"It's More than Sadness": The Discursive Construction of Depression on Australian Mental Health Websites

Grace R. Horwood

School of Psychology

University of Adelaide

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Abstract

Depression has been the subject of increased awareness and concern in Australia in recent decades. Whilst previous studies have examined the discursive construction of depression in the mass media and in government policies, there is a lack of research into how depression is constructed on mental health websites, which are an influential source of information frequently accessed by the public. In this study, a discourse analytic approach informed by critical discursive psychology was employed to analyse the informational content of eight major Australian mental health websites concerning depression. Analysis focused on identifying interpretive repertoires used to talk about depression, the associated subject positions they made available and how they negotiated any ideological dilemmas around conflicting constructions of depression. Four interpretive repertoires were identified in the data – a biomedical, a self-optimization, a normal-natural and a societal-structural repertoire of understanding depression. The biomedical and self-optimization repertoires were predominant, and constructed depression as an illness within an individual occurring as a result of a biological or psychological deficit. The recommended response was for individuals to seek treatment or education from professionals. It is argued that this way of understanding depression is particularly compatible with neoliberal ideology in that the problem is located within the individual rather than with society, and individuals may be positioned as responsible for managing their own mental health, under the guidance of experts. The implications for individuals and societies of understanding depression in this way, and not in alternative ways, are discussed.

Declaration

This thesis contains no material which has been accepted for the award of any other degree of diploma in any University, and, to the best of my knowledge, this thesis contains no material previously published except where due reference is made. I give permission for the digital version of this thesis to be made available on the web, via the University of Adelaide's digital thesis repository, the Library Search and through web search engines, unless permission has been granted by the School to restrict access for a period of time.

September 2020

Contribution Statement

In writing this thesis, my supervisor and I collaborated to generate a research question of interest, select the data corpus and design the appropriate methodology for analysis. I conducted the literature search, collected the data, performed the analysis of the data and wrote up all aspects of the thesis. My supervisor reviewed the thesis and suggested changes, which were incorporated.

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"It's More than Sadness": The Discursive Construction of Depression on Australian Mental Health Websites

Chapter 1: Introduction

1.1 Models of Mental Illness

The concept of mental illness has long been a contested one. Since the nineteenth century, psychiatry in the Western world has sought to establish itself as a branch of the natural sciences, and a medical approach to mental illness has become dominant. The medical model of mental illness posits that mental illnesses are equivalent to physical illnesses in that they are caused by a dysfunction or disease in the physical body, in this case the brain or nervous system (Kiesler, 2000; Thachuk, 2014). The cultural hegemony of the medical model has been strengthened by recent growth in the fields of genetics and neuroscience (Fulford, 2014; Rose & Abi-Rached, 2013). However, alternative ways of understanding mental and behavioural disturbances have always existed. Fulford (2014) identifies seven models of mental illness – scientific (medical), psychological, social role theory, labeling theory, political, existential and moral. The common thread over time between various models has been a tension between the scientific or medical model, with its deterministic biological understanding of mental illness, and alternative models, which all seek in some way to reclaim a role for human agency and subjectivity. This indicates that there exist two fundamentally opposed ways of understanding mental illness – the medical and the moral (Conneely et al., 2020).

1.2 Depression

According to the World Health Organization ("WHO"), depression is a "common mental disorder … characterized by persistent sadness and a lack of interest or pleasure" in previously enjoyed activities (WHO, 2020). Depressive disorders are now the single largest contributor to disability worldwide, and are likely to be the leading cause of disease by 2030 (WHO, 2012; 2017). In Australia, the current prevalence of diagnosable depression in the general population is around six to seven percent (Lim et al., 2018; Slade et al., 2009), and lifetime prevalence is around 15 percent (Slade et al., 2009). Depressive disorders result in the largest number of days of reduced functioning of any mental disorder (Slade et al., 2009). As such, depression is considered to represent a significant proportion of the burden of ill health in Australia.

Depression has come to be seen as the illness most emblematic of the modern age (Horwitz, 2011). Whilst the medical model of mental illness generally has been dominant for over a century and a half (Malla et al., 2015), the application of the medical model to milder forms of depression is a relatively recent development. Up until around 50 years ago, depression was a relatively rare diagnosis usually limited to severe cases requiring hospitalization (Horwitz, 2011; Shorter, 2013). Since that time, however, depression has become the most common mental illness treated by professionals. This may reflect a real increase in the number of people who are depressed; but is also likely to reflect the broadening of diagnostic boundaries from 1980 onwards to encompass mild and moderate forms of depression as well as severe forms (Horwitz, 2011; Wakefield & Horwitz, 2016).

1.3 The Medical Model and Depression

Since the 1980s, concerns have risen in Australia about the impact of depression upon individuals and the national economy. Since it was found that depressive disorders were

common, and that most people with depression went untreated, efforts to tackle the problem focused on closing the 'treatment gap' (Jorm, 2014). Antidepressant consumption has steadily increased since that time (Jorm et al., 2017), with 15 percent of Australian adults now prescribed antidepressant medication (Whitely et al., 2020). The delivery of psychological therapy has also increased exponentially since 2006 through the Better Access scheme (Jorm, 2018). Provision of treatment has been supplemented by educational measures to improve the 'mental health literacy' of the population (Jorm, 2012). A key aim of mental health literacy campaigns has been to encourage the public to view depression as an illness just like a physical illness (Jorm, 2000), which has nothing to do with a person's character. Official sources of information now typically endorse the medical understanding of depression as the correct and enlightened view, and denounce moral understandings as incorrect, outdated and a source of harmful stigma (Conneely et al., 2020). Mental health literacy campaigns in Australia since the mid-1990s have led to a marked increase in the prevalence among the public of medical and biological explanations for depression (Jorm et al., 2006a; Kokanovic et al., 2013; Pilkington et al., 2013; Read, 2007). Yet despite increased provision of treatment, and despite improvements in the 'mental health literacy' of the population, rates of depression have either stayed the same, or have increased (Jorm, 2014; Jorm, 2018).

Shifts in the popular understanding of depression in Australia towards medical explanations have tended to reflect similar trends in other Western countries (Schomerus et al., 2012). However, moral explanations of mental illness have proved surprisingly difficult to extinguish from the public consciousness (Conneely et al., 2020; Kokanovic et al., 2013). In a 2011 Australian survey, 88 percent of respondents attributed depression to a biological cause, e.g. a chemical imbalance; 95 percent saw depression as a meaningful response to day to day

problems, loss or trauma; and 39 percent saw depression as a sign of weakness of character (Pilkington et al., 2013). Conneely et al. (2020, n.p.) suggest the resilience of the moral model indicates that "the moral view of depression represents an enduring aspect of our understanding of ourselves, which the medical view has been superimposed onto, but has not managed to suppress".

The main rationale behind the promotion of the medical model has been that, if depression is seen as an illness outside of the control of individuals, then this will reduce blame and stigma and encourage help-seeking (Barney et al., 2009; Jorm & Griffiths, 2008). A person's distress is socially legitimized as 'real', and a potential threat to their moral identity is avoided (Conneely et al., 2020; Lafrance, 2009). However, others argue that the premise that an illness discourse will reduce stigma is flawed (Read, 2007; Sarbin & Mancuso, 1970). Whilst increases in biomedical explanations among the public do reduce blame and result in greater acceptance of medical treatment, they also result in unchanged or, in some cases, worse attitudes on other measures such as perceived dangerousness and social distance (Schomerus et al., 2012). When diagnosed with a mental illness, people are often viewed as fundamentally broken, different and defective (Malla et al., 2015; Phelan, 2002).

1.4 Critiques of a Medical Discourse of Depression

A central challenge raised to the validity of the DSM diagnosis of 'Major Depressive Disorder' is that nearly all of the symptoms listed could feasibly occur without a mental disorder or dysfunction being present at all (Kutchins & Kirk, 1997). As such, concerns have been raised about the inappropriate 'medicalization' of normal human emotions (Rapley et al., 2011). Horwitz and Wakefield (2007) have argued that a short, or indeed long, period of intense sadness following an experience of major loss is a universal part of the human experience, and, far from

being disordered, is probably adaptive. More general states of unhappiness or existential despair may not be dysfunctional but may be a sign of an accurate appreciation of the transience of life, or may act as a catalyst for positive change (Dowrick & Frances, 2013).

Another major critique of a medical discourse of depression is that the role of social and societal factors in causing mental distress is obscured. This means that responses are misdirected at fixing the individual rather than fixing the society. Evidence shows that the past and present circumstances of people's lives, as well as many environmental factors characteristic of modernity, are highly associated with the development of depression (Boyle, 2011; Brown & Harris, 1978; Hidaka, 2012; Mirowsky & Ross, 2003; Wilkinson & Pickett, 2010; Hari, 2019). Social factors which have consistently been shown to be related to depression include child abuse, domestic and sexual violence, discrimination, inequality, racism, poverty, unemployment, loneliness and social disconnection.

1.5 Medical Discourses of Depression and Neoliberalism

How depression is understood is important because the way we construct the nature of a problem determines the nature of our response to it, and whom we see as responsible for responding to it (Burr, 2003). From a governmentality perspective, how subjects are governed will depend upon how they are understood by governments, and what kind of subjects they perceive themselves to be (Barry et al., 1996; Rose, 1990). Foucault theorized that in modern liberal societies, the governing of individuals occurs just as much through processes of free individuals choosing to act upon themselves, as it does through individuals being forced to act upon themselves (Barry et al., 1996). Governments must therefore employ a complex range of techniques which 'act from a distance' to translate their goals into the choices of individuals (Rose, 1990). Foucault also theorized that the regulation of the bodies and health of subjects, or

bio-politics, has emerged as a key feature of modernity. Since the mid-twentieth century, the psyche in particular has become a primary site through which governments, via experts, are able to constitute the modern subject in desired ways.

Since the 1980s, neoliberal economic policies have been implemented by governments in many developed nations including Australia. Neoliberalism is a worldview which elevates the ideals of human worth and individual freedom above all other ideals (Harvey, 2005). Neoliberalism understands individuals as rational, autonomous entities motivated primarily by self-interest (Cosgrove & Karter, 2018). From this it follows that individual needs can best be met through the reduction of government involvement and the participation of individuals in the free market (Burchell, 1996; Cosgrove & Karter, 2018). As it is premised upon a certain understanding of what kind of beings humans are, neoliberalism produces corresponding forms of subjectivity. Teo (2018, p. 583) speaks of the "neoliberal form of subjectivity", which is dominated by the economic form of life, and which "colonizes" all other forms of life such as the intellectual, social, artistic, political and religious - even colonizing the self. Market values and market-based thinking have increasingly pervaded every area of life (Sandel, 2012). Objects, practices and persons become commodified and valued primarily in terms of their monetary worth or utility. Under neoliberal forms of subjectivity, the self becomes understood as an 'entrepreneurial entity' competing in the marketplace (Teo, 2018; Tseris, 2017). The need to continuously promote the self and compete means that qualities such as flexibility, adaptability, resilience, optimism, self-reliance, confidence and extraversion are most valued in neoliberal societies. This way of being thus tends to become normalized in neoliberal societies as natural and healthy, whilst other ways of being tend to become regarded as aberrant and unhealthy

(Cosgrove & Karter, 2018). Ideals such as equity, civic engagement, civic duty, social solidarity and generosity tend to become increasingly obsolete.

While those with a clear vested interest, such as pharmaceutical companies, have played a major role in the promotion of a medicalized discourse of depression (Raven, 2012; Moncrieff, 2006), neoliberal governments have been willing partners in this project. It has been suggested that this is because the medical model accords well with neoliberal ideology, in that both emphasize the role of the individual and de-emphasize the role of society (Moncrieff, 2014; Rose, 1996; Tseris, 2017). In neoliberal societies, the worth of individuals is based on their productiveness as workers and consumers, which they are expected to maximise. Depression is costly to the economy in lost productivity, but rather than being the target of interventions by the state, individuals in neoliberal societies must take responsibility for their own health (Rose, 2007). Thus, individuals who are distressed or struggling to cope are encouraged firstly to understand themselves as having an illness; and secondly to responsibly and without delay consume expert commodities such as diagnoses, medications, therapies, educational resources and lifestyle advice (Timimi, 2017) in order to restore themselves to health and productivity. While this way of knowing and doing depression is now so pervasive as to seem like common sense, it is historically novel and is the result of concerted and sustained efforts to represent and understand depression in this way.

1.6 Online Mental Health Information

The internet is increasingly used by the public to source general health and mental health information, particularly by younger people (Carlisle et al., 2019; Torous et al., 2019; Wong et al., 2014). Accessing health information online has advantages for users of convenience, cost and privacy. The use of the internet to source health information is significantly higher amongst

those suffering from commonly stigmatized illnesses such as anxiety and depression, compared to those suffering from less stigmatized conditions such as cancer, heart disease and diabetes (Berger et al., 2018; Gowen, 2013; Powell & Clarke, 2006). The internet is thus a prime site for educating the public in regard to mental health.

Since the 1990s, Australia's national mental health strategy has included efforts to increase the mental health literacy of the population, and one of the ways this has been done is through the creation of online resources. The *Beyondblue* website was one of the first of these and has been a key platform for the dissemination of information around depression (Jorm, 2012). Exposure to *Beyondblue* messages has been found to influence public attitudes toward mental health (Jorm et al., 2006b). Since 2000, mental health websites and online resources have proliferated in Australia. In 2017 the Australian federal government launched *Head to Health,* a single online 'mental health gateway', in order to link mental health professionals and consumers to online resources judged to be of high quality (Sturk et al., 2019). Websites providing information about mental health are therefore recognised as an important influence upon public and private discourses around depression in Australia.

1.7 The Present Study

In this thesis, critical discursive psychology will be used to analyse eight major Australian mental health websites, looking specifically at how the concept of depression is constructed in the information provided on those sites. Reviews of Australian mental health websites exist, but most have appraised sites chiefly in terms of the evidence-based nature of the information presented (Griffiths et al., 2005), or in terms of their effectiveness in reducing stigma and increasing mental health literacy and help-seeking (Griffiths et al., 2004). Whilst such reviews are valuable, they do not question the epistemological underpinnings of depression

websites and how they might serve to construct depression in particular ways, nor what other discourses might be excluded (Fullagar, 2008).

Discourse analysis has been used to study health websites concerning other health conditions, for example dementia prevention (Lawless et al., 2018) and breast cancer (Gibson et al., 2016). Discourse analytic research has been carried out in respect of the portrayal of depression in the mass media (Clarke & Gawley, 2009; Rowe et al., 2003), and in government policy documents (Fullagar & Gattuso, 2002; Teghtsoonian, 2009). However, few studies have analysed the information presented on mental health websites using discourse analysis. Young et al. (2004) deconstructed six Australian depression websites from a critical feminist perspective using material-discursive analysis. A particularly relevant study was carried out by Fullagar (2008), who critically analysed the discursive construction of depression on the *Beyondblue* website. Fullagar (2008) found that biomedical language and discourse predominated. Depression was primarily constructed as a biochemical dysfunction of the brain affecting the individual and requiring expert knowledge to understand and treat. Except in the case of post-natal depression, power relations, social roles and structural inequalities were not addressed in any detail as potential explanations for persistent emotional distress (Fullagar, 2008). No other studies have been located which have employed a discursive perspective to examine the information content of Australian mental health websites.

This study will adopt a critical discursive psychological approach (Edley, 2001; Parker, 2015b; Wetherell & Potter, 1992) to examine how the concept of 'depression' is constructed and understood on Australian mental health websites currently. Findings will be interpreted and discussed in light of the historical, political and cultural context, and the personal and social implications of how depression is understood.

Chapter 2: Method

2.1 Data Corpus

The data for this study are comprised of the content of the eight mental health websites which are linked to the Australian government's *Head to Health* mental health gateway, in the section on depression. These eight sites are all major, well-known Australian mental health websites. All of the sites receive government funding but are independently operated and administered. Given that these are the information resources which users are directed to by the Australian Government, these websites can reasonably be considered to be representative of the discourses around depression that are dominant and culturally sanctioned in Australia currently.

To manage the large amount of website material, analysis was restricted to web pages or fact sheets which addressed the general questions "what is depression?", "what causes depression?", and "what should be done about depression?". Discussion forums, message boards and other interactive resources were not included in the analysis. This project did not require ethics approval as the material was in the public domain and accessible to anyone.

The websites analysed are listed in Table 1 below in alphabetical order.

Table 1

Summary of Websites Selected for Inclusion in Analysis

Website Name	Website Address
Beyondblue	www.beyondblue.org.au
Black Dog Institute	www.blackdoginstitute.org.au
BluePages	www.bluepages.anu.edu.au
Headspace	www.headspace.org.au
MindSpot	www.mindspot.org.au
ReachOut	www.au.reachout.com
SANE Australia	www.sane.org
Youth Beyondblue	www.youthbeyondblue.com

The websites above were all visited on one day, 31 March 2020, and all data analysed in this project was as at that point in time. Pages about depression which were relevant were captured via either screen shot or copying and pasting text into a document. Any additional fact sheets or brochures on depression which were within the scope of this study were downloaded and saved to the same electronic folder. Analysis was carried out in two stages in line with the procedure recommended by Potter and Wetherell (1987). Firstly, website data was read repeatedly and carefully to build familiarity. Whilst reading, systematic patterns were searched for in language, terminology, images, metaphors or figures of speech. Secondly, hypotheses were formed as to the functions and effects which might explain the patterns observed, including

what potential alternative versions of reality may have been countered. Extracts were chosen to illustrate each of the main themes identified, and findings were considered in light of the historical, political and social context.

2.2 Data Analysis

Analysis in this project drew upon insights from discursive psychology, and especially critical discursive psychology. In its widest sense, 'discourse' refers to all written, spoken and other forms of communication (Potter & Wetherell, 1987). Foucault (1972/2010, p. 49) described discourses as "practices that systematically form the objects of which they speak". Discourse analysis is "the systematic study of discourse and its role in constructing social reality" (Augoustinos, 2017, p. 205). Discursive psychology is grounded in a social constructionist epistemology, and focuses on the action orientation of language to do, achieve and create things. This is in contrast to mainstream psychology which is based on a positivist epistemology and tends to see psychological constructs as existing 'out there' in the world awaiting discovery and description (Augoustinos, 2017). Critical discursive psychology draws on a range of intellectual traditions in linguistics, philosophy and psychology. It also draws on the influential theories of Foucault on power in the modern world through the shaping of subjectivities. Critical discursive psychology looks at how psychological discourses are situated in the larger historical, cultural and political context, how psychological discourses operate to create and structure the understandings and identities of subjects, and how and why certain discourses come to be dominant and attain the status of fact in a certain place and time (Edley, 2001).

Key concepts in critical discursive psychology are interpretive repertoires, ideological dilemmas and subject positions (Edley, 2001). These central analytic concepts were used to guide the analysis of the data in this study, and are briefly outlined here.

Interpretive repertoires were defined by Potter and Wetherell (1987, p. 138) as “a lexicon or register of terms and metaphors drawn upon to characterize and evaluate actions and events”. More recently they have been described as “coherent ways of speaking that form over time, becoming easily recognisable arguments, assumptions, metaphors, figures of speech, and images” (Van Der Merwe & Wetherell, 2020, p. 230). An interpretive repertoire can be thought of as a ‘toolkit’ of linguistic resources which people in a culture can draw on to construct a certain version of an event or phenomenon (Burr, 2003). This ‘toolkit’ contains a selection of related terms, descriptions, metaphors, tropes, images or figures of speech which are typically drawn upon when talking about a social object. Interpretive repertoires are closely related to discourses, but focus less upon the abstract workings of power and more upon how the content of discourse is organized and used by people to perform actions in social situations (Wetherell & Potter, 1992). There are no set analytic rules or procedures for identifying interpretive repertoires in data (Edley, 2001). Rather, the researcher builds familiarity with the data to the point where certain recurring patterns of talk or argument become apparent in regard to the topic of interest. Often two or more distinctive interpretive repertoires or ways of talking about the same issue will emerge from the data. Different repertoires can construct the same event or phenomenon in different ways, and people may draw upon different repertoires simultaneously or at different times, depending on the context and their purpose at the time.

Whilst there are a number of different ways of thinking about ideology, critical discursive psychology focuses on ideology as “knowledge deployed in the service of power” (Burr, 2003, p.

85), and in the form of the ‘common-sense’ of a culture, referred to as its “lived ideologies” (Edley, 2001, p. 203). Billig (1991) has argued that lived ideology is by nature “dilemmatic”, that is, the lived ideologies of a culture do not form a consistent and unified whole but will always contain at least two opposing ideals or arguments, which will tend to be organized rhetorically against the alternative. These conflicting ideologies prevailing within a society at any one time have been referred to as ‘ideological dilemmas’ (Edley, 2001).

Ideological dilemmas informed the analysis in this study, as it was anticipated that there would be likely to be different ways of thinking and talking about depression. Given that descriptions are generally chosen and constructed against an alternative, “could-have-been-otherwise” account (Edwards, 1997, p. 8), attention was paid to dilemmas within the data; but also to whether there were any interpretive repertoires which exist in society but which were absent from the websites. Often what is left out of a description or explanation is significant, as this can perform the rhetorical work of bolstering one explanation by constructing the alternative as being irrelevant to the issue (Potter, 1996).

Subject positions are the identities produced and constructed for people by particular discourses or ideologies (Edley, 2001). The possible subject positions available to individuals undergoing certain experiences will be limited to the discourses or ideologies that are available to them in their society or culture at the time (Burr, 2003). Different subject positions will come with different roles, responsibilities, rights, obligations, possibilities for action and degrees of agency. As distinct ways of talking about social objects, interpretive repertoires will often provide or make relevant certain subject positions for participants (Edley, 2001). Subject positions were identified in the analysed material by repeated and close re-reading, with an eye to what a particular interpretive repertoire implies about the identity and position of the person

speaking and the person being spoken to, and what functions the implied subject positions might serve.

Chapter 3: Results

3.1 Interpretive Repertoires

On the eight websites analysed, depression was constructed and explained through the use of two main interpretive repertoires, which will be referred to as the 'biomedical' and the 'self-optimization' repertoires. A third interpretive repertoire, which will be referred to as the 'normal-natural' repertoire, was explicitly argued against. A fourth interpretive repertoire, which will be referred to as the 'societal-structural' repertoire, was noted to have a minimal presence on the websites.

3.1.1 The Biomedical Interpretive Repertoire

The biomedical repertoire was the predominant interpretive repertoire on nearly all of the websites analysed. Under this repertoire, depression was constructed as an illness occurring in an individual, and requiring intervention by medical experts to diagnose and treat. Terminology typical of the biomedical repertoire included symptoms, diagnosis, illness, medical condition, disorder, patient, doctor, clinical, treatment, recovery and relapse. Under this repertoire, depression was spoken of as an entity separate to the individual, which invaded their mind or brain and caused changes to their usual mood and behaviour. Depression was constructed as being unrelated to the individual's character or choices, and thus outside of the bounds of personal responsibility.

When it came to the question, "what is depression?", the predominant explanation was that depression is an illness or medical condition, as exemplified in Extracts 1 and 2.

Extract 1 - from *Black Dog Institute*, under the heading, 'What is depression?'

1. Depression is a common medical condition. It can cause a low mood that

2. doesn't go away and makes us feel very sad or withdrawn. It interferes with
3. the way we go about our everyday lives and can make it hard to cope.
4. Some people describe it as being in a really dark place that's difficult to come
5. back from. Others describe it as a numb feeling.
6. It's important to get help to manage depression. There are lots of ways to treat
7. it, and you can feel better.

Extract 2 – from *SANE Australia*, under the heading, 'What is depression?'

1. Clinical depression is an illness, a medical condition. It significantly affects the way
2. someone feels, causing a persistent lowering of mood.
3. Depression is often accompanied by a range of other physical and psychological
4. symptoms that can interfere with the way a person is able to function in their
5. everyday life. The symptoms of depression generally react positively to
6. treatment.

Extracts 1 and 2 both begin with a categorical assertion that depression is an illness or medical condition. The lack of any qualification, modality or hedging around these assertions serves to build factuality by conveying the impression that the statements are certain, undisputed and self-evident (Latour & Woolgar, 1986; Macdonald, 2002). Yet, despite the certainty expressed about depression being a medical condition, the descriptions of the symptoms that follow are vague, ambiguous and hedged - a pattern that occurred repeatedly across the websites. In these extracts, vagueness arguably functions to augment the factuality of the initial assertion, by removing the opportunity for the reader to scrutinize the detail for contradictions or errors which might undermine the overall argument (Potter, 1996). Carefully adjusted combinations of vagueness and detail may perform the "delicate rhetorical work" of rendering a claim difficult to

question, whilst providing just enough information to lead the reader to arrive at the desired understanding (Augoustinos et al., 1999). Both Extracts 1 and 2 end with a statement as to the importance of seeking help in the form of medical treatment. Thus, constructing depression as an illness provides the basis for the conclusion that seeking medical treatment is the solution.

In Extract 3, as in Extracts 1 and 2, depression is reified as a disease entity separate to the individual, and 'treatment' is referred to as the solution.

Extract 3 - from *BluePages*, under the heading, 'Types of help'

1. You deserve help
2. Are you finding it difficult to reach out for help? Perhaps your depression is making you
3. feel withdrawn and unable to cope with talking to a doctor. You might be feeling
4. embarrassed, or that your problem is not important enough to 'bother' a doctor. Perhaps
5. you imagine that depression is something you should be able to handle and fix yourself.
6. You might even think that you are not suffering from a real illness. If so, you are not
7. alone. Many people don't seek help for depression. However, depression is a serious
8. illness and you deserve help.
9. Depression is a serious illness.
10. Not convinced? Well, just consider this. Panels of experts have found that moderate
11. depression disrupts a person's life as much as multiple sclerosis, severe asthma or
12. deafness. Imagine not seeking help for multiple sclerosis or severe asthma because you
13. didn't want to bother the doctor!

In Extract 3, the taken-for-granted assumption is that the doctor's clinic is the proper place to seek help for depression. Other non-medical sources of help are not mentioned, despite the majority of the public rating support from family and friends as helpful for a person with

depression (Morgan et al., 2014; Reavley & Jorm, 2012). This is an example of 'ontological gerrymandering', or bolstering a particular definition of a phenomenon by strategically drawing the boundary between what is considered relevant to the description and what is not (Potter, 1996). By invoking medical help as relevant to a description of depression, and ignoring non-medical sources of help, the definition of depression as an illness is built up. In lines 11 and 12, metaphors likening depression to physical illness are drawn upon; a common feature of the biomedical repertoire. This serves to build the physical reality of the abstract construct of depression by suggesting a similar (if yet unknown) physical etiology (Read, 2007). Overall, the purpose of persuading the reader that depression is an illness appears to be to encourage them to seek medical help without delay (ll. 2-3).

Where the question of what causes depression was addressed on the websites, it was usually acknowledged that a range of factors could contribute. Extracts 4 and 5 demonstrate the varying and sometimes contradictory ways in which causation was talked about.

Extract 4 – from *SANE Australia* website, under the heading, 'How Medication Works'

1. Medical research suggests that Depression seems to be often associated with a
2. biochemical imbalance in the brain. Just as people with diabetes may need to take
3. insulin, so people with Depression may need to take medication to restore the
4. chemical balance in the brain and so reduce symptoms.

Extract 5 – from *Beyondblue* website, under the heading, 'What causes depression?'

1. Changes in the brain
2. Although there's been a lot of research in this complex area, there's still
3. much we don't know. Depression is not simply the result of a 'chemical

4. imbalance', for example because you have too much or not enough of a
5. particular brain chemical. It's complicated, and there are multiple causes of
6. major depression. Factors such as genetic vulnerability, severe life
7. stressors, substances you may take (some medications, drugs and alcohol)
8. and medical conditions can affect the way your brain regulates your moods.

In Extract 4, from *SANE Australia*, it is implied that depression is caused by a chemical imbalance in the brain in most cases. In contrast, other websites downplayed the 'chemical imbalance' theory of causation, such as *Beyondblue* in Extract 5. However, what the websites all shared was certainty that something disordered was going on in the brain of a person with depression. For example, in Extract 5 (l. 8), the various causal factors linked to depression are all said to disrupt the way the brain regulates the moods in some way.

When the websites discussed what should be done about depression, seeking medical treatment from a doctor/GP was recommended as the first step, as shown in Extracts 6 and 7 below.

Extract 6 – from *Beyondblue* brochure entitled, 'Understanding anxiety and depression', under the heading, 'Who can assist'

1. Anxiety and depression can go on for months,
2. sometimes years, if left untreated, and can have
3. many negative effects on your life. It's important
4. to seek support early – the sooner you get
5. treatment, the sooner you can recover.
6. Different health professionals offer different
7. types of services and treatments.

8. If you think that you or someone you know
9. may have anxiety or depression, talking to a
10. GP is a good place to start. A GP can make a
11. diagnosis, check for any physical health problem
12. or medication that may be contributing to the
13. anxiety and/or depression, and discuss treatment
14. options.

<u>Extract 7 – from *ReachOut*</u>

1. People don't choose to have depression.
2. People don't choose to be depressed, in the same way that people don't choose to
3. have cancer. So telling a person with depression to just 'get a grip' is more harmful
4. than helpful. If they could, people with depression would choose to stop feeling that
5. way.
6. Depression can be treated with the right help from mental health professionals;
7. however, recovery takes time and will involve lots of ups and downs. If you notice
8. someone displaying symptoms of depression, ask them how you can help,
9. encourage them to get support, and remind them that what they're going through is
10. not their fault or their choice.

Receiving a diagnosis and treatment from a doctor is portrayed in Extract 6 (ll. 1-2) as essential for recovery - it is implied that depression will go on indefinitely until medical treatment is received. On the websites, the family and friends of a person with depression were usually told that the main way they could help was by encouraging the person to see a medical professional. Accordingly, the biomedical interpretive repertoire is strongly associated with the

subject position of 'patient' being made relevant to a person who is depressed. Meanwhile, the health professional occupies the status of 'expert', a subject position which comes with a much higher degree of agency. In Extract 7 (ll. 3-4), depression is constructed as an illness similar to cancer that people do not choose to have, and cannot simply choose to recover from. This reduces blame but also reduces positive agency and control, as recovery is only possible through treatment from experts. The possibility of medical treatment not leading to recovery was seldom discussed; but when it was, it was frequently attributed to the patient not following expert advice. As such, failing to follow the advice of experts was positioned as morally blameworthy.

3.1.2 The Self-Optimization Interpretive Repertoire

The self-optimization repertoire was the next most predominant in the data. Under this repertoire, depression was constructed as an illness resulting from a lack of skills and education, and/or an unhealthy lifestyle. Therefore, the appropriate treatment for depression was to learn new skills, educate oneself and improve one's lifestyle. Terminology typical of the self-optimization repertoire included skills, education, information, habits, practice, self-help, control, action, plan, work, effort, strength, courage, success, mastery, overcoming, achievement, self-monitoring, self-management and resilience. This functioned to locate depression initially as a matter of personal deficit, but ideally as the catalyst for a process of personal improvement. Under this repertoire depression was characterized as an illness which individuals can prevent or manage, potentially introducing a moral aspect.

Extracts 8 and 9 provide an insight into how causation is understood differently under the self-optimization interpretive repertoire.

Extract 8 - from *Black Dog Institute* fact sheet entitled 'Treatments for Depression', under the heading, 'Cognitive Behaviour Therapy (CBT)'

1. People suffering from depression, particularly
2. 'non-melancholic depression', will often have an
3. ongoing negative view about themselves and the
4. world around them. CBT shows people how their
5. thoughts affect their mood and teaches them
6. to correct faulty negative thinking. CBT can be
7. very beneficial for some individuals who have
8. depression but there will be others for whom it
9. may not be helpful. For information, access
10. the free online program 'The Mood Gym' to learn
11. cognitive behaviour therapy skills for preventing
12. and coping with depression.

Extract 9 - from *Beyondblue*, under the heading, 'Psychological treatments for depression'

1. Psychological treatments (also known as talking therapies) can help you
2. change your thinking patterns and improve your coping skills so you're
3. better equipped to deal with life's stresses and conflicts. As well as
4. supporting your recovery, psychological therapies can also help you stay
5. well by identifying and changing unhelpful thoughts and behaviour.

In Extracts 8 and 9, faulty, negative thoughts are said to affect a person's mood, implying that negative thinking can cause depression. This is a different understanding of causation than the biomedical interpretive repertoire, where the illness of depression was said to cause negative

thinking. Under this repertoire, a person is able to change how they think, so as to avoid becoming depressed in future. Rather than the goal being to restore one's old self, under the self-optimization repertoire the goal is to work on creating a new, improved self. In Extract 8 (l. 10), the reader is referred to an online CBT program called 'MoodGym'. This metaphor likens mental health to physical fitness, with both requiring regular effort to achieve and maintain.

In Extract 10, another metaphor is used to liken widespread education of the population using CBT to immunization programs for physical diseases.

Extract 10 - from *BluePages*, under the heading, 'Online Prevention'

1. Depression is a major public health problem. It is one of the leading causes of disability
2. in the world.
3. What can we do?
4. In many areas of medicine, we accept that prevention is essential to our health and well-
5. being. Imagine how different the world would be today without widespread immunization
6. programs. We have been much slower to see that prevention programs may also be an
7. important way of protecting our mental health.
8. Prevention programs show promise.
9. There is evidence that special training programs might actually prevent
10. depression. These programs use cognitive behaviour therapy (CBT) to increase
11. resilience.

The metaphor of immunization suggests that there is an epidemic of depression in society today which is leading to widespread disability. The solution to this epidemic is not a vaccination, but population-wide training in new skills of positive thinking and resilience. The implication is that, as with many physical diseases, depression could be eradicated if enough

people received this intervention early in life. Thus, constructing depression as an illness involves an unspoken moral and political judgement that the world would be a better place if depression were eliminated and everyone was happy all the time (Conneely et al., 2020).

When it came to the question of what should be done about depression, under the self-optimization interpretive repertoire the appropriate treatment was learning skills and building awareness, or becoming informed about lifestyle factors and self-help strategies. In these accounts, health professionals are primarily dispensing education rather than medication, signifying that responsibility is being passed from expert to patient. Once patients have received appropriate education and advice, they are expected to assume responsibility for the ongoing management of their symptoms.

Extracts 11 and 12 show how responsibility is returned to the individual under the self-optimization repertoire.

Extract 11 - from *SANE Australia*, under the heading, 'Looking After Yourself'

1. Practical steps to help yourself
2. There are lots of things you can do to fight back against the symptoms of
3. Depression.
4. Understanding makes all the difference
5. A good example of this is the flow of negative thoughts into the mind, a
6. common feature of Depression. Sometimes we are hardly even conscious of
7. these thoughts, which may cause us to feel that things will always turn out for
8. the worst or that a task is completely beyond us.
9. Once we understand why this happens, however, we can start looking out for
10. and tackling these thoughts. They are often unjustified or irrational. They are

11. often negative about things that are just as likely to turn out well.

12. There are often alternative, more practical and positive ways of dealing with

13. these concerns, which can be discussed with the treating doctor or other

14. health professional.

15. Recognise the warning signs

16. Depression is often an episodic illness. This means we need to recognise our

17. own early warning signs than an episode of Depression is coming on, so that

18. we make sure we see a doctor promptly

Extract 12 - from *MindSpot*, under the heading, 'About *MindSpot* Treatment Courses'

1. What does a *MindSpot* treatment course look like?

2. Most people choose to complete our treatment courses online. Each course is a carefully developed and tested set of lessons and resources, delivered

3. in a structured way, over eight weeks. We also give course participants a further six months access to a course after they have completed it, to allow

4. them to re-visit course materials and refresh knowledge and skills.

5. Each lesson in a *MindSpot* treatment course will require you to complete four key activities that will help you increase your knowledge about your

6. symptoms and build practical skills to manage these symptoms.

In Extract 11, the metaphors of 'fighting back' (l. 2) and 'tackling' (l. 10) reify depression as a separate entity, but rather than the individual being helpless, they are depicted as having the power and the responsibility to fight back. One of the benefits of education will be the ability to recognise signs of depression at an earlier stage, leading to seeing a doctor more promptly in future (l. 18). Extract 12 discusses *MindSpot* online courses, which despite being

described in medical terms as 'treatment', consist entirely of education. Responsibility lies with the reader to follow instructions, complete the lessons and activities and practice skills. Elsewhere on the *MindSpot* website the role of personal responsibility and work ethic was emphasized, and recovery from depression was linked directly to a person's level of effort and commitment.

Extract 13 exemplifies the kind of lifestyle advice found on most of the websites.

<u>Extract 13 - from *Headspace*, under the heading, 'What can I do?'</u>

1. There are lots of things that you can do to improve how you feel and get better at managing tough
2. feelings.
3. It can feel hard to find the energy or motivation to do these things. Sometimes it might feel like nothing will
4. help. Try starting with one thing you know you can do, then slowly add things in step by step. This can
5. help you feel like you're making progress.
6. Take care of yourself
7. Looking after our minds and bodies can help us with our general mental health and wellbeing. You can:
8. Eat well to improve your mood, energy levels and general health and wellbeing
9. Sleep well to help your brain and body rest
10. Get moving to help you sleep better, manage stress and boost your mood
11. Avoid, or at least limit, your use of alcohol and other drugs

Extract 13 urges the individual to live a healthy lifestyle, framing lifestyle factors in terms of their effect upon the brain (l. 9), a link which was drawn frequently on the websites. In

this way the biomedical interpretive repertoire was integrated with the self-optimization repertoire. Even though depression might be caused by a biological dysfunction in the brain, individuals were portrayed as having the power to optimize their brains through responsible lifestyle choices.

As illustrated in the above extracts, the subject positions made available to a depressed person under the self-optimization interpretive repertoire are simultaneously that of patient, and that of responsible, instrumental individual. The treating professional still occupies the role of expert, but it is the role of the patient to responsibly follow expert advice. Thus, there is potential scope for moral blame of a person who does not responsibly act to optimize the self and live a healthy lifestyle, although this was never stated explicitly.

3.1.3 The Normal-Natural Interpretive Repertoire

Another interpretive repertoire which often appeared on the websites analysed will be referred to as the ‘normal-natural’ repertoire. This repertoire was negatively evaluated and was only mentioned in order to be refuted. The normal-natural repertoire as it appeared on the websites[1] constructed depression as a mild and temporary sadness in response to the inevitable ups and downs of life. Terminology characteristic of this repertoire on the websites included sadness, normal, natural, low, flat, blue, down, unhappy, a bit, occasional, sometimes, human, passing and bounce back. According to this understanding, depression is usually not an illness requiring medical treatment. Depression was seen as part of the person and within the person’s power to control and change. As such, this understanding was criticized as resulting in negative moral judgments of people with depression.

[1] See Horwitz and Wakefield (2007) for a more nuanced account of this way of understanding depression.

There was thus a clear ideological dilemma between the biomedical interpretive repertoire and the normal-natural interpretive repertoire. The negation of the normal-natural repertoire was accomplished on the websites through the rhetorical device known as a 'contrast structure' (Potter, 1996) or 'concession/criticism' format (Wetherell & Potter, 1992). This typically involves an initial description of an activity or an argument with a limited concession to its legitimacy, followed by a description which undermines the activity or argument as unjustified or illegitimate. On the websites, this usually involved 'normal' sadness being acknowledged first, followed by a contrasting description of the illness of clinical depression, which was sharply delineated from 'normal' sadness. This worked to mark the boundary between normality and abnormality, and to locate depression as the proper territory of the medical or psychological expert. In Extracts 14, 15 and 16, the factuality of the category of depression as an illness is built up in this way.

<u>Extract 14 - from *Black Dog Institute*, under the heading, 'Am I just feeling down or could it be depression?'</u>

1. We can all feel 'down' and being sad sometimes is a normal response to life
2. events. It's part of what makes us human. Sometimes we just feel 'blue' for no
3. apparent reason.
4. People often incorrectly use the term 'depression' to describe these passing
5. feelings after loss and during hard times.
6. Our sadness and depressed feelings usually resolve with time. However,
7. people with clinical depression may become irritable, lose interest in things,
8. and find it hard to cope.
9. Clinical depression is more than the occasional low mood.

10. If you find yourself having intense, sad or depressed feelings for longer than
11. two weeks, and they start to affect the way you're living life, it's important to
12. find help.

Extract 15 - from *Beyondblue* brochure entitled 'Understanding anxiety and depression', under the heading, 'What is depression?'

1. While we all feel sad, moody or low from time
2. to time, some people experience these feelings
3. intensely, for long periods of time (weeks, months
4. or even years) and sometimes without any
5. apparent reason.
6. Depression is more than just a low mood – it's a
7. serious condition that affects your physical and
8. mental health.

Extract 16 - from *Headspace* fact sheet entitled, 'Understanding depression (it's more than sadness)'

1. Many people feel sad after they have gone through stressful or
2. difficult times. This could be a relationship break-up, trouble
3. with friends or family, changing schools or exam times.
4. It's normal to feel down from time to time, and it can actually
5. help you to figure out what's important to you.
6. The word 'depression' is often used when people are
7. talking about moments when they're feeling sad or
8. down. Depression and feeling depressed is more than

9. 'feeling sad'.

10. Different people will experience depression in different ways.

11. It usually includes these signs and symptoms – for a period of

12. at least 2 weeks – without improvement.

The above extracts all start by acknowledging that there is such a thing as sadness in response to adverse life events, heading off any accusation that this possibility has not been considered. This limited concession is then followed by a contradiction of the idea that these experiences of sadness may be categorized as 'depression'. However, exactly what the difference is between normal sadness and the illness of depression is unclear, with descriptions of each often sounding similar. As in Extract 14 (l. 11), the decisive differentiating criteria appears to be a duration of longer than two weeks, and an impact on normal functioning. Thus, being sad about anything for longer than two weeks is constructed as abnormal; and the concepts of 'health' and 'illness' are associated with the ability or inability to continue to carry out one's usual functions.

The normal-natural repertoire was said to create a subject position for the depressed person as someone who is irresponsible, weak and lazy, because they have the ability to control whether they are depressed, but do not. This account was referred to in Extracts 17 and 18.

<u>Extract 17 - from *ReachOut*</u>

1. Depression is not a sign of weakness.

2. The belief that depression is a sign of weakness is a harmful misconception. If you

3. think about it, it doesn't make much logical sense. Depression can affect all different

4. kinds of people, even those who are traditionally considered to be 'strong' or who

5. have no obvious reason to be depressed. The connection that's assumed between
6. weakness and depression makes it difficult for people with this form of illness to get
7. the help they need. That's why it's important to break down the stigma around mental
8. illness and reinforce the fact that depression and other illnesses aren't the
9. result of a lack of willpower. In fact, the opposite is true, as living with and recovering
10. from depression takes a lot of personal strength.

Extract 18 - from *SANE Australia*, under the heading, 'Reluctance to seek advice from a doctor'

1. Symptoms may seem hard to describe. Fear of being shrugged off as 'neurotic' or
2. not listened to, can make people reluctant to talk to a doctor, or to describe
3. symptoms fully.
4. The stigma attached to having Depression can also discourage some people from
5. seeking help. They may feel that admitting to having a mental illness is somehow
6. shameful or labels them as a 'failure'. This makes it all the more necessary to
7. understand that depression is a medical condition, is no one's fault, and -
8. importantly - is treatable.

In Extract 17, it is said that some people believe that depression is the result of a weakness of character and lack of willpower. In Extract 18, people with depression fear others seeing them as 'neurotic', 'shameful' and a 'failure'. In both Extract 17 (ll. 6-7) and Extract 18 (ll. 2-3), the main problem with stigmatizing beliefs about depression seems to be that they deter people from seeking and receiving medical help. In both extracts, the normal-natural interpretive repertoire is positioned directly against the biomedical interpretive repertoire. The alternative to viewing depression as a sign of weakness and shameful failure is to view depression as a medical illness which is no one's fault. These are the only two interpretations mentioned, implying that

the choice is dichotomous and there are no other possible constructions of the situation that can be made.

3.1.4 The Societal-Structural Interpretive Repertoire

A fourth potential interpretive repertoire around depression, which will be referred to as the 'societal-structural' repertoire, was referred to in passing on some websites but was not discussed by the majority in their section on depression. As such, the societal-structural repertoire was notable for its minimal presence on the websites. Under this repertoire, depression is constructed as the result of stressful and traumatic life experiences such as abuse, oppressive societal norms and structures, or a political and historical context of inequality between certain groups. Terminology indicative of this repertoire included life events, social conditions, discrimination, abuse, inequality, injustice, social norms, social pressures, intergenerational trauma, racism, oppression and culture. According to this repertoire, depression is not an illness but a reasonable and understandable response by individuals to oppression. The person with depression is not to blame for becoming depressed, as they are a member of a less powerful group in society who has been oppressed by more powerful groups in society.

Extract 19 illustrates what the discourse around depression can look like when a societal-structural interpretive repertoire is adopted.

Extract 19 - from *Beyondblue* brochure entitled 'A guide to what works for depression', under the heading, 'Depression and Aboriginal and Torres Strait Islander Peoples'

1. These higher rates of depression need to
2. be understood in the historical context of
3. intergenerational trauma. Since colonization,

4. individuals and communities have shown
5. resilience through the many hardships and
6. experiences of grief arising from the loss of land,
7. children, culture, community, identity and pride.
8. Trauma from these losses has been passed down
9. from one generation to the next and can be
10. compounded by new experiences of racism (the
11. systematic oppression through society and its
12. Institutions) and hardship.
13. These experiences can contribute to Aboriginal
14. and Torres Strait Islander peoples' experiences of
15. anxiety, depression, suicide and attempted suicide.
16. Culturally safe and trauma-informed services, that
17. recognise the role of trauma in depression, may
18. be particularly important for Aboriginal and Torres
19. Strait Islander peoples.

In Extract 19, the direct contribution of inequality, racism and discrimination to depression is recognised. The depression of ATSI people was referred to twice elsewhere in the same section as "psychological distress". The use of language such as 'distress', 'grief' and 'trauma' functions to construct the depression of ATSI peoples as a meaningful and rational response to historical and systemic oppression, rather than as an illness or dysfunction. Later in the same section, the help that ATSI peoples could access through community health services was referred to as "support for depression" rather than as 'treatment'. Overall, there was a noticeable lack of biomedical or self-optimization language – there was no talk of illness, of

medical treatment, of chemical imbalances, of brains, of genetics, of 'triggers', of faulty thinking patterns, of medication or of cognitive behaviour therapy. There was no talk of depression occurring for no reason or being "no-one's fault", for it was clearly someone's fault, in this case those who have committed or have been complicit in colonization, racism and oppression.

Another context in which the societal-structural repertoire was sometimes made relevant was in relation to gender. Extracts 20 and 21 are taken from the sections of the *Beyondblue* website discussing factors affecting women and men.

Extract 20 - from *Beyondblue*, under the heading, 'Women'

1. While good mental health is essential to the overall health of both men and women, women experience some mental health conditions at higher
2. rates than men.
3. In fact, around 1 in 6 women in Australia will experience depression and 1 in 3 women will experience anxiety during their lifetime. Women also
4. experience post-traumatic stress disorder (PTSD) and eating disorders at higher rates than men.
5. Depression and anxiety can affect women at any time in their life but there is an increased chance during pregnancy and the year following the
6. birth of a baby. Up to 1 in 10 women experience depression while they are pregnant and 1 in 6 women experience depression during the first year
7. after birth. Anxiety conditions are thought to be as common with many women experiencing both conditions at the same time.
8. There are a range of ways in which you can care for your mental health to improve your quality of life for you and the people you love. The
9. important thing to remember is that effective treatments are available, and, with the right care, most people recover.

10. Factors affecting women
11. Major life transitions such as pregnancy, motherhood and menopause can create physical and
12. emotional stresses for women. Negative life experiences – infertility and perinatal loss,
13. poverty, discrimination, violence, unemployment and isolation – also impact on women's
14. mental health and wellbeing. Unequal economic and social conditions also contribute to
15. women's higher risk of depression.

Extract 21 - from *Beyondblue*, under the heading, 'Men'

1. Blokes make up an average six out of every eight suicides every single day in Australia. The number of men who die by suicide in Australia every
2. year is nearly double the national road toll …
3. Many of us blokes think we need to do it all ourselves. We put off having a chat with our mates
4. when we're feeling down, put off going to our GP, and put off talking to our partner about how
5. we're feeling because we have the idea that 'being a man' means being silent and strong.
6. These kinds of social norms around masculinity can be really harmful, especially when it comes
7. to your mental health. It can make it really hard for many of us to acknowledge when we're not
8. doing too well and even harder to reach out for the kinds of support we need when we're
9. struggling.

The role of gender inequality and social norms in contributing to depression was mentioned in both of the above extracts, indicating partial reference to the societal-structural interpretive repertoire. However, the dominance of the biomedical and self-optimization repertoires was re-asserted when it came to what should be done about depression, which was to seek individual medical treatment from a GP. In Extract 21, the main problem with social norms around masculinity seems to be that they discourage such help-seeking (ll. 3-4, 8-9).

3.2 Ideological Dilemmas

Of the four interpretive repertoires around depression identified in the data, two were predominant and evaluated positively – the biomedical and the self-optimization. One repertoire, the normal-natural, was evaluated negatively, and one, the societal-structural, received relatively little attention. The existence of four different interpretive repertoires around depression creates a number of ideological dilemmas additional to that acknowledged between the biomedical and the normal-natural.

3.2.1 Attributions of Responsibility

There was an unstated dilemma between the biomedical and self-optimization repertoires. The biomedical interpretive repertoire sought to remove all moral implications from depression, whereas under the self-optimization repertoire depression could be avoided through personal responsibility and effort. Thus, there was potential for moral blame if an individual had had the opportunity to learn the necessary skills or make lifestyle improvements, but did not. This dilemma was avoided on the websites by the speaker making the assumption that people with depression must have never had the chance to learn the skills they needed, as demonstrated in Extract 22.

Extract 22 - from *MindSpot*, under the heading, 'Managing depression'

1. Beating depression is hard work – it takes courage, commitment and practice.
2. Having depression does not mean that a person has a weak personality or a weak character. Instead, we believe that people with depression often have
3. not had a chance to learn skills for managing these symptoms. Psychological treatment programs, such as those offered by *MindSpot*, can help people

4. with depression learn about their symptoms, learn skills for managing these symptoms, and then gradually resume their usual activities. Getting
5. effective treatment for depression often also reduces symptoms of other psychological disorders, such as anxiety disorders.
6. People who have symptoms of sadness and low mood, but do not have depression, can also benefit from learning the skills taught in psychological
7. treatment programs. This is known as early intervention. Early intervention can stop symptoms from becoming chronic and severe.

In Extract 22 (l. 2), the reader is told that being depressed has nothing to do with a person being weak. However, in line 1, "beating" depression requires courage, commitment and willingness to work hard to learn skills. The speaker resolves this apparent inconsistency by expressing the belief in line 3 that people with depression have never had the chance to learn the skills they need. This construction avoids blaming the person for becoming depressed up until this point, but at the same time puts their future mental health within their control.

3.2.2 Location of Problem

Another dilemma occurred between the biomedical and the self-optimization interpretive repertoires, which locate the problem of depression with the individual, and the societal-structural repertoire, which locates the problem of depression with society. The primacy of the biomedical and self-optimization repertoires was maintained by framing societal and structural factors in individual terms as 'risk factors' for depression.

Extract 23 refers to post-natal depression, which is individualized as the woman's problem.

Extract 23 - from *Black Dog Institute* fact sheet entitled, 'Depression during pregnancy and the postnatal period'

1. Risk factors and triggers for
2. pregnancy related depression
3. include:
4. A previous history of depression, bipolar
5. disorder or psychosis
6. Stressful life events
7. Lack of social supports
8. A history of physical, sexual or emotional
9. abuse
10. Pregnancy loss
11. Child-birth related distress
12. A baby that is difficult to settle, restless or
13. unwell
14. Personality types that increase vulnerability
15. to depression such as the anxious worrier or
16. socially avoidant personality styles.
17. Finding help
18. Various health professionals and allied health
19. professionals are qualified to help people
20. experiencing depression during pregnancy and
21. the postnatal period including:
22. Doctors – general practitioner (GP)
23. Obstetrician

24. Psychiatrist
25. Midwives
26. Child and family health nurses
27. Social workers
28. Counsellors
29. Psychologists.

In Extract 23, the language used functions to individualize the problem of pre- and post-natal depression and erase context (Boyle, 2011). Various ‘risk factors’ and ‘triggers’ are listed, including “stressful life events”, “lack of social supports”, and “a history of physical, sexual or emotional abuse” (ll. 6-9). However, these risk factors are attached to the woman with depression as something she has, locating the current problem with the woman, rather than with society or the perpetrators. Perpetrators of abuse are invisible in the description; rather, it is the woman who carries the baggage of a ‘history of abuse’ (ll. 8-9). It is the woman who has ‘a lack of social support’ – this suggests that the father of her child is not sharing parenting responsibilities, but once again he is invisible, as is the responsibility of society to new parents. The juxtaposition of ‘risk factors’ with ‘finding help’ suggests that a woman possessing such risk factors has a greater obligation to be alert for signs of depression, and to find appropriate help early. In lines 18 to 29, the help available is mainly professional help aimed at treating and educating the individual. The woman’s problem of ‘lack of social supports’ on a day-to-day basis remains unsolved.

Social or societal factors were often described as ‘triggers’ of depression in those with a susceptibility, as illustrated in Extract 24.

Extract 24 - from *Beyondblue*, under the heading, ‘What causes depression?’

1. Life events
2. Research suggests that continuing difficulties – long-term unemployment,
3. living in an abusive or uncaring relationship, long-term isolation or
4. loneliness, prolonged work stress – are more likely to cause depression
5. than recent life stresses. However, recent events (such as losing your job)
6. or a combination of events can ‘trigger’ depression if you’re already at risk
7. because of previous bad experiences or personal factors
8. …
9. Remember
10. Everyone’s different and its often a combination of factors that can
11. contribute to developing depression. It’s important to remember that you
12. can’t always identify the cause of depression or change difficult
13. circumstances. The most important thing is to recognise the signs and
14. symptoms and seek support.

In Extract 24, the role of social factors is recognized, but they are characterized in mechanistic terms as “triggers”. This language functions to associate depression with biological processes occurring within the individual, and thereby to downgrade the contribution of social factors. In Extract 24 (ll. 12-13) it is also said to be important to remember that difficult circumstances cannot always be changed. What is “most important” is to recognise the signs and symptoms of depression and seek (medical) support. Thus, social or societal problems are dismissed as too difficult to solve, and the only realistic solution remains medical treatment of the individual.

Chapter 4: Discussion

4.1 Overview

This study has analysed the ways in which depression is discursively constructed in the online setting of Australian mental health websites. Data was analysed within the framework of critical discursive psychology, with attention paid to identifying repertoires of understanding depression, as well as the subject positions made available to those seen as 'having' this condition. It also sought to analyse how ideological dilemmas arising from contradictory repertoires of depression were managed and negotiated on these websites.

4.2 Summary of Key Findings

The biomedical interpretive repertoire was predominant in the data overall and constructed depression as a medical illness located within an individual, requiring prompt diagnosis and treatment by medical professionals. Whilst this construction releases sufferers from attributions of blame and failure, Foucault (1961/2004) has observed that the mentally ill have been freed from the domain of morality only to become enslaved to biological determinism and the will of doctors. When an illness discourse of depression is adopted, the subject position of patient becomes relevant to the person with depression, a role associated with passivity and dependence upon medical experts for recovery.

The self-optimization interpretive repertoire was almost equally as dominant in the data as the biomedical, with the two usually occurring together. Whilst the person with depression still occupied the position of patient, responsibility was transferred from expert to patient, with determination, hard work and strength on the part of the patient being necessary for recovery. Despite ascribing a different degree of responsibility to the person with depression, the biomedical and self-optimization repertoires were highly compatible, with both reinforcing the

medical model of mental illness. Both defined depression as an illness or disorder, both located the problem as a deficit within the individual (Fullagar & O'Brien, 2014), and in both cases the solution was treatment or education of the individual under the guidance of experts.

The normal-natural interpretive repertoire represented depression as a normal or natural part of life, and was only mentioned in order to be condemned as wrong and harmful. The normal-natural repertoire was generally held up in direct contrast to the biomedical, and a dichotomous choice was constructed between seeing depression as a medical illness, or seeing depression as a sign of weakness of character. However, the normal-natural repertoire as it appears in sources external to the websites analysed (Horwitz & Wakefield, 2007; Rapley et al., 2011) is not so simplistic. As there is a greater acknowledgement of personal agency, there is greater potential for moral blame; but blame and stigma are not inevitable in that depression is seen as an understandable and reasonable response to loss and hardship, and receiving support for depression from family, friends and community is also seen as normal and reasonable.

Finally, the societal-structural repertoire constructed depression as the result of social and structural factors such as oppression, discrimination and inequality. Although individuals are recognised as having a degree of agency, it is also recognised that the agency of individuals is frequently constrained by external factors. This repertoire was relatively muted in the data. The societal-structural repertoire is compatible with the normal-natural repertoire, in that depression is seen as a reasonable and understandable reaction, and not as an illness or dysfunction, and both see the individual as socially situated. As such, both of these repertoires could be said to fall within a moral model of mental illness.

4.3 Depression and Neoliberalism

One of the key questions asked by critical discursive psychologists is why certain discourses or versions of reality become dominant in a culture at a certain point in history, and whose interests are served by this being the case (Edley, 2001). The medical model of mental illness is not new and has been dominant for some time (Malla et al., 2015). However, the relationship between medical discourses of mental illness and the socio-political context is one which is under-explored and little acknowledged (Tseris, 2017). The application of the medical model to less severe and more common forms of depression and its intensive promotion to the public in relation to depression have coincided with the growing cultural influence of neoliberal ideology. The construction of depression on the websites arguably functions to contribute to the reproduction of a neoliberal discourse that, firstly, deems all forms of depression as problematic and locates the problem with the individual, and, secondly, emphasizes the role of personal responsibility in solving the problem.

4.3.1 The Depressed Individual as Anti-Neoliberal

The disciplines of psychiatry and psychology are powerful actors in a knowledge structure in Western culture that provides the theories and possibilities for how people think about themselves (Parker, 2015a). These disciplines have arguably played a critical role in normalizing the neoliberal form of subjectivity as the benchmark of mental health. Sugarman (2015, p. 106) argues that the utilitarian concept of ‘mental health’ has replaced the historical notion of ‘character’; and moreover, that definitions of mental health have come to resemble a “checklist of capacities” required for success in the modern neoliberal world. Mental health is currently defined by WHO (2018) as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community”. As Lewis (2006) notes, the distinctions made in a

culture between mental health and mental illness are rarely neutral, detached observations, but almost always function to reinforce existing power hierarchies and value preferences.

Although the medical model purports to be non-moral, it has been argued that medical psychiatry and psychology are at heart moral and ideological enterprises, which have co-opted the authority of science to enable the labelling and reform of those who behave in ways that hinder the smooth functioning of society (Foucault, 1961/2004; Sarbin, 1997). In a market-based, neoliberal society, economic dependency is regarded as highly problematic behaviour (Conneely et al., 2020). Those who cannot carry out the functions expected of them in a neoliberal society are labelled as mentally ill, rather than as lazy or immoral as in the past, but the consequences are much the same, that is to mark certain behaviour as undesirable and return the individual to the culturally approved state as soon as possible (Moncrieff, 2014). Neoliberal subjectivities of the self as entrepreneur have been translated by the psy-professions into measurable ‘positive’ psychological constructs, such as optimism, self-regulation, self-efficacy, self-esteem and resilience (Teo, 2018). Meanwhile, behaviours, emotions and traits antithetical to neoliberal ideals, such as social avoidance, shyness, inflexibility, lack of enjoyment, anger, self-effacement, pessimism, despair and unhappiness are increasingly pathologized as ‘illnesses’ needing treatment (Sugarman, 2015). Depression in particular has been identified as “quintessentially anti-neoliberal” in that the depressed subject is unable to function effectively as a self-motivated and competitive entrepreneur in the marketplace (Cosgrove & Karter, 2018, p. 675).

Under neoliberalism, the seriousness of the problem of depression is typically framed in terms of the economic costs, or productive years lost, when an individual is unable to work or perform their usual functions (Australian Government, 2018). Mental health treatments in the

form of medication or psychological therapies are then positioned as products available for consumption by individuals in order to expedite a return to 'health' (Cosgrove & Karter, 2018). Medical or psychological treatment is often touted as an effective way to quickly restore people to full functioning and reduce welfare costs to the state in the long term (Layard et al., 2007). On the websites analysed, a theme repeatedly emphasized was the importance of seeking medical treatment for depression promptly, especially if it was affecting the reader's ability to cope with their usual educational, employment, home or caring responsibilities, indicating an over-arching concern with returning individuals to a state of 'health' in the form of productivity.

4.3.2 'Beating' Depression as an Individual Responsibility

Whilst previous studies have identified the dominance of the biomedical interpretive repertoire in relation to depression, this study adds to previous research by identifying the emerging role of the self-optimization repertoire, in which individuals are increasingly positioned as responsible for managing and preventing their own depression. In recent times, the ever-increasing cost of providing mental health treatment has caused governments to turn their attention to preventative measures in the hope that these will be more cost-effective long-term. This requires that all citizens be equipped to take on the responsibility of maintaining their own mental health (Parker, 2007). Rose (1990) presciently observed that the 'disease model' of mental illness was being supplemented or supplanted by an "educational and skills" model. 'Treatment' for depression now includes the individual being trained by experts in how to think in rational, positive and useful ways in order to guard against the development of mental illness. Teghtsoonian (2009) has described a trend in official mental health information towards the "responsibilization" of those with, or at risk of, depression, who are urged to make their mental health their own personal project. Neoliberal policy directions towards reduced government

responsibility and increased individual responsibility are transformed into public health discourses advocating seemingly empowering notions of personal development and 'self-care'. Even the brain is opened up as a new site for self-governance by individuals, under the guidance of experts. Individuals are given to understand that they are able to shape their own 'plastic' brains through lifestyle interventions such as diet, exercise, sleep and avoidance of alcohol and drugs (Pitts-Taylor, 2010; Rose & Abi-Rached, 2013).

4.3.3 Implications of a Medical Discourse of Depression

Under the medical model, the distress that results from social, political and economic injustice is de-coupled from its context and de-politicized; reconstructed as a disorder that an individual 'has', diverting attention from external factors and denying the possibility of collective action for social change (Cosgrove & Karter, 2018; Mulder et al., 2017). By normalizing an individualized, deficit-based interpretation of depression, and by positioning individuals as responsible for their own mental health, contemporary medical discourses of depression play an important role in preserving the neoliberal status quo (Adams et al., 2019; Tseris, 2017). Ideological considerations may help explain why a medical discourse around depression remains dominant in Australia and other developed countries, despite lack of progress in reducing rates of depression.

An illness discourse and a focus on individuals taking responsibility for their own mental health also obscures the ways in which the ideology of neoliberalism may itself cause mental distress. The effect of the implementation of neoliberalism since the late 1970s has been to increase wealth inequality and to redistribute power from the working classes to wealthy elites worldwide (Harvey, 2005). Neoliberal policies have sold false hope that happiness and fulfilment can be achieved through consumption and self-promotion; reduced social cohesion

through increased individualization and workforce mobility; and caused stable and meaningful employment to be replaced with casual, insecure and low paid work (Moncrieff, 2014). Meanwhile, the duty imposed upon citizens to compete with others and to optimize their physical and mental health through continuous self-surveillance and self-work produces a constant state of anxiety and self-doubt (Moncrieff, 2006; Moncrieff, 2014).

4.4 Limitations and Recommendations

The purpose of this research is not to argue that there is no place for medical understandings of depression, nor is it our intent to criticize messages encouraging help-seeking for depression or to devalue the important work done by the mental health websites analysed. The websites were all clear, professional, informative and compassionate towards people with depression, and continue to perform a vital role in helping people in distress on a daily basis.

This research examined only official information provided on mental health websites, which by its nature is a one-sided interaction. We were not able to examine how this advice is evaluated, interpreted or acted upon by its audience. Nor were we able to explore the discursive construction of depression in other contexts. Future discursive research could apply a similar form of analysis to different contexts, such as media reports, telephone counselling interactions, consultations with health professionals, social media posts, or online discussions and blogs. Popularizing the present and any future research, and sharing the results with those researched, could increase awareness of the rhetorical tools used to build the factuality of certain versions of reality, and draw attention to alternative ways of constructing depression (Potter & Wetherell, 1987). Language is a powerful tool which is central to the way in which problems are constructed as personal and not as social or cultural (Boyle, 2011); and therefore, research such

as this could play an important part in any wider re-thinking of how as a society we conceptualize and respond to the problem of depression.

4.5 Conclusion

Depression is an issue of concern for societies worldwide, but current approaches to the problem appear to have limited effectiveness. This research invites discussion as to whether the continued cultural hegemony of the medical model and suppression of the moral model is warranted. A greater recognition is needed that most depression can be understood as meaningful in context; and as related to social, structural, economic and political factors external to the individual. Re-imagining persistent misery as a social and political problem rather than just as an individual and economic problem would mean that humans were understood more fully as social and moral beings whose place in the larger collective is vital to their identity and wellbeing.

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