, as Joanne explains, workers without insurance who cannot afford their prescription are then left to cope (or not) with distress without medication.

Anna Murray also expresses concerns over the cost of medication, as well as developing a dependence on them:

I don't want to take them for very long. I feel like the longer you take them the harder it would be to stop. Also, the price is going to... Like, right now it's affordable for me, but without insurance I think it would be like, \$80 a month or something like that. It's a lot. [Anna Murray, a 21-year-old part-time student and student union worker]

Several interviewees raised the issues of dependence and withdrawal. Some interviewees had quite negative experiences of antidepressants, which made them seriously question whether antidepressants should be used as a go-to treatment. For example, Sarah Tony suggests that personal support in the way of psychotherapy as an alternative:

It would be nice to have psychiatrist clinics that you could go to like, a walk-in, and not relying on antidepressants all the time as a first treatment. I think that's the first thing that they give you if you go in you're like, "I'm sad," or whatever, they're like, "Oh, here. Try these." And then you get hooked on them and you can't get off because the withdrawal symptoms are just too much. [Sarah Tony, a 32-year-old fulltime worker with accommodation needs]

Additionally, some interviewees expressed that they did not want to remain on antidepressants for long because they did not want their ability to cope with distress to be attributed to medication; they considered this artificial. They wanted more genuine control

over their mental health and recognized that this meant making changes to their external conditions, not so much their internal bodily functioning. Ankur makes this point:

I didn't want to be happy because I was on Cipralelex. I wanted to make changes and Cipralelex enabled me to start making certain changes, but it also would leave me lazy at times. Or, it would leave me feeling like I didn't have to make certain changes. [Ankur, a 24-year-old unemployed former student]

Ankur also raises the important point that antidepressants are designed to alleviate distress and this may cause a false sense of fulfillment. Antidepressants, when effective, can result in an impression of the social reality as no longer damaging. A structural approach to health, for which I am arguing, focuses on making changes to damaging social conditions. Simply altering people's perception of the social conditions to make them appear less damaging is a superficial fix and does not achieve genuine health.

Several interviewees also remarked on the lack of information shared with them about the medication. Doctors often do not actually explain how the medication actually works in the body, or even what the patient should expect in terms of effect. More often, they will attempt to remove technical language, or "dumb down," their explanation with vague metaphors that frame medication as the obvious solution. This can leave patients with the impression that medical experts assume laypeople are incapable of understanding the mechanisms of their own body. This can make the doctor/patient relationship feel patronizing and offensive. Stella Martin expresses their frustration with this:

Understanding that there's a whole variety of folks with different language issues and IQs, and a whole bunch of things, so they have to try and accommodate and include most folks in there. But, to me, it did feel very patronizing. There was some stuff that they were telling me where I was like, "I'm not really sure that's true." By that time I knew that the chemical imbalance hypothesis was kind of bullshit, so stop telling me it's like insulin for diabetes. That's not how it works! [Stella Martin, a 24-year-old graduate student on leave of absence]

This patronizing tone may also send the message that their opinion will not be heard if they voice disagreement with the treatment, which may inhibit patients from actively participating in the treatment process.

Stella also spoke about having adverse reactions to their medication without being told what was happening: “I had a lot of cognitive symptoms, I couldn’t form cohesive sentences, constant ear ringing, tremors – all these sorts of things that really were rough and they weren’t explaining them to me.” This tendency for some doctors to not communicate rather important details regarding medications to patients is troubling in terms of standards of care. These omissions emphasize the role of medical authority assuming compliance on the part of patients to carry doctors’ orders with only a minimum of information. Also, keeping patients uninformed about their own medical treatment, or worse yet, assuming it is not necessary, reinforces reliance on the medical expert. Often, taking an antidepressant medication for the first time, or finding the right medication in the right dose, can be a frightening experience, especially without the proper information around what to expect or what to do in case of an adverse reaction. This can be dangerous and has the potential to further traumatize people already in distress.

### *Coping with Treatment*

Interviewees presented a range of experiences with antidepressants. Some participants said that they did not experience any noticeable adverse side effects. Adverse reactions that did occur varied by degree. Interviewees complained most of weight gain, ringing in the ears, tremor, oversleeping, overeating, and “buzzing” or “jolting” sensations. In most instances bad reactions induced pain as well as fear and/or confusion since participants were typically not informed about possible side effects. Kitty’s story was

particularly remarkable. Kitty recalls their family suggesting they go back to the doctor following a severe reaction:

I wasn't eating. I tasted metal in my mouth all the time. And so, when I wasn't eating all the Christmas stuff they were like, "You should go see someone." So, I went back and she asked me how I was feeling and I told her, "Like death. Straight up like death." And she asked if I had suicidal thoughts and I was like, "Yes." I was a little bit nervous about saying that because I didn't want her to write it down. But yeah, it seemed so nonchalant. I don't even remember her saying how to feel better. I can remember going on Facebook and asking people for harm reduction strategies to get through it. [Kitty, a 32-year-old doctoral student]

Kitty raises an important point about not wanting to share certain information about the severity of their distress. This demonstrates a lack of trust and perhaps a fear that this information may stigmatize them or even be used against them in future.

Kitty had already taken at least two different antidepressant medications, including Welbutrin and Celexa, as treatment for chronic feelings of anxiety. Upon going to a medical clinic to secure a medical note needed to apply for a leave from studies, they were prescribed a third medication, Effexor. Kitty tried to tolerate an adverse reaction to the drug, but finally decided to stop taking it and was hit with severe withdrawal. They recall this disturbing experience:

As soon as I took the first dose of Effexor I started feeling like shit. But I kept it up too because they were like, "Well, you know, they take a while so just keep up with it." And then when I felt like I was going to die I decided I had to stop taking it, but then at the same time I didn't realize that by stopping the Effexor, and I had stopped the other ones, I was going to go into hard-core withdrawal syndrome. That was even worse than the first time and then so I just gave up at one point and thought I'm just going to back to my original set of medication. But I had just decreased the dose a little because it was quite high at that time. The main thing that bothered me was sweating. I was constantly, constantly sweating especially at night. It was to the point where people were like, "What the hell is wrong with you?" I'm like, "I don't know. I just produce fucking sweat." That was just a super-duper annoyance... and then trying to perform femininity and just sweating constantly. When I had stopped taking them, all the different side effects that I had were so troubling. I had the brain buzz thing that people describe, which is disturbing. Then I had zaps that were constant in my arms and my shoulders. I

was constantly vomiting. It was gross. I wasn't really eating or getting out of bed. I had suicidal thoughts. I think it was mostly because of the pain. It was so intense. It was pretty miserable and it was around Christmas time too. It was over Christmas and it so unpleasant. It didn't stop until I went back to the other medication. [Kitty, a 32-year-old doctoral student]

Kitty's story exemplifies the way in which antidepressant medication can disrupt one's life, and actually take away functionality. They also had also tried several different kinds of medication from various sources with no real communication or investigation of them the medical community charged with supervising patient's consumption of the drug.

When asked if, at any point, the doctor they had spoken to at the clinic told them about the possibility that any of this could happen – what to expect on the new meds, what to do in case of a bad reaction, or the dangers of stopping a medication cold – Kitty responded with, “No, they didn't say anything about what it was going to feel like or even the steps.” Other participants also spoke of their need for additional support in coping with both their interactions with the medical community and their experiences with medication. Reaching out to additional sources of information and support, such as the Internet and friends, help to offset alienating experiences with the medical community and the lack of information provided by medical experts.

One example of a much milder reaction is Ankur's experience of the antidepressant Ciprolex:

I play guitar and I found I wasn't being as creative once the medication had started working for me. I couldn't get into a vibe that satisfied me. And in terms of topics for paper and stuff, I found I kind of flat lined and plateaued. There was also an attitude of, “Oh, I can weather anything.” So, while I was motivated to do what I needed to do, there was also this kind of bizarre, “Well, everything's going to be okay anyways” that almost worked against it... There's definitely a numbing. [Ankur, a 24-year-old unemployed former student]

The loss of creativity and generalized numbing can be helpful in regaining productivity and dulling stress, especially for labour consisting of repetitive tasks. Also, the impression that things will be okay indicates a perceived increased capacity to tolerate uncertainty and stress. However, it is worth noting the loss of worry may also result in a loss of action, which may even be counterproductive. As mentioned previously, Ankur was aware of the need for changes to their life circumstances. However, an effect of the antidepressants was the feeling that these changes were no longer necessary or important. Effects such as these can stunt the radical imagination and enable conformity to the status quo, both of which carry negative implications for collective action and its healing potential.

### **7.5 Reflections on Recovery**

Recovery can be defined as 1) the process of becoming healthy or returning to a normal state of health, mind, or strength; and 2) to find or regain something that has been lost or stolen.<sup>51</sup> This definition helps to gain perspective. Recovering from distress, in the sense of achieving genuine health, requires the recovery of what capital has stolen from working class people. In my opinion, meaningful recovery would require the decommodification of labour that would allow people to live independent of wage labour. Recovery would also involve workers having control over the labour process and collectively reuniting people within their communities. At the heart of this recovery is collective action and care.

In line with Yuill (2011) I believe that struggles against the inequities of the capitalist system are possible and the damaging effects of alienation can be counteracted

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<sup>51</sup> Retrieved from <http://www.merriam-webster.com/dictionary/recovery>

through fostering social support and meaningful relationships. Several interviewees also stated the importance of communal care and collective action as ways of pushing back against oppressive and damaging social structures.

### *Resurgence and Communal Care*

Reflecting on what is required to achieve genuine health (read: according to the needs of humans, not the needs of capital), interviewees were generally of the opinion that communal care was an important component, if not essential. Building community through the fostering of “sustaining” and mutually supportive relationships, as well as a worldview grounded in the interdependence of social relations were considered especially important. Kitty spoke of the work they do with a community organization that centers on the idea of communal care – “being together in a good way” – and what those relationships have meant for their genuine health:

Right now I kind of rely on it. I rely on it to be ok. And I feel like that’s how the collective works. We all rely on one another and are there through all the shitty things and the good things. [...] That was really freeing for me and it’s just a healthier way of understanding the world, when care is at the centre of it and respect and mutual interdependence... Building strength and health together... [Kitty, a 32-year-old doctoral student]

Here, Kitty describes the building of meaningful and mutually caring relationships as contributing to not only their immediate genuine health, but also a positive worldview.

Commodity fetishism created by capitalist production obscures social relations as mutually interdependent. This gives the false impression that it is possible to live independently of others. Recall that commodity fetishism perceives the market as made up of interactions between objects (products, commodities) instead of interactions between people. This is reflected in the reliance on individual, commodified technologies, such as antidepressants, as a response to distress. It is also reflected in the depoliticizing effect of

medicalization on personal distress and illness by removing social, political, and economic factors from consideration.

The neoliberal focus on individualism also results in social isolation and disintegration, as well as the dismantling of social security. This isolation serves to disempower workers and the unemployed poor from demanding better conditions as a unified force. Mark reflects on how social isolation as a factor of distress works to the advantage of capital:

Imagine if all the workers in a workplace were really assertive and grounded and compassionate people. They'd probably go, "Hey. There's lots of us and just one boss. Maybe we should figure out some kind of way we could organize to run this place without being bossed around all the time and treated like our lives don't matter and the only thing that's important is money." For capitalism and class and work, it totally needs people to be mentally not healthy so that they can't resist... So that they're so involved with trying to cope with all their symptoms that they don't have the time to organize. [Mark, a 36-year-old ODSP recipient]

Here, Mark is making the point that building community and engaging with fellow workers can serve to (re)politicize the workplace. This has the potential for collective action and a greater sense of empowerment and control over workplace conditions. This collective action is rooted in compassion and the caring of workers by demanding working conditions that cultivate genuine health, instead of distress. However, distress located in the individual and functional health, framed by capital as an individual responsibility, breaks the social ties needed for communal care. This works to the advantage of capital by dispersing potential threats to the current social and economic order of capitalism.

In order to begin recovering from the continued distress related to current conditions of capitalism, rebuilding ties between workers and communities living in precarity is of great importance. Recall that the negative effects of unemployment on

individuals are worsened in communities with high levels of unemployment. Reframing health as rooted in interdependence of relationships in society sheds light on the impact of capitalism on mental health, and promotes the idea that in helping each other we strengthen ourselves.

## **7.6 Conclusion**

This chapter presented the reflections of interviewees on work, health, medicine, healing, and survival. Participants also shared stories and thoughts regarding their experiences with antidepressants specifically. The purpose of participant narratives in my research is to complement the theoretical analysis conducted in previous chapters based on broader trends in the literature. Much of what I found in the literature was backed up by the thoughts and lived experiences of the interviewees, and by my own observations. Interviewees were quite critical of current work arrangements and the way current capitalist society is organized. Many pointed to specific ways social conditions created distress for them. The first major area that interviewees offered their thoughts was on the conception of functional health framed by capital, and the expectations this placed on workers. This was juxtaposed with the ideas of participants regarding what constituted genuine health beyond the values and demands of capital.

Interviewees perceived mainstream conceptions of functional health as reinforced by the institutions of capital such as the state, and tied to the maximization of profitability and productivity. Participants' accounts of health framed by capital were perfectly in line with the conception of functional health presented earlier on in the dissertation, so I continued to refer to it as such. In this context the primary component of functional health is the maintenance of work ability at any cost. For workers who are experiencing distress

or illness, maintaining work ability involves the repression of illness and performing wellness (i.e. performing work tasks). This requires the demonstrated ability to absorb the stress created by prolonged and deepening precarity and exploitation inherent to capitalist production. Based on what the participants were saying, as well as existing literature, it becomes evident that the performance of work ability over time is not sustainable, leading to increasing distress, exhaustion, and the possibility of burnout.

Neoliberal ideology regarding individual responsibility and resilience reinforces the expectation that workers are to take care of themselves independently. Due to the emphasis on commodity consumption in capitalist society, much of the prescribed health-seeking behaviours around self-care require the purchase of commodities (for example, organic foods, exercise classes, spa retreats, etc.). This is reflected by the existence of the health industry. Functional health is then not only focused on work ability, but also the exchange of objects on the market. Here the relationships between people on society (also referred to as social relations) are rendered invisible.

The maintenance of work ability is enabled by class privilege. Workers who have more access to resources, such as time and money, may also have more opportunities for self-care. Some interviewees said that they put pressure on themselves to push through anything to achieve high levels of success. This is reflective of the feelings of entitlement around success and upward mobility in more privileged workers. Those who do not have the capacity or resources to engage with self-care in this way speak of a cycle of survival where self-care basically means getting through each day with no opportunity for any real improvement to their situation.

Interviewees spoke of the shame and judgment that comes with the loss of work ability and not feeling able to cope with distress. This is tied to the capitalist notion that workers have a moral and civic duty to be active producers and consumers participating in the economy. Workers and the unemployed poor who are unable to work are shamed as shirking their responsibilities as market-citizens. They are consequently driven deeper into poverty and desperation, or even criminalized and institutionalized. Even though the medicalization of mental health has opened up dialogue around experiences of depression and anxiety, the inability to work is still stigmatized and considered a drain on resources. Interviewees also spoke to the fact that in order to gain access to many services and be taken seriously by society, and particularly the state, a medical authority must confirm illness experiences with official diagnoses. Furthermore, the need for an official designation confirming the inability to work, as required for access to disability support, reinforces the notion of the defective worker.

For capital, the primary purpose of medicine is to recuperate work ability and reintegrate workers back into the workplace, often commodity-based treatment such as antidepressants. Due to the medicalization of mental health, people who experience distress often seek medical attention when they feel they can no longer cope on their own. Also, doctors are the only way to legitimately secure medication. Medicalization as a social process alienates patients from the treatment process, from their own illness experience and the functioning of their body, and from the collective experience of shared distress. Interviewees shared their experiences navigating the medical community and seeking help for their distress. Several spoke of medical treatment and their interactions with doctors as

not fully addressing their concerns, which left them feeling confused and lacking important information.

Navigating the medical community for interviewees was a cold and clinical experience with doctors/psychiatrists seeming uncaring, detached, or even patronizing. Interviewees often felt rushed and unheard during appointments where they would be prescribed antidepressants based on minimal consultation. Some interviewees also said that they felt that the explanations they were given by medical experts were oversimplified and did little to contribute to any firm understanding of the underlying causes of their distress. In terms of information about medication, several interviewees recalled that doctors did not offer any meaningful explanations regarding how the medication worked, what could be expected while taking them, or the risks associated with adverse reactions.

The effectiveness of antidepressants is indicated by an increased capacity to tolerate distress and maintain work ability in a social and economic environment of insecurity and exploitation. Some interviewees expressed the instrumental usefulness of antidepressants in enabling them to do what they needed to do in the everyday. However, the main issues with antidepressants identified by participants were cost, concerns around dependence and withdrawal, and intolerance to side effects. Adverse reactions to antidepressants can be a traumatic and dangerous experience, the recovery from which may take an extended period of time. Also, there were concerns around antidepressant use resulting in a false sense of wellbeing that enabled the tolerance of distress through a kind of numbing, but also enabled conformity to a damaging status quo. For some participants, this inhibited them from challenging structural oppression and engaging in alternate modes of care and recovery.

Interviewees also shared their opinions on what is required in order to achieve more genuine health. They spoke of resisting the internalization and reproduction of destructive capitalist social relations. Two primary components of genuine health were identified as the practicing communal care and organizing of collective action. This involves the fostering of sustaining relationships rooted in mutual aid. Additionally, cultivating genuine health involves building community based on interconnectivity and a relocating of distress within social, political, and economic structures.

## **Chapter 8: Conclusion**

## **8.1 Introduction**

The sociological examination of health and work benefits from considering 1) the historical trajectory of psychiatry and mental health as a professional practice, 2) how capitalist and neoliberal ideology informs dominant responses to mental health issues, and 3) the ways in which the medicalization of distress has been broadly internalised.

This dissertation has demonstrated that the insecurity, alienation, and exploitation inherent to capitalist commodity production is damaging to the mental health of workers. However, the primary contribution of this dissertation is an examination of the medical response to the distress felt by workers and the unemployed poor living in precarity, specifically with the use of antidepressant medication. The technomedical approach to treatment is reinforced by the conceptualization of functional health and work ability, where distress and illness are treated with commodified medicine developed and marketed by an opportunistic pharmaceutical industry. This medicalized response to mental health issues is insufficient, as the broader social and economic conditions of capitalism are not taken into consideration as contributing factors. A structural approach is needed if genuine health is to be attained.

## **8.2 Medicalization and Depoliticization**

Western medicine categorizes health and illness based on measurements falling

outside of a normal range of functioning. In this way, illness is considered abnormal and tied to concepts of dysfunction and disorder. Medical diagnosis provides a confirmation of disease and locates dysfunction in the individual treated with the use of medical technologies that target biological functioning. By locating dysfunction in the body, feelings of illness and distress becomes the purview of the medical community and detached from broader social structures that could be contributing to the development of these illness experiences. Framing the body as a machine to be restored to normal functioning reinforces a “technomedical” approach to health that relies on pharmaceuticals as treatment. A term developed by Davis-Floyd and St. John (2001), this approach outlines the underlying precepts of a Western approach to health as reflective of medical ideology and capitalist values regarding the disease model, detached expert authority, and profit generation. The technomedical model then, fetishizes commodity-based treatments and objectifies the patient, alienating them from the treatment process as well as from the workings of their own body.

#### *Individual Responsibility and the Patient-Consumer*

The social and legal authority extended to the medical expert reinforces social convention to seek out medical help for distress and illness, particularly when patients feel like they can no longer cope on their own. The inclusion of a growing number of illness experiences associated with negative affect has led to the medicalization of everyday life stress. At once medicalization serves to alleviate some the stigma attached to mental health issues, and reinforce an individual approach to their treatment. This places the responsibility to return to normal functioning on both the doctor and the patient.

The notion of individual responsibility is tied to neoliberal ideology regarding personal autonomy and resilience. Here, stigma, judgement, and shame are reapplied to the individual through a moralizing discourse, referred to as “healthism,” that disciplines people to follow certain popular conceptions of functional health and prescribed health seeking behaviours. Healthism is defined as a form of medicalization that reinforces a depoliticized, individualistic view of health (Crawford, 1980, 1977). These behaviours include self-care and self-help practices that often require a certain level of class privilege to access. In this way, if people do not engage in health seeking behaviours, they are then blamed for causing their own health issues. Lacking in class privilege, this negative perception disproportionately affects precariously employed workers and the unemployed poor.

The notion of the patient-consumer is integral to the profitability of the pharmaceutical industry, that advertises directly to consumers (however possible). This includes not only the marketing of particular drugs, but also of particular disorders. This is known as “condition branding,” which usually takes the form of public awareness-raising campaigns and the promotion of pharmaceutical treatments to both doctors and patients. The emphasis on profitability in the pharmaceutical industry and the commodification of medicine has raised ethical concerns within the medical research community. Many of these concerns revolve around the influence of private industry in the development of new treatments, as well as the development of new disease categories. The pharmaceutical industry has been at the centre of much controversy regarding conflicts of interest, unethical practice, and disease-mongering.

### *Prescribing a Return to Productivity*

The proliferation of pharmaceuticals as treatment is reflective of an approach that relies on biomedicine to repair the objectified body, removed from broader social and economic conditions. The point I am raising here is that medicine exists as a commodified good within a capitalist economic system that prioritizes profitability and production over human need. Remember that mine is a structural analysis of health. As such I am not speaking to individual practitioners, but to the social, political, and economic institutions that influence the way medicine is practiced. The oppressive nature of capitalism prioritizes profitability and productivity, making work ability the primary component of functional health. For capital, functional health is defined as the ability to work and participate in the capitalist market as a producer and consumer of commodities. This reinforces the idea that the primary purpose of medicine is to increase work ability and boost productivity in workers.

A consideration of alienation theory and the basic organization of capitalist commodity production demonstrates that capitalism is incompatible with genuine human fulfillment and health. Chipping away at past gains in worker security, the goal of capital is to make it impossible for workers to be self-sustaining. Workers are then wage-dependent, relying on the purchase of the commodities they, as a class, have produced under oppressive conditions. In this way, capital is at once the purveyor of health, through the distribution of commodities such as medicine; and the purveyor of illness, through an organization of work that relies of the deepening of precarity and exploitation.

The development of disease categories reflects the social construction of health and illness, as well as the way in which dysfunction is defined. The medicalization of mental

health was a central development in the socio-historical trajectory of psychiatry as a profession. The role of the psychiatrist is now similar to that of other medical doctors in that the primary focus is on the reintegration of patients into the workplace and returning them to “normal” functioning. Psychiatry typically relies heavily on the use of pharmaceutical treatments such as antidepressants. The widening of diagnostic boundaries and inclusion of a growing number of disease categories in the Diagnostic and Statistics Manual of Mental Disorders (DSM) illustrates the extent to which negative affect, such as sadness or anxiety, has been medicalized. This has led to criticism and continued controversy around distress as pathology within the medical and wider communities.

Struggling to survive precarious living and working conditions is harmful to physical and mental health. Neoliberal policy and cuts to the public funding of healthcare and education have worsened the situation. Even though a significant part of the problem is structural, distress/dis-ease in workers is treated individually due to the medicalization of distress. Locating dysfunction in the individual can also lead to internalization and reification of oppressive social and economic conditions. The medicalization of distress related to broader social issues serves to depoliticize them. This depoliticization exacerbates social isolation and disintegration, which enables the perpetuation of harmful conditions. It also limits people’s capacity to organize together for social change and stunts people’s capacity to imagine alternative ways of living that do not rely on capitalist commodity production.

### **8.3 The Precarious Foundations of Capitalism**

Precarious employment has always been an objective for capital. The first order for a capitalist mode of production is the removal of all other means of subsistence. Workers

must be made dependent on wages and the purchase of commodities for survival. For capital, the goal is to keep wages at a minimum while maximizing the extraction of surplus value from labour. Capitalist commodity production objectifies the labour of workers and alienates them from their creative essence, from the labour process, and from each other. This serves to dehumanize workers as a source of cheap and disposable labour and prevents them from fulfilling their human potential. The attainment of genuine health revolves around the development of human potential through meaningful labour and relationships.

### *Working Class Distress*

Through an examination of current working conditions, it becomes evident that the capitalist organization of work, as a system, is detrimental to genuine health. Advancements in information-technology and the outsourcing/insourcing of cheap labour have enabled the suppression of wages and the casualization of employment. Increasing scarcity in the international labour market has lent to the creation of a global reserve of labour. This abundance of labour power has exacerbated competition between workers, breaking down solidarity and chipping away at the gains fought for by the labour movement. Additionally, neoliberal ideology – based on the maximization of self-interest and the deregulation of the market – has led to cuts to public funding of social services. These cuts have downloaded risk and increasing insecurity onto precariously employed workers and the unemployed poor.

Increasing social precarity reinforces the notion of the sovereign market-citizen left to survive by their capacity to participate and compete in the capitalist labour market. Precarious conditions of labour result in the intensification of alienation and distress. This distress leads workers to seek medical help where, if their distress is confirmed as valid,

they receive individual commodity-based treatment. Because, for the worker, survival depends of their ability to work, functional health is determined by work ability and productive output. Furthermore, genuine health is not possible due to the fundamentally exploitative and alienating nature of the capitalist mode of production.

Recall that the first order of capitalism is to cut off all other means of subsistence from workers, forcing their dependence on commodity production under threat of facing ruin. Increasing conditions of precarity are conducive to this dependence and deepens workers' desperation, causing them to be more likely to accept whatever wages they can get. One example of this is the casualization of academic labour where contingent workers are contingent in status only, while performing essential labour and occupying positions that are in actuality permanent components of the institutional structure.

Through cuts to social assistance and the demonization of the unemployed poor, increasing social precarity threatens the very survival for working class people who, for whatever reason, are unable to work. Even when backed by medical authority, people lacking in work ability are perceived by capital as defective and a burden to the system.

#### **8.4 Towards Genuine Health**

The stories and reflections shared by participants reveal the limitations of the treatment of distress with antidepressant medication. Many of their conceptualizations of genuine health included taking a critical look at the social structures of capitalism as an economic system. The prioritization of employment and productivity as an indication of health is misleading. This functional view of health is unsustainable given current conditions. What is needed is the constitution of genuine health as a departure from the way in which health is defined by capitalism. Efforts in genuine recovery, as indicated by

interviewees, require a return to the fulfillment of human needs. This involves caring for ourselves and for each other in ways that destabilize workers' dependence on wages and commodity consumption.

### *Communal Care and Collective Action*

Genuine recovery from the distress related to the organization of capitalist society requires the recovery of the means of subsistence for workers, which would enable the pursuit of more meaningful labour. This way, workers would not be limited to work for whatever meagre wage was made available to them through precarious employment. Here, subsistence could be achieved through increased worker cooperation and control over the labour process with the ultimate goal of decommodifying labour altogether. It becomes possible to imagine a future where workers are no longer estranged from their labour or the product thereof. In this context, the interconnectedness of social relationships that make up society becomes more apparent, as does the importance of solidarity.

Many of the gains won through the collective actions of workers in the labour movement have been dismantled through the neoliberal restructuring of work, resulting in the casualization of labour and control taken away from workers. Reclaiming these gains and demanding new ones would involve the reuniting of people through workplace political organizing with an emphasis on solidarity between worker groups, as well as solidarity between workers and the unemployed poor. This reconnection works against social isolation and alienation. It also repoliticizes the workplace by locating mental health within broader social structures, including the organization of work. Collective action must be rooted in compassion, the need for meaningful labour, and the fulfillment of human

potential. In this way, part of caring for each other is protecting the rights and dignity of all.

Another essential component of recovery is communal care and the cultivating of mutually supportive relationships. Building networks of support is essential for genuine health. Communal care also fosters social cohesion and feelings of social security through mutual aid and trust. Such an organization of society is reflective of the principle popularized by Marx (1970 [1875]: part 1), “From each according to [their] ability, to each according to [their] needs.” This is indicative of a society built on a foundation of genuine health, instead of distress and work ability.

## **8.5 Conclusion**

This dissertation has situated the relationship between declines in mental health and precarity within the broader conditions of a specifically capitalist society. The inherent alienation and exploitation of capitalist commodity production underlie the progressive deepening of precarity and removal of social and economic security. The deepening of precarious working and living conditions are damaging to the mental health of workers and the unemployed poor. These damaging social and economic conditions – for example, the organization of work – must be addressed in order to achieve a genuinely healthy society. In this way, work and health must be recognized as not only an embodied experience, but also a collective experience.

The analysis presented throughout demonstrates that the medicalization of mental health reinforces a reliance on commodity-based treatment and inflates market demand for medication, such as antidepressants. The primary contribution of this dissertation is a theoretical analysis that investigates the pharmaceutical treatment of distress and illness.

Ultimately, my conclusion is that an individual, medicalized approach to mental health is insufficient given the damage that the broader social and economic conditions of capital are known to cause mental health. Therefore, in order to develop more sustainable and equitable ways to achieve and maintain genuine health, a structural approach is needed.

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## APPENDIX A

TITLE: “Medicating the Crisis: Investigating the links between precarious employment, mental health issues, and the reliance on antidepressants as treatment ”

### INTERVIEW GUIDE

#### Interview Themes:

##### *Health and everyday life:*

- What is means to be “healthy.”
- How health is managed in everyday life.

##### *Emotions:*

- How emotions, trauma, everyday life stress are framed and understood.
- What to say when asked, “How do you feel?”
- The idea of controlling your emotions.

##### *Medicalization:*

- Treatment and the kinds of things that require treatment.
- Why people take pharmaceuticals (like, antidepressants).

##### *“Work ability”:*

- What is required to be able to work (emotionally/physically).
- How people are able to make a living.

#### Interview Questions:

##### **DEMOGRAPHICS:** (without stating your name)

- Where do you live?
- How old are you?
- What do you do for a living?
  - Do you like it?
- How would you describe a typical day?

##### **HEALTH:**

- From your perspective, what does it mean to be “healthy”?
- What is important to health?

- How would you say you manage your health?
- How do you respond to someone if they were to ask you “How are you feeling?”
- Do you find that you’re stressed?
  - What contributes to your stress level?
  - How do you cope with the stress you feel?
- Do you have a diagnosis?
  - What does your diagnosis mean to you?

**ANTIDEPRESSANTS:**

- Are you on antidepressants right now?
  - Have you in the past?
  - What kind?
- When did you first hear of antidepressants?
- When did you first start thinking of taking antidepressants?
- What did you know about them?
  - What did you think they would do for you?
  - Why did/do you take them?
- What role do you see antidepressants playing in your life?
  - Do you see them as long term? Short term?
- When did you start/stop taking them?
  - What was that like?
  - I’m wondering if you could just talk a bit more about your experience taking antidepressants...
- How did you come to be prescribed antidepressants?
- How would you compare how you felt on a typical day before antidepressants to how you feel while taking antidepressants?
- Have there been any negative effects from taking antidepressants?
  - Given any negative effects, are the antidepressants still worth it? Why? / Why not?
- How has taking antidepressants affected your relationships with family / friends / coworkers?
- Do you know other people who also have taken, or who are on, antidepressants right now?

- Besides antidepressants, is there anything else that you do that you would consider self-medicating or habitual (i.e.: smoking, alcohol, caffeine, etc.)?

**WORK:**

- What is required to be able to work (emotionally/physically).

- How people are able to make a living.

- Would you say that employment has the capacity to damage one's health? How so?

- Would say it also has the capacity to contribute to one's health? How so?

- How would you describe your job? (looking for a job?)

- How would you describe your relationships with your family / friends / coworkers?

- Do they seem to share the same stresses as you?

- How do they cope with stress?

**EMOTION:**

- What role would you say emotions play in your life?

- Have you ever looked into or received any kind of therapy (i.e.: talk therapy, psychologist, counselling, group support, etc.)?

- Has it made a difference?

- Do you feel like you are part of a community?

- Would you say you have a strong social support network? What makes you say that?

- How would you describe your sense of control/power in everyday life?

- Do you feel as though you can affect change in your life?

- Is there anything in particular that makes you feel that way?