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Consensus on Campus? Tension and Multiplicity in Student Mental Health

by

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A THESIS

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Abstract

In Canada (as elsewhere), postsecondary student mental health is increasingly positioned as an urgent social problem, even a crisis. Scholarly, professional, and popular publications detail the escalating prevalence, complexity, and costliness of student mental health problems; myriad campus initiatives and services have arisen to enhance, maintain, or restore mental health.

Despite the considerable power of psychiatric and psychotherapeutic discourses, heterogeneous meanings of *mental health* persist—often implicit in the logics of varying campus activities and messages. At sites where incommensurable logics intersect, tensions may arise that must be actively navigated or managed, whether by institutions or by students themselves.

In this dissertation, I investigate tensions of postsecondary student mental health using situational analysis (SA), an interpretive qualitative method that seeks to make visible relations of difference, axes of discursive variation, and sites of silence in a multiply co-constituted material-discursive situation of interest. I apply SA to scholarly mental health literature, texts produced by campus stakeholders, and interviews with university students who self-identify as having experienced mental health problems, mapping heterogeneous constructions of mental health and lingering analytically in sites of potential tension. Students' meaning-making around mental health is rich, diverse, complex, and situated, and may not fit easily into prevailing institutional logics of efficiency, rationalization, and risk management.

My aim with this study was to generatively complicate the student mental health conversation, working against premature discursive closure. I offer an unconventional account of student mental health, one in which meanings remain unsettled, contested, and political. Such analysis is difficult to distil into best practices, but supports a posture of flexible, pluralistic, and

situated responding to the remarkably diverse concerns that have come to be classified as “mental health problems.”

Keywords: student mental health, college, post-secondary, university, campus, situational analysis, discursive research, wellness culture, therapeutic culture, pluralism

Preface

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Chapter 1: Introduction

This is a dissertation about postsecondary student mental health. Or, to be more specific, it is a dissertation about *what is going on right now* in Canadian postsecondary student mental health.

The question of *what is going on* has already been addressed in numerous ways. Media report that Canada faces a campus mental health crisis and that on-campus counsellors are “drowning in mental health needs” (Pfeffer, 2016). Certain pundits have retorted that students have become too sensitive, or over-reliant on mental health language to excuse their shortcomings (e.g., Marano, 2015; Wentz, 2017). Topics like mental health awareness, stigma, accessible treatment, and campus culture are prominent in nation-wide conversations about what is happening among our students—and what needs to happen next (e.g., Canadian Association of College and University Student Services & Canadian Mental Health Association [CACUSS & CMHA], 2013).

Another way to answer the question of *what is going on* is literally—in which case, goings-on include wellness fairs and “puppy therapy”; student club meetings; tweets and Facebook posts; task force meetings and strategic plan launches; counselling and doctor’s appointments. Of course, these goings-on involve people: students and psychologists, university presidents and professors, to name a few.

Asking *what is going on* is, in my reading, at the heart of situational analysis (Clarke, 2005b), the interpretive theory-methods package in which I have grounded this project. Situational analysis (hereafter SA) is empirically inclusive: Researchers are urged to consider, at

least in a preliminary way, anything and everything that might *matter* in a situation of inquiry.¹

What matters is even broader than *what is going on*. With regard to student mental health, *what matters* might include research, statistics, and other truth claims; objects such as medications and Smartphones; places, policies, people, and events (including suicides or acts of lethal violence). In my field, counselling psychology, a key matter is students' embodied experience and concurrent sense-making: How do students experience, and talk about, mental health or ill-health in their lives? Crucially, *what matters* in student mental health extends well beyond on-campus discourse. Students live their lives across multiple realms, and although campus resources and messages may shape their understandings of mental health, so too do memes, movies, cultural and family narratives, and so forth. To make sense of student mental health, then, we also need to consider how mental health is being “done” (Law & Singleton, 2014) elsewhere in society.

Through the questions *what is going on* and *what matters* I begin to invite readers to step back from taken-for-granted understandings of mental health and instead consider this ubiquitous phrase via the specificities of heterogeneous, situated, and embodied material-discursive practices (phrases to which I will return in later chapters). Within this research, I understand mental health not as a social construct per se, but as a historically and culturally accomplished *situation*. Such a situation is *real* in the sense that “situations defined as real are real in their consequences” (Thomas & Thomas, as cited in Clarke, Friese, & Washburn, 2018, p. 26), but also in the sense that it is comprised of a dense net of practices, matter, bodies, institutions, and

¹ In the tradition of materialist scholarship, I invite readers to hear *matter* in a polyvalent way that not only signals consequentiality (as a verb) but invokes the word's sense as a noun: the material “stuff,” substances, and nonhuman “things” that co-constitute complex and situated phenomena (e.g., Barad, 2003).

relations amongst these elements. Whether robust and apparently stable or tenuous and fragile, such arrangements are nonetheless real—that is, they are neither lies nor phantasms.

Importantly, realness does not imply naturalness or inevitability in any *a priori* sense (as Law and Singleton, 2014, posit, “reality is not destiny”; p. 388). A key premise of this research is that the meanings of a concept such as mental health are not taken as fixed (e.g., specified or operationalized in advance) but are themselves problematized and opened to study. I carry my own general definition of *mental health problems*: broadly, experiences of emotional suffering and/or disruptions to culturally appropriate functioning (what Pilgrim, 2014, classifies as misery, madness, and incorrigible eccentricity). However, even this very general description is provisional, following Wittgenstein’s (1958) maxim that “the meaning of a word is its use in the language” (p. 20e). *Mental health* does not mean the same thing to everyone, nor does mental health discourse hold a monopoly on emotional suffering (cf. Brinkmann, 2014). Although I refrain from placing *mental health* and *mental health problems* in scare quotes—a stylistic choice, but also a nod to the terms’ situated realness—I invite readers to hear my use of these terms in a provisional way.² The realness *and* meaning(s) of student mental health are ongoing accomplishments in matter, language, and practices (i.e., material-discursive practices).

Throughout my research process, the big-picture questions of *what is going on* and *what matters* have remained key touchstones for my thinking, in keeping with the wide-ranging spirit of SA. To focus my inquiry (since anything *could* matter, but all researchers have limited time and resources), I developed the following research questions:

² An exception: I use scare quotes in my research questions as a shorthand signal of my critical distance from the terms.

1. In what ways is “mental health” discursively constructed in Canadian university policies and program descriptions, online media and social media, and mental health awareness campaigns?
2. In what ways do postsecondary students discursively construct “mental health problems” in their lives, and with what implications for self-understandings and responses?

To explore these questions, I interviewed 10 students at the University of Calgary (U of C) who indicated that they had experienced a mental health problem; I gathered reams of website data from universities across Canada and pored over widely-shared articles from websites like BuzzFeed and the Huffington Post, as well as reader comments on these articles. I looked at user-generated posts on social media sites Tumblr and Reddit and sifted through text, images, and videos from two Canadian mental health awareness campaigns. Rather than synthesize this wide-ranging data into a master set of overarching themes, I used SA’s analytic mapping techniques to foreground variations, complexities, and tensions. Such non-reductive maps are a unique affordance of SA, generating novel answers to the question of what is going on in student mental health.

As I will detail in Chapter 2, SA is one of several variants or evolutions of grounded theory (first presented by Glaser & Strauss, 1967). Most crucially for this study, SA allows researchers to incorporate discourse analysis into their empirically-grounded theorizing—moving beyond “the knowing subject” (Clarke, 2005b, p. xxix) to consider “forms of representation, conventions and habits of language use producing specific fields of culturally and historically located meanings” (Brooker, 1999, pp. 66-67). Discourse, for Clarke, involves not only language but visual images, symbols, cultural objects, and nonverbal/embodied communication. Put differently, discourse entails practices, values, and logics (cf. Mol, 2008).

As evidenced by my research questions, in this project I am particularly interested in the ways that student mental health is “made and molded” (Hacking, 1999, p. 125) in discourse. I follow Hacking in preferring the phrase *made and molded* over *socially constructed*, signalling that student mental health inheres not only in language and meanings but in material things (bodies, neurotransmitters, genes, medications), practices and institutions (medicine, therapy), people (collective and individual), and myriad other features of our material-discursive world. I follow Barad (2003) in emphasizing that “discourse is not a synonym for language. ... Discourse is not what is said; it is that which constrains and enables what can be said” (p. 819). Discourses, in this sense, are historically situated boundary-making *practices*, “practices that systematically form the objects of which they speak” (Foucault, 1972, p. 50). As I will discuss in the following chapter, as discourses produce phenomena like student mental health, they simultaneously produce ways of being a person—including ways of “doing” and experiencing mental health problems. Different discursive practices of student mental health, therefore, are highly consequential but have received little empirical attention to date.

Why Now?

Current discourse on student mental health is suffused with urgency and worry. Canadian readers might recall noticing, in grocery checkout lines in September 2012, a photograph of two sombre young adults staring out from the cover of *Maclean's* magazine. Emblazoned between their grave faces was the headline “THE BROKEN GENERATION,” with “BROKEN” highlighted in red font. A closer look revealed the heading “Crisis on Campus” and a dramatic sub-heading: “A shocking number of Canadian students feel depressed, even suicidal. Why our best and brightest are so troubled” (see <https://archive.macleans.ca/issue/20120910>; Lunau, 2012). This was not the first Canadian media story on postsecondary student mental health, but it

was perhaps the highest-profile at the time. *Broken, shocking, crisis*: Student mental health had become newsworthy. Since then, most major Canadian outlets have produced similar features: “Off Course on Campus: The Student Mental Health Crisis” (CBC Toronto, 2013); “Degrees of Stress” (Kennedy, 2013); “The Kids Aren’t Alright: It’s Time to Get Serious and Invest in Student Mental Health” (Liptrap, 2018). In addition to a “crisis,” student mental health struggles have been called a “hidden problem” (Tamburri, 2012) and an “epidemic” (Kennedy, 2013).

Although throughout this research I take a critical analytic stance that interrogates the construction of such urgency, I also take seriously that students are suffering—possibly more than in the past, or perhaps in new ways (e.g., Petersen, 2017). During my recent pre-doctoral internship at a university counselling centre, I saw all too clearly the distress and despair with which many students struggle, and the frustration of campus mental health professionals unable to keep up with needs that outstrip available resources. Canadian universities do not publish statistics on student deaths by suicide, but at the counselling centre we were all-too-keenly aware of them. Acts of lethal violence, too—tied in ambiguous and contested ways to mental illness—hover as unspoken influences in imagined worst-case scenarios. At U of C, this spectre was actualized in 2014 when five young people were killed at a party in the Brentwood neighbourhood, near campus, by a former student who was later pronounced mentally ill (see Tucker & Hixt, 2016). Such events, rare as they are, *matter*; not only were the Brentwood killings tragic, but they will likely reverberate (explicitly or not) in U of C’s mental health practices for years to come.

Why SA?

As real as student mental health problems are (in the sense articulated above), uncertainties remain. As a counsellor, how should I understand the concerns that students bring

to my office? Arguably, the very term *mental health* is always-already cognitive (mental) and medicalized (health). Cognitive-medicalized discourse is indeed prominent in formulations of emotional distress and impairment, not only in North America but increasingly globally (Mills, 2014; Watters, 2010). However, alternative discourses remain in circulation; for instance, Brinkmann (2014) identifies four “languages of suffering” that construct emotional struggles in non-diagnostic yet culturally legible ways (existential, religious, moral, and political). Struggling students may speak of spiritual trials, “dark nights of the soul,” alienation, or colonial oppression. Regardless of whether one considers such multiplicity a resource or a sign of mental health illiteracy (cf. Marcus & Westra, 2012), variation is part of *what is going on* in student mental health and necessitates a research method that preserves and depicts heterogeneity, including minority or “quieter” voices.

Meanings associated with student mental health are not only heterogeneous, but contested. Different actors make claims about “correct” or superior language and practices; they make efforts to advance particular discourses or interests and delegitimize others. There are multiple stakes and interests at play. In short, the situation is political, and to describe it requires attending to questions of power (another focus of SA). Consider how a campus counsellor might respond to a student who presents with a non-normative account of distress—a spiritual explanation, for instance. The counsellor might accept the account as unproblematic and respond in kind (if they also speak this “language”); they might attempt to “correct” it via psychoeducation (“actually, what you are describing is a medical condition called depression”). They might accommodate it superficially as a cultural novelty, or join the student’s account in-session but document something quite different in clinical notes (“patient reports symptoms of ...”). The counsellor’s response is shaped by their broader (material, discursive, relational,

institutional) situation: the notes they must complete, the training they received, their knowledge of campus resources that require a diagnosis, and so forth. They may be accountable to supervisors, managers, policies, professional licensing bodies—and they may feel pulled in different directions by said accountabilities (cf. Strong, Gaete, Sametband, French, & Eeson, 2012). The counsellor is only one example; any actor in the situation of student mental health—from presidents to security guards to parents—will have different accountabilities to navigate and negotiate. SA allows researchers to study situations *in their political complexity*, considering various flows and pulls of power, accountability, and influence.

In short, SA equips researchers to study multiplicity and tensions. This capacity is arguably crucial to theorizing complex and contested social arrangements like those of student mental health. In their book *The Mediated Construction of Reality*, Couldry and Hepp (2017) suggest that contemporary scholars must move beyond “standard” social constructionism to a more nuanced approach that “emphasizes the irreducible and conflicted uncertainty at the heart of the process of social construction: the unending conflicts about the ontology of the social” (p. 25). They cite Boltanski’s exhortation to “put *dispute* and, with it, the *divergence* of points of view, interpretation and usages at the heart of social bonds” (as cited in Couldry & Hepp, 2017, p. 25). This sensibility is consistent with Clarke’s (2005b) vision that SA might “conceptually replace modernist unidimensional normal curves with postmodern multidimensional mappings” (p. 25). SA allows researchers to engage, rather than pave over, apparent contradictions. Situational analysts can theorize tensions, contradictions, and instabilities as sites of creative and generative potential: spaces in which reality remains contested, underdetermined, and amenable to “tinkering” (Mol, Moser, & Pols, 2010, p. 11).

Situating Myself in the Inquiry

In SA, a researcher's sensibilities, assumptions, and embodied experiences are not "bracketed" or set aside but are considered part of the analytic situation. This heightened reflexivity and accountability requires that researchers' perspectives be made explicit. I will acknowledge different aspects of my situatedness throughout this dissertation, but begin here with an introductory account.

When I started my PhD at U of C in 2012, I worked as a research assistant for my primary supervisor, Dr. Tom Strong, on his project "Medicalizing Tensions in Counsellor Education" (see Strong, Vegter, Chondros, & Job McIntosh, 2017). Dr. Strong introduced me to scholarly critiques of (bio)medicalization, that is, processes whereby issues once considered moral, social, or legal problems are redefined as (bio)medical problems (Clarke, Mamo, Fosket, Fishman, & Shim, 2010; Crawford, 1980). In brief, the "Medicalizing Tensions" project emerged from Dr. Strong's concern with how counselling might be pulled toward monolithic diagnose-and-treat logics of practice, away from pluralistic sensibilities that have previously characterized the field. Intertwined with accounts of medicalization, I began to encounter critiques of neoliberalism and how the valorization of private enterprise and corporate management practices simultaneously shapes our very subjectivities, that is, ways of being a person (e.g., Illouz, 2008). I was soon gripped by angst; as a student of a *psy* discipline (Rose, 1998), was I perpetuating market-based norms of functionality and productivity (Esposito & Perez, 2014)? Was I implicitly treating people as consumers and entrepreneurs who are solely and individually responsible for their own success in life?

Even as I worried about affirmative answers to these questions, I had to hold them alongside observations that people appreciated and needed the counselling services I was

providing. Across different counselling settings, I have been reminded that medical discourses are useful, even indispensable and life-saving, to some people. Political, feminist, and postcolonial discourses are liberating and transformative to others (though not all). Some find strength and solutions in therapeutic discourse; others take up religious, spiritual, or moral discourses. I began to “try on” pluralistic understandings of counselling: Different things work for different people at different times (Cooper & McLeod, 2011). Opportunely, pluralistic counselling shares philosophical roots with SA (the pragmatism of Dewey, Rorty, etc.; Clarke et al., 2018). In my engagements both with pluralistic counselling and with SA, I have learned to sit with tensions: for instance, to critique student mental health discourse even while working sincerely within its affordances.

In retrospect, I believe my original conceptualization of this dissertation project involved a sense that I should expose the insidious effects of medicalization and neoliberalism within campus mental health discourse. Although I still find “unmasking” arguments compelling, over the years I have been reminded that over-zealous lines of critique can hurt people I care about, whether clients or friends at a dinner party. Life experiences glossed as “mental health problems” are deeply personal and often painful, and discourses are rarely experienced as “constructed” or contingent to those who live by them. I am not interested in creating research that hurts vulnerable people, so I have endeavoured to keep a foot in each of two interpretive stances: the hermeneutics of suspicion, which problematizes and deconstructs, and the hermeneutics of faith, which appreciatively restores meaning and gives “voice” (Josselson, 2004). For examples of this balance, I have repeatedly turned to the gracious yet incisive work of Cheryl Mattingly (2014) and Annemarie Mol and her colleagues (2010). Their books *Moral Laboratories: Family Peril and the Struggle for a Good Life* and *Care in Practice: On Tinkering in Clinics, Homes, and*

Farms convey love and generosity alongside keen observation and theorizing; they model the spirit in which I aspire to think and write.

Why Might This Matter?

My aim, with this dissertation, is to ask *what is going on* and *what matters* in the situation of student mental health, with a particular focus on sites of tension, axes of discursive variation, and relations of difference (divergent stakes, interests, power relations, etc.). What is valuable about that? First, I share my supervisor's concerns about the potential for young people's self-understandings, problem-solving practices, and perceived futures to become constrained by a narrowing field of discourse (Strong, Ross, & Sesma-Vazquez, 2015). Specifically, medicalized, psychological-therapeutic, and/or neoliberal discourses seem especially poised to "capture" students' meaning-making in relation to what Szasz (1960) famously called *problems in living*. By showcasing the range of discursive possibilities at play in my data, I aim to celebrate the creative and unexpected ways in which students interpret and respond to mental health problems. Therefore, my first hope is that this dissertation might sensitize counsellors and other mental health professionals to discursive pluralism, better equipping them to join and work within student clients' theories of change (Duncan & Miller, 2000).

Relatedly, I come from an assumption that discursive flexibility increases people's options for responding to stuckness, whether in therapy or daily life (e.g., Strong, 2002). I hope that this dissertation might sensitize mental health workers to "quieter" discourses that could spark "lines of flight" (Deleuze, as cited in Winslade, 2009) for students who have reached impasses in their problem-solving. Moving beyond appreciation, my analysis also demonstrates that discursive pluralism (like multiculturalism) is not always peaceful in practice. A third offering of my study, therefore, is an account of tensions and paradoxes that students navigate in

moving through mental health challenges—again useful to front-line mental health workers who wish to better support students through their lived dilemmas.

Finally, my analysis raises fresh considerations (and provocations) for student mental health policy. An arguable downside of SA is that its results are messy (Mathar, 2008); they cannot be boiled down to cohesive bottom lines with straightforward policy implications. But I align myself with scholars who suggest that policies, like realities, are always-already ontologically multiple, particularly from post-colonial vantage points (see Law & Singleton, 2014). “If we think we’re dealing with a single reality when we try to implement a policy,” write Law and Singleton (2014), “then we’re simply deluding ourselves” (p. 391). They suggest that “policy ... might be better conceived of as a list of questions or issues, of considerations that might be relevant to the policy or policy concerns” (p. 392). This is a vision of policy that sets aside definitive concepts that “provide prescriptions of what to see” in favour of *sensitizing concepts* that “suggest directions along which to look” (Blumer, as cited in Clarke et al., 2018, p. 16). It is policy that does not force consensus at sites of controversy (cf. Potter, 1996) but leaves space for discursive multiplicity and a robust range of meanings and responses with which to navigate complex and fluctuating circumstances (cf. Cobb, 2013).

Chapter Breakdown

In the following chapter, I describe the theoretical-methodological framework in and through which I have developed this study. In Chapter 3 I survey the student mental health literature, using SA mapping techniques to depict variation, tensions, and contested issues in the

situation.³ I present my analysis across the subsequent two chapters: Chapter 4 focuses on social worlds/arenas maps, primarily drawing upon document analysis, and Chapter 5 features positional maps grounded chiefly in my interview data. In Chapter 6 I juxtapose the analytic stories of the preceding chapters, placing positions in analytic dialogue with each other and with current literature to come to a provisional and partial sense of integration. I close, in Chapter 7, by reflecting on my experience of this research; I articulate lessons learned, limitations of the current study, possibilities for further research, and potential implications of my analysis.

³ In SA, scholarly literature comprises part of *what matters* in a situation; therefore, literature review is considered an analytic, rather than preparatory, activity.

Chapter 2: Theory/Methods Framework

The work of an intellectual ... is, through the analyses that he carries out in his own field, to question over and over again what is postulated as self-evident, to disturb people's mental habits, the way they do and think things, to dissipate what is familiar and accepted, to re-examine rules and institutions ... (Foucault, 1988b, p. 265)

As I have already begun to describe, in this research I approach student mental health in ways that attempt to unsettle common sense and make strange the familiar. Importantly, as Foucault specifies in the epigraph above, I carry out this investigation *within my own field*—not an attack from without, but a critique from within. Through analytic attention to contingency, heterogeneity, and tensions, I hope to re-politicize issues that have come to feel self-evident—to re-open compromises and controversies that have become “dead” (cf. Potter, 1996) and therefore feel inevitable and universal rather than historically accomplished. My analysis is grounded in an epistemological-ontological framework—an *epistem-ontology* (Barad, 1998)—in which humans co-constitute the reality we experience. In this chapter I will introduce this epistem-ontology via some of the theoretical influences that comprise my research stance, and link these to the methods of SA through which my analysis has proceeded.

To bundle epistemology and ontology is already to make a theoretical claim: that being and knowing are inseparable, or, more poetically, “joined at the hip” (Clarke et al., 2018, p. 15). Any research method is thus a *theory-methods package* (a term attributed to science and technology scholars Star and Fujimura; Clarke, 2010). According to Clarke (2010):

A theory/methods package does *not* mean that one can opt for two items from column A and two from column B to “tailor” a package. Nor does one element automatically “come with” the other as prefabricated. Instead using—really generating—a “package” takes all the work involved in learning both the theory *and* the methods practices *and* how to articulate them across time and circumstance. It becomes a way of knowing and doing together. For pragmatists, these are one. (p. 587)

The message, here, is that we cannot divorce methodological techniques from their grounding theoretical logics. Such logics structure the entire research process, from literature review to dissemination of results, and must be taken seriously. Practices of quantitative survey research, for instance, largely emerge within classical realist ontologies and (post-)positivist epistemologies that assume researchers can access subjects' (pre-existing) traits and opinions through asking the right questions in the right way. As will become apparent, my research inheres in very different assumptions—inflected by several complementary “camps” and *isms* such as social constructionism (e.g., Gergen, 1985; Lock & Strong, 2010), critical ontology (e.g., Foucault, 1984), historical ontology and dynamic nominalism (e.g., Hacking, 2002; Sugarman, 2009), material semiotics (Law, 2016), and, less directly, the symbolic interactionism and pragmatism that suffused Clarke's development of SA. My core ontological commitments are nicely summarized by Barad (1998) in relation to her *agential realist* epistem-ontology:

The ontology I propose does not posit some fixed notion of being that is prior to signification (as the classical realist assumes), but neither is being completely inaccessible to language (as in Kantian transcendentalism), nor completely of language (as in linguistic monism). That reality within which we intra-act—what I term agential reality—is made up of *material-discursive phenomena* [emphasis added]. Agential reality is not a fixed ontology that is independent of human practices, but is continually reconstituted through our material-discursive intra-actions. (“On materiality,” para. 4)

To Barad (following Niels Bohr), the referents of science and knowledge are not observation-independent objects (“things-in-themselves”) but phenomena—“things-in-themselves” *plus* their “agencies of observation” (apparatuses, technologies, people, practices, etc.). With her neologism *intra-actions*, Barad rejects the commonly enacted “cut” between so-called objects and observers, reformulating *interactions* between allegedly separate entities as relations of within-ness. What Barad calls phenomena, Clarke (2005b) might call situations—but I get ahead

of myself. The core message, to retrieve a thread from the previous chapter, is that language matters, practices matter, matter matters, and relations amongst these elements matter.

At the outset of this chapter, I claimed to be undertaking this project *within my own field*, which I earlier identified as counselling psychology. Although I am indeed pursuing a doctorate in counselling psychology, the question of whether it is my field is a complicated one. Throughout my work on this dissertation, I have been informed deeply by the work of sociologists (e.g., Illouz, 2008; Spector & Kitsuse, 1977/2011), philosophers (e.g., Foucault, 1972; Hacking, 1999; Mol, 2008), anthropologists (e.g., Mattingly, 2014), and feminist scholars (e.g., Barad, 2007).⁴ Only a few of the authors who have informed my theory-methods framework have written from within psychology (Brinkmann, 2016; Danziger, 2003; and arguably Potter, 1996) and even fewer within counselling psychology (other than my supervisor and his former students; e.g., Mudry, 2016; Strong, 2017).

I posit that counselling psychology research is greatly enriched by scholarship from beyond its disciplinary borders. Narrative therapy draws on Foucault (White, 2007), and Winslade (2009) has argued convincingly that counselling can be enriched by ideas from Deleuze. Lock and Strong (2012) have compiled an excellent volume in which the philosophical work of Wittgenstein, Bakhtin, and Merleau-Ponty, among others, is integrated into therapeutic practice under the banner of *discursive therapy*. The global community of counselling psychologists informed by social constructionist and postmodern or poststructuralist

⁴ I acknowledge that disciplinary boundaries and identities may be fluid, multiple, and oversimplifying. Nonetheless, I hope the point stands that I have drawn widely from beyond “my” field.

philosophies is relatively small but active. What has yet to emerge is a movement of counselling psychologists engaging with the provocative insights of science and technology studies (STS).

STS (which can alternatively stand for science, technology, and society) is an interdisciplinary field that “deals with the inseparability of science and technology from social structures and practices” (Rohracher, 2015, p. 200). Contemporary STS scholars are generally interested in both the structures of science—science as a social institution and localized set of practices—and its content, that is, how scientific knowledge and expertise are produced, taken up, contested, and so forth. Several key authors cited in this dissertation identify with STS, most notably Clarke (2005b; Clarke et al., 2018) but also Latour (1999) and Law (2004; Law & Singleton, 2014).

Counselling is a technology, to the extent that it is a “complex of standardized means to attain predetermined results” (Rohracher, 2015, p. 201). Counselling psychologists, commonly styled as “scientist-practitioners,” (e.g., Chwalisz, 2003), both conduct and use scientific research. Our work is ripe for STS analysis, given the historical-political nature of prevailing wisdom and trends in the field. For instance, evidence-based practice has become a powerful discourse that valorizes aligning counselling “treatment” with scientific evidence, preferably the gold standard of randomized controlled trials (Busch, 2010). Counter-discourses and alternative or resistant positions have persisted or emerged—practice-based evidence (Barkham, Mellor-Clark, Connell, & Cahill, 2006), common factors research (Laska, Gurman, & Wampold, 2014), pluralistic approaches (Cooper & McLeod, 2011)—and counselling practitioners may feel pulled in different directions (Strong et al., 2012). To zoom out from the contending arguments and study the controversy itself as a socially-politically-materially-historically-discursively situated phenomenon would be to take an STS approach.

Although this is not an STS dissertation *per se*, Clarke's (2005b) close identification with STS means that SA is always-already inflected with these sorts of curiosities. Hess (2001) asserts that STS scholarship tends

to go outside the citadel of expert knowledge to the viewpoints of lay groups, activists, social movements, the media and popular culture; to examine the contours of orthodoxy and heterodoxy in a discipline's development, including the political, institutional, and economic forces that govern the selection of research fields and programs; and to examine variations in expert knowledge and technology across cultures. (p. 236)

As will soon become apparent, this passage could just as easily describe SA. It is easy to imagine how such a sensibility would be valuable not only to counselling psychology, but to cross-disciplinary understandings of mental health and wellness more broadly.

As Clarke (2016) observes, "people find themselves in STS unexpectedly" (p. 173). Whether or not they identify with STS, some scholars have begun exploring mental health topics in STS-inflected ways (e.g., Birk, 2016; Mudry, 2016; Strong, 2017); with any luck, such inquiry will continue and expand. Counselling psychology will grow and mature as a field not only by aligning itself with positivistic notions of science, but by zooming out to critically interrogate its own structure and content, drawing theoretical and methodological resources from philosophy, sociology, anthropology, STS, and other unexpected fields to do so.

As touchstones for the theory-methods framework that I will articulate over the course of this chapter, I reiterate my research questions (hereafter Q1 and Q2):

1. In what ways is "mental health" discursively constructed in Canadian university policies and program websites, online media and social media, and mental health awareness campaigns?
2. In what ways do postsecondary students discursively construct "mental health problems" in their lives, and with what implications for self-understandings and responses?

In what follows, I will unpack key assumptions within these questions and ultimately address the relationship between the two. I begin with the premise of Q1: What does it mean to understand mental health as *discursively constructed* in policies, websites, media, and awareness campaigns?

Constructing Mental Health

As noted above, I place scare quotes around “mental health” and “mental health problems” in my research questions to signal that I consider their meanings contested, emergent, and specific to their “use in the language” (Wittgenstein, 1958, p. 20e). Nonetheless, I want to venture two complementary theoretical answers to the question of what mental health *is*, according to this dissertation: (student) mental health is an epistemic object, and (student) mental health is a social problem.⁵

Mental health as an epistemic object. *Epistemic objects* are, simply put, the things that are studied and about which knowledge can be gained (Danziger, 2003). We can describe sub-categories of epistemic object: psychological objects, for instance, or scientific objects (“the things that scientists confront as material to be explored, worked on, manipulated, and understood”; Danziger, 2003, p. 20). Danziger’s body of work has demonstrated that epistemic objects, including psychological objects such as personality, intelligence, mental health or disorder, and so forth, are historically and culturally contingent (see also Hacking, 1983). Rather than treating epistemic objects as “natural” classifications that mirror pre-given features of human nature, Danziger demonstrates that such objects have *biographies* involving precursors, champions and advocates, and confluences of spatial-cultural-political-historical circumstances

⁵ I prevaricate here between *mental health* and *student mental health* because student mental health as an epistemic object or social problem emerges in relation to more inclusive understandings of mental health both in other sites (e.g., workplace mental health) and “in general,” whatever that is taken to mean.

that made possible their articulation and rise to prominence. What's more, humans cannot encounter an epistemic object in some idealized empirical form, but only through particular texts, records, instruments, and procedures. Seen this way, "data are not raw 'findings' but careful constructions in accordance with explicit and implicit rules" (Danziger, 2003, p. 21). Said differently, epistemic objects like mental health *exist as recognizable phenomena* thanks to historically specific scientific practices and documents (e.g., diagnostic interviews; screening tools; counselling norms), institutional arrangements, cultural conditions (e.g., valorization of health and happiness; expectations of productivity), and so on.

These intertwining elements can be visualized as a *circulatory system of scientific facts* (Latour, 1999) comprised of five "loops," interconnected flows of activities with no definite beginning or end point. The most familiar starting point, for a scientific fact, might be the practices by which the material world is mobilized or made "available for arguments" (p. 100)—that is, "all the means by which nonhumans are progressively loaded into discourse" (Latour, 1999, p. 99). Respectable scientific discourse is not invented in an arbitrary or haphazard fashion, "out of thin air"; rather, scientists develop procedures and instruments that establish some sort of *relation* between the world and discourse.⁶ Whenever some aspect of the world is transformed into "data" through intentional activity, it is being "loaded into discourse." With regard to student mental health, this might involve surveys and questionnaires that purport to capture and represent students' inner experiences (e.g., students' online responses to the National

⁶ In Latour's work, "the world" is quite obviously material—soil samples, microbes, etc. The current study confuses things somewhat, since aspects of the world to be "loaded into discourse" are immaterial, subjective, and patently discursive: stress, depression, self-esteem, etc. Material reality is nevertheless involved (and invoked) in many ways—neurotransmitters, pencil markings on a final exam or questionnaire, bodily presence in class, payment of tuition.

College Health Assessment), as well as statistics on dropout rates, course failure, or student deaths. As data collection *mobilizes the world*, other loops of activity proceed apace: *autonomization*, that is, the development of a collegial or professional community with associated institutes, departments, conferences, journals, and so forth (a process that is well underway with regard to student mental health), and *alliances*, through which other actors are recruited to care about and participate in one's scientific endeavours. Without alliances, work on putative scientific or social problems—and therefore the meaningful existence of the problems themselves—would wither on the vine; student mental health could not exist as a scientific problem without the ongoing concern of governments, non-profits, and postsecondary institutions. Lastly, alliance-making, autonomization, and mobilization are all intertwined with *public representation*: all the activities by which the general public is recruited into acknowledging a proposed fact. Crucially, “information does not simply flow *from* the three other loops *to* the fourth [public representation], it also makes up a lot of the presuppositions of scientists themselves about their objects of study” (Latour, 1999, p. 106). In other words, public depictions (e.g., in the media) are not afterthoughts floating at arm's length from science proper, but actively shape and shift the situation(s) within which epistemic objects are constituted and maintained.

Alongside the four “loops” of activity articulated above, Latour (1999) suggests that a fifth loop inheres in the *links and knots* created by the intersection(s) of the other loops. Such links and knots, which tie together many heterogeneous activities and resources, stand in for what might traditionally be called the concept, theory, or problem “itself.” The epistemic object in which we are interested—in this case, student mental health—is the cluster of links and knots. Here Latour presages a key maxim of SA: “*The conditions **of** the situation are **in** the situation.*”

There is no such thing as ‘context’” (Clarke, 2005b, p. 71). If any loop in the circulatory system (i.e., any aspect of the so-called context) were to be cut off, the epistemic object would quickly “die” (Latour, 1999). And if the activities of any loop change, different sorts of links and knots will form, changing the nature of the object.

This is not to claim that “anything goes,” or that “all is discourse” (Danziger, 2003, p. 22). Although social factors co-constitute scientific knowledge and concepts such as mental health, they “are not the sole determinant—things don’t just come out any way we’d like them to be ... there is a sense in which ‘the world kicks back’” (Barad, 1998, “On Agency and Causality,” para. 11; cf. Pickering, 1995). A great deal of scholarship that can be loosely classified as *materialist*—significantly though not exclusively in science and technology studies (STS)—has flourished in the last two decades. Materialist arguments push back against versions of social constructionism that stray too far toward linguistic reductionism or monism (Barad, 2007; Danziger, 2003), (re)asserting that “words have *reference* to the world and that science grasps ... things themselves” (Latour, 1999, p. 16), that facts are indeed fabricated through human activity but well-fabricated facts allow reality to express itself with autonomy (Latour, 1999).⁷ One can “believe in reality” (Latour, 1999, p. 1) while acknowledging that our epistemic objects are historical and far from inevitable. Psychological objects such as mental health are arguably a special case because the data that must be “loaded into discourse” (Latour, 1999, p. 99) are properties not of soil or electrons but of human subjectivity. As I will discuss below in relation to Hacking’s work on *making up people*, “the subject matter in most psychological

⁷ Rather than *facts*, Latour introduces the neologism *factish*—fact plus fetish—but explication of this provocative idea is beyond the scope of this chapter.

investigations is pliable in a way that the subject matter of the natural sciences is not” (Danziger, 2003, p. 27). People may accept the authority of proposed psychological ideas, taking them up in ways that establish and extend their truthfulness. Nonetheless, there seems to be some genre of shared human experience—we might call it distress, or emotional suffering—that is important enough to warrant signification across many (if not all) cultures.⁸ To study mental health as a historical and contingent epistemic object is not to dismiss it as phantasmic, but to take scientific language and practices seriously in new ways: to examine *any and all* of the circulatory loops that substantiate its links and knots.

Mental health as a social problem. Student mental health is indeed an epistemic object, but it is a special breed of epistemic object that is also a *social problem*. Here I draw on Spector and Kitsuse (1977/2011) in orienting to social problems not as a condition but a sort of *activity*. The activity in question is that of claims-making: “*the activities of individuals or groups making assertions of grievances and claims with respect to some putative conditions*” (Spector & Kitsuse, 1977/2011, p. 75). Again, this is not to suggest that social problems have no material basis (political, biological, or otherwise) but that a given arrangement of material circumstances only becomes a *problem* when work is done to define and respond to it as such. This work may be done by scientists and professionals; special-interest and lobby groups; activists, “crusaders,” and grassroots leaders; politicians and celebrity figureheads; and so forth. Claims are normative statements about how things ought (or ought not) to be, and may be deployed in parliamentary debates, community meetings, institutional board meetings, and—powerfully—in all forms of

⁸ Critical realist approaches to mental health have tried to undertake explanations of what might be universal in terms of mental health problems; this is not my aim.

media (news, opinion, edutainment; print, televised, online; etc.). If enough claims and complaints are made, or if they are made by powerful enough actors, an agency or department may be created or directed to address the putative social problem. Such institutions “legitimate, institutionalize, and routinize the handling of complaints. Once created, they assume a life of their own” (Spector & Kitsuse, 1977/2011, pp. 150-151).

Most readers will easily call to mind diverse claims-making activities through which mental health is enacted as a social problem in Canada in 2019. Bell Let’s Talk, an annual awareness campaign and corporate social responsibility initiative of the telecommunications company Bell Canada, has been prominent in the media landscape for nearly a decade. Newspapers run stories on depression among the elderly or campus suicides; non-profit organizations and interest groups like *Jack.org*, the Canadian Mental Health Association (CMHA), or provincial Colleges of Psychologists circulate social media content that asserts a problem-claim and specifies a desired response (write to your Member of Parliament; “end the stigma”; donate; share this post). Spector and Kitsuse’s innovation is to suggest that a social problem can be studied *through the work done to define it*: the activities of counselling psychologists, CMHA volunteers, Bell marketers, student services staff, and so forth (dovetailing nicely with SA’s emphasis on social worlds, as I will describe later in this chapter). They also upend conventional assumptions about the “order” of social problems, suggesting that the establishment of an institution concerned with a particular problem might elicit or activate complaints *consistent with the institution’s focus*. Dissatisfactions that might have been expressed in other ways, or might have gone unnoticed or resolved ad hoc, become articulable as aspects of a newly-legitimized social problem. In other words, “*solutions produce problems* [emphasis added] by providing the framework within which those problems can be stated”

(Spector & Kitsuse, 1977/2011, p. 84). Similarly: “professionals do not merely serve. They define the very wants they serve” (Spector & Kitsuse, 1977/2011, p. 85). Such claims provocatively trouble assumptions about the *a priori* status of student mental health needs—not to claim that such needs are frivolously invented, but that they become “possible, perceptible, nameable, and actionable” via already-available “vocabularies of discomfort” (Spector & Kitsuse, 1977/2011, p. 85).

I articulate the above to help justify Q1: “In what ways is ‘mental health’ discursively constructed in Canadian university policies and program websites, online media and social media, and mental health awareness campaigns?” To study mental health as an epistemic object and a social problem is to recognize that claims about mental health—whether in scholarly literature, institutional documents, or popular media—are not reflections or approximations of the “real” thing, but rather, all participate to *constitute* the thing (though not independent of matter/bodies and extra-linguistic practices). Such an inquiry is enriched by data drawn from *any and all* activity loops of Latour’s (1999) circulatory system, hence my choice to analyse textual and visual data from university policies and websites, social and online media, and awareness campaigns. From this perspective, scholarly literature is also a site of discursive construction (whose truth claims may vary in the quality of their fabrication; cf. Latour, 1999). No person or institution can claim the final word on *mental health*’s meaning; all bids add their threads and pulls to the extant “links and knots” of discursive activities that *are* its current meaning.

Thus far, I have been discussing mental health as an epistemic object and a social problem—that is, as a locus of study and claims-making for scientific and professional communities, interest groups, policymakers, the general public, and so forth. Clearly, however, mental health is not only an academic or political topic. Its existence as a concept is tied to its

putative relevance for people's subjective lives. Here, we come to Q2: "In what ways do students discursively construct mental health problems in their lives and with what implications for self-understandings and responses?" I wish to briefly consider Q2 separately from Q1, although—as I will subsequently explain—the two questions are intimately related.

Language Games of Mental Health

Conventionally, language is treated as a neutral medium through which we can accurately label and express our inner experiences. Regardless of which language one is speaking, we assume a simple order of operations; we feel sad, for instance, and upon perceiving the emotion we identify it as *sadness* (or *tristesse*, or *sorg* ...) and can communicate it to others. Talk is considered an incidental conduit to "underlying" experiences. From this starting point, it would make little sense to study how students discursively construct (for instance, how they talk about) mental health problems in their lives, unless one was concerned with measuring the extent to which students use "correct" mental health terminology (cf. mental health literacy measures; e.g., Wei, McGrath, Hayden, & Kutcher, 2015).

This research begins from a markedly different approach to language. I take the position that there is no ultimately superior way to parse and communicate reality (including subjective reality)—our language cannot "get it right" in relation to some universal, idealised accuracy. Certain ways of speaking will nonetheless feel true or common-sensical if they fit with our established *language games* (Wittgenstein, 1958), shared arrangements of speaking and relating by which groups "keep things acceptably familiar" (Lock & Strong, 2010, p. 159). To call these arrangements *games* is not to imply that they are entered voluntarily or frivolously, but rather that they have de facto rules or *grammars* that structure what can be discussed, and in what ways, in order to remain within the expectations of the game. Language games extend beyond

semantics to constitute *forms of life* (Wittgenstein, 1958) that involve tacitly agreed-upon styles of meaning-making, relating, problem-solving, and even sensing and emoting (as I will unpack below).

To some extent, the notion of language games is intuitive: Imagine the sense-making that might be “acceptably familiar” within a circle of Instagram eco-wellness influencers versus a varsity men’s hockey team (though old stereotypes may be increasingly misleading, I hope the point is made). Language games vary by gender, class, generation, politics, and countless intersections of these and other identifications; they may be historical, cultural, *and* local (e.g., there may be certain ways in which men speak with one another, other ways in which hockey players speak with one another, and more specific ways in which *this* team speaks with one another). The more provocative claim here is that the truth of an utterance can only be judged against the criteria of its language game, that is, the value it holds for group members’ purposes. Different languages are appropriate and useful in different circumstances, and exclusive reliance on a single (e.g., psychiatric) language game to interpret human experience may “[obscure] and [subordinate] many other, equally compelling aspects of being human” (Lock & Strong, 2010, p. 148).

With regard to subjective experiences such as pain or fear, language games operate in a “double-edged way”; not only do they supply us with vocabularies to describe such experiences, but they simultaneously “construct that which we are describing” (Lock & Strong, 2010, p. 239). From infancy, we begin to learn not only emotion words, but nonverbal distinctions—for instance, which emotional expressions will be met with sympathy and which will be ignored or chastised. We learn *in relationship with others* how the emotional world “hangs together” for our discursive community. We gain a sense of what counts as a problem warranting attention *and*

what sorts of problem-solving efforts are appropriate or thinkable. We learn how to *do* emotion, that is, how to perform or enact emotions in legible ways (Harré, 1986; cf. notions of doing gender, e.g., Butler, 1990).

Returning to my research questions, Q2 might be rephrased in Wittgensteinian terms: When it comes to mental health problems, in which language games and forms of life do students participate? Studies of so-called mental health literacy have established that not everyone is fully or exclusively immersed in a psychiatric language game (e.g., Marcus & Westra, 2012). However, the current project proceeds from markedly different assumptions: namely, that there are multiple valid ways of constructing emotional realities and that language (and associated practices and ways of relating) plays an active and constituting role in these realities.

Linking Public Discourse and Private Subjectivity

Thus far I have made a case for studying mental health as an epistemic object and social problem constructed in discourse (including claims-making activities; Q1), as well as for inquiring how students speak about and *do* mental health problems within particular language games (Q2). My final task in this section is to theorize the relation between Q1 and Q2: How do culturally available discourses of mental health come to matter to student's self-understandings?

Making and being made in language. The first premise is perhaps the most obvious. When we find ourselves in ambiguous or novel circumstances, we do not invent altogether new ways in which to speak about our concerns, but pit our “best available language” against that which we are struggling to express (Strong et al., 2015, p. 600). Such language, of course, is drawn from the sociocultural setting(s) to which we have access. Therefore, surveying a range of

professional *and* popular mental health meanings on offer (as articulated in Q1) gives a sense of available meanings through which students might name and explain their emotional difficulties.

However, as Strong and Knight (2012) point out, people do not “shop” for new language from a place of discursive neutrality, nor do they always choose language in an intentional or reflective fashion. Certain explanations will fit within existing frameworks, while others seem implausible or even unthinkable. Furthermore, we cannot simply say anything that strikes our fancy; people *hold one another* to expected forms of sense-making (Garfinkel, 1967). Certain ways of acting and speaking are in-bounds; stepping too far out-of-bounds may constitute a *breach* to which others respond with uneasiness, anger, confusion, and/or attempts to return the offender to a normative framework. On the other hand, culturally acceptable formulations operate as “passwords” to unlock concessions or resources; for instance, a student who states that they “didn’t feel like” writing their final exam might achieve a different outcome than one who explains that they suffered a relapse of depression. Often without realizing it, people may be inclined to adopt linguistic resources that align with institutional services—which might be the most readily-available resources anyway.

Alongside “bottom-up” processes (people looking to cultural discourses to explain their subjective experience), we find “top-down” effects through which language *makes up people* (Hacking, 2007). Broadly, we can point to ways in which language games or discourses proffer certain subjectivities, that is, ways of being a person (including styles of thinking and feeling and characteristic relations to others and the world). A familiar example is discourses of gender and

how (from birth, or even from conception) girls and boys are *interpellated* (i.e., hailed or called; Althusser, 1971/2006) to enact gender in specific ways.⁹

Hacking (2007) proposed a more specific sense of *making up people* in that scientific classifications create new subjectivities “that in a certain sense did not exist before” (p. 293). Consider the rise of *two-continua* (or *dual-factor*) models (e.g., Keyes, 2005, 2007), whose core premise is that mental health and mental illness are distinct (though related) spectra that vary independently. Two-continua models raise the possibility that someone who is experiencing symptoms of mental disorder may nonetheless enjoy good mental health, conceptualized as happiness, satisfaction with life, and positive functioning in various life areas. Conversely, a psychiatrically asymptomatic person may nonetheless have poor mental health. The model’s intersecting axes of mental health and mental disorder create quadrants: not only *well-adjusted* (high life satisfaction and few symptoms) and *distressed* (low life satisfaction and many symptoms), but *at-risk* (few symptoms but low life satisfaction) and *ambivalent* (high life satisfaction alongside clinically significant symptoms; Eklund, Dowdy, Jones, & Furlong, 2011). Where previously we might have had students who were disengaged or aimless, we now have *at-risk* students; where previously we saw students who were struggling in some ways but fulfilled in others, we now see *ambivalent* students. To borrow from Hacking’s (1999) account of the “child viewer” (i.e., a child who watches television): “Once we have the phrase, the label, we get the notion that there is a definite kind of person ... a species. This kind of person becomes reified” (p. 27). As a classification is disseminated, other people—counsellors, advisors,

⁹ There is arguably increasing variation in what is acceptable in terms of gender, but recognizable patterns endure—as does the potential for policing if someone acts or speaks in ways that go too far beyond what is expected of them.

professors, parents, peers—may begin to think of, and interact with, students as *at-risk* or *ambivalent*: special types of student (not just unique people navigating the demands of early adulthood). The labels are not neutral descriptors, but flags for study and concern. Students themselves may begin (consciously or not) to interpret *and experience* themselves according to the terms and expectations of the classification, and to relate to others from within these terms. *At-risk* and *ambivalent*, in this example, have become new kinds of people, new ways of being a person.¹⁰

Institutional discourses and the production of selves. “Making up people” requires not only classifications, experts, and subjects to be classified, but “*institutions* within which the experts and their subjects interact” (Hacking, 2007, p. 295). This includes disciplinary institutions (Foucault, 1975/1995) such as schools, universities, hospitals and clinics, workplaces, and prisons, “each seeking to implant a mode of conduct into body and its correlate soul” (Rabinow & Rose, 2006, p. 198). Specific to mental health, scholars have explored the subjectivating (subject-making) influence of situated discursive practices including pharmaceutical marketing and awareness campaigns (Barker, 2011; Watters, 2010), clinic policies and practices (Hardin, 2003; Mik-Meyer, 2009), and public education websites (Fullagar, 2008). Intertwined with the institutions named above, popular media has “played an essential role in codifying, legitimizing, and disseminating the worldview of psychology and in providing a platform for the performance of the therapeutic self” (Illouz, 2008, p. 242). Media

¹⁰ Differently-worded classifications can create different “kinds of people”: consider the different implications that might follow from the classification *ambivalent* (Eklund et al., 2011) versus an alternative label for the same quadrant: *symptomatic yet content* (Renshaw & Cohen, 2014).

bridges gaps between disciplinary experts and the public, teaching, disseminating, policing, and refining both professional and popular mental health “knowledge.”

Governmentality. One of Foucault’s hallmark theoretical accomplishments was to more fully theorize *how* power and knowledge produce (substantiate and constitute) subjectivities. In brief, Foucault proposed that when people enter into a discourse, such as one related to mental health, they not only take advantage of its explanatory resources but also police or manage themselves according to its logics and practices (Foucault & Senellart, 2008). Said differently, when citizens *interpret* themselves according to the problem-solution frameworks articulated within a discourse, they are inclined to *choose* to manage themselves according to its practices. Foucault considered this voluntary, expertise-guided self-discipline to be the characteristic mode of *governmentality*—the conduct of conduct—in contemporary (neo)liberal societies. Analytics of governmentality can be used to theorize relations of structural resonance or *homology* (Nadesan, 2008) across situations writ large, from national or global socio-political discourses through local and intimate hopes, explanations, and problem-solving practices (e.g., Cromby & Willis, 2013; Dahlstedt & Fejes, 2015).

Since at least the eighteenth century, the management and control of life and health (whether of individuals or populations) has been a priority of liberal governments (Nadesan, 2008). The notion of *biopower*, introduced by Foucault (1978) but much elaborated by subsequent scholars, refers to rationalized efforts to intervene upon human life, health, and/or death. According to Rabinow and Rose (2006), biopower includes at least three components: *truth discourses* about the nature of human life/health, plus authorities who can speak to these truths; strategies for intervening in population life/health; and subject positions and practices whereby individuals are brought to *work* upon their own life/health. Such practices can be

conceptualized as *technologies of the self* (Foucault, 1988a), culturally valorized practices of self-making and self-transformation through which people hope to attain happiness, fulfilment, and, particularly in the case of biopower, health and vitality. Importantly, while such practices or technologies are often voluntarily and eagerly taken up, they also come to constitute social obligations. As a governing rationality, biopower includes features of empowerment but also of surveillance and coercion; citizens who ignore or defy “health” imperatives may be subject to correction ranging from subtle peer disapproval to institutional sanction. To summarize in relation to Q1 and Q2: Discourses of mental health hearable in public and institutional representations (surveyed via Q1) include truths, norms, and practices to which students *subject* and apprentice themselves (Q2), whether in pursuit of the good life or through an absence of permissible alternatives.

Looping effects, positioning, and agency. Finally, we arrive at a crucial point. If people act and *interact* from expected subject positions in prevailing discourse, are we nothing more than “cultural dopes” (Garfinkel, 1967, p. 68)? The brief answer is no; although we are co-constituted by and within discursive structures, such processes are not (exhaustively) deterministic. As Barad (1998) points out, “subject formation may involve conflict, struggles, and local acts of resistance” (“On Agency and Causality,” para. 4). Somewhere “between free will and discursive marionettes” (Hardin, 2001, p. 11), a meaningful sense of agency can emerge. Many scholars have addressed this question in fruitful and complex ways; here I will limit myself to a few examples.

Looping effects. Hacking (1999) points out that humans, unlike *indifferent kinds* such as minerals or grasses, are *interactive kinds*: that is, they are aware of being classified and can therefore resist, redefine, or amplify the meanings applied to them. As classified people change

themselves (in practices, emotions, self-understandings, etc.), experts and institutions may be compelled to adjust the classification in what Hacking calls a *looping effect*. We can see such effects at play in relation to mental health; for instance, in a testament to “the sanitizing power of mental illness discourse over many decades” (Giles & Newbold, 2011, p. 421), many people now welcome psychiatric diagnoses as proof that they are *not* crazy. Diagnoses that once denoted limitations can be reclaimed as valued self-identifications, as was made clear when the elimination of Asperger’s syndrome from the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM–5)* (American Psychiatric Association, 2013) was met with vociferous protest from the “Aspie” community (Giles, 2014). A discourse may be embraced by one group and roundly rejected by another; for instance, adolescents may resist the implications of a neurological discourse that impugns their rationality and full personhood while people diagnosed with autism endorse the same discourse for its validation of their (bio-)distinctive status (Ortega & Choudhury, 2011). Particularly in our era of easily-accessible and participative online spaces, expert meanings released “into the wild” seldom remain static (and classifications must therefore be constantly adjusted to remain “accurate” and relevant). To draw from Marxist philosopher Bakhtin (1986), people retain authorship in their use of language. They do not have *carte blanche* with words but can creatively “double-voice” existing language with tweaked meanings that better fit their intentions, purposes, and circumstances.

Positioning theory. Positioning theory offers a way of theorizing how understandings of the self and others arise in dynamic discursive interactions. *Positions*, here, are clusters of moral rights and duties within a discourse or narrative (Davies & Harré, 1999; Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009). Discourses typically involve complementary positions such as student/professor, doctor/patient, consumer/vendor. To take up a particular position is to

interpellate one's interlocutor with a "position call" (Drewery, 2005), casting them in a complementary position. The interlocutor may accept the positioning, that is, respond as expected, or may refuse it, changing the conversation's "footing" (Goffman, as cited in Davies & Harré, 1990) by responding from a different position. A change of footing differently positions the first person, and the dance continues. Said differently, the start of any interaction involves an implicit "bid" for the sort of story in which the participants find themselves. Though it is common for all parties to fall into the familiar or default positions of a proposed story, at any point a person may "negotiate a new position by 'refusing' the position that the opening rounds of a conversation have made available to us" (Davies & Harré, 1990, p. 53).

To bring positioning theory into the realm of student mental health, consider a student who attends a mental health awareness event where a keynote speaker encourages attendees to take up a position of *self-advocate* with the right to define their mental health needs, rights, and preferences. The student asserts this position during her psychiatric appointment the following week, where the doctor (implicitly) rebuffs her bid and repositions her as a *patient* (with the duty of following expert medical advice, which it is the *doctor's* right to dispense). Meanwhile, perhaps her father is positioning her as a spoiled millennial, while her classmate is including her in a collective positioning as oppressed women. In any or all of these relationships, the student may self-position in ways that fully or partially accept or resist these positionings, which are unlikely to remain static.

Research interviews are also shaped by positioning. Interviewer and participant have broadly understood rights and duties; the current study is also shaped by dynamics such as the presumed rights and duties of a counselling professional and a person with mental health problems, plus more specific positioning signalled by my recruitment materials and interview

questions. We cannot avoid positioning others, although with practice we can become more intentional about our position calls and our responses to counter-positioning and resistance (Drewery, 2005). In all this relational-discursive flux, *who one is* remains “an open question with a shifting answer depending upon the positions made available within one’s own and others’ discursive practices” (Davies & Harré, 1990, p. 46).

Multiplicity. My research questions very intentionally orient to multiple meanings: not *how* mental health is discursively constructed, but *in what ways*—plural. This plurality is crucial to conceptualizing how agency might operate within discursive structure. Some authors theorize agency as the possibility of choice between the “many and contradictory discursive practices that each person could engage in” (Davies & Harré, 1999, p. 35). In a study of how snowboarders engage with often-sexist representations of women in snowboarding media, Thorpe (2008) observes that female boarders

confront numerous and even contradictory discourses, but in everyday life they actively participate in deciding which discourses activate them; ... this is a matter of existing within relations of power with a degree of liberty to negotiate individual agency. (p. 217)

Seen this way, our ongoing subjective movement within cultural discourses “is a process of negotiation, working out the meanings of various interactions, ... and choosing particular images to take up or resist” (Fenwick, 2002, p. 162; cf. Hardin, 2001). People may take up some aspects of a discourse but reject others; they may “braid,” remix, or “queer” discourses (Cobb, 2013; LeFrançois & Diamond, 2014); they may use the terms of one discourse to resist or offset the odious implications or totalizing momentum of another. Discursive pluralism opens generative possibilities for discursive flexibility and creativity.

Despite the intuitive appeal of such formulations, we should be careful not to over-state the “freedom” of people’s self-positioning choices. The subjectivities through which we gauge

which meanings and practices seem best, truest, or most ethical to us have always-already been formed in circulating social and historical discourses. Nonetheless, we know that people *can* be exhorted to reposition within a new discourse—this is the premise of consciousness-raising (Weedon, 1987; cf. Drewery, 2005). Regardless of how we configure the structure-agency scales, the presence of alternative discourses is essential to resistance and change. As Butler (2015) points out:

It is possible to break with certain norms as they exercise the power to craft us, but that can happen only by the intervention of countervailing norms. And if the latter can and does happen, it means simply that the ‘matrix of relations’ that forms the subject is not an integrated and harmonious network, but a field of potential disharmony, antagonism, and contest. (p. 9)

In a multicultural country and increasingly-globalized world, we can easily cite examples of discursive disharmony and contest; look to any newspaper or political campaign for examples of people advocating for *their* norms and positions over others’. In many ways, the current cultural moment is *centrifugal* (Bakhtin, 1935/1981), characterized by the proliferation of many different and incommensurable meanings and ways of communicating. Scholars and pundits have proclaimed the “gradual erosion of a common arena of discourse” (Couldry & Turow, 2014, p. 1712), citing audience fragmentation (Webster & Ksiazek, 2012) and the Internet-fuelled rise of pocket-sized subcultures (Ulusoy & Firat, 2018). Valorization of “diversity” is increasingly mainstream, as are calls for representation of “diverse voices” or even diverse knowledges in public and private institutions.

In contrast, we simultaneously witness powerful *centripetal* tendencies (Bakhtin, 1935/1981) toward singular, authoritative meanings and communicative practices. Such discourses hold out the promise of capital-T *Truth*, underwritten by religious or political power or—significantly—by science. During uncertain times and circumstances, such discourses offer

the reassurance of clarity, coherence, “bottom lines,” and “best practices.” They also include discursive resources for policing others’ meanings—attempting to hold others to specific ways of speaking. Of course, the same people who advocate pluralism in one realm (e.g., increasing representation of women and people of colour in government) may insist upon singular meanings in another (e.g., scientific “best practices” for mental health treatment).¹¹

In relation to mental health, centripetal tendencies are distinguishable in efforts to standardize mental health treatments in line with (dominant understandings of) evidence-based practice, or to advance diagnostic-psychiatric meanings via mental health literacy or psychoeducation initiatives. These tendencies have led some people to be concerned about diagnostic expansionism and (over-)medicalization, including in relation to postsecondary students, and the narrow-tracking and eclipsing of alternative meanings (Frances, 2013). Such concerns certainly animate this dissertation. More central, however, is a curiosity about centrifugal tendencies: Where do we find multiplicity, tensions, surprises, and *heteroglossia* (multiple possible meanings associated with the same term; Bakhtin, 1935/1981)? These are sites in which people are particularly aware that “things could be otherwise” and must actively *account* for their positions. Furthermore, as described above, it is within sites of contest and variation that agency can be (tentatively) located; such sites offer glimpses of the *polyphonic* (multi-vocal; Bakhtin, 1984) meaning-making through which new possibilities emerge for individuals, institutions, communities, or societies.

¹¹ An opposite pattern is becoming increasingly familiar: people who rail against cultural pluralism and “relativism” even as they dismiss dominant science and opinions as “fake news,” instead embracing “alternative facts.”

Q1 and Q2 are concerned with culturally accessible and individually deployed discourses of mental health (within which language and knowledge are “bundled” with self-understandings and problem-solving practices). As articulated above, cultural discourses are intertwined with individual subjectivities and self-interpretive efforts in complex and multi-directional ways. Implicit in my research questions is an emphasis on multiplicity. Such interests can be explored via a theory-methods package that permits analysis not only of dominant discourses (cf. many forms of critical discourse analysis; e.g., Richardson, 2007) but of multiplicity and relations between discursive elements. I turn now to introducing the principles and practices of SA.

Situational Analysis

And here we encounter the difficulty of “Everything is in flux.” And perhaps that is the very point at which to begin. (Wittgenstein, 1998, p. 11e)

I alluded in the previous chapter to some of SA’s unique characteristics: concern with *what is going on* and *what matters* in a situation, with particular attention to tensions and heterogeneities. The situation is conceptualized as a field of co-constitutive relations amongst “people and things, humans and nonhumans, fields of practice, discourses, disciplinary and other regimes/formations, symbols, controversies, organizations and institutions” (Clarke, 2005b, p. 72). In SA, “there is no such thing as context” (Clarke et al., 2018, p. 46): The interrelated elements of a situation are “not merely surrounding it or framing it or contributing to it. *They are it*” (Clarke et al., 2018, p. 46). Situation boundaries are porous and fuzzy; a given element is considered part of a situation if it seems to “‘matter’—make a serious difference—in the situation empirically” (Clarke et al., 2018, p. 17). Methodologically, the research situation is constructed via three types of analytic maps that I will describe below.

Before proceeding, I should acknowledge what I am *not* including in this chapter. I will not enumerate the ways in which SA pushes its primary precursor, Straussian grounded theory (GT),¹² around the “postmodern” or “interpretive” turns (Clarke et al., 2018), nor will I compare and contrast SA with GT. Such histories and comparisons are extensively documented by Clarke (2005b) and Clarke and colleagues (2018). In early writings on SA, Clarke indicated that a deep understanding of GT was essential to the practice of SA; however, she and colleagues have since suggested that novice qualitative researchers may learn SA on its own terms (Clarke et al., 2018). Like Charmaz (2015), I believe that SA has “come of age” as a distinctive method and need not be *routinely and exclusively* compared to GT (cf. Whisker, 2018). Although GT has been and will remain co-constitutive of SA, here I will tell a selective theoretical-methodological story of SA as *I* have used it.

Old roots, new roots: Theoretical commitments of SA. Clarke (2005b) and Clarke and colleagues (2018) use the metaphor of *roots* for the theoretical traditions that are woven into current articulations of SA. Clarke’s origin story of SA begins in pragmatist philosophy (e.g., Dewey, 1938) and the tenet that “reality is not ‘out there’ but rather continually in the making on the part of active beings” (Strübing, 2007, p. 555). To pragmatists, meanings and truths are accomplished locally, by specific actors, in and through practical activities that enhance useful transactions with their environment (see Hammersley, 2004). Mead, Blumer, and others extended pragmatist thought into a sociological tradition of *symbolic interactionism*, which holds that meanings are products of social interaction and “human beings act toward things on the

¹² Strauss was one of the co-authors of *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). Straussian GT refers to GT undertaken in the spirit of Strauss (e.g., Strauss & Corbin, 1990, 1998) as opposed to the more positivist forms of GT advanced by Glaser (e.g., Glaser, 1992). Much has been written about the divergence of Glaser and Strauss (e.g., Stern, 1994), which I will not repeat here.

basis of the meanings that the things have for them” (Blumer, 1969, p. 2). Symbolic interactionists “[shun] abstract and totalizing truths in favour of local, grounded, everyday observations” (Plummer, 2004, p. 1105), a preference evident in Mead’s concern with *perspective* (the dialectic relation between an individual and the world; Lock & Strong, 2010). In Mead’s formulation, perspectives are central to the construction of reality; all perspectives (and thus realities) are necessarily partial and situated. Clarke carries this notion forward to SA, in which researchers forego any search for “ultimate” truths or absolute reality and instead seek to represent “the full multiplicity of perspectives in a given situation” (Clarke, 2015a, p. 125).

Continuing along this historical root, pragmatism and symbolic interactionism begat Chicago School sociology and the “Chicago ecologies” of urban communities, neighbourhoods, locales, and “signal events” such as strikes (see Kurtz, 1984, for a review). These ecological studies often involved mapmaking, either literal (e.g., plotting the distribution of saloons and churches on a city map) or more abstracted (e.g., depicting urban spaces as a series of concentric “zones”). Particularly relevant to the eventual development of SA, in Chicago ecologies “relationality was a featured concern” (Clarke, 2005b, p. 41). Eventually, attention shifted from social groups who interacted face-to-face toward “*shared discourses* as boundary making and marking” (Clarke, 2005b, p. 45), provoking interest in *social worlds* that were united across geographies by shared language, ideologies, practices, resources, and commitments (understood as “*both* part of identity construction *and* as predisposition to act”; Clarke et al., 2018, p. 71). Each social world, whether a profession, political party, religious sect, or hobbyist group, operated as a discursive microcosm. The convergence of multiple social worlds in relation to some issue of concern was termed an *arena*. “Insofar as it meaningfully exists,” Clarke (2005b)

writes, “society as a whole ... can be conceptualized as consisting of layered mosaics of social worlds and arenas” (p. 46).

Social worlds theorizing is a clear antecedent of SA, as will be apparent when I describe social worlds/arenas maps below. Another obvious precursor of SA is the *conditional matrix* developed by Strauss and Corbin (1990, 1998), in which a social process under study is diagrammed in the centre of a series of concentric (or spiralling) layers of context, from local through global. Anyone familiar with figures of Bronfenbrenner’s (1979) ecological systems theory, with its nested rings of micro-, meso-, exo-, and macro-systems, can easily visualize a conditional matrix. With these matrices, according to Clarke (2005b), Strauss sought to more adequately represent an action’s situatedness; however, conditional matrices failed to *empirically* specify how the contextual layers related to the action under study. In early stages of developing SA, Clarke (2005b) proposed a new model that dissolved micro/meso/macro distinctions as well as the very premise of “context”—of outside versus inside, proximal versus distal. This dissolution forces a “zooming out” to the situation in its entirety. Wide-ranging conditional *elements*¹³—human and nonhuman, spatial and temporal and political and sociocultural, local and global, symbolic and discursive—are brought *within* the epistem-ontological borders of the situation under study.

Discourse matters. As Clarke (2005b) has noted, “*we and the people and things we choose to study* are all routinely both producing and awash in seas of discourses” (p. 145). If such discourses work to constitute subjectivities, as discussed above, qualitative researchers must

¹³ In SA, *element* can refer to any co-constituting aspect of a situation: actors, actants, ideas, events, and so forth. It is an intentionally flexible and inclusive concept.

trouble the ideal of “the knowing subject” (Clarke et al., 2018, p. 14) who reveals an “authentic” inner experience via surveys or interviews. With SA, Clarke turns attention to discursive formations in which authoritative knowledge is bundled together with valorized or expected practices (Foucault, 1972), for instance, “the institutions of medicine and the media [that] together produce extensive discourses on health and the responsibilities of citizens to produce it” (Clarke, 2005b, p. 54). As Foucault (1975/1995) famously theorized via the Panopticon, citizens internalize the surveilling *gazes* of power (of medicine, morality, the state, patriarchy, etc.) and associated obligations to conduct themselves in accordance with prevailing norms and practices. Understanding people’s conduct and self-interpretations, therefore, demands at least some analysis of the situating discourses wherein their conduct and interpretations have emerged.

Clarke (2005b) suggests that SA can be applied to most lines of discursive inquiry, including how discourses are negotiated in social relationships and interactions; how identities and subjectivities are produced in discourse; or how discourses intersect with power/knowledge, ideologies, and control. Of the many valuable and generative approaches to discourse analysis, SA is distinguished by its analytic attention to heterogeneity and relations among discourses. In SA, researchers aim to depict *all* the substantial discourses in the situation of study, reminding us that no single discourse holds complete power (even *within* a given social world). People are subject to multiple simultaneous gazes and are (self-)disciplined in partial, hybrid, and overdetermined ways. As noted above, recognition of such multiplicity opens up “at least a possibility of notional choice” (Davies & Harré, 1999, p. 35); SA therefore offers an elusive methodological position from which to “draw together studies of discourse and agency, action and structure” (Clarke et al., 2018, p. xxvi).

Nonhumans matter. To date, social science has focused near-exclusively on humans: their opinions, relationships, reactions, and so forth. If nonhuman objects are mentioned in research reports, it is typically as incidental stages or vehicles through which *human* processes might unfold (cf. Birk, 2016); antidepressant pills (the physical tablets in their bottle or blister pack) are largely ignored, as are smartphones (though much attention is paid to their effects on *human* communication, socialization, and information gathering). Scholars in STS were among the first to problematize this analytic divorcing of humans from the nonhuman (or material) world, arguing that nonhumans and humans are embedded in “a seamless web” of co-constitution (Clarke et al., 2018, p. 88). Humans *are not humans* (as such) without nonhumans: tools, toys, books, places, animals, plants, and minerals, not to mention flesh, blood, organs, and brains. Now more than ever, humans and nonhumans are mutually enfolded into *cyborgs* (Haraway, 1991) whose embodied states and subjectivities are co-formed by eyeglasses, pharmaceuticals, medical implants, FitBits, smartphones, and countless other ubiquitous technologies.

Given Clarke’s background in STS, it is unsurprising that SA requires the empirical specification of nonhumans within a situation. Nonhuman (including material and/or technical) elements are *actants* (cf. Latour, 1999) with their own forms of agency and capacities to *act* on other things and people. Pills act on neurotransmitters (that act on brains, that act on people); computers (and smartphones) “configure their users” (Woolgar, 1990); chairs in a waiting room “structurally condition the interactions within the situation through their specific material properties and requirements” (Clarke, 2015b, p. 93). Just as humans are intertwined with discourse, so too are nonhumans: Actants may be materially *and* discursively present and

consequential in a situation. To put it bluntly, “methods that ignore the materialities of existence are today inadequate” (Clarke et al., 2018, p. 16).

With social worlds, discourses, and nonhumans all churning together in a co-constitutive *situation* with no clear boundaries, it is no wonder that SA is often described as messy (Mathar, 2008; cf. Law, 2004). SA’s handles within this mess are a set of data-grounded mapping practices. These maps comprise the distinctive “how-to” of SA, and I turn to them now.

Doing situational analysis. After identifying a general situation of interest—in my case, postsecondary student mental health in Canada—SA researchers empirically work up the situation via a series of maps. Some of these maps become part of the project’s formal results, but most are intended as behind-the-scenes analytic tools that “intentionally work *against* the usual simplifications so characteristic of scientific work (Star 1983) in particularly postmodern ways” (Clarke, 2015b, p. 100). There are three types of map: *Situational maps* lay out the situation’s heterogeneous elements; *social worlds/arenas maps* depict collective commitments, stakes, activities, and interactions; and *positional maps* plot positions taken and not taken in discourse. Crucially, these maps are data-grounded but not intended to “accurately” represent the situation in an objective or mirroring sense (cf. Gergen, 2015). They involve a “*relational* mode of representation [that] does not concern itself particularly with frequency” (Clarke et al., 2018, p. 53); they function to sensitize researchers to multiplicity and complexity and to provoke analysis of relations between elements, actors, and positions.

Situational maps. Situational maps are free-form, messy visualizations akin to what might elsewhere be called a brainstorm or mind map. Their purpose is to “lay out the major human, nonhuman, discursive, historical, symbolic, cultural, political, and other elements in the research situation of concern” (Clarke, 2015b, p. 100). When creating a situational map,

researchers are guided by broad questions: “Who and what are in this situation? Who and what matters in this situation? What elements ‘make a difference’ in this situation?” (Clarke, 2005b, p. 87). Anything that is conceivably part of, or related to, the situation could merit provisional inclusion in situational maps; elements can subsequently be ordered and classified (individual human elements/actors, collective human elements/actors, nonhuman elements/actors, discursive constructions, political/economic elements, spatial elements, etc.; see Clarke, 2005b, p. 90). Figure 1 shows an extract from one of my early situational maps; the full version spanned several pages and included many more elements.

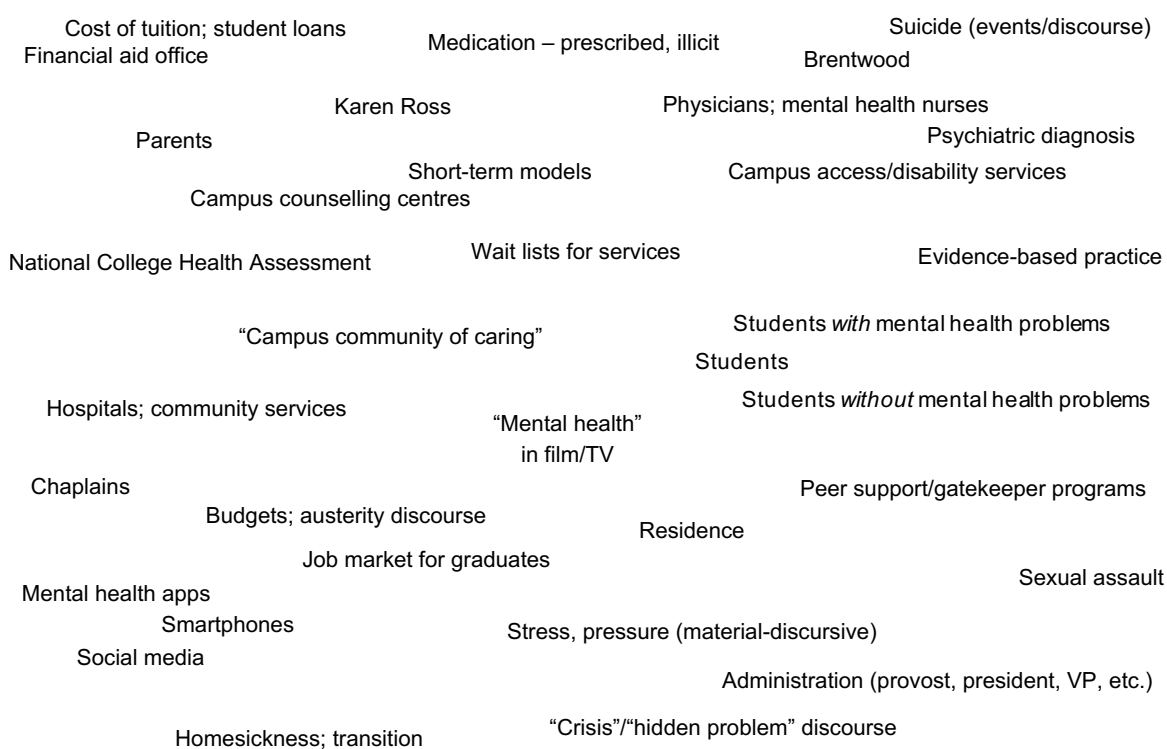


Figure 1. Extract of abstract/messy situational map created at the design stage of this project.

The first situational maps are created at the design stage, before a project formally begins. These preliminary maps are sometimes termed *abstract* situational maps to signal that they are not yet grounded in empirical data (beyond that to which the researcher has been exposed in their

previous work and everyday life). These maps include everything about which it might be worth gathering some data—which, in SA, can include anything from ethnographic field notes and interviews to narrative or historical documents and visuals. For practical reasons, it may not be realistic to gather *extensive* data about each element on the abstract situational map, but researchers should plan at least to take “a peek” (Clarke, 2015b, p. 101).¹⁴

Once data collection is underway, analysis begins immediately and is ongoing throughout the project. Researchers engage closely and reflexively with their data, reading and re-reading empirical materials while creating “wide-ranging” notes and memos of their observations, reactions, curiosities, and provisional claims. Simultaneous with this “digesting” and memoing, researchers continually revisit and revise their maps. As they engage with the data, they may add elements to the situational map; other elements may fade in importance and fall away. One function of situational maps is to keep researchers visualizing, scrutinizing, and “playing with” the elements of the situation (Clarke, 2005b)—memoing (i.e., creating analysis) as they go.

Another key purpose of situational maps is facilitating relational analysis. Clarke (2005b) suggests drawing lines between each element and describing the nature of the relationship represented by the lines, asking what a particular element might “have to say” (p. 103) about each of the other elements. Relational analysis is one way of “[getting] the analyst up and moving into the data, into the analysis, and into memos” (Clarke, 2005b, p. 108), and exploring as many relations as possible can “trigger breakthrough thinking” (Clarke, 2005b, p. 102) in unanticipated ways. Critiquing and extending Clarke’s (2005b) approach to relational analysis,

¹⁴ Figure 1, for instance, includes film and television depictions of mental health. I ultimately chose not to formally sample film and television data to keep my project manageable; however, when I watched a movie or TV show that dealt with mental health I would write a brief memo. SA is not strict about which data are allowed “into” the analysis; SA researchers do not aspire to random or representative sampling.

Mathar (2008) argues for more explicit attention to how so-called elements (people, animals, technologies, etc.) always-already exist in relationships of dialogic transformation (cf. Barad's [1998] *intra*-actions in which there are no things-in-themselves, only relations in phenomena). Instead of asking what each element (e.g., nurses) "has to say" about others, Mathar (2008) urges researchers to consider "how nurses are being (re-)constructed in that situation, by whom and, conversely, how nurses alter or stabilize other elements" (Section 3.1, para. 7). Humans are interactive kinds (Hacking, 1999) in an era of cyborgs and chimeras (Haraway, 1991); analyses must be pushed to account for multiple identities-in-relations and emergent hybridity.

Social worlds/arenas maps. A second type of map identifies the *collective* actors in a situation. Social worlds—that is, groups characterized by shared discourse and common interests, commitments, and activities—are mapped as participating in one or more meso-level *arenas*, that is, broader spheres in which social worlds have some stake. Arenas are typically populated by multiple social worlds, and social worlds may participate in multiple arenas. Arenas and social worlds may vary in scale, depending on a researcher's analytic interest; for instance, "the media" and a specific campus newspaper are both arenas co-constituted by the activities of multiple social worlds, and the latter could also be a social world in itself. Boundaries of social worlds are drawn as dotted lines, signalling that these worlds are porous and encompass heterogeneous stances. It is important to specify and analyse variation within, as well as between, social worlds (Clarke, 2005b). Mathar (2008) suggests that Clarke (2005b) may not go far enough in recognizing that social worlds analysis inevitably necessitates some collapsing across multiplicity and complexity. This is partially justified by Clarke's specification of social

worlds/arenas mapping as a useful analytic for *meso-level* claims making; such analysis foregrounds one set of heterogeneities and (temporarily) excludes others.

In the vein of the symbolic interactionist/Chicago School theorizing described above, during social worlds/arenas mapping a researcher “enters into the situation of interest and tries to make *collective* sociological sense of it, starting with the questions: What are the patterns of collective commitment and what are the salient social worlds operating here?” (Clarke, 2005b, p. 110). Researchers are encouraged to write memos about each major social world: What work is the world undertaking? What commitments does it hold? How do its participants go about fulfilling these commitments and discursively representing themselves? (see Clarke, 2005b, p. 115). Other memos should describe the broader arena(s) of interest, including social worlds that are present or notably absent and contested topics or controversies in the discourse of each arena. Clarke (2005b) describes this reflective and reflexive memoing process as “analytically walking round and round and through and across the worlds and staring relentlessly until their commitments, ideologies/discourses, work organization, technologies, and so on can be specified” (p. 115). Social worlds/arenas maps offer a “working big picture” of how action is structured in the situation of inquiry, diagramming the “conceptual infrastructure” (Clarke, 2005b, p. 116) of the project.

In addition to the immediately apparent actors and social worlds in a situation, researchers seek to identify *implicated actors* who are discussed by a social world and impacted by its actions but are absent from or denied full agency in that world. For instance, at least until recently, people experiencing serious distress or mental difference have often been implicated actors in the situation of Canadian mental health policy: much discussed but rarely invited to the

table. Analytic attention to silent, silenced, and implicated actors is a hallmark practice of SA, one that substantiates its feminist commitment to amplifying quieter voices (Clarke, 2015a).

Positional maps. The third type of analytic mapping lays out major discursive positions taken (and not taken) in the data. *Discursive positions*, in SA, are possible orientations or stances in relation to a given concern within a discourse (although it is tempting to describe positions as “opinions,” “viewpoints,” or “perspectives,” these cognitive and visual metaphors fail to convey the embodied, material, moral, dialogic, etc., implications of discursive positions). Clarke (2005b) recommends using intersecting axes, each representing continua such as “more” versus “less” endorsement of a particular position. Discursive positions are plotted in the field created by these x and y axes. Positional maps can be created for all major issues or controversies that are deemed important to the situation of interest. To the extent possible, positions should be mapped “on their own terms”; that is, researchers should try to “grasp and represent the positions taken in the discourses *by those who produced those materials*” (Clarke et al., 2018, p. 166).

Although researchers may be interested in the relative power of each position mapped (and are encouraged to memo about this), “there is no such thing as a ‘negative case’—no ‘normal’ versus ‘deviant’ position” (Clarke, 2005b, p. 126). To Clarke, this reflects a democratizing commitment to representing all positions, no matter how marginalized or “alternative.” Taking this logic even further, Clarke encourages analytic investigation of “missing positions” or “sites of silence” on these maps. What is unsaid, and why? Has a position been repressed or self-censored? What might be rendering that position illogical, unthinkable, or undesirable? The systematic investigation of absent discursive positions (which might otherwise go unnoticed) is one of the most important functions of positional maps (Clarke, 2005b).

Bringing a project together. Although I have described the maps sequentially, researchers typically move amongst mapping activities as they study their data, creating many revisions and variants of each map. Taken together, the mapping strategies and accompanying memos constitute the analytic work of a project. Broadly, the analysis should address the questions of *what is going on* and *what matters*, as well as how various matters and goings-on are co-constituted in the situation by elements-formerly-known-as-context.

Here we come to a special challenge of SA: wrangling the analysis into something manageable. A full SA can generate much more content than could reasonably be presented in a single dissertation; much will be left on the proverbial cutting room floor. To quote Clarke (2005a) at length:

The overall project analysis should yield a number of possible stories worthy of telling and publication. These can be histories, historicizations, accounts of basic social processes, narrative and/or visual discourse analyses, arena maps, positional studies, and so on. *The ultimate goal is to tell the most interesting and most important analytic stories* [emphasis added]. Sometimes these are the previously untold stories. In a large (dissertation or book) project, analysis has gone well when you begin to see the different stories you could tell, realize that you cannot tell them all, and start trying to decide which to tell. Then you get into which to tell now and which later ... and which materials you want to collect and analyze for the postdoc/next project ... (“Doesn’t situational analysis go too far?,” para. 2)

This passage echoes my own struggles to bring my copious analysis to some sort of (provisional) closure. I appreciated Clarke re-framing my difficulty as a sign that “analysis has gone well”! In brief, Clarke (2005b) recommends that final reports should zoom in and out between “big news” (i.e., maps that survey the full situation) and “close-up shots” (p. 142). When a researcher encounters “big, thorny problems during the analysis, especially conundrums that do not fit comfortably into our analytic categories and/or our expectations, and that do not go away over time” (Clarke, 2005b, p. 125), these complexities may be precisely the Big News to feature. As

researchers select stories to foreground in their project, they may transform one or more working analytic maps into project maps—that is, polished maps that illustrate and clarify the accompanying analytic commentary.

Why SA, revisited: Highlights and appreciations. Thus far, I have introduced SA via its theoretical foundations and methodological procedures, emphasizing SA's unique value as a method that foregrounds variation, relationality, and tensions. There is, of course, a great deal more that can be (and has been) written about SA as an interpretive qualitative method that is “coming of age” in interdisciplinary and international ways (Clarke et al., 2018). I bring this section to a provisional close by identifying several of my own favourite features of this relatively new method.

Explicit and ongoing reflexivity. Research is never neutral, whether politically or epistemologically. To represent is to intervene (Hacking, 1983; 2007); researchers “*are, through the very act of research itself, directly in the situation [they] are studying*” (Clarke et al., 2018, pp. 34-35). We cannot help but participate in the reality that our work purports to document (cf. Haraway, 1997 and the positivist fiction of a detached, objective *modest witness*). SA carries heightened expectations of reflexivity—that is, attending to one's own participation in knowledge construction and in the situation more broadly. SA researchers typically place their own names on situational maps and associated relational analyses, writing ongoing memos on questions such as: “How and why have we come to study X topic? With what goals in mind? For whom? Cui bono? Is it possible to ‘do no harm’? Given that we *are* intervening, are we clear about our goals and means?” (Clarke, 2005b, p. 14). Importantly, researchers' entanglement in the research situation is a source not (only/necessarily) of liability, but of direction and motivation; as Haraway (1997) argues, “the point is to make a difference in the world, to cast our

lot with some ways of life and not others. To do that, one must be in the action, be finite and dirty, not transcendent and clean” (p. 36).

Continuing in this vein, SA eschews ideals of the *tabula rasa* researcher. Situational analysts are not expected to erase or bracket their experience (personal and/or professional), commitments (i.e., “biases”), or knowledge of literature and prior theory. As Clarke and colleagues (2018) point out, “we cannot help but come to almost any research project already ‘knowing’ in some ways, already inflected, already affected, already ‘infected’” (p. 35). The challenge for a researcher is to acknowledge (even welcome) the influence of such knowledge while striving to open space beyond it—to resist analytic domination or “capture” by extant narratives. Again, researchers are expected to memo continually, guided by pointed questions:

How can we be present and hold ourselves accountable in our research? How can we do so without discrediting our research through personal bias? How can we remain seriously open to considering alternative perspectives or interpretations of the situation we are studying? (Clarke et al., 2018, p. 35)

Dozens more such questions can be found throughout Clarke’s oeuvre, and have been invaluable to my reflexivity processes.

In SA, researchers and data are both considered participants in knowledge-making. Inquiry, here, is *abductive*: Researchers tack back and forth between the specifics of empirical data and more abstract analysis and theorizing (Clarke et al., 2018). Seen this way, data do not speak for themselves, nor do findings “arise” or “emerge” of their own accord. On the other hand, data cannot be made to say *anything*; a researcher’s claims must be plausible and well-supported (theoretical interpretations remain “on probation” while they are interrogated in relation to the data; Fann, as cited in Clarke et al., 2018, p. 29). Data remain central but are joined by recognition that theorizing can only push “*beyond the known*” (Clarke et al., 2018, p.

29) when catalyzed by a researcher's own creativity, hunches, and inspiration—which come from experience. If experience is to be used as “an analytic device used to stimulate reflection about the data at hand” (Clarke et al., 2018, p. 35), researchers must maintain careful and critical reflexive practices.

Modest, provisional, and complex analytics. According to Denzin (1992), society “is an emergent phenomenon” and “*it makes no sense to write a grand theory of something that is always changing*” (p. 23). Like society, the situation of student mental health is continually in flux as it is made and re-made by social action. The intended outcome of my project, consistent with SA principles, is not theory but *theorizing*: provisional working understandings of situations in their particularity (Clarke et al., 2018). To theorize is to acknowledge that ever-evolving realities may render one's work outdated even before it is published, and to respond to this dynamism with nimbleness and grace. In a similar vein, SA invites researchers to relinquish the search for *definitive concepts* that “provide prescriptions of what to see” in favour of *sensitizing concepts* that “suggest directions along which to look” (Blumer, 1969, p. 148), analytics that are at once rigorous and provisional. To summarize, the goal of SA is results that are “modest and partial but serious, useful, and provocative” (Clarke et al., 2018, p. 55).

SA results are not only modest but messy, intentionally working “*against* the assumptions of the normal curve” (Clarke et al., 2018, p. 51) in favour of portraits of complexity. SA research will not generate a coherent “main story” or describe a composite “typical experience,” nor does it engage much with questions of relative frequency (e.g., which discursive positions are most and least common). It follows that SA is ill-matched to goals of prediction or generalizability *per se*, although its theorizing can certainly “travel” beyond the original study. The important distinction is that sensitizing concepts must be transported thoughtfully and

carefully; to apply SA findings, research consumers must critically reflect on the connections or possibilities that *might* be suggested for their own situations. SA knowledge tends not to “[map] easily onto taken-for-granted regimes of meaning” (Lather, 2007, p. 85), instead fruitfully “[interrupting] our proclivities toward the easily understood” (Mazzei & McCoy, 2010, p. 505). There are no methodological shortcuts in SA that guarantee validity or quality; in their absence stands an aspiration to “thick analysis” (Fosket, as cited in Clarke et al., 2018, p. 55). Ultimately, it is readers and other stakeholders who will judge the adequacy of SA research claims.

Deconstructive means to socially just ends. Clarke has stated that her hope in developing SA was to facilitate research that is “radical, democratic, and transgressive” (Clarke, 2012, p. 392). SA makes differences visible, “helps silences to speak” (Clarke et al., 2018, p. 32), and calls attention to a situation’s heterogeneous and co-constitutive elements in ways that can inform socially just program development and policy recommendations. Mental health concerns, however understood, relate to human struggle and suffering; with this study, I have sought to better understand these concerns *in their complexity*, supporting the development of responsive and multiple options for supporting students as they navigate these difficult experiences.

Although SA is designed as an explicitly feminist and socially just method, it is *not* re-representational; it does not uncritically reproduce participants’ accounts or “voices.” It is deconstructive and analytic, and from some stances could be “criticized for ‘fracturing’ data, for ‘violating’ the integrity of participants’ narratives, for ‘pulling apart’ stories, and so on” (Clarke et al., 2018, p. 27). Clarke and colleagues (2018) do not deny these charges but suggest that such deconstruction is essential to analytic knowledge-making. Particularly in positional maps, deconstructive analysis “creates an important ‘space between’ actors (individual and/or collective) and positions” (Clarke et al., 2018, p. 173), allowing the possibility for actors to hold

heterogeneous (and inconsistent) positions at different points in time. Furthermore, as Lather (2009) points out, “the demand for feminist research to be centered on such concepts as ‘empathy,’ ‘voice’ and ‘authenticity’ ... is much troubled by critiques of the coherent subject” (p. 17). If (as I argued above) subjectivities are co-constituted in discourse, research must go beyond showcasing participants’ narratives and respectfully but critically interrogate the situations in which such narratives are made and molded (Hacking, 1999).

Clarke often writes about SA’s potential to foreground epistemic diversity (“knowledge production by differently situated producers”; Clarke, 2012, p. 389), a practice that may “work against epistemic violence that erases or silences minor voices and perspectives” (Clarke, 2012, p. 389). Considered from a postcolonial or feminist stance, this is a worthwhile endeavour. However, at the current political moment researchers may also encounter minority voices that they consider angry, hateful, or otherwise distasteful or repugnant. “Odious” positions must be retained in the analysis; they are present and consequential, even if the researcher wishes they were not, and understanding these motives and logics can be invaluable to efforts to resist them (a goal that, if held by the researcher, should be made explicit). Whatever a researcher’s beliefs, Clarke and colleagues (2018) indicate that all positions should be represented “on their own terms” (p. 174). I interpret this not to mean that data “speak for themselves” or should not be interrogated and deconstructed, but that researchers must begin from a stance of curiosity about each position’s locally situating frameworks and perspectives—what Cobb (2013) might call their “terms of legitimacy” (p. 14). What stakes does this position invoke, and toward what solutions does it gesture? What knowledge, experience, and assumptions might ground its plausibility and/or moral worth to variously situated actors? Akin to historical researchers who

work against (over-)imposing contemporary preoccupations onto historical texts, such readings are less “sympathetic” than soundly empirical.

Flexibility within coherence. SA may be messy, but it is not haphazard. Clarke and colleagues (2018) take seriously the ontological, epistemological, and practical commitments that co-constitute the method, and oppose the “shearing off” (p. 24) of such commitments. That said, Clarke and colleagues have modelled a spirit of openness regarding SA, citing Strauss and Corbin’s maxim that “no inventor has permanent possession of the invention” (as cited in Clarke et al., 2018, p. 40). SA is a relatively new method, and Clarke is enthusiastic about the ways in which it might be pushed in unforeseen directions. Researchers are given permission to “pull in concepts from elsewhere, or tweak a map to do some other kind of work” (Clarke et al., 2018, p. 367), to “take a little of this and a little of that” (Clarke, 2005b, p. 305), and to “have fun and don’t worry about making a mess” (Clarke et al., 2018, p. 369), as long as we explicate our choices and the analytic implications of our tinkering. Maps are not intended to be used in formulaic ways, but as *suggested* entry points for exploring and playing and thinking in the data. This generative spirit—of creativity, exploration, invention—was animating for me as I moved through the research process, constantly referring to Clarke’s oeuvre but imagining and testing out new mapping variations along the way.

Project Design

My original project design involved two sequential phases, one focused on document analysis and the second on interviews. However, I soon came to see such neat separations as ill-suited to the spirit and practices of SA; in my maps and memos, I was constantly connecting elements across “phases,” which quickly felt arbitrary and distracting. I re-articulated my design to involve multiple coterminous sites of data collection and analysis—scholarly literature,

document analysis, and interviews—which I mapped in dozens of overlapping combinations. I did not decide in advance which groupings and maps would be showcased in my final dissertation, instead taking time to explore different configurations and reconfigurations of situated elements and narratives.

Literature review. As I will elaborate in the next chapter, my approach to reviewing scholarly literature was specifically informed by SA principles. I treated literature as data, mapping key discursive positions and relations among elements and memoing about how these positions and elements matter in the situation of postsecondary student mental health. I later placed these maps of the literature “in conversation” with maps of document and interview data, leading to fresh mapping—integrating, revising, and newly inquiring in iterative flows of analysis.

Document analysis. Given my theoretical position that publicly available discourse shapes (and is shaped by) people’s sense-making around mental health, I wanted to analyse publicly available documents that are widely circulated and *may* be influential for postsecondary students. Mental health is discussed in countless popular media sites—newspapers and magazines, film and television, self-help books, novels, podcasts, and so on—but for practical reasons, I needed to limit the range of documents I collected for analysis. In discussion with supervisory committee members, I selected four categories of document data, as follows:

- a) Highly-shared online texts, including news, wellness, and “edutainment” content, plus user comments posted in response to these texts;
- b) User-generated posts on social media sites Reddit and Tumblr;
- c) Media from two prominent Canadian mental health awareness campaigns; and
- d) Mental health policies and program descriptions at 11 Canadian universities.

Selection criteria and rationale. It hardly needs stating that contemporary postsecondary students spend a great deal of time online (e.g., Mark, Wang, & Niiya, 2014) and largely access news and information via online sources and social networks (Rosengard, Tucker-McLaughlin, & Brown, 2014); it therefore seemed reasonable to prioritize online texts in my data. Media increasingly converge in ways that favour digital forms. Content is replicated across multiple platforms; online technologies incorporate print, audio, and video; and mergers abound between traditional media, Internet, and telecommunications companies (Dwyer, 2010; Pavlik & McIntosh, 2015). Due to such convergence, my sample of online texts included some content that was concurrently published in print newspapers and magazines.

Contemporary media audiences have been described as fragmented (Webster & Ksiazek, 2012), arguably resulting in “a gradual erosion of a common arena of discourse” (Couldry & Turow, 2014, p. 1712). In other words, we can no longer assume (if we ever could) that “most” young people are consuming the same media, or that a given media text, however viral, has been encountered by a specific person. Nonetheless, I needed a strategy for identifying online mental health texts that *may* have been viewed by Canadian postsecondary students. I chose to collect and analyse texts with high viral reach (social media share rates), one indicator of a text’s circulation amongst a large audience (Alhabash, McAlister, Lou, & Hagerstrom, 2015).¹⁵ I identified these texts using the content search tool BuzzSumo, a paid service that enables users to

¹⁵ Viral reach (number of shares) was chosen from among several possible methods of selecting “popular” online texts. I had initially hoped to collect texts (keyword: “mental health”) with the highest hit rates (i.e., click/view rates); however, a review of comparable projects and consultation with research librarians revealed no services or organizations that compile hit rates for individual texts or “articles” (as opposed to lists of the most popular websites overall). I considered an alternative method of sampling “mental health” texts from websites that are most-accessed by young adults but rejected this strategy because it would exclude “one-off” texts from lesser-known websites that achieved viral status in the previous year.

search for the most frequently-shared links across multiple social media platforms (including Facebook, Twitter, Google+, LinkedIn, and Pinterest). Although demographic data is not available regarding *who* is sharing these articles, young adults are frequent users of social media platforms such as Facebook and Twitter (Duggan & Smith, 2014); furthermore, at the time of data collection BuzzSumo results for “mental health” included sites such as *Huffington Post* that were frequently viewed by students in their final year of high school (Niche Ink, 2014). I conducted my BuzzSumo search in March 2016, limiting results to the preceding 12 months and using the search term “mental health”; I compiled and printed the 20 most-shared links (total share numbers ranged from 232 200 to 773 000) as well as two additional links (#24 and #26 by total shares) that focused specifically on student/campus mental health.

Because I am interested not only in available discourses but in people’s responses to them (alignment/elaboration, resistance, negotiation, counter-claims, etc.), I also analysed user comments on the above texts, where available. To additionally increase the breadth and richness of positions in my data, I gathered posts from the social media sites Tumblr and Reddit; these sites feature many user-generated posts and may include more marginalized perspectives. Rather than selecting the most *popular* Tumblr and Reddit posts, I selected the ten most *recent* posts tagged or categorized with the term “mental health” on two separate days and times (in October 2016 and February 2017), creating and saving screenshots for subsequent analysis.

I chose to include mental health awareness campaigns because they are explicitly designed to disseminate and recruit people into “correct” mental health knowledges, language, attitudes, and/or practices. Awareness campaigns may be perceived as particularly authoritative actants in a situation (though this authority is sometimes doubted or contested). Based on my lived experience as a counsellor and media consumer in Canada, I selected for analysis two

prominent annual mental health awareness campaigns: Bell Let's Talk (run by the telecommunications corporation Bell Canada) and the CMHA Mental Health Week (an initiative of a Canada-wide charitable mental health organization). I focused on campaign materials from 2015–2016 (both campaigns included press releases, news pieces, and text, graphic, and video website content; Bell Let's Talk also included billboards and bus stop posters).

My final source of (formally collected) document data was publicly accessible a) institutional mental health policies and b) program descriptions of counselling, mental health, and/or “wellness” services, events, and programming at the ten English-language Canadian universities with the largest undergraduate populations (full-time and part-time enrolment),¹⁶ plus U of C. Official policies and service descriptions proffer sanctioned forms of self-interpretation and self-management with which students are (implicitly) expected to align to access services or accommodations (Aubrecht, 2012), and may therefore be highly consequential within the situation of student mental health.

Analysis. Consistent with SA principles and procedures described above, I began mapping and memoing prior to formal data collection and never stopped. Once I selected a text for analysis I printed a hard copy and “immersed” myself in it, making notes in margins and writing wide-ranging memos on key claims, language, arguments, assumptions, themes, and implicit logics or values, as well as elements such as who produced the media, what sorts of people are depicted in it, to whom it is addressed, and so forth (cf. Clarke et al., 2018). I concurrently created hard-copy working maps on chart paper and frequently paused to revise,

¹⁶ When I began data collection in June 2015, these ten universities were University of Toronto (U of T), University of British Columbia (UBC), York University (YU), Ryerson University, University of Ottawa (U of O), University of Alberta (U of A), University of Waterloo (UW), Concordia University, Athabasca University, and McGill University (McGill; Universities Canada, n.d.).

refine, and memo about the maps. Throughout my analysis I particularly attended to variations, exceptions, and sites of silence (Clarke et al., 2018), periodically engaging in theoretical sampling to substantiate interesting relations and lacunae; however, given that my initial sample already included many hundreds of document pages, I needed to be selective in my theoretical sampling. Although I sought to map and analyse as many situational elements as possible, I remained aware that no sample (however large) can reflect all available discourses on student mental health. SA requires researchers to make peace with the partiality of their analysis, as I learned many times over when choosing *not* to gather and analyse more (and more, and more) of the seemingly endless texts involved in the situation of student mental health.

Interviews. There is no imperative for SA projects to include interview data; found documents such as those described above provide ample content for richly theorizing a situation. Nonetheless, I believe that interviews are invaluable not only for the data they generate, but for the researcher experience of approaching and engaging the situation differently—as an interlocutor with variously-positioned actors who may name unexpected elements or discursive positions and articulate new relations amongst social worlds. For the current study, I conducted semi-structured interviews with ten young adults who were students at U of C. I developed inclusion criteria requiring that participants must (a) fall within the ages of 18-25 (a range representing “emerging adulthood”; Arnett, 2000), (b) self-identify as having gone through an experience that they *or others* might understand as a mental health problem within the past five years, and (c) indicate that they are not currently at risk or in significant distress. By describing the target experience as one that *might* be described as a mental health problem by the student *or by others*, I hoped to increase the possibility of recruiting a number of participants who challenge, or only partially take up, mental health discourse in narrating their experiences (see

O'Reilly, Taylor, & Vostanis, 2009).¹⁷ I also sought to recruit both participants who *had* and *had not* sought professional medical or psychological help for their concerns; this criterion was met without additional recruitment techniques.

Participants. With a small number of interviewees (consistent with qualitative research of this nature; Willig, 2008), I recognized that it would be difficult to ensure diversity of participants. Recruitment strategies were adjusted as interviews were completed to ensure that interviewees included women and men (no participants self-identified as transgender or otherwise gender-diverse) and students from different ethno-cultural backgrounds. These adjustments were not intended to generate a representative sample, but to (imperfectly) attempt to include a broader range of experiences in the interview data. Six interviewees self-identified as women (though one indicated that she did not strongly identify with her gender) and four as men; they ranged in age from 18–23. Five interviewees self-identified as white, Caucasian, or European; others indicated (sometimes using language such as “mixed” or “half and half”) that they were Chinese-Canadian, Filipino, Filipina-Canadian, and Latina-Canadian. One said that he did not identify with an ethnicity, but that his family comes from Egypt. Among the interviewees were international or newly-arrived students from the United States and the Middle East. Although I did not inquire specifically about sexual orientation, during the course of interviews two of the ten interviewees described themselves as gay or as lesbian/bisexual (the latter interviewee used both terms). I recognize that the results of this study may not reflect the

¹⁷ To somewhat denaturalize the term *mental health problems* and open space for other possible understandings of student distress, my recruitment materials initially placed the phrase in scare quotes. Interestingly, a reviewer from the U of C's Ethics Review Board requested that I remove these scare quotes out of concern that they have “the potential to trivialize genuine mental health concerns” (J. Jayanthan, personal communication, March 9, 2016). This underscores the challenge, within discursive research, of problematizing prevalent terms even as we affirm the very real distress and difficulties with which they are associated.

experience of students from across different diversity spectra; this is inevitable, given the modest scale of the study.

Recruitment. Recruitment was primarily accomplished through paid online advertisements on the social media sites Facebook and Instagram (see Appendix A). Nine of ten participants were recruited in this way; one additional participant responded to posters placed around the U of C campus. Advertisements invited prospective participants to contact me by e-mail. I replied to such emails with screening questions reflecting the above inclusion criteria (see Appendix B) and a letter of information and informed consent (see Appendix C). If participants indicated that they met inclusion criteria and were interested in participating, we scheduled an interview. Throughout this process participants were encouraged to ask questions and seek clarification.

Procedure. I conducted semi-structured interviews lasting 1-2 hours in a private room on the U of C campus between August 2016 and February 2017. Prior to beginning each interview, I reviewed the previously-emailed letter of informed consent with the participant, invited them to suggest their own pseudonym, and collected age, gender, and cultural self-identification. After ensuring that any concerns and questions had been addressed, we both signed the letter of informed consent and the participant was offered a hard copy of the letter. The semi-structured interview focused on participants' accounts of their mental health problem(s), their responses to it, its influence on their subsequent or current self-understandings, and social, professional, or institutional responses (see interview guide in Appendix D). After concluding the interview, I

thanked participants and offered them a \$25 gift card to Chapters-Indigo bookstores as a gesture of appreciation (all accepted).

Analysis. I transcribed the audio-recorded interviews verbatim using Transana software, removing or disguising identifying details. I emailed each participant a copy of their original and disguised transcripts to ensure they were satisfied with the level of anonymity; no participant raised concerns or requested changes. As described above, I again used SA procedures to engage with the data, making copious notes on hard copies of transcripts concurrent with analytic mapping and ongoing memoing. I created maps specific to each interview transcript, maps grounded in the emerging corpus of interview data, and maps that encompassed interviews *and* documents (plus literature). This analytic mapping was largely paused while I completed my pre-doctoral internship; upon resuming full-time focus on the research in September 2018, I created many fresh maps and revised previous ones. In short, this project has involved *working* analytic maps of all manner of elements, relations, collective actors, and discursive positions—most of which were only provisional tools as I continued the abductive process of exploring the situation in as many ways as possible, working up the storylines that follow.

Having given an account of the theory and methods that guided my development and execution of this project, I am eager to begin leading readers along the analytic footpaths I have taken through the situation of postsecondary student mental health. We begin with a data site that typically carries special privilege and primacy in defining research situations: scholarly literature.

Chapter 3: Mapping the Literature

Literature reviews typically lay out “what we know” about a topic of interest—in this case, postsecondary student mental health. However, as I will demonstrate in this chapter, the question of “what we know” has many answers, known by the many different knowers active in the variegated situation. Some knowledges synergize with one another or coexist in untroubled ways; others exist in explicit opposition or implied tension. Discrepant knowledges often resist synthesis; they are incommensurable in ways that preclude deciding which is “true,” although one can make such judgments on political, moral, or pragmatic bases (Star, 1995). In my reading, SA suggests the possibility of juxtaposing heterogeneous literatures *without synthesis*, allowing and examining tensions between them and exploring how such tensions might be consequential within a situation.¹⁸

As noted above, this approach makes literature review into an analytic activity rather than a preliminary one. And why not? Scholarly literature is part of any situation of which it writes, certainly including the situation of postsecondary student mental health. Literature *acts* upon other elements of the situation, particularly (though far from exclusively) via collective and individual actors’ work in policymaking, program development or evaluation, and knowledge translation. Conversely, diverse elements in the situation act upon the literature: For instance, authors take up and theorize “hot-button” issues prominent in media, politics, and other realms of public consciousness.¹⁹ Given that literature is part of the continually co-constituting situation, it

¹⁸ I would like to thank Dr. Tom Strong for alerting me to this capacity of SA.

¹⁹ This “two-way traffic” (Mik-Meyer, 2009, p. 143) is exemplified by the emerging genre of “coddled students” scholarship that was all but absent when I began reviewing this literature in 2013.

should be analysed as such, with specific and *non-reductive* curiosity dedicated to tensions, variation, and minority voices.

Clarke and colleagues (2018) briefly discuss literature reviews, but I believe they miss an opportunity to reimagine the endeavour as part of SA's unique theory-methods package. Their advice to researchers is relatively generic (begin your review with 10–20 citations, prioritizing review articles; identify gaps that might generate valuable, fundable, and publishable projects; use literature to refine research questions and sampling strategies and gain an “initial grip” on analysis; Clarke et al., 2018). I was surprised to find no mention of the heterogeneous elements, social worlds/arenas, and discursive positions that co-constitute any healthy field of scholarship. Therefore, in my own (iterative) reviews of the literature, I sought to move beyond the letter of Clarke's guidance to enact its spirit, treating articles as situated data to be mapped and memoed with attention to heterogeneity, power, and implicated actors.

The risk of applying SA to a literature review is that readers may finish the chapter feeling like they *know* less, or know with less certainty, than they did before. However, this may be precisely what is needed: reading for divergence rather than convergence, pulling at threads of dissent that have been massaged into tenuous accord (cf. Potter, 1996), and troubling what “we all know” about student mental health. What *else* is known, and by whom? What else is going on in the scholarly situation, and what else might matter? The resulting literature review lays an uncertain foundation shot through with fault lines, to which I hope Clarke might exclaim approvingly: begin as you mean to go on!

Discursive Variation in Current Literature

Consistent with SA practices, I analysed the literature using situational, social worlds/arenas, and positional maps before selecting the framework and narrative I present in this

chapter. The map in Figure 2 (below) depicts a discursive field anchored by individual and collective poles on the *x*-axis and medical and sociocultural poles on the *y*-axis. Unlike a mathematical graph, the poles depicted on this map are not precise opposites (in working versions of the map, these poles were *not* counterposed on the same axes; rather, each descriptor had its own axis ranging from *less* to *greater* individualism, medicalization, etc.). Like any representation, this map is partial and imperfect; it suggests differences of emphasis, focus, or priority but is not intended to imply mutual exclusivity. It is a project map with the purpose of representing “messiness in ways that can travel” (Clarke, 2005b, p. 30); specifically, it establishes a field across which discursive tensions in the literature can be visualized.

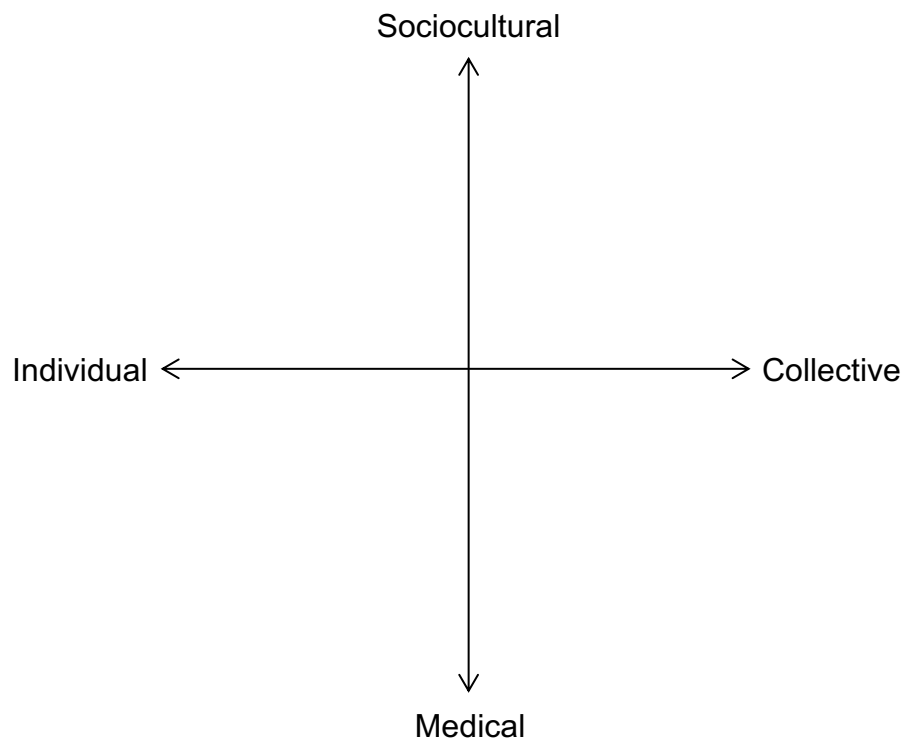


Figure 2. Map of discursive variation in student mental health literature.

In the chapter that follows, I have structured my analysis of the literature according to the quadrants of Figure 2. Although I will articulate discursive positions (i.e., ways of formulating and orienting to a contested issue or concern) within sociocultural discourse, I chose against crystallizing medical discourse into positions *per se* and instead describe its characteristic aims, preoccupations, and/or sensibilities. Nonetheless, I maintain that Figure 2 is a (modified) positional map, not least because I want to convey the *spatiality* of discursive positions. To step into a position (or to be positioned by others) is not merely to think or see in a certain way, but to act in a certain way, relate in a certain way, and have access to certain features of the situation.

At risk of oversimplification, Table 1 offers an orienting sense of the sorts of response and theory that *may* characterize each quadrant. The theoretical and disciplinary associations listed should be considered highly tentative; in SA, discursive positions are mapped separately from the authors or groups with which they are most commonly associated, given that actors can and do take up heterogeneous positions, sometimes within the same article. After substantiating each quadrant (and highlighting tensions or debates within them), I will conclude the chapter by discussing tensions across the map, tensions which are themselves consequential *and* echo or influence elements of the situation that are taken up in subsequent chapters.

Table 1

Characteristic Responses and Associations of Literature by Quadrant of Figure 2

Quadrant	Response	Possible theoretical or disciplinary associations
Individual/Medical	<i>Treat</i>	Psychiatric, psychotherapeutic; (neuro)biopsychosocial
Collective/Medical	<i>Prevent</i>	Primary prevention; health promotion; healthy settings
Collective/Sociocultural	<i>Resist</i>	Structural, political; Foucauldian; critical disability studies
Individual/Sociocultural	<i>Reinterpret</i>	Humanistic, psychodynamic, existential; “saving normal”

Medicalized Discourse: *Treat and Prevent*

Given the significant burden of mental illness among young adults and the self-perpetuating link between mental health and socioeconomic status during the course of life, colleges offer a promising venue for prevention and treatment. ... To seize this opportunity, it is important to improve the research base and coordinate a more cohesive response informed by the evidence. (Hunt & Eisenberg, 2010, p. 8)

The passage above encapsulates several characteristic features of medicalized discourse.

Mental illness is foregrounded as the substantive locus of the student mental health problem, and the longitudinal effects of said illness—the (disease) burden—are cited not only as a challenge but a *promising opportunity* for institutions to mount an effective and *cohesive* response aligned with scientific evidence and so-called best practices. Medicalized discourse tends to be underwritten by modernist and naturalistic assumptions: Through research, we can move closer to objective truth about (human) nature and learn how best to control its malfunctions. Such discourse leaves little space for multiplicity, and knowledges that defy scientific corroboration may be treated as “folk” explanations, placebo effects, or harmful myths.

At the heart of the epigraph, and of medicalized mental health discourse more broadly, are complementary concerns of *treatment* and *prevention*. Spanning the individual/collective axis of medicalized discourse (see Figure 2), both priorities are grounded in a corpus of epidemiological data that justifies and extends ongoing research efforts. Though seldom named as such, epidemiology—the branch of medicine focused on the incidence, distribution, and causes of illnesses in a population (World Health Organization, n.d.-b)—is omnipresent in student mental health literature. Statistics have become indispensable to scientific claims-making (Spector & Kitsuse, 1977/2011); it seems fitting, therefore, to begin this chapter with a scan of these widely-cited claims.

Epidemiological foundations. How many students experience mental health problems?

Prevalence estimates vary, but the scientific consensus seems to be: “a lot.” The WHO World Mental Health International College Student project (WMH-ICS) found that over 35% of first-year college students across eight countries met diagnostic criteria for at least one of six mood, anxiety, or substance disorders (Auerbach et al., 2018). Similar results are reported by the University of Michigan’s ongoing Healthy Minds Study of U.S. college students, which most recently found that nearly 39% of students surveyed met criteria for depression, anxiety, or an eating disorder or had self-injured or thought of suicide in the previous year (Eisenberg, Lipson, Ceglarek, Kern, & Phillips, 2018). In Canada, the National College Health Assessment (NCHA) reported in 2016 that 26% of students surveyed had been diagnosed or treated by a professional for a mental health condition in the preceding 12 months (up from approximately 20% in 2013; American College Health Association [ACHA], 2013, 2016), with anxiety/panic and depression (alone or in combination) the most commonly-reported diagnoses by far.

As Auerbach and colleagues (2018) point out, “direct comparisons of prevalence estimates are not possible” (p. 633) due to differences in methodology and definitions. For instance, should heavy drinking be classified as a mental disorder (see Auerbach et al., 2018) or as a *risk factor* for disorder (see Eisenberg et al., 2018)? Should ADHD be considered a mental health problem (see Turner & Keller, 2015) or not? Operationalization aside, certain puzzling discrepancies have garnered surprisingly little attention. For instance, a seminal large-scale study (Blanco et al., 2008) reported that personality disorders were the second-most common disorder among college students (17.68% of students screened), second only to alcohol use disorder and far more prevalent than mood or anxiety disorders. In contrast, Turner and Keller (2015) found that personality disorders represented only 1.3% of student mental health diagnoses, compared to

anxiety at 44.3% and depression at 33.5%. Have personality disorders really decreased so dramatically since 2008? Did the advent of *DSM-5* affect classification of student distress? Such questions are rarely addressed, with inconsistencies rendered invisible by sweeping generalizations: for instance, that “30-50% of college students have a psychiatric disorder” (Downs, Galles, Skehan, & Lipson, 2018, p. 72).

In some epidemiological-style surveys, working understandings of *student mental health problems* are broadened beyond diagnoses to include difficult emotional experiences or “symptoms.” This strategy yields much higher statistics: according to the NCHA, within the preceding 12 months Canadian students had felt overwhelmed by all they had to do (89.5%), exhausted (88.2%), very sad (73.5%), very lonely (66.6%), overwhelming anxiety (64.5%), hopelessness (59.6%), overwhelming anger (47.3%), and “so depressed that it was difficult to function” (44.4%); more than half of students rated their overall past-year stress levels as “more than average” (46.2%) or “tremendous” (14.4%; ACHA, 2016). Furthermore, according to the NCHA, 13% of students had “seriously considered suicide” in the preceding year (up from 9.5% in 2013). If one were looking to establish that a great many students are struggling and distressed, these figures would certainly do the trick (at least at first glance, as I will discuss later).

Prevalence is one component of “student mental health crisis” narratives; another is whether rates and seriousness of student mental health problems are *rising*. Certain evidence suggests that this is indeed the case. As previously mentioned, the NCHA has reported increasing proportions of students being diagnosed and treated for mental disorders, as well as greater endorsement of “symptom” experiences across-the-board (ACHA, 2016; cf. Oswalt et al., 2018). In a study of U.S. counselling centre data gathered between 2010 and 2015, Xiao and colleagues

(2017) found “small but significantly increasing trends for self-reported distress” (p. 407), particularly in the forms of generalized anxiety, social anxiety, and depression (on the other hand, substance use was trending significantly downward). Campus counselling centre directors consistently report that the number of students with serious, complex, and comorbid psychological problems is increasing; that such students represent a growing concern for their campus; and that their centres struggle to meet the demand for mental health services (Gallagher, 2014; Mistler, Reetz, Krylowicz, & Barr, 2012; Prince, 2015; Watkins, Hunt, & Eisenberg, 2011). The perceived purview of campus counselling centres is shifting away from “benign developmental and informational needs” (Eklund et al., 2011, p. 79) toward treating psychological conditions; consistent with this mandate shift, counselling centres are increasingly integrated (streamlined and/or collocated) with medical and psychiatric services.

Although there is broad agreement within medicalized literature that rates of student psychopathology are rising, relatively little attention has been devoted to why this might be the case. One explanation is that mental disorders have always been highly prevalent within student populations (since young adulthood is a common period in which disorders emerge), but that students are increasingly willing to seek diagnosis and/or treatment and to disclose pre-existing conditions due to improved mental health awareness and lower stigma (e.g., Much & Swanson, 2010; Wiens et al., 2017). A related argument is that improved pharmacological and psychotherapeutic treatments in childhood or adolescence have increasingly enabled mentally ill young people to succeed in high school and therefore enrol in college (e.g., Castillo & Schwartz, 2013). Regarding the possibility of a “true” rise in student mental health problems (beyond improved detection and diagnosis), Gallagher (2012) offers a laundry list of potential contributors:

increased family dysfunction, early exposure to drugs, alcohol, and sexual experiences that students are not emotionally prepared to handle, and excessive pampering and protected childhoods, leaving them vulnerable to the stressors of college life ... parental divorce, the impact of technology, and changing societal mores. (p. 177)

He concludes that “there are many potential factors, but none are definitive” (p. 177). Gunnell and colleagues (2018) call for more research into possible generational stressors, including social media and anxiety about climate change, global terrorism, and financial insecurity.

In addition to prevalence and its trends, epidemiological research is concerned with risk factors and the elevated incidence of mental health problems among oppressed or marginalized social groups. The Healthy Minds Study (Eisenberg, Hunt, & Speer, 2013; Eisenberg et al., 2018) has found higher rates of anxiety among women compared to men, higher rates of depression among students of colour compared to White students (see also Byrd & McKinney, 2012; Cheng & Mallinckrodt, 2015), and higher rates of all mental health problems among financially stressed and non-straight students (see also Cokley, McClain, Enciso, & Martinez, 2013; Oswalt & Wyatt, 2011; Przedworski et al., 2015). In the WHO-ICS, students who identified as non-cisgender had such elevated rates of disorder and impairment that they were excluded from the main statistical analysis (Auerbach et al., 2018). Within a medicalized framework, such “differences across student characteristics point toward the potential benefit of targeted and tailored interventions and also point toward promising [social] factors to intervene on” (Eisenberg et al., 2013, p. 67).

Although many authors would agree that “we are facing a true and profound crisis of college mental health” (Balon, Beresin, Coverdale, Louie, & Roberts, 2015, p. 496), others have cautioned that available evidence does not support such sweeping claims. For instance, Much and Swanson (2010) reported that several large-scale longitudinal studies had failed to find

evidence of increasingly severe student mental health problems, and that other studies purporting to substantiate such an increase were marred by serious methodological flaws. More recently, while Xiao and colleagues (2017) reported that scores on several measures of student distress had indeed trended upward, they cautioned against uncritical uptake of a “crisis” narrative, noting that the “heterogeneity of these domains between [counselling] centers appears to warrant a nuanced approach that focuses on local demand and service availability” (Xiao et al., 2017, p. 414). Nonetheless, student mental health has been successfully established in scholarly literature as both a *social problem* (Spector & Kitsuse, 1977/2011) and a medical problem of some urgency. I turn now to the Individual/Medical (bottom-left) quadrant of Figure 2, in which *treatment* and its effective delivery are central concerns.

Individual/Medical quadrant: *Treat*. When student distress is conceptualized as mental illness, a key priority becomes availing students of the “effective pharmacological and psychological treatments” (Nunes et al., 2014, p. 102) that can mitigate their symptoms. Despite concerns that pharmaceutical treatment might eclipse talk therapy (Whitaker & Cooper, 2007), students seem just as likely to access counselling as they are to take medication for mental health problems (Eisenberg et al., 2018); regardless, the classification of therapy as *treatment* is a “tell” of medicalized discourse (cf. Strong, 2017). Medicalized literature largely treats the value and necessity of treatment as self-evident; attention therefore logically shifts to reducing barriers to treatment (i.e., increasing “help-seeking”), screening and referring at-risk students, and managing treatment costs.

Barriers to treatment. Considerable concern has been raised around the claim that many students who meet criteria for mental disorder receive no treatment (see Blanco et al., 2008; Hunt & Eisenberg, 2010). Studies have found that around half of students who screened positive

for mental health conditions (Eisenberg et al., 2018) or seriously considered suicide in the preceding year (Drum, Brownson, Burton Denmark, & Smith, 2009) had not accessed professional help. Stigma is frequently invoked as a barrier to help-seeking (e.g., Condra et al., 2015; Giamos, Lee, Suleiman, Stuart, & Chen, 2017); while ample literature supports this assumption (e.g., Clement et al., 2015; Gulliver, Griffiths, & Christensen, 2010; Jennings et al., 2017; Wu et al., 2017), recent results of the Healthy Minds Study suggest stigma is relatively low and does not substantially deter treatment-seeking (Eisenberg et al., 2018). The role of stigma will likely remain contested for some time, given its current momentum and credibility in popular and professional discourse.

Stigma aside, students give many reasons for not seeking mental health support. Lack of time is commonly cited, as is the belief that services will not help (Nash, Sixbey, An, & Puig, 2017). Other students report preferring to deal with issues on their own, believing that stress is normal for college students, having plenty of support from family and friends, and anticipating the problem will resolve on its own (Eisenberg, Hunt, & Speer, 2012; Eisenberg et al., 2018). In my reading, students' reasons for *choosing* not to seek treatment are often glossed over and tacitly delegitimized. Eisenberg, Hunt, and Speer (2012), for instance, suggest that "people with mental health problems may not be in a position to make rational decisions about help seeking" due to compromised cognition or being uninformed about "their health conditions and their treatment options" (p. 223). If professional treatment is taken for granted as the (only) rational response to mental distress, then to decline treatment becomes evidence of ignorance or pathology. Extending this logic, Eisenberg, Speer, and Hunt (2012) suggest that institutions could "[reframe] the default option" (p. 713) by "introducing regular, automatically scheduled emotional wellness check-ups" (p. 713) that students must attend unless they actively opt out.

Taken together, the above claims (and the very language of *removing barriers*) work to establish and reinscribe a normative (i.e., healthy and proper) path toward professional diagnosis and help.

Identification and referral. Treatment-centred responses to student distress are further reinforced by literature on gatekeeping, screening, early intervention, outreach, and referral: practices whereby “at-risk” students are identified and enrolled in professional treatment (e.g., Eisenberg, Hunt, & Speer, 2012; Pedrelli, Nyer, Yeung, Zulaug, & Wilens, 2015; Stewart et al., 2014). Since mental health staff cannot interact directly with every student, strategies to monitor (or surveil) student distress become necessary. These include gatekeeper programs through which students are trained to monitor their peers (that is, “to identify those in distress”; Ng & Padjen, 2019, p. 538), sometimes guided by a formalized framework such as “Question, Persuade, Refer” (www.qprinstitute.com) or mental health first aid (www.mhfa.ca). Although one large-scale trial found that gatekeeper training did not increase campus mental health service use (Lipson, Speer, Brunwasser, Hahn, & Eisenberg, 2014), such programs remain broadly popular, valued by peer trainees (Lipson et al., 2014) and touted as a best practice of early intervention (Ng & Padjen, 2019). A parallel strategy involves educating faculty and frontline campus staff on symptoms of mental disorder in order to “improve case identification and facilitate referral” (Kirsch et al., 2014, p. 525).

Alongside gatekeeper programs, technology-aided screening approaches seem increasingly popular. Through email or online academic platforms, “surveillance measures that allow colleges to better monitor the well-being of students” (Oswalt et al., 2018, p. 8), such as the brief Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001), are easily distributed to the entire student body (Garlow et al., 2008; cf. Hunt & Eisenberg, 2010). There is also growing interest in *early alert* programs wherein faculty and other campus staff can

electronically flag students whom they consider “at risk” (academically, psychologically, etc.; see De Somma, Jaworska, Heck, & MacQueen, 2017; Ng & Padjen, 2019). “Alerts” are tabulated in a central database and trigger an institutional intervention, such as emailing the student to recommend campus services (Tampke, 2013). Variations on early alert systems, such as one implemented at UBC, permit students to report (on) their distressed peers (Hanlon, as cited in De Somma et al., 2017). Beyond occasional acknowledgment of privacy and confidentiality issues associated with collaborative approaches to mental healthcare (Moss, 2017), I found no mention of the ethical implications of classifying certain students as “risky” and circulating this information (e.g., to campus security services) without students’ active consent or knowledge. It remains to be seen whether early alert programs will attract legal and ethical attention and, if they do, whether concerns about increasing surveillance of the student body will be downplayed in favour of the “critical” (De Somma et al., 2017, p. 165) objective of (pro)actively identifying (and managing) student risk.

Cost and efficiency. Demand for campus mental health services is higher than ever (Eisenberg et al., 2018), and many scholars now take for granted that pastoral models of mental health care—traditional fifty-minute, face-to-face individual counselling sessions—are inadequate to meet current and future demands, not least because they are positioned as unsustainably expensive (Auerbach et al., 2018; Cornish et al., 2017). Over one-third of campus mental health centres have waitlists (LeViness, Bershad, & Gorman, 2017) and short-term models of therapy are the norm (with or without session limits and prolonged intervals between sessions; Jaworska, De Somma, Foneska, Heck, & MacQueen, 2016).

For managers, dilemmas can arise as demands “from above” to increase direct counselling services collide with union contracts and tenure agreements (Fu & Cheng, 2017). At

the campus counselling centre where I recently interned, managers had begun circulating the book *It's Not About Us* (Leader, 2016), which in the name of client-centredness rails against conventions such as private clinician offices, dedicated administrative time, and “curiosity-and-interest-driven” (p. 139) professional development. The book’s seductive message is that mental health systems do *not* need more money or staff, but a reorganization of priorities (placing client needs over staff expectations). Furthermore, it touts evidence-based treatment (i.e., methods that are scientifically supported beyond placebo or common effects) as essential to ethical and effective practice (Leader, 2016)—a stance strengthened by reports that evidence-based practice represents “a potential solution for [counsellor] burnout” (Wilkinson, Infantolino, & Wachamontes, 2017, p. 543).²⁰

Some scholars make an economic case for greater investment in student mental health services. For instance, Eisenberg and colleagues (2018) estimate that spending \$1 million to expand a campus counselling centre (offering evidence-based care within a brief treatment model) “would retain more than 40 students who would have otherwise left, yielding well over \$1 million in additional tuition revenue and over \$5 million in additional lifetime earnings for the retained students” (p. 84). Alongside such bargaining, however, are those who maintain that “we will likely never be able to hire our way out of the service demand problem” (Cornish et al., 2017, p. 430). Consistent with the latter position is a flurry of activity focused on “innovation” in student mental health—specifically, forms of innovation that promise greater impact with fewer

²⁰ Wilkinson and colleagues (2017) found that burnout among campus counsellors was correlated with *not* using evidence-based practice, and therefore recommend training in such practices; the authors express no curiosity about participants’ reasons for practicing in divergent ways or how delegitimization of preferred practices might occasion burnout. They also fail to discuss actionable implications of their ‘other identified correlates of burnout: being required to spend evenings and weekends on-call, perceiving one’s salary as incommensurate to one’s work, anticipating few opportunities for promotion, not being offered routine raises, and holding a second job.

resources (see projects funded by Ontario’s Mental Health Innovation Fund; Ng & Padjen, 2019). Internet-based interventions, whether fully self-guided or clinician-supported, are touted as low cost, convenient, and stigma-circumventing alternatives to counselling (Auerbach et al., 2018; Nguyen-Feng, Greer, & Frazier, 2017). Calls have simultaneously increased for “coordination of care” with community-based services “such as hospitals, outpatient programs, and private practice practitioners ... capable of offering longer term and more specialized treatment approaches than can be offered by college-based counselors” (Ng & Padjen, 2019, pp. 534-535; discussion of the expense of private practice therapy and the limited purview and availability of provincially funded programs is notably absent).

A concept that seems poised as “the next big thing” in student mental health is Stepped Care 2.0 (hereafter *stepped care*), a “a system for *rationaly distributing* [emphasis added] limited mental health resources to maximize the effectiveness of services for all students” (Cornish et al., 2017, p. 440). Stepped care is designed to “[mirror] primary medical care” (Cornish et al., 2017, p. 430) through an *efficient* model of walk-in consultations during which a student seeking mental health services is assigned to the least intensive “step” of intervention possible (e.g., online or app-based self-help resources; drop-in psychoeducational sessions). Within the stepped care model, individual therapy is reformulated as *intensive* and difficult, appropriate only for students with “high symptom complexity,” “moderate to high risk” (Cornish et al., 2017, p. 432), and clear, change-oriented goals. Less-intensive (and less expensive) self-help options are treated as boons to shifting “away from a consumer model to a philosophy of empowerment, autonomy and shared responsibility” (p. 437).

It is beyond the scope of this chapter to fully critique stepped care—and certainly, it has many critics (its developers acknowledge that “innovation is sometimes disruptive” and that

stepped care “may be at odds with mainstream counseling theoretical orientations and could disrupt traditional professional identities and ethical values”; Cornish et al., 2017, p. 440). Cornish and colleagues’ (2017) formulation of stepped care is baldly medicalized, from the “behaviour prescription form” (p. 431) used by a “primary care mental health consultant” (p. 433) to the option of “watchful waiting” (p. 432) and reference to therapeutic “doses” (p. 434). Such language and logics can occasion tensions for counsellors who wish to practice in less-medicalized ways (cf. Strong et al., 2012). Furthermore, although its proponents insist this need not be the case, some counsellors compare stepped care to “trying to sell a product or convince a reluctant buyer” (Cornish et al., 2017, p. 435) when the model recommends a lower “level” of care than a student expects. A counsellor trainee quoted by Cornish and colleagues (2017) tellingly laments her struggle to “[avoid] the dreaded step 7 (individual therapy)!” (p. 435). It is a testament to the presumed inevitability of ever-tightening budgets (what some might consider an austerity mindset) that the possibility of offering counselling to a struggling student has become thinkable as *dreaded*.

Students have reportedly been satisfied with stepped care services (Cornish et al., 2017). Nonetheless, the juxtaposition of stepped care with broader mental health discourse might create tensions akin to a bait-and-switch. Repeatedly exhorted by awareness campaigns to *seek help* and *open up* about their mental health concerns (no matter how minor), a student may approach a campus counselling centre expecting to *talk*. However, upon arrival they learn that the face-to-face counselling they anticipated (and may have experienced at another university), while available to others, is *not appropriate for them*; the “consultant” instead prescribes self-help websites, mindfulness apps, and drop-in goal-setting seminars. Of course, the student may accept these recommendations, persuaded by the consultant’s explanation or hesitant to cause trouble.

Nonetheless, they might experience some unease or bewilderment, having been subtly rebuffed for their attempt to follow prevailing advice. A modified mantra for the stepped care era might exhort students to *seek help—but not too much*.

As I will discuss in later chapters, mixed messages can be analysed as the upshot of intersecting institutional priorities: for instance, attempts to minimize liability *and* spending. Universities have a (contested) “duty to care” (Washburn & Mandrusiak, 2010); *risky* students constitute a legal, financial and reputational liability. By urging students to *seek care* via awareness campaigns, gatekeeping programs, and early alert systems, universities maximize the number of students brought under the institutional *gaze* (Foucault, 1975/1995) through which (it is hoped) riskiness can be assessed, contained, and monitored. This tactic sweeps up a great many students who turn out to be not-so-risky, and counselling centres become overwhelmed and/or run over-budget. Medicalized discourse comes in handy in “settling” (cf. Billig, 1992) this tension; after all, doctors have the authority to inform patients whether their symptoms are benign or serious and what treatment (if any) is necessary. Seen this way, the *worried well* are right to present themselves for assessment—but it would be inappropriate for counselling centres to offer such students “treatment” when they simply require education and new skills.

Collective/Medical quadrant: *Prevent*. Alongside “innovations” of efficient service delivery, there is a flourishing literature addressing what Eisenberg and colleagues (2018) call the “primary prevention spectrum of public health approaches” (p. 84). Primary prevention²¹—preventing mental disorder *before* it occurs—is lauded as a forward-thinking strategy that will

²¹ Although the phrase *disease prevention* is common in public health discourse, the literature on student mental health favours vaguer terms such as “primary prevention,” perhaps signalling a reluctance to classify mental health problems as diseases.

ultimately reduce demand for overburdened mental health services (Auerbach et al., 2018; Eisenberg et al., 2018), alleviating student suffering and saving money for institutions.

Primary prevention. According to Ng and Padjen (2019), best practices of campus mental health dictate that prevention initiatives “should be focused on reducing stress, providing social support, and encouraging self-care in order to build protective factors against later stressors” (pp. 538-539). Oswalt and colleagues (2018) add foci such as sleep, physical activity, and mindfulness (the latter of which, at the time of writing, has been deemed useful for preventing, relieving, and/or managing an ever-growing array of difficulties).²² Workshops and webinars disseminate psychological knowledge and skills, from deep breathing to assertive communication to cognitive restructuring, in hopes of preventing future psychopathology (Bettis et al., 2017; Conley, Durlak, & Kirsch, 2015). Counselling centres’ outreach efforts are reconfigured to goals of “reducing demand as opposed to promoting services” (Golightly et al., 2017, p. 451).

Here we arrive at another tension. According to the logic of primary prevention, interventions should reach as many students as possible, including those not currently experiencing mental distress. To render an intervention sensible, outreach efforts problematize an aspect of student experience (e.g., exam stress) in mental health terminology and position a desired behaviour change (e.g., mindfulness) as the appropriate response (cf. mental health literacy; Jorm et al., 1997). Intentionally or not, large-scale psychoeducational campaigns thus participate in the “branding or marketing of mental health” (Golightly et al., 2017, p. 452).²³

²² Barker (2014) argues that, despite their sheen of spirituality, psychologized formulations of mindfulness constitute “do-it-yourself medicalization of every moment” (p. 168).

²³ For a critical analysis of the “marketing” of mental illness, see Watters, 2010.

Rather than *reducing* demand for mental health services (by teaching students to self-manage via “healthy” practices), prevention efforts might paradoxically *increase* it (by teaching students to interpret their difficulties via mental health discourse). I will critique this dynamic elsewhere (see also DeFehr, 2016), but the question of whether prevention campaigns successfully reduce mental health problems (and thus demand for service) or extend frameworks of pathology (thus amplifying demand) remains very much unsettled.

Health promotion. The goal of *preventing* mental illness is increasingly accompanied or eclipsed by that of *promoting* mental health, although distinctions between these allegedly independent activities are often ill-defined. In the spirit of the World Health Organization’s (n.d.-a) definition of health as a state of holistic well-being beyond the mere “absence of disease or infirmity” (para. 1), *mental health* has been aspirationally defined as

the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections, and personal dignity. (Government of Canada, 2006, p. 2)

Corresponding efforts to operationalize and study mental health *qua* health have yielded *two-continua* or *dual-factor* models (e.g., Keyes, 2005, 2007) in which mental health and illness are distinct (though related) properties that vary independently. Under such models, symptoms of mental disorder do not preclude “flourishing” (Keyes, 2005, p. 539) in a state of positive mental health (enjoying happiness, satisfaction/interest in life, autonomy, relationships, sense of purpose, etc.). Conversely, one need not experience mental illness to be “languishing” (Keyes, 2005, p. 539) in a state of poor mental health (see Durand-Bush, McNeill, Harding, & Dobransky, 2015; Eklund et al., 2011; Renshaw & Cohen, 2014).

As will be discussed in the next chapter, Canadian campuses are flush with initiatives to boost student wellness, flourishing, thriving, and resilience. Many schools offer large-scale events like “Play Days” during which students make balloon animals, jump rope, build with Lego, and cuddle therapy dogs (Golightly et al., 2017), though I found no scholarly evaluations of such initiatives. Moderate evidence has been found for certain manualized health promotion interventions, including a group-based resilience and coping intervention (Houston et al., 2017) and a mindfulness skills training program (Galante et al., 2018). At University of Toronto Scarborough, the Flourish project (Rashid et al., 2017) offers all first-year students an online self-assessment that “helps determine whether the student is flourishing, languishing, or functioning somewhere between these two states” (Rashid et al., 2017, p. 29); this assessment triggers customized feedback that includes “evidence-based and personalized strategies to build their character and academic strengths” (Rashid & Loudon, 2018, p. 22). The program’s developers assert that Flourish “[expands] the horizons of student transition and success” (Rashid & Loudon, 2018, p. 21) by moving from a “failure prevention and survival mindset to one that promotes flourishing and a resilient perspective” (p. 65).

Although the health promotion and primary prevention initiatives described above are delivered to populations (whether whole campuses or high-risk subgroups), they are not truly collective. The onus remains on *individual* students to take up and enact the proffered information or practices; for this reason, such literature might be more appropriately placed in the Individual/Medical quadrant of Figure 2. To move beyond “the delivery of individually-oriented lifestyle-focused health promotion” (Dooris, Wills, & Newton, 2014, p. 7), we must look to approaches that foreground *structural* determinants of student mental health.

Healthy settings. *Healthy settings* and related socio-ecological, whole-systems, or salutogenetic approaches (see Dooris et al., 2014) orient to how mental health may be determined by students' "environmental, economic, social, organizational and cultural circumstances" (Dooris et al., 2014, p. 7). Such approaches underpin the Healthy Universities movement in the UK (healthyuniversities.ac.uk), the Healthy Minds | Healthy Campuses initiative in British Columbia (healthycampuses.ca), and the Canadian Health Promoting Universities and Colleges Network (www.healthpromotingcampuses.ca). A particularly important document in Canadian healthy settings discourse is the *Okanagan Charter: An International Charter for Health Promoting Universities*. This charter, developed at the 2015 International Conference on Health Promoting Universities and Colleges (ICHPUC) in Kelowna, British Columbia, exhorts post-secondary schools to "embed health into all aspects of campus culture" and to "lead health promotion action and collaboration locally and globally" (ICHPUC, 2015, p. 3). Formally adopted by 20 Canadian post-secondary institutions at the time of this writing (Canadian Health Promoting Universities and Colleges Network, n.d.), the *Okanagan Charter* articulates aspirational principles through which institutions might "enhance the campus environment as a living laboratory, identifying opportunities to study and support health and well-being ... in the built, natural, social, economic, cultural, academic, organization and learning environments" (ICHPUC, 2015, p. 7).

Similar principles of healthy settings discourse are echoed in the scholarly literature. For instance, Brownson and colleagues (2016) urge universities to

reduce some sources of unproductive stress (i.e., stress that creates wear and tear on the individual but does not contribute to self-efficacy, resilience, or educational goals) by reducing common institutional barriers to academic success, unnecessary academic pressures, competition, and distress, and so forth. (p. 110)

Specifically, they suggest emphasizing collaborative coursework, promoting academic and career advising services, offering preparatory courses to students who lack the necessary skills and knowledge for postsecondary studies, and working against discrimination of all sorts. In line with the latter point, Byrd and McKinney (2012) argue that “greater attention needs to be paid to minority students’ subjective sense of integration in the campus life” (p. 191).

More than any literature reviewed thus far, healthy settings approaches acknowledge the consequentiality of “power relations and inequalities within the university context, appreciating that different ‘stakeholders’ have different degrees of access to and control over the determinants of their health and wellbeing” (Dooris et al., 2014, p. 13). Questions of equity, sustainability, and social justice become part of the conversation, in service of *health* as the ultimate meta-value. It is *health*, not justice or equity, which must be embedded “into all aspects of campus culture, across the administration, operations and academic mandates” (ICHPUC, 2015, p. 3). Political sensibilities are filtered through the medico-scientific priorities of health promotion. Although some healthy settings discourse reads as radical or revolutionary, the details tend toward reforming rather than overturning status quo structural arrangements. Institutions, researchers, clinicians, and students are positioned as natural *partners* in health promotion. To wit: Dooris and colleagues (2014) argue that “health can make an organization perform better” (p. 14) and “the key challenge is thus to find ways to align health with the organization’s core business ... and routine life” (p. 14). Such win-win stances distinguish healthy settings positions (which I have mapped as Collective/Medical) from those I will discuss below as Collective/Sociocultural, in which the “core business” and “routine life” of contemporary neoliberal institutions are theorized as central to the production and perpetuation of student distress.

I myself made the dividing “cuts” in Figure 2 (Barad, 2007); there is considerable fuzziness and movement across said cuts, and countless alternative cuts are possible. That said, I posit that healthy settings and psychiatric approaches similarly construct students’ emotional struggles as matters of illness and health. Prevention and treatment are complementary responses within a medicalized logic, and most scientific literature gives no hint of alternatives. However, lesser-known but growing bodies of scholarship approach student mental health not as a psychiatric or public health challenge but as a sociocultural issue. The associated responses, as we will see, differ markedly from those I have introduced thus far.

Sociocultural Discourse: *Resist and Reinterpret*

The difficulties people have in meeting society’s expectations should not all be labeled as mental disorders. Thirty percent of college students cannot suddenly have developed ADHD. (Frances, 2013, p. 186)

It is increasingly difficult to discuss “the difficulties people have in meeting society’s expectations” without defaulting to diagnostic frameworks. Nonetheless, therapeutic and psychological discourse offers some resources—we might say that a student is “burnt out” or “self-sabotaging.” Everyday parlance also includes motivational explanations (“her heart isn’t in it”), moral aphorisms (“he needs to grow up”; “she needs to face the music”), or circumstantial accounts (“the deck was stacked against him from the start”; “she has way too much on her plate”). Each of these less-medicalized explanations opens new possibilities for understanding and responding to distress. In varying ways, the positions below—which I locate in the top half of Figure 2 (see p. 68)—critique the apparent crisis of student mental health as “a cultural problem masquerading as a medical one” (Furedi, 2017, p. 60), cueing up responses not of treatment and prevention but of resistance and/or reinterpretation.

Collective/Sociocultural quadrant: *Resist*. As discussed above, medicalized approaches to student mental health increasingly include systemic, preventive interventions focused on institutional features such as policy, built environments, accessibility, and “campus culture.” Many similar concerns animate the positions I have placed in the Collective/Sociocultural (upper-right) quadrant of Figure 2. The distinction I am making hinges on whether a position foregrounds epidemiological and public health logics (medicalized) or political and interpretive ones (sociocultural), the latter often associated with a critical or antagonistic stance toward status quo power/knowledge structures. From my analysis of the literature, I have articulated three Collective/Sociocultural positions or premises, which I will review in turn:

1. Contemporary social arrangements *cause* student distress.
2. Mental health expertise *governs* student self-understandings and conduct.
3. Student mental differences are not inherently problematic but become so when *marginalized* and/or *excluded* by ableist institutions.

Position 1: Contemporary social arrangements cause student distress. To take up this position is to maintain that emotions such as anxiety, despair, and anger should not be pathologized but recognized as “totally valid and adequate reactions to very elusive, difficult, uncertain social conditions” (Illouz, 2014, p. 24). In other words, students may not be depressed but *oppressed* (cf. Lafrance, 2014); rather than a mental condition, student distress becomes “a structural and relational condition, symptomatic of the stressed and anxiety-ridden environments in which we live and work, best addressed by protesting against and working to change these environments” (Peake & Mullings, 2016, p. 259).

As discussed above, medicalized literature reports that students who belong to marginalized and devalued social identities, including those who are racialized, non-straight,

and/or non-cisgender, are at heightened risk of mental disorder (e.g., Eisenberg et al., 2018; Przedworski et al., 2015; Woodford, Han, Craig, Lim, & Matney, 2014). Such statistics, while useful for social justice claims-making (Busfield, 2012), often fail to interrogate the systemic racism, homophobia/heteronormativity, and transphobia/cisnormativity that transform these diverse forms of embodiment into “risk factors” (cf. Eliason, 2010). As DeFehr (2016) argues, “ambiguous ‘at-risk’ and ‘trauma’ discourses conceal why it is that some groups are more exposed to risk than others, thus diminishing the culpability of authorities and dominant settler groups” (p. 29). From this position, actors might problematize programs that metaphorically “inoculate” so-called vulnerable students with resilience-boosting knowledge and skills—tantamount to making victims responsible for their own self-protection—and insist instead that universities redouble efforts for cultural-political transformation, on campus and beyond.

To take another example, given that students from lower socioeconomic backgrounds or financially stressed students are substantially more likely to experience distress or mental illness (e.g., Eisenberg et al., 2018), Eisenberg and colleagues (2013) recommend integrating campus mental health services with financial services. Though well-intentioned, this suggestion may do more to reassure the counsellor than help the student: Already-limited grants and bursaries continue to dwindle in tandem with public funding for higher education, as tuition and costs of living rise (Harden, 2017). Student loans offer cold comfort, given their long-term mental health repercussions (Walsemann, Gee, & Gentile, 2015). Undergraduate degrees no longer confer the job security they once did, and students are increasingly pessimistic about their economic futures; according to one counselling centre director, “the hypercompetitive environment at universities where students are pitted against each other in a perceived zero-sum game for fewer and fewer jobs, is pushing a generation of youth to the edge” (Fleet, 2011, para. 2). Seen

critically, student suffering takes on a distinctly economic tinge, “a consequence of the exploitative conditions that organize how higher learning gets done within the context of a competitive labour market productive of surplus peoples” (Aubrecht, 2012, p. 80).

A number of scholars situate their concerns about student suffering within critiques of *neoliberalization*: “the encroachment of an economic ethos into higher education” and associated rise of a “highly individualized, privatized, competitive, survival-oriented campus culture, which has heightened performance and productivity pressures with few opportunities for relief” (Peake & Mullings, 2016, p. 266; see also Denzin & Giardina, 2017). Neoliberalism has far-reaching consequences not only for administration of campus resources, but for valorized ways of being a person (i.e., subjectivities). Ideal neoliberal students are ceaselessly productive, flexible, versatile, decisive, and proactive (Cederström & Spicer, 2015; Petersen, 2017). According to Petersen (2017), the “chronic stressor” of striving to embody these norms can engender their opposite; students become nervous, self-doubting, immobilized, and so forth. Because neoliberalism links moral worth to performance and achievement, students who struggle to perform and achieve may berate themselves for their shortcomings, exacerbating their distress (Rosenbaum & Liebert, 2015). Overall, this position critiques how medicalized understandings not only obscure the injurious effects of status quo social arrangements, but—to borrow a currently-popular term—*gaslight* distressed students into believing the pathology is their own (originating in their brains or psyches; cf. Reynolds, 2016).

Position 2: Mental health expertise governs student self-understandings and conduct.

A second Collective/Sociocultural position, often taken up in tandem with the first, critiques expert mental health knowledge as a vehicle of governance and control (cf. Titchkosky & Aubrecht, 2009). In the preceding chapter I introduced Foucault’s notions of biopower and the

associated *technologies of the self* through which people hope to attain happiness, health, and power. Logically, these practices and principles of self-transformation are intertwined with regimes of *ruling relations*, that is, prevailing norms, values, and social arrangements. As noted above, current ruling relations arguably include neoliberal ideals of productivity, flexibility, individualism, and willingness to take personal responsibility for one's problems (Esposito & Perez, 2014), which become taken-for-granted as hallmarks of "healthy" and functional citizens. Understandably, people wish to shape themselves in accordance with these values; citizens who fail to embody them (who are idle, inflexible, apathetic, etc.) are at risk of being classified as ill, unhealthy, or "languishing" (cf. Teghtsoonian, 2009).

Psychological expertise, including the myriad psychoeducational and mental health promotion initiatives on campus, exhorts students to "live as if making a *project* of themselves: they are to *work* on their emotional world ... to develop a 'style' of living that will maximize the worth of their existence to themselves" (Rose, 1998, p. 157; cf. Martin & McLellan, 2013). Such guidance operates as a governing technology through which students choose to regulate their conduct (Bracke, 2016), often through the tacitly familiar neoliberal postures of *consumer* or (self-) *entrepreneur* (May, 2012). The expertise disseminated by campus mental health campaigns and professionals is "thus viewed as benevolent and perhaps even indispensable in the pursuit of a fulfilling and productive life" (Esposito & Perez, 2014, p. 416).

In many ways, this is a harmonious arrangement. Students want to live better, and mental health techniques promise to help them do so. Downsides only become apparent when the bargain falters, when students who have been offered therapeutic resources nonetheless founder. Neoliberal regimes of health construct an "individualistic and meritocratic understanding of academic failure" (Aubrecht, 2012, p. 72) under which struggling students are *failing to help*

themselves. The challenge becomes exhorting such students to participate more enthusiastically in their own recovery. Empowerment is cast as a matter of knowledge, skills, and positive thinking, rather than political action. From resilience discourse (in which “every crisis is an opportunity”), students arguably learn not only to expect futures of hardship and precarity, but that *they* are responsible for turning suffering to their competitive advantage (Evans & Reid, 2013). The neoliberal emphasis on individual self-responsibility aligns conveniently with austerity measures; for instance, educational campaigns demonstrate that an institution cares and is “doing something” about a social problem, even as it quietly eschews more costly or disruptive changes (Gagnon, Jacob, & Holmes, 2010).²⁴

Imagining alternatives to neoliberal governance requires “a wholesale rethinking of the question of what a politics of [student] life is and can be” (Evans & Reid, 2013, p. 83). What values can we imagine beyond individual productivity and self-optimization (cf. Brinkmann, 2017)? How might we resist norms of commodification and competition and shift instead to relational modes of living and learning (Bracke, 2016)? Although answers remain to be worked out, they might begin with an assumption that student distress represents not a failure of self-care but an expression of “agency, protest and affirmation” (Aubrecht, 2012, p. 81).

Position 3: Student mental differences are not inherently problematic but become so when marginalized and/or excluded by ableist environments. From this position, student distress and impairment are understood as forms of *dis-ability*, that is, deviation from expected norms of functioning. Such disability is located not in bodies or minds but in their relationships

²⁴ As discussed above, much literature takes for granted that one-on-one, face-to-face counselling services are cost-prohibitive—an assumption that arguably naturalizes and extends austerity logics.

to institutions that marginalize and exclude certain modes of human difference. People who are dis-abled by institutions are thought to share social and political experiences, making mental disability legible as an identity marker for people who variously identify as mentally ill, mad, neurodiverse,²⁵ and so forth.

This position is most commonly associated with the field of disability studies, where the experience of mentally and emotionally dis-abled students is beginning to garner attention. In her book *Mad at School: Rhetorics of Mental Disability and Academic Life*, Price (2011) articulates the consequences of deviating from expected *ways of being a student*:

What does ‘participation’ in a class mean for a student who is undergoing a deep depression and cannot get out of bed? Or a student who experiences such severe anxiety, or obsession, that he can barely leave his dorm room or home? ... The instruments of exclusion are ... quiet, insidious: we flunk out and drop out. ... We transfer schools; we find a way to get a job or a degree elsewhere. Or not. (pp. 5-6)

According to Price (2011), ableism “contributes to the construction of a rigid, elitist, hierarchical, and inhumane academic system” (p. 8). She describes various survival tactics and catch-22s that characterize day-to-day life for disabled students, who are forever at risk of being labelled “lazy, unmotivated, low-achieving, or—to borrow one of the neuroticism descriptors from the ‘Big Five’—self-pitying” (Price, 2011, p. 72).

This position powerfully challenges the medicalized goal of treating and/or managing mental-emotional “symptoms” to help a student resume *normal* academic participation. Such dominant norms are considered fraught with the “violence of exclusion” (Kempf, 2009, p. 14); here, disability studies shares critical sensibilities with anticolonial stances. According to Price

²⁵ *Neurodiverse* (contra *neurotypical*) is a neologism intended to redefine pathologized forms of cognitive functioning (most prototypically autism) as non-pathological variations (e.g., Jaarsma & Welin, 2012).

(2011), mentally disabled students may *not* be able to “measure up to current ‘standards’ of academic discourse”; instead, she asserts, “academic discourse needs to measure up to us” (p. 9). Simply put, this position maintains that “university campuses are enriched when they recognize and make space for the diversity of mental states that constitute the human condition” (Peake & Mullings, 2016, p. 25).

Thus far, I have introduced three Collective/Sociocultural positions that are often taken up in complementary ways: first, that student distress is less a symptom of disorder than a reasonable reaction or response to unequal and oppressive circumstances; second, that mental health expertise insidiously governs student conduct, pre-empting critique and resistance; and third, that mental experiences, no matter how painful, become *problematic* only through encounter with rigid normative contexts. Social justice, from these discursive positions, goes beyond legally mandated accommodations and the normalizing aspirations of health promotion toward new political, decolonial, and revolutionary *hyperstitions* (“fictions that make themselves real”; Cybernetic Culture Research Unit, 2004, p. 275), counter-narratives that imagine alternative ways of relating to human difference and pain.

Individual/Sociocultural quadrant: *Reinterpret*. The Collective/Sociocultural positions reviewed above each place considerable emphasis on structural causes of student suffering, whether direct/mechanistic (e.g., racism, poverty, etc.) or indirect/interpretive (e.g., moral self-responsibilization for success or failure). Within these positions, the student mental health crisis cannot resolve without *institutional* transformation; therefore, logical responses centre on critique, resistance, and advocacy.

The positions that I will discuss next, though they also critique medicalization and interpret the student mental health crisis as a sociocultural phenomenon, reverse the emphasis of

power. These positions, which I have mapped in the Individual/Sociocultural quadrant of Figure 2, recognize the ways in which universities and other social institutions extend medicalized and therapeutic discourse; however, they ultimately call upon individuals (parents, professors, counsellors, and students themselves) to reject medicalized discourse and (re)affirm students' own agency, responsibility, interpretations, and problem-solving. I have again organized the literature into three positions or premises:

1. Young adulthood (particularly university/college) is a time of normative and meaningful emotional upheaval and identity crisis.
2. Today's students are underprepared and unmotivated for postsecondary studies.
3. Students experience themselves as (disproportionately) fragile and vulnerable due to a "culture of victimhood and therapeutic response."

Position 1: Young adulthood is a time of normative and meaningful emotional upheaval and identity crisis. From this position, medicalization threatens a longstanding understanding of the postsecondary years as a crucible of psychosocial development and exploration. Translating generative and multifaceted emotional turmoil into the flattened, sterile language of symptoms "hijacks the meaning-making process" (Rosenbaum & Liebert, 2015, p. 185); symptoms become inconveniences to eliminate, rather than emotional signals to interpret.

Drawing on Erikson's seminal work on psychosocial development, Côté (2018) argues that many of students' so-called mental health problems may be better interpreted as stress reactions to "the normative identity crisis of adolescence" (p. 257) with its characteristic "ambivalence, anxiety, resentment, and rebellion" (p. 253; see also Rosenbaum & Liebert, 2015). Though painful, self-definitional struggles may be essential to the development of adult identities; as Erikson himself remarked at the First International Conference on Student Mental

Health in 1956, “confusion can presage a new order, a fact which should prevent us from rushing with psychiatric terms into crises which are not only necessary, but maybe desirable” (Erikson, 1959, p. 80). Young people (mis)diagnosed during this sensitive developmental phase may be particularly likely to take up therapeutic identity narratives that endure long after their troubles might otherwise have resolved (Côté, 2018; cf. Hardy et al., 2013).²⁶

Unfortunately, risk-averse institutions are increasingly unwilling to act as holding environments for students’ crises and the unpredictable emotions they may provoke. As Rosenbaum and Liebert (2015) observe,

it is well known that one purpose of the counseling center is to alleviate the anxiety of not only the students, but also the college. This expectation can manifest as a pressure to ‘fix’ or ‘cure’ students, especially difficult ones, rather than bear the anxieties of a slower process. (pp.185-186)

If institutions are uncomfortable with student distress, students (and parents) may be doubly anxious for what Whitaker and Cooper (2007) call “quick fixes” (p. 245) such as medication. In a culture that values “the production of producers” (Fromm, 2007, p. 38), students may be fearful of any disruptive and upsetting emotions, such as those provoked by the exploration, testing, and bungling of new commitments, relationships, and responsibilities (cf. Carter, 2007). However, this position suggests that students must be supported to traverse these formative disruptions as *active agents in their own identity development*.

Position 2: Today’s students are emotionally and academically underprepared for postsecondary studies. In her latest bestseller, psychology professor Jean Twenge shifts her attention from “Generation Me” (i.e., millennials) to youth born after 1995—the bulk of

²⁶ Côté (2018) notes that the temptation to diagnose confused students may be exacerbated by the *DSM-5*’s elimination of identity-focused diagnoses, with identity struggles reformulated as symptoms of anxiety, depression, and/or personality disorders.

contemporary undergraduate students. According to research cited in *iGen: Why Today's Super-Connected Kids Are Growing Up Less Rebellious, More Tolerant, Less Happy—and Completely Unprepared for Adulthood* (Twenge, 2017), this cohort has been especially slow to grow up, relying more and longer on parents to meet their needs and handle their responsibilities, even in college. Twenge (2017) speculates that this dwindling independence, though apparently acceptable to many youth, may be connected to what she calls a “sudden, cataclysmic shift downward in life satisfaction” (p. 96) beginning around 2012-2013. Côté (2018) has similarly argued that students’ increasingly delayed transition to adulthood, if experienced as arbitrary rather than meaningful, can amplify and prolong normal identity crises.

Other literature has advanced the notion that millennials and the subsequent “Generation Z” (White, 2014) struggle to make their own decisions and “haven’t learned how to fail” (Watkins et al., 2011, p. 325), thanks to helicopter parents (hovering and over-involved) and snowplow parents (who clear away every obstacle; Robinson, 2013). Furedi (2017) laments the disempowering effects of a “risk-averse regime of child-rearing, the (unintended) consequence of which has been to limit opportunities for the cultivation of independence and to extend the phase of the dependence of young people on adult society” (p. 57). In Furedi’s analysis, contemporary students enter university expecting to be validated rather than tested; he concludes that “unfortunately, higher education has become complicit in continuing to treat students as if they are children” (p. 61).

Much has been made of the omnipresent technology and social media that have shaped this generation’s social and intellectual development. As digital natives who grew up with the Internet and social media, today’s young adults have learned to curate online identities, arguably to the detriment of spontaneous self-expression and in-person connection (Turkle, 2017; Gardner

& Davis, 2013). Social media has been associated with loneliness, feelings of inferiority and failure, and the quantified and external self-evaluation of “chasing likes” (Twenge, 2017, p. 56). Compared to previous generations, contemporary students may be confronted by more options than ever before—arguably setting the stage for unprecedented uncertainty, indecision, and overwhelm (Rosenbaum & Liebert, 2015).

More concretely, Côté (2018) argues that increasing numbers of students are academically unprepared for postsecondary studies. He cites reports that 60% of American college students had been admitted despite scoring below the standardized SAT cutoff for college readiness (I could find no similar research on Canadian students, perhaps because Canada has no standardized university entrance exam). Students are also dedicating less time to their studies: on average, 25 hours per week, approximately half of what was typical in the 1960s and prior (Côté, 2014). While some might wonder if students are busy with other obligations, Twenge (2017) found that in 2015 students entering college spent four fewer hours per week on homework, paid work, volunteering, and extracurriculars than in 1987. Secondary and postsecondary institutions are complicit in falling norms of academic engagement, since students continue to graduate (cf. Srigley, 2015); regardless, students who are in “over their heads in terms of their ability to function” (Côté, 2018, p. 259) might reasonably become overwhelmed and distressed. Because remedial classes are frequently ineffective, Côté (2018) suggests that badly struggling students should be counselled to explore alternative pursuits rather than press on miserably in academic settings for which they are unprepared, unsuited, and/or unmotivated.

Position 3: Students experience themselves as (disproportionately) fragile and vulnerable due to a “culture of victimhood and therapeutic response.” This position is concerned not only with medicalization but with an affiliated therapeutic culture that assigns

newly pathological and therefore threatening implications to common student experiences. The medicalized and therapeutic (re)formulation of “problems in living” (Szasz, 1960, p. 113), it is argued, results in “the aggrandisement of victimhood, a lowering of expectations about human competence and agency and an increasing reliance on therapeutic intervention” (Wainwright & Calnan, 2002, p. 112) over moral, relational, and other “everyday” interpretations and responses.

An additional concern, from this perspective, is that therapeutic narratives may “[heighten] individuals’ sensitivity to emotional harm” (Sugarman & Martin, 2018, p. 320), creating a self-fulfilling prophecy (Furedi, 2017). As medicalized and therapeutic labels proliferate (e.g., “pre-exam anxiety syndrome”; Furedi, 2017, p. 58), students (deliberately or not) scan their own lives for evidence of disorder. Because human experience varies widely, with frequent ups and downs, nearly everyone can find some psychological deficit in need of therapeutic attention or repair—an expectancy furthered by “crisis” narratives that establish psychological turmoil as the normal state of student life. Even wellness-focused narratives contribute to these pathologizing processes; as Illouz (2008) points out, “the very injunction to strive for higher levels of health and self-realization produces narratives of suffering” (p. 176). Increasingly detailed specifications of how mental health looks and feels invite students to measure themselves against these idealized standards. The self, in other words, becomes understood as fraught with psychological problems or risks for future problems that demand preventive action (Furedi, 2004).

With ubiquitous messages about vulnerabilities to be managed, critics have expressed concern that “the sensibility of being ‘not well’ has today become part of many people’s identity” (Furedi, 2017, p. 58). Medicalized discourses of mental health arguably operate as languages of “self-enfeeblement” (Gergen, 1994, p. 150) that invite people into a “cycle of

progressive infirmity” (Gergen, 1990, p. 361). As students are perceived as increasingly “at-risk,” they are no longer trusted to deal with emotional, existential, and practical harms on their own and are routinely encouraged to seek professional support. Furedi (2004) cites the website of a British university counselling centre, which promises that “the counselling team are fully aware of the importance of managing transition and are here to help you find the way ahead” (Furedi, 2004, p. 108) and supplies a list of circumstances during which counselling might be needed: beginning university, moving from residence to off-campus accommodations, returning from internships, beginning graduate studies. In effect, nearly *any* transition is elevated into a potential problem warranting professional intervention. As help-seeking for mental health issues increases on university campuses, Furedi expresses concern that common experiences previously considered uncomfortable but manageable (via personal skills, relationships, meaning-making, etc.) are newly *expected* to be overwhelming, fostering dependence on the ministrations of *psy* professionals (see also Rosenbaum & Liebert, 2015).

From this position, it is unsurprising that rates of self-reported mental health problems continue to rise among students. As medical-therapeutic meanings are disseminated (e.g., via mental health literacy campaigns), students will increasingly “recognize” and report their personal problems as symptoms. Furthermore, psychological threats such as *trauma* or *bullying* have expanded considerably, whether *horizontally* (including a broader range of experiences) or *vertically* (including milder and milder instances of the experience; Haslam, 2016; Sugarman & Martin, 2018). Consider the section of the NCHA survey in which students are asked to indicate whether, in the previous 12 months, various aspects of life have been “traumatic or very difficult to handle” (ACHA, 2016, p. 15). This wording not only elides any distinction between *traumatic* and *very difficult to handle*—essentially making the terms equivalent or interchangeable—but

positions the language of trauma as applicable to matters of finance, academics, “personal appearance,” and so forth.²⁷ As Neocleous (2012) observes, “‘that was really traumatic!’ is now thought to be an appropriate response to any event that would once have been described as ‘rather unpleasant’ or ‘quite difficult’” (p. 189).

Cederström and Spicer (2015) begin their book *The Wellness Syndrome* with a colourful comparison. “As students at the École Normale Supérieure,” they write, “Sartre and his close friends had more important things to contemplate than their personal wellness” (p. 1); they go on to describe Sartre’s collegiate smoking, drinking, and other immoderate habits of body and mind, simultaneous with impressive intellectual boundary-pushing. The authors juxtapose this image with an array of campus wellness initiatives across North America, from “wellness contracts” whereby students commit to “holistic” and sober lifestyles to nature walks and mandatory “parfait nights” (p. 2). A dream for many parents and university stakeholders (including some students)! The problem, they assert,

is that this project produces a very particular version of the student: the sanitized and straight-thinking student, who would not mix well with Sartre and his radical friends. What is likely to disappear here is a particular kind of college education where students experiment with transformative politics, take mind-expanding substances, encounter the ravages of an unhealthy diet, and experience intense and soul-destroying relationships. (Cederström & Spicer, 2015, pp. 2-3)

Good riddance, some might say. Others might wonder along with Cederström and Spicer: if we continue suffusing ever-more campus experiences with mental health norms, when and where can students go a little crazy?

²⁷ Of the NCHA, Côté (2018) wonders “how much these surveys might be playing into the high drama of some current therapeutic narratives with the choice of wording of some questions, such as ‘trauma’ instead of ‘challenge’” (p. 258).

In his now-classic paper “The Myth of Mental Illness,” Szasz (1960) argues for psychiatric disorders to be “removed from the category of illness, and ... regarded as the expressions of man’s struggle with the problem of *how* he should live” (p. 117). Student mental health problems, seen this way, are *moral* problems involving values, responsibilities, and the *ought-ness* of life. Moral questions may be particularly salient during young adulthood, as students wrestle with how they will respond to disappointments, dilemmas, failures, and limitations. According to Szasz (1960), it is dangerous folly to opt out of these struggles by defaulting to medicalized and therapeutic frameworks. Mental health, he writes, is an illusory goal; rather, “it is the making of good choices in life that others regard, retrospectively, as good mental health” (118).

It is tempting to gloss Individual/Sociocultural positions as politically conservative, given their foregrounding of private responsibility and their sheen of nostalgia or traditionalism (cf. Furedi’s latest book, *What’s Happened to the University? A Sociological Exploration of Its Infantilisation*). McLaughlin (2012) anticipated this, remarking that any scholar who criticizes the “therapeutic turn” may be accused of “being a right winger unsympathetic to the psychological suffering of the distressed” (p. 102). This invites the question: *Are* such positions unsympathetic to student suffering?

As I reviewed the literature, I deliberately read for the best possible intentions that could be inferred from a text; that is, I chose to assume that each author was *genuinely* concerned about students and their lives. However, as I did so, I encountered a not-insignificant amount of what could be read as condescension, mean-spiritedness, even contempt. Though occasionally obvious—witness Stewart’s (2017) disdain for “the political Left” (p. 343), “the progressive agenda” (p. 350), and “the campus ‘snowflakes’ of this generation” (p. 345)—more often such

positioning consisted of the sorts of spectral or “dog-whistle” allusions that allow an author to remain strategically ambiguous about their position while signalling alignment with (in this case) right-wing or libertarian sensibilities.

Many authors also indulge the temptation to generalize from high-profile (and extreme) incidents such as the 2015 furor at Yale University involving advice from administration regarding Halloween costumes, a professor’s dissenting response, and subsequent student protests (see Desroches, 2015; Friedersdorf, 2015). In my reading, discussions of trigger warnings, safe space policies, attention to microaggressions, and identity politics often tend toward caricature, spun into exaggerated strawman arguments that evince little to no curiosity about the local expression of these practices and principles and the values and intentions of the students who champion them.²⁸

Nonetheless, interwoven with these currents of disdain are genuine worry and care for today’s hyper-distressed students, who—to offer an oversimplified analogy—are drowning in waist-deep water, unable to hear the bystanders who call them to *stand up*. Concern is not only for students, but for university communities at large. In her book *Conflict is Not Abuse: Overstating Harm, Community Responsibility, and the Duty of Repair*, which critiques not therapeutic culture *per se* but the “current discourse of overreaction” (p. 93), Schulman (2016) argues that amplified notions of violence and abuse render us dependent on higher authorities for control of those whose words and actions upset us, foreclosing possibilities for dialogue and

²⁸ To her credit, Twenge (2017)—despite devoting the better part of a chapter to the current generation’s “fear, caution, and love for safe spaces” and winkingly noting a friend’s suggestion to “call this generation ‘Gen P’ ... for *pussy*” (p. 166)—includes a lengthy quote from an 18-year-old who defends his generation’s efforts to “be more understanding” of others’ feelings and health and points out that this only “looks like coddling because when my parents were kids lots of people were oppressed” (p. 163).

healing *within* a community. Few would classify Schulman—a queer and feminist novelist, playwright, scholar, and activist—as right-wing, revealing that “trigger warnings” and “call-out culture” can be thoughtfully critiqued from multiple political positions.

A particularly evocative lament of the current state of Canadian postsecondary education comes from Srigley (2015), and is worth quoting at length:

The worst fate for our children, yours and mine, is that because their education has been about little more than fun, self-affirmation, and “skills acquisition,” when the easy pleasures of youth run out and self-affirmation is all they’ve got left, because the student services cheerleaders aren’t around any longer to reinforce that particular illusion, what will remain for them is ... the absence of something to *live for*, the highest and most beautiful activity of their intelligence. To cheat them of that is the real crime, and the most profound way in which modern universities have betrayed the trust of an entire generation of young people. (sec. 8, para. 3)

Srigley’s essay does not explicitly address therapeutic culture, but in my reading has something to say about student mental health (illustrating the situation’s blurry borders). Paralleling Côté’s (2018) developmental analysis, Srigley (2015) laments the deterioration of academic standards and the prevalence of grade inflation, which deprives students of the “honest low grade or failure that might have been the womb of a real success” (sec. 4, para. 5). As Srigley surveys razed humanities departments, he casts an unhappy eye on the ever-growing “student services cabal” whose counterproductive purpose, he claims, is to help students “feel happy, empowered, valued, and the center of their own learning experience” (sec. 6, para. 6). Such student services presumably include counselling centres, not to mention newly-minted directorates of campus wellness or campus mental health strategy. At stake here is the issue of “what universities are actually supposed to do” (Furedi, 2017, p. 58) and whether channelling resources toward student wellness enhances or undermines the institution’s “proper” mandate.

Sociocultural discourse: Tensions within. To recap, in the Individual/Sociocultural quadrant I have reviewed positions that reinterpret student mental health problems as normal and meaningful expressions of transition and identity formation; as consequences of emotional immaturity or academic weakness; and as unnecessarily inflated artifacts of therapeutic culture. These discursive positions differ not only from medicalized ones, but from Collective/Sociocultural positions that attribute student distress and suffering to oppressive, alienating, and exclusionary circumstances. As Furedi (2017) writes:

Those concerned with the emotional fragility of university students frequently assert that the reason for their reaction is linked to the unprecedented economic insecurity that they face, or to the threat of mass-casualty terrorism, or to *something or other out there in the big bad world* [emphasis added]. University students are often portrayed as confronted with a wide range of unparalleled problems and as struggling to make ends meet. (p. 61)

Furedi swiftly dismisses this interpretation; although he acknowledges that many students indeed experience considerable financial pressure, he maintains that “it is far from evident that there is a link between [students’] economic status and their emotional fragility” (p. 61).

A neatly contrasting passage can be found in Ask and Abidin’s (2018) study of student-created memes, many of which centre on self-deprecating depictions of overload and distress. Of one such meme, the authors write:

The management of seemingly normal everyday responsibilities (money, assignments, work, exams, sleep) presents as an overwhelming experience. While there are memes dealing with each of these issues separately, they are often shown as an unmanageable package deal. *Some might interpret this as a sign of a coddled or immature student body* [emphasis added], but an equally valid interpretation is that students are undergoing financial struggles, feeling academically inadequate, attempting to balance work with studying, and not finding time to rest. These various strands of distress, especially when compounded over time, are in fact a set of powerful stressors. (p. 839)

To corroborate their interpretation, the authors cite NCHA statistics regarding the high proportions of students who feel overwhelmed, exhausted, and hopeless; they conclude that

“something an adult/non-student might find mundane or manageable is actually a struggle in the context of student life” (Ask & Abidin, 2018, p. 839). Unfortunately for their argument, the statistics they cite do nothing to prove what is “actually” the case, only that students report their circumstances as overwhelming. It begins to emerge that whether student distress is, “in fact,” proportional to overwhelming circumstances or artificially elevated by coddling environments is less a scientific question than a political and philosophical one.

As discussed in the preceding chapter, SA researchers must reflexively consider their own position in the analysis. I am currently a graduate student and was an undergraduate student not-so-long ago; I have worked in student mental health services on multiple university campuses. I tend to consider myself progressive and left-leaning and have been increasingly concerned with interrogating my blind spots in terms of intersectionality and the perspectives of marginalized others. As an older millennial, I find myself part of a generation that has been repeatedly lambasted as “snowflakes.” Given all this, I found myself prickling with anger at what I read as exaggerated moral rhetoric about an ostensible campus “culture of fear and victimhood” (Sugarman & Martin, 2018, p. 321)—on a campus where I had worked, no less, and witnessed no such culture—and snide remarks about privileged student “activists” that seemed a little too close to the “social justice warrior” jabs that pepper alt-right discourse.

On the other hand, I occasionally felt uneasy with certain Collective/Sociocultural positions that, to me, strained credibility. For instance, in their analysis of student memes, Ask and Abidin (2018) reproduce a meme that made me chuckle: an image of a man standing on a balcony, throwing a single bucket of water onto a raging fire in the adjoining apartment, under the caption “me trying to save my grades after a whole semester of procrastinating” (p. 842). I laughed because I can relate, as can many students; we know how it feels to be the architects of

our own all-nighters. However, Ask and Abidin (2018) do not seem to appreciate the joke, instead critiquing this and other memes' individualization of student stresses. While I respect their efforts to raise consciousness of institutional failures and economic constraints (e.g., pressures experienced by students who must work part-time or full-time jobs), I am concerned that their analysis so strongly favours structure over agency that it falls out of resonance with lived experience. Such analyses might become easy targets of caricature for those who, like Furedi (2017), lament "the downsizing of expectations regarding human agency" (p. 60).

At issue here are questions of *responsibility*. Who is responsible for causing and/or solving student mental health problems? Illouz (2014) astutely observes that therapeutic discourse "is very powerful because it splits the locus of responsibility" (p. 23): On the one hand, students are not to blame for their foibles, which have been caused by some non-self force, whether neurobiology or traumatic upbringings. On the other, students are positioned as responsible for understanding and transforming themselves going forward. Although the sociocultural positions I have presented all critique medicalized interpretations of student distress, they emphasize opposite sides of this split locus: Individual/Sociocultural positions dispute the first premise that common human problems should be blamed on faulty brains, low self-esteem, bullying, or "something out there in the big bad world" (Furedi, 2017, p. 61), while Collective/Sociocultural positions challenge the second premise that it is our individual responsibility to improve our selves and transcend our struggles.

There are at least two layers of tension at play. One could be considered a moral or ethical tension about how society *ought* to respond to students in distress. Plausible arguments have been put forth that students must not be infantilized but heartened to problem-solve as the adults they are (or as part of *becoming* the adults they will be); other positions emphasize our

collective moral responsibility to unmask and address systemic causes of distress (cf. Smail, 1999). One position calls for “saving” normalcy (e.g., Frances, 2014), another for abolishing normativity (e.g., Price, 2011). These positions are not opposites, exactly, but neither are they easily reconciled.

A second layer of tension is equally troublesome: Which positions *work* to reduce student distress? If universities continue further in the direction of recognizing and accommodating students’ diverse psycho-emotional experiences, will our institutions become more compassionate and enriched—or bogged down by student distresses multiplying *ad absurdum*? If, on the other hand, universities were to begin *reversing* their concern with student mental health (that is, to revive a stance that “how students and faculty [cope] with their existential problems [remains] a personal matter”; Furedi, 2017, p. 55), will this liberate universities to resume their noble educational and research function—or throw us back to a “dark age” in which minority experiences of many sorts are stigmatized and ultimately pushed out while students struggle (and fail) in silence? Do students have *more* or *less* control over their suffering than they think? Again, these questions are extremely difficult, if not impossible, to answer scientifically. They are political and ethical questions masquerading as pragmatic ones.

In addition to questions of responsibility, at the heart of this morass are questions of *reality*. Few would dispute that student mental health problems are real in the sense of the Thomas theorem, that is, situations perceived as real are real in their consequences. What is at issue is whether *distress itself* should be critically deconstructed as a contingent discursive phenomenon or taken at face value as a fundamental human reaction to injurious circumstances. Some authors, like Illouz (2008), speak to both sides of this tension, observing that

there is a poignant irony in the therapeutic discourse. The more the causes for suffering are situated in the self, the more the self is understood in terms of its predicaments, and the more ‘real’ diseases of the self will be produced. (p. 246)

If Individual and Collective positions are united on any point, it may be a shared opposition to medicalized and therapeutic preoccupations with inner suffering, which are thought to obscure and thwart some more important imperative (whether this be sociopolitical transformation, celebration of human diversity, intellectual rigor, or individual development and responsibility). Nonetheless, a great deal of polarization is possible between understandings of anxiety and depression as expressions of the uncertainty and anguish of life under neoliberal regimes (Aubrecht, 2012) versus as “the *go-to excuses* [emphasis added] for substandard academic performance among students who adopt the therapeutic identity narrative” (Côté, 2018, p. 259). Given the broader situation of fault lines that some have called the “campus culture wars” (Sugarman & Martin, 2018, p. 320), in which student mental health is implicated, such tensions are unlikely to dissipate anytime soon.

Conclusion

Having reviewed the literature, what now do “we know” about postsecondary student mental health? If we stand in the Individual/Medical quadrant of Figure 2 (see p. 68), we know that mental disorder (whether clinical or subclinical) is highly prevalent among students, but can be effectively treated via therapy, medication, and/or evidence-based self-help. We know, therefore, that we must encourage students to recognize their own symptoms and seek treatment; we know that we must screen and identify students in distress, connecting them to professional help; and we know that we must innovate to do *more* of these activities in less costly ways. We are driven by the imperative to relieve suffering and preserve life, and we know that this can be done by *detecting, treating and managing students’ mental illness*.

Next door in the Collective/Medical quadrant of Figure 2, we know some slightly different things. We know that *preventing* mental disorder is more effective than treating it, and that this can be done by equipping students to better cope with the stressors that arise in their life and to make healthier choices. We also know that our purview must broaden beyond prevention of illness to active *promotion* of holistic student health, wellness, and flourishing. Finally, we know that systemic and structural features of the campus environment are particularly significant determinants of student health, and that these truly collective features may represent the most promising levers of population-level change. Here our guiding aspiration is to *maximize health*.

Stepping over the (constructed) x-axis of Figure 2 into the Collective/Sociocultural quadrant, we know that student distress is a valid response to inequitable, unjust, and/or alienating social arrangements. Knowing this, we resist certain privatizing, depoliticizing, and pathologizing effects of medicalized discourse, effects that render students *docile* (Foucault, 1975/1995) and incite them to self-govern in normalizing ways that replicate the status quo. We know that human mental and emotional experience is diverse and complex; we believe that genuine social justice demands transformation of how institutions relate to this diversity.

Finally, over in the Individual/Sociocultural quadrant, we know that things have gotten out of hand: that sadness, uncertainty, and angst, far from representing a crisis, are *normal* emotional and existential experiences, particularly during the considerable upheaval, growth, and new challenges of the university years. We know that academic standards are slipping, and students are increasingly ill-disposed to and ill-equipped for adult responsibilities. We know that reported rates of student mental health problems are increasing every year, despite exponentially greater investment in awareness, education, and services; we posit that this escalation will continue if campuses continue to pour resources into mental health services that, paradoxically,

bring forth the very problems they seek to prevent. “Our” hope, based on this knowledge, is that students will begin to reclaim agency over their difficulties and institutions will scale back their (over-)involvement in student “mental health,” allowing more idiosyncratic, practical, relational, and/or everyday forms of problem-solving and meaning-making to regain legitimacy.

Having toured the literature, we know many useful things; the difficulty, of course, is that several of these useful things are not easily reconciled. Relations of tension create tripping hazards across the field of literature, demanding careful navigation by stakeholders (counsellors, administrators, activists, policymakers, etc.) who attempt to consider the literature broadly (of course, many actors remain zoomed in on a single discourse, thus simplifying their decision-making). Consider the following passage from Condra and colleagues (2015):

Students in a study by Quinn et al. (2009) reported that they often did not recognize their symptoms as [mental health disabilities] and some did not identify with having a disability. This speaks to the importance of education and outreach to enable all members of the campus community to recognize the signs of poor mental health in themselves and in others. (p. 282)

This claim begins with a common premise of medicalized discourse: Many students do not *recognize* their “symptoms” as psychiatric problems (or mental health disabilities), nor do they *identify* as persons with such problems. This formulation depends upon the assumption of an ultimately correct interpretation of reality: Students *have* mental health disabilities (and *are* therefore persons with disabilities), whether they realize it or not. The underlying reality is assumed to be objective, that is, unaffected by anyone’s beliefs about it, and the logical response becomes to minimize the time during which students suffer under what gets positioned as ignorance, myth, stigma, or misunderstanding (and the presumably inadequate responses cued up by such “false” beliefs). By extension, the task of correctly “[recognizing] the signs of poor mental health” is too pressing to be left in the hands of professionals alone; “all members of the

campus community” must be deputized to detect “the *signs* [emphasis added] of poor mental health” and, presumably, persuade such students to self-present for diagnosis.

As I hope has been suggested throughout this chapter, the above passage from Condra and colleagues (2015) can be contested from several different positions. Let us return to their opening problematic: that many students do not name their experiences as “symptoms” of mental disorder, nor identify with having a mental disability. *What else* might this “speak to”? At risk of stating the obvious, we can surmise that such students explain their “symptoms” in non-medical ways; alternatively, perhaps they are not especially concerned with these “symptoms” at the moment and have not bothered to “recognize” them as anything in particular. They may be managing these experiences adequately on their own (i.e., via their local resources and relationships), or acutely distressed but attributing meaning or value to the struggle (cf. notions of “dark nights of the soul,” political anger or despair that catalyze activism, identity crises that re-organize priorities, etc.; Gergen & McNamee, 2000). Even postsecondary students who ultimately choose to seek mental health treatment “themselves [articulate] an important tension between interpreting these experiences as a mental disorder and acknowledging them as a part of their own ways of being in the world” (Hjeltne, Moltu, Schanche, & Binder, 2015, p. 10); students express, for instance, frustration with the limiting effects of social anxiety *and* appreciation of the virtues of introversion (“I am an only child, and comfortable in my own company”; Hjeltne et al., 2015, p. 7). As for students who fail to recognize their experiences as “mental health disabilities,” here is what one such student had to say:

I wouldn’t say I had a mental health difficulty . . . I would say I went through a bit of depression . . . mental health is a bit final . . . it doesn’t really describe what’s wrong with me. (Quinn, Wilson, MacIntyre, & Tinklin, 2009, p. 409)

In my reading, this student's final utterance hangs in the air like an invitation, a hint, a thread waiting to be pulled: How *would* you describe what's wrong with you? That this utterance can instead be reduced to evidence of unawareness or "illiteracy" reflects what is perhaps the saddest limitation of medicalized discourse: For all its clarity and certainty, it leaves precious little space for curiosity.

Condra and colleagues (2015) take as obvious that students' non-identification with mental health discourse "speaks to the importance of education and outreach to enable all members of the campus community to recognize the signs of poor mental health in themselves and in others" (p. 282). From the Collective/Sociocultural positions articulated above, such education and outreach efforts work to "[colonize] relations to anguish and to knowledge" (Titchkosky & Aubrecht, 2009, p. 180). Seen this way, it is unsurprising that local forms of sense-making and problem-solving are excluded from medicalized discourse; as DeFehr (2016) argues, mental health frameworks "[translate] struggle and discontent into psychiatric pathology as though human suffering is a *terra nullis* available for psychiatric acquisition" (p. 20). The goal, whether explicit or implicit, is to position psychiatric discourse as the authoritative *and* default repertoire for student distress; alternative understandings are rendered quaint at best, stigmatizing and dangerous at worst.

This "psychiatric imperialism" (DeFehr, 2016, p. 30) is twinned with technologies of *lateral surveillance* or peer monitoring (Andrejevic, 2005). The distinction between *watching out for one another* and *watching one another* is blurry, if it exists at all; under the auspices of caring, students are exhorted to "recognize their neighbours' distress as psychiatric sickness and turn their neighbours in" (DeFehr, 2016, p. 30). This is another way in which mental health discourse operates as a form of governmentality (the conduct of conduct); students watchfully

hold not only *themselves* to prevailing norms and practices, but one another. As Rose (1999) points out, “community is not simply the territory within which crime [and risk] is to be controlled; it is itself a means of government” (p. 250). Although this certainly does not preclude genuine love and concern for one’s fellow students, it furthers “the capillary extension of surveillance” (Andrejevic, 2005, p. 486) and subtly supplants spontaneous relations of care with “uninvited, continuous psychiatric assessment and intervention in every formal and informal domain of community life” (DeFehr, 2016, p. 19).

At risk of oversimplifying, we can posit that medicalized discourses tend to advocate for *more* activity in relation to the social problem of student mental health: *more* education and outreach; *more* screening, monitoring, assessment, and diagnosis; *more* evidence-based treatment (with an emphasis on less-intensive, that is, inexpensive treatments such as online psychoeducation or drop-in group seminars). Campuses that keep doing these things *more* and/or *better*, the logic goes, will eventually gain control over their mental health situation. Of course, the sociocultural discourses reviewed above tell a different story, calling for *less* surveillance and diagnosis of student distress, *less* proselytizing of psychiatric knowledges, and less medicalized, psychocentric (Rimke, 2016), and/or professionalized forms of student support. In many ways, these alternatives also imply less control—a tough sell to risk-averse campus stakeholders powerfully drawn to modernist medical-scientific promises of *solutions*. Nonetheless, as critical analyses gain purchase in the broader sociocultural situation (as will be discussed in the next chapter), actors become increasingly *accountable* to them; the tensions articulated above will likely be increasingly salient.

To continue this discussion of tensions, let us consider a second passage, this one from Eisenberg and colleagues (2018):

Stigma is relatively low and is not necessarily the main barrier for many of those who fail to access services when they are struggling with mental health problems. ... We would advocate for approaches that ingrain mental health more firmly in the daily culture and routine of student life, such as integrating consideration of mental health with academic advising or academic curricula in creative new ways. (p. 85)

The first tension hearable in this excerpt falls *within* medicalized discourse, and centres on the relevance of stigma in the student mental health situation. Stigma is very commonly invoked in the social problem of mental health; in Latour's (1999) terminology, it has been *autonomized*, its truth status stabilized (though never guaranteed) by the development of dedicated institutions, conferences, journals, and so forth. To wit: One author I cite above "holds the Bell Canada Mental Health and Anti-Stigma Research Chair," consults on "Canada's Open Minds anti-stigma initiative," and has chaired the "World Psychiatric Association's Stigma and Mental Health Scientific Section" (Giamos et al., 2017, p. 135). For stigma's importance to be questioned by Eisenberg and colleagues' Healthy Minds Study, one of the most reputable population-level projects on student mental health, creates the potential for tensions among actors who are already ideologically and materially invested in anti-stigma initiatives.

Controversy aside, if we accept Eisenberg and colleagues' (2018) claim that it is not stigma that holds students back from seeking mental health services, does it follow that mental health must become even more omnipresent in daily student life? An alternative line of thinking is possible. If students neither think less of, nor believe that *others* think less of, those who seek mental health treatment, perhaps students *have valid reasons for choosing not to access mental health services*: "I prefer to deal with issues on my own" (41% of respondents in the 2014-2015 Healthy Minds Study; Eisenberg et al., 2018, p. 78); "stress is normal in college/graduate school" (38%); "I get a lot of support from other sources, such as friends and family" (30%); "the problem will get better on its own" (22%). As noted above, medicalized discourse subtly

pathologizes these beliefs, treating them as *barriers* to proper treatment rather than *reasons*. However, a very different interpretation would be suggested by Individual/Sociocultural positions concerned with student agency, responsibility, and resourcefulness (e.g., Côté, 2018; Furedi, 2017; Rosenbaum & Liebert, 2015). From such positions, these students may be seen as admirably resisting the vulnerable, infantilized identities proffered by therapeutic culture; as rising to demands with grit or stoicism (cf. Stewart, 2017); as leaning on their loved ones; as wisely recognizing that *this too shall pass*. Must we really insist that *all* distressed students subsume their interpretations and responses to professional mental health frameworks? Common sense might suggest not—and yet, worst-case scenarios haunt decision-making. Suicidal students also say they prefer to deal with problems on their own (Downs & Eisenberg, 2012; see also Drum et al., 2009); surely they cannot be trusted to do so? For campus stakeholders, uncertainties such as these may be keenly felt.

In the passage above, Eisenberg and colleagues (2018) “advocate for approaches that ingrain mental health more firmly in the daily culture and routine of student life, such as integrating consideration of mental health with academic advising or academic curricula in creative new ways” (p. 85). Recommendations such as these, common within healthy settings and “systemic” approaches, mount a vision of seamlessness: mental health and wellness as omnipresent background discourses that underwrite and shape all aspects of academia. Of course, Furedi (2017) claims this is already happening, with disastrous effects. Redoubling efforts to ingrain mental health in campus culture, he argues, will only guarantee an ever-rising supply of students who self-interpret via this lens and experience heightened distress and vulnerability. Rather than *more* (and more widely distributed) attention to mental health, he

pleads for *less*, and for the restoration of scholarship, instruction, and critique to their proper priority within “the student experience.”

Zooming out from critiques of therapeutic culture, we can ask whether it is desirable to extend *health* into ever-more spaces of university life. Health has arguably become a meta-value, standing in for moral conceptions of the good life (Crawford, 1980) in nearly all human conduct. We can now speak not only of physical and mental health, but of sexual health, spiritual health, financial health, intellectual health, and so on. Cheek (2008) has argued that the increasing panoply of expert-led duties and disciplines through which citizens strive to enact healthy lifestyles represents a powerful form of governmentality, placing us at “increasing peril of a tyranny of health” (Fitzgerald, as cited in Cheek, 2008, p. 981). Health promotion, according to Crawford (2000), represents a powerful ritual:

Structured in domination, rituals work to imprint and legitimate prevailing arrangements, roles, and agendas; they are a means for extending power through incorporating individuals within institutional projects. However, as stylised evocations of experience, rituals also rehearse and provide repertoires for making sense of widely shared conflicts or dilemmas. (p. 220)

The dilemmas to which Crawford refers are between the polarised virtues of contemporary capitalism: the control and productivity of the worker and the release and self-indulgence of the consumer. This tension can never be resolved, Crawford argues, only tenuously and continually managed via “healthy” practices. In such a society, balance—that ultimate badge of mental health—remains perpetually “ephemeral and unstable” (p. 232). Crawford is not a health promotion abolitionist, but suggests that “alternative, more emancipatory ... conceptions of self-control and discipline, release and pleasure” (p. 234) could follow from interrogating the tensions and paradoxes of contemporary capitalism (cf. Aubrecht, 2012).

Echoing Crawford, I do not necessarily think that the tensions in the student mental health literature can or should be resolved. Where I have set up binaries (e.g., *more* versus *less*), these should be heard as illustrative; my goal has been to make clearer the multi-directional pulls, accountabilities, and uncertainties that situated actors might experience as they design interventions, policy, or other responses that are ostensibly grounded in “the literature.” As will become clear in the coming chapter, institutions are increasingly interested in *complexity* but assume that complex systemic elements can be fit together within a single model of reality. Holding space for multiple nonfungible realities is a different matter.

Confronted with heterogeneous knowledges, it is perfectly valid to cast one’s lot with the position(s) that appear most convincing, exciting, or consistent with one’s values (see Star, 1995). Alternatively, possibilities have been articulated for lingering in, and working from, spaces of multiplicity—perhaps particularly relevant to administrators, public officials, and policymakers, but also to counsellors and educators who wish to *join* students’ local ways of knowing (cf. Strong et al., 2015). Cobb (2013) writes of narrative braiding, a deliberative process wherein different parties’ stories about their selves, grievances, and hopes—their “terms of legitimacy” (p. 14)—are woven together into a *collective* account of a problem. Such braiding does not homogenize or collapse across narrative strands, but constructs “junctions where the legitimacy of one party touches the terms of the Other’s legitimacy” (Cobb, 2013, p. 14), offering parties in conflict a basis for “respectfully going on together” (Verran, 2002, p. 754). Another set of tools, grounded in actor network theory and feminist material semiotics, is offered by Law and Singleton (2014). If realities are done in practices, they argue, and practices are multiple, then policies will also be multiple: “In practice even a single policy enacts different realities” (p. 391; cf. Mol, 2002). Although policymakers might prefer to work with “bottom

lines” and coherent realities, Law and Singleton (2014) maintain that “this is not an aspiration that makes sense in anything other than a local way” (p. 392). “Realities and politics or normativities are all wrapped up together” (p. 392), they write, and thus good policy (particularly in a multicultural and post-colonial society) requires careful reflection on how different realities enact different logics and “goods” (Mol, Moser, & Pols, 2010). Such responses are inherently pluralist and pragmatic; they require a loosening of the imperatives to know, solve, and control. As we will soon see, such loosening may be a tall order indeed.

Chapter 4: Social Worlds of Student Mental Health

While values sometimes go together, on other occasions they clash—giving rise to ongoing tensions or a victory of one alternative over the other. (Mol, 2010, p. 216)

In any complex situation, a range of values or *goods* organize and justify actors' activities. Like logics (Mol, 2008) and realities (Mol, 2002), goods are *done* in material-discursive practices; as Annemarie Mol observes in the epigraph, they do not always align. When clashes arise, work may be undertaken to negotiate new relations between goods: for instance, to coordinate them or hold them apart. Because goods are entangled in mangles of co-constitutive elements—logics, practices, actors, materials—such work is rarely simple, and requires attention to many potential sites of tension and resistance.

As I will demonstrate in this chapter, goods are neither static nor monolithic. Their legitimacy must be actively accomplished, maintained, and defended; they exist in tension with alternative goods and may be actively contested. Such tensions and contests may be made explicit in protests or debates or may be spectral, inferable only from pre-emptions and *sites of silence* (Clarke et al., 2018). Tensions suggest places where the student mental health conversation remains unsettled, perhaps despite one party's efforts to declare matters resolved (as Potter, 1996, points out: "attempting to constitute the controversy as dead is itself one move in the controversy"; p. 41).

I had intended to centre this chapter on my first research question (Q1): In what ways is "mental health" discursively constructed in Canadian university policies and program websites, online media and social media, and mental health awareness campaigns? I began analysis as recommended by Clarke (2005b), iteratively reading and annotating my printed copies of gathered materials, creating inclusive memos and maps, "analytically walking round and round

and through and across the [social] worlds and staring relentlessly until their commitments, ideologies/discourses, work organization, technologies, and so on can be specified” (Clarke, 2005b, p. 115). As my graduate program deadlines began to weigh on me, I forced myself to return more specifically to Q1 and begin selecting and refining maps and memos that might address it. However, I struggled to make the analytic narrative come alive. I felt as though I was cataloguing the familiar and, to an extent, repeating my Chapter 3 analysis of ways in which mental health is constructed as a biomedical concern, a sociocultural concern, a disability justice concern, and so forth. I sensed that my data could support more creative and provocative analyses of *what is going on* and *what matters* in the student mental health situation.

In the spirit articulated by Clarke (2005a; 2005b), I gave myself permission to zoom out (again) from Q1, relax my analytic gaze, and revisit my maps and memos with a curiosity about “big news,” that is, about “big, thorny problems ..., especially conundrums that do not fit comfortably into our analytic categories and/or our expectations, and that do not go away over time” (Clarke, 2005b, p. 125). Of course, within SA, thorny problems are likely to involve heterogeneous discursive constructions of mental health (the focus of Q1); I thus reasoned that my research question would be addressed, though not as directly as I had initially anticipated.

I also ultimately gave myself permission to prioritize campus-based documents (institutional mental health policy/strategy documents; descriptions of campus-based mental health services and events) as my primary data for this chapter.²⁹ I could not travel all analytic roads and be one traveller (cf. Clarke, 2005a). When I surveyed my memos and working maps, I

²⁹ I have presented analyses of other data (awareness campaigns, popular online articles, social media) at conferences and in a book chapter (Ross, 2019); they may form the basis of future publications.

felt that those grounded in campus-based data would be more local, and therefore potentially more useful, to campus counsellors, administrators, student leaders, and other stakeholders.

This may seem like a lot of reflexivity with which to begin a chapter, but more still is necessary. This is because we, as researchers, do not simply notice and report on “big news,” but select it. There is a story behind what I “saw” as notable in my data, and I will try to tell it as briefly as possible. As I shifted my analytic attention from the literature to my data, I was struck by a sense that, despite the bleak headlines and “crisis” talk mentioned in Chapter 1, there are reasons for optimism in the situation of student mental health. Many Canadian postsecondary institutions have endorsed a holistic, systemic approach to mental health (CACUSS & CMHA, 2013; ICHPUC, 2015) that attends to upstream, structural predictors of wellbeing. A published scan of student mental health policy in Canada reported an “emerging trend” of institutional interest in “developing policy strategies that address the broader social determinants of campus mental health, such as freedom from violence and discrimination, social inclusion, financial and housing security” (Olding & Yip, 2014, pp. 22-23). Even if this interest is only partially or imperfectly translated to campus procedures, it seems promising: students, faculty, campus staff, and administrators are all talking about social justice, flourishing, and thriving. Although policies of accommodation for mental health concerns remain largely grounded in medical logics (i.e., requiring a psychiatric diagnosis), conversations have begun to problematize and perhaps reform such practices (see Condra et al., 2015; Olding & Yip, 2014) or move toward principles of universal design and accessibility (Fichten et al., 2016). This all seems quite good.

As I picked my way through the situation, hermeneutics of suspicion (Josselson, 2004) in full force, I sometimes found myself at a loss. What could I say about all this sincere and hopeful work, other than “carry on”? And yet—something gave me pause. I lingered with this hunch for

a while, toying with different angles, until I found myself revisiting Mol's (2008) study of *choice* and *care* in diabetes management. Mol does not deny that patient choice and autonomy are good. However, she maintains that these goods come into tension with competing goods of *care*. Elsewhere, Mol (2010) writes about practices of meal preparation at nursing homes. Here, goods of nutrition come into conflict with goods of taste, or cosiness. Sometimes obvious goods come into conflict with less-obvious ones. If one good is always prioritized, other goods can suffer.

Mol's work offered me a handle on what I was reacting to in the many well-intentioned mental health efforts described in my data (and those I had encountered during my recent internship at a campus counselling centre). The goods in play are (usually) genuine; they do not need to be refuted or unmasked. But they do prioritize certain things over others; they serve some interests over others. Intentionally or not, they exclude alternative goods that are present in the situation in a quieter or marginalized way. I realized that I struggled to articulate my misgivings not because they were baseless but because they involved goods that were not obvious, tensions that went unnamed or unspoken. Even naming and speaking such tensions would require considerable close analysis. And this is where I rolled up my sleeves and got to work.

In this chapter, I tell an analytic story of three powerful goods: community-minded cooperation, an emphasis on wellness, and the integration and harmonization of services. These goods are ubiquitous in my data, although—as I will show—not uncontested. My aim is to render these familiar principles newly strange, freshly contingent; that is, to reiterate the epigraph of Chapter 2, “to question ... what is postulated as self-evident, to disturb people's mental habits, the way they do and think things, to dissipate what is familiar and accepted, to re-examine rules and institutions” (Foucault, 1988b, p. 265). As I trouble prevailing goods, I will

also articulate competing goods and potential tensions. For readers who are campus staff or administrators, this chapter may shed light on scenarios in which a prized initiative is met with pushback rather than enthusiastic endorsement. Other readers may find that my analysis resonates with their own misgivings and thus proves useful in advocating for preferred goods. Overall, it serves my goal of articulating *what matters* in the situation of student mental health by asking what is at stake, to whom, and why.

“All in This Together”: Social Worlds of Student Mental Health

I begin with an apparent contradiction. In SA, social worlds mapping proceeds from an assumption that “all of the social worlds involved in a particular arena of committed action will have differing identities and *different agendas for action in that arena* [emphasis added]” (Clarke et al., 2018, p. 150). In other words, the situation under study is presumed *political*. Yet in campus mental health documents, considerable rhetoric is deployed to establish mental health as a shared problem that transcends partisan interests to concern “everyone” in interconnected ways. Such a stance “considers the University community as a single entity” with a “collective, shared responsibility” (U of T, 2014, p. 13) for student mental health. Distinctions between groups (executives, faculty, staff, students, etc.) are dissolved, leaving only “healthy people in our community” (U of C, 2015, p. 13). The campus itself becomes the only salient collective, comprised of community members who are all “in it together” (College Student Alliance, Ontario Undergraduate Student Alliance, Colleges of Ontario, & Council of Ontario Universities, 2017, p. 1). Under these descriptions, to diverge from the “shared vision”—that is, to self-position, individually or as a group, as a *political* actor—is to shirk one’s responsibility and impede collective progress toward the self-evident goal of improved mental health for all.

Not only are campuses *said* to be united on the matter of mental health, but such unity is enacted via institutional policies, strategies, or reports that “speak” in a single voice. Such documents are typically authored by task forces and steering committees whose members come from varied campus groups, yet controversies or debates that may have played out during the development process are absent from the final product.³⁰ If publicly available data (upon which I relied for this study) both rhetorically claim and performatively enact consensus, then SA—a method predicated on the study of *difference*—would be of little analytic use.

Fortunately, my study as designed still offered possibilities for studying student mental health as a political situation. I soon realized that I would need to gather additional data from social worlds such as students’ unions and student-led newspapers that have traditions of opposing and critiquing university administrations (an instance of theoretical sampling; Clarke et al., 2018). But even institutionally-produced documents occasionally break from discourses of unity and community. Consider the meanings that may be cued up by referring to campus actors not as community members but as “stakeholders”:

Stakeholders can be helped to endorse wellness as a goal, by linking it to tangible benefits. For faculty members, the benefits of student wellness include more productive undergraduate and graduate students who complete excellent work in a timely way. For the administration, a campus with healthy students supports recruitment and drains fewer resources. For students, wellness leads to increased opportunities to realize potential with concrete benefits, such as, improved employability. (Fitzpatrick & Di Genova, 2014, p. 6)

There is much to critique in this passage: not only does it invoke a corporate or managerial discourse (*stakeholders*) but a frankly economic one (productivity, recruitment, resources, employability). Unlike community members, who care intrinsically for the wellbeing of those

³⁰ A valuable complement to the current study would be a “behind the scenes” ethnography (e.g., Smith, 2005) of *how* coherent mental health narratives are accomplished or imposed at a given university.

around them, stakeholders can be “helped to endorse wellness as a goal” to the extent that it benefits them instrumentally. The implications of such a discourse are not, here, my point; rather, I am simply demonstrating that a campus can be constructed not only as a unified community, but as an arena of differently positioned actors with distinctive interests and priorities.

Subtle clues about a campus’ political landscape can also be heard in the *positioning* efforts undertaken by various social worlds. Consider a webpage created by one group (a campus disability service) to answer the (ostensibly) Frequently Asked Questions (FAQs)³¹ of a second group (faculty members) about a third, implicated group (students with mental health disabilities; YU, n.d.-a). Faculty members, here, are positioned as recipients of “education” dispensed by the disability service; such “education” carries out normative and thereby disciplining functions. Faculty members are taught, for instance, that students with mental health disabilities are not to be treated more *leniently* than other students, but *fairly*. This distinction relates less to the material features of accommodation than to its “appropriate” interpretation: that is, what faculty may misinterpret as lenience is *actually* fairness. Simultaneously, professors “learn” about appropriate and inappropriate stances toward students with mental health disabilities. One question sets up a posture of exasperation: “Why does a student wait until the last minute to ask for help, especially if the course work is outlined in the syllabus?” (YU, n.d.-a, para. 4). Having rhetorically invoked unfavourable assumptions (e.g., of students as irresponsible or disorganized), the answer immediately supplants them: students are said to be “fiercely independent” or to “feel undeserving of help” (YU, n.d.-a, para. 7). The proper posture toward

³¹ Lists of FAQs are often rich sites of discursive work: what questions are selected, how the question *and* answer are articulated, what questions are significantly absent, etc.

such students, therefore, is one of admiration, compassion, and flexibility. Professors' freedom to decline this positioning, should they be so inclined (that is, to differently understand and respond to students' conduct) relates to questions of power—for instance, whether the understandings proffered by the disability service are also ensconced in compulsory policies. As this example illustrates, positioning work need not be adversarial to be political; indeed, friendly “collegial” discourse may be an especially effective form of governmentality.

I have gone into some detail to trouble the prevalent formulation that a campus is necessarily a “diverse community of *individuals* [emphasis added] who come together to learn, work, connect, achieve, and flourish” (U of C, 2015, p. 7). It may be that, but it is also a political arena in which collective actors—social worlds—act, contend, and relate according to their own stakes, interests, agendas, logics, and priorities. Each campus has its own landscape; Figure 3 shows a composite social worlds map. This map is empirically informed but necessarily generalized and simplified. Individual students (i.e., those who are not acting within a collective such as the newspaper or Students' Union) are represented on the map as *Ss*. I have attempted to signal that nested accountabilities are at play in the situation: for instance, counsellors may be answerable to a manager or director, who is answerable to a vice-provost, who is ultimately answerable to a president. Some social worlds are coterminous with formal organizations and thus relatively stable; others are temporary and/or contested. For instance, a Students' Union might critique “the University,” thus discursively creating a putative social world that might include administration, student services, and faculty. Any of these actors might respond by resisting this grouping, perhaps positioning themselves as “on the students' side” against a common enemy. The collective situation could be meaningfully parcelled up through any number of interpretive “cuts” (Barad, 2007).

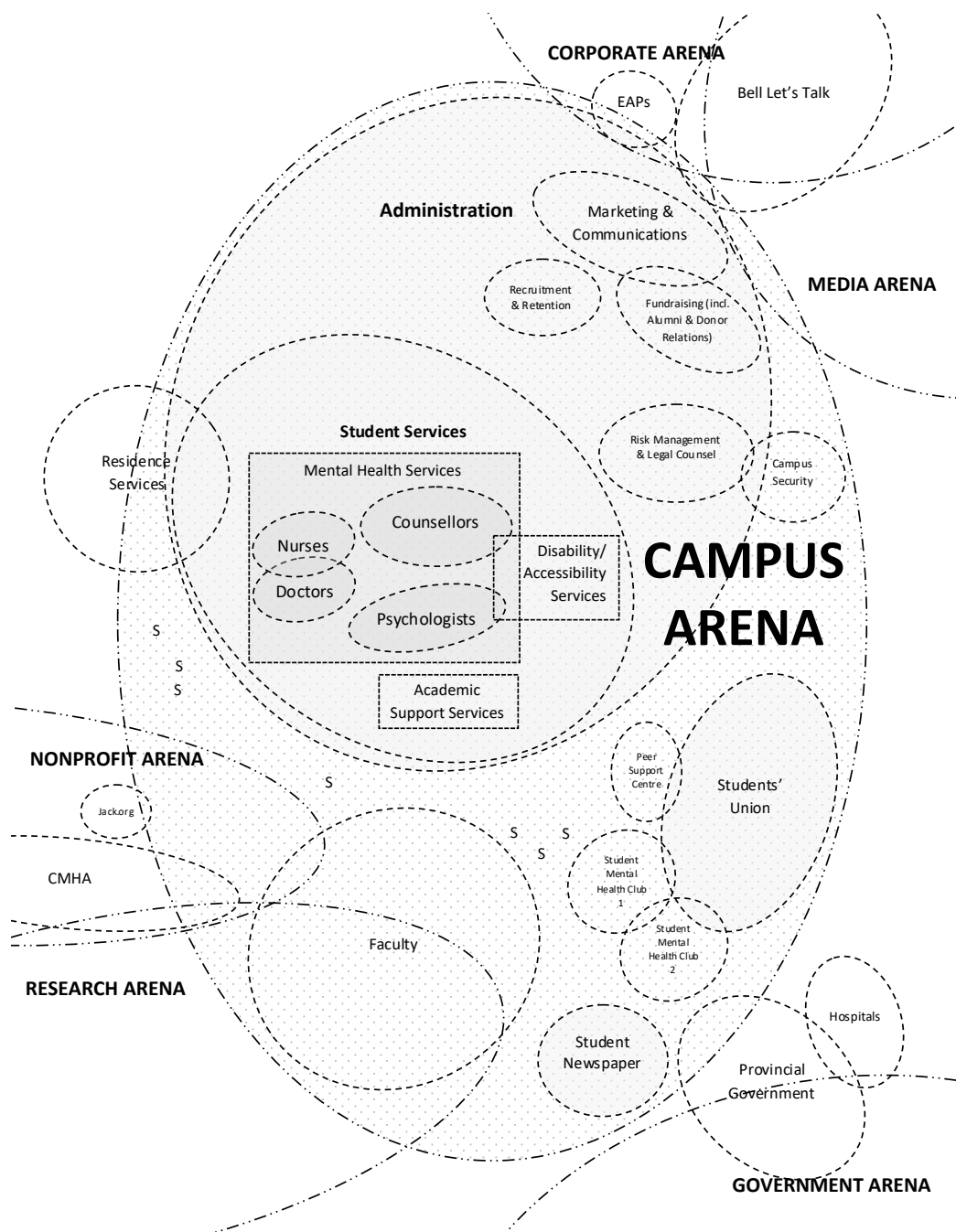


Figure 3. Composite social worlds/arenas map of a campus arena.

“We do not consent”: Contest and dispute in mental health claims-making. With Figure 3 at hand, I would like to exemplify a series of ways in which social worlds enact and defend their heterogeneous concerns, beliefs, and positions through their (material-discursive)

activities. On one campus,³² an annual Mental Health Wellness Day—apparently organized by the Campus Wellness Office (falling under the portfolio of the Associate Provost, Students)—included a “Sea of Orange t-shirt campaign worn by staff and faculty and student leaders to *show unity* [emphasis added] for the events and the three key messages” (UW, 2016, “The events,” para. 1). Unity is not merely invoked verbally, but *done*—sartorially (coordinated orange t-shirts), on social media (with a dedicated hashtag), and spatially-temporally (25 stationary bikes temporarily set up in a prominent location, where students, staff, and faculty attempt to “beat last year’s record of over 4,000 collective minutes of spinning”; UW, 2016, Register to spin for mental health, para. 2). Assertions that the university is a “caring community and a safe place to ask for help” with “the resources to help you” (UW, 2016, “The three key messages”) are framed not as questions or topics of discussion, but as *key messages*—that is, agreed-upon facts—about which “awareness” must be raised. These activities hang together as a coherent mode of acting on, and enacting, student mental health.

At the same campus, we find another, strikingly different, mode. An ad-hoc social world—comprised of students enrolled in an interdisciplinary course called “Discourse of Dissent”—organized the “Waterloo Walkout for Mental Health” (Bouchard, 2018). Here, a different constellation of material features was salient. The rally was held outdoors in snowy, cold weather; participants held homemade signs (e.g., “Mental health before education!”) and enacted protest conventions such as call-and-response chants. A substantial, if uncertain, number of students participated (“about 200,” “approximately 400,” or “several hundred,” according to

³² Throughout this chapter, I use examples to substantiate my analytic discussion of dynamics within the broader situation of Canadian student mental health; these examples are emphatically *not* to be taken as representative of a given campus’s “characteristic” approach to student mental health. Similar tensions and negotiations play out across many, if not all, campuses.

different reports). The campus newspaper covered the protest (Clarín, 2018), as did the student newspaper of another university in the same town (with an unusually lengthy feature of 1641 words; Bouchard, 2018) and the local news radio station (Johansen, 2018). Both campus papers reported that the event was provoked by the suicide, earlier that week, of a fourth-year student in residence. Reports of the event invoke familiar *community* discourse (e.g., “all members of the community ... must work in tandem to enact change”; Clarín, 2018, para. 7), but also, strikingly, an unusual repertoire of *consent*: “we do not consent to practices and narratives that do not affirm life. We do not consent to this institution’s notion of productivity” (Clarín, 2018, para. 9).

Embedded within the students’ intertextual self-positioning as *people who do not consent* is a complementary positioning of the university as an actor who ignores or violates consent—a powerful accusation accompanied by a moral responsibility to immediately withdraw the unwanted thing or practice. Unsurprisingly, the University refused or ignored this positioning in its acknowledgement of the protest, a brief blurb (82 words) in the concluding “Other Notes” section of a daily e-bulletin that summarized the event thusly: “Attendees gave voice to a range of emotions and ideas on issues related to mental health at the University and in the community at large, with senior University leaders there to listen” (UW, 2018, March Break Open House and other notes, para. 3). Slight as it is, this account accomplishes much. A vague “range of emotions and ideas” stands in for specific complaints, any critique is diluted by broadening the locus of concern to “the community at large,” and the administration is constructed as engaged and receptive (“there to listen”)—all claims in tension with accounts offered by the student newspapers. Notably absent is any reference to the student death by suicide that sparked the protest. The blurb concludes with an invitation to a forum announcing the recommendations of the President’s Advisory Committee on Student Mental Health (which itself had been a contested

object; an elected student representative who participated on the Committee had publicly criticized the process, claiming that “students have been constantly sidelined by the administration in mental health services on campus” and decrying the limited timeline, funding, and professional advice allotted to the project; Kim, 2017, para. 7).

Student mental health, as a *social problem* in the sense articulated by Spector and Kitsuse (1977/2011), inheres in (material-discursive) claims-making activities. The texts above are full of claims-making—not only about the putative problem but, importantly, about the *positions* (i.e., moral rights and responsibilities) of parties to that problem. Along with questions of responsibility are interplays of *answerability*—who is answerable, or accountable, to whom? Whose claims and accusations are owed a response, and what sort of response will it be?

Here is an exchange that unfolded at a different university. In an interview with the campus newspaper, the university’s president was asked whether anything was underway to improve mental health services for students. His response is worth quoting at length:

Mental health, again, is a huge challenge, and it’s a challenge for all universities in Canada. But much effort is going into that already. Is it enough? Certainly not. But I know our services are overburdened now ... I was discussing that with my team the other day, and part of the challenge (is that) we get nothing from the state, so this has to be taken from the general budget, and it is taken from the general budget, and it’s fine like this. But at some point, we wish we could provide more support. (Awde & Robertson, 2017, para. 10)

The president accomplishes some complex positioning in this account. He subtly refuses unique blameworthiness (“it’s a challenge for all universities in Canada”) and cites the considerable *effort* being made to address the problem, which he assures interviewers has been a topic of (specific) conversation with his “team.” Nonetheless, he concedes that *it’s not enough*, and

introduces a new social world: “we get nothing from the state.”³³ Through the introduction of this third party, “the state”—an external enemy, so to speak—he positions himself on the same side as the students. “We wish we could provide more support,” he concludes: Don’t blame us, our hands are tied.

The following day, the newspaper printed an open letter, addressed to the university administration, from a fourth-year student who claimed that the campus counselling centre “hasn’t offered me any support”: “Each time I was ‘assessed’ ... the result remained the same: the university was unable to provide proper services for the kind of counselling that I was seeking and I was encouraged to look beyond the U of O for help” (Homayed, 2017, para. 3). She continued:

I pay for [counselling centre] services. My tuition money covers my medical costs, including mental health costs. When my mental health is failing because I feel incredibly stressed and overwhelmed with all of the responsibilities of being a post-secondary student, I expect the university to offer proper counselling services. As a student, it’s unreasonable for me to be expected to pay \$80-100 an hour on outside psychological support. (Homayed, 2017, para. 4)

This student here positions herself as a *consumer*, with attendant rights. She has paid for services and expects to receive them, particularly since she positions studenthood as the cause of her distress. The point, at this moment, is not whether her construction is *accurate* or fair, but whether it is *effective*—and whether it will be disputed by another actor.

In the interest of space, I will limit my analysis of the two open letters that followed this one (though I find them very interesting). A reply came from the Vice-President, Academic and Provost in which he emphasizes the administration’s commitment to student well-being while

³³ This was unusual in my data; funding, budgets, and the government were sites of relative silence in administration-produced documents.

refuting blameworthiness, again invoking an external actor: “Sometimes more specialized assistance is required and we must rely on our provincial health system for these resources” (Laurier, 2017, para. 2). He then invokes an additional social world, the Student Federation, claiming that the administration has “begun to work closely” with the Federation and other “partners” to improve services (para. 3). Rather than directly refute the student’s claim to (consumer) rights, the vice-president skirts them and reiterates the administration’s commitment to student mental health (in general), as evidenced by a close working relationship with a *student* organization. In a subsequent letter, however, this rhetorical move was countered by an excoriating response from a representative of the Student Federation, who not only rejects the administrator’s claim of close partnership (“during my two year term I have only successfully met with you twice”; Dorimain, 2017, para. 1) but raises the stakes, invoking a litany of injustices ranging from food insecurity to the dearth of racialized counsellors on campus and positioning the administrator as *personally* accountable for his role in the problem (“Michel, you have seen professors and deans abuse their power and take advantage of students ...”; Dorimain, 2017, para. 3). One can assume this was not the effect the Vice-President had hoped for.

Reading this exchange of letters, some might conclude that while the situation of student mental health is indeed political, it simply offers a new stage upon which to play out well-established antagonisms: Administrations can *never* do enough to satisfy students’ unions, whatever the issue. That may well be; while some student groups have targeted “the state” in their advocacy for increased mental health funding (e.g., Council of Alberta University Students, n.d.), “the administration” remains a more common adversary. An animating tension of the situation relates to what an institution is responsible for providing to its students—or, framed differently, what it is reasonable to expect an institution to provide. Students assert their *right* to

more or better mental health care; institutions insist that they share students' concerns but are providing *reasonable* service, under the circumstances; position and counter-position, claim and counter-claim, and on it goes. *Plus ça change*. But as I studied students' grievances, I came to believe there is something else at play, something in addition to the standard complaint of *not enough*. This something relates to a discursive move that I have been calling a "pivot to wellness."

Pivoting to Wellness: From Problem to Opportunity

In the preceding chapter, I introduced two-continua models (e.g., Keyes, 2005, 2007), in which mental health and mental illness are disentangled from one another, at least theoretically, and visualized as varying along two intersecting axes. I did not obtain permission to reproduce a two-continua diagram, so please see Figure 4 in which I have reimagined the model according to SA positional mapping conventions.

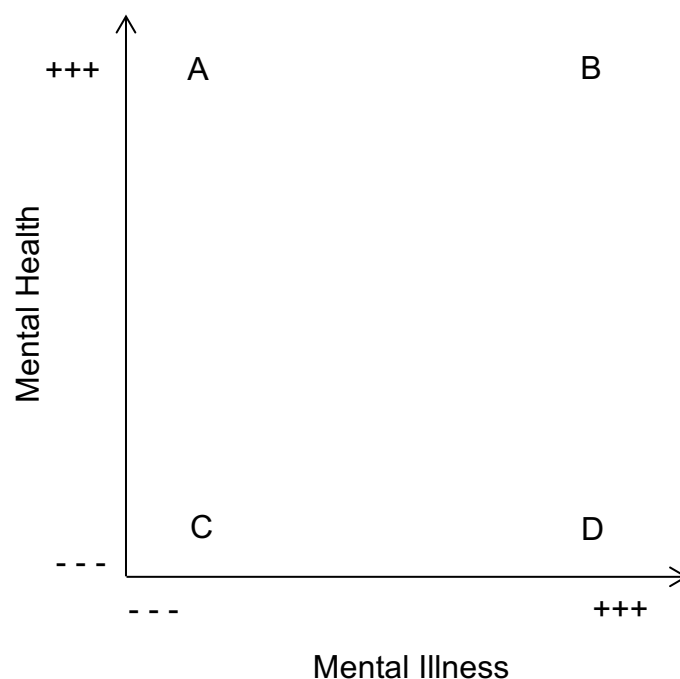


Figure 4. Representation of a two-continua model of mental health (e.g., Keyes, 2005, 2007).

Two-continua models propose the novel possibilities of being mentally healthy (i.e., flourishing) *despite* the presence of mental illness or disorder (Position B in Figure 4 above) or being mentally unhealthy (i.e., languishing) even in the absence of mental disorder (Position C above; Keyes et al., 2012). Within this logic, *improving mental health* becomes a worthwhile and achievable goal for a much broader range of people. People in Position C can be helped toward Position A, those in Position D can be helped toward Position B, and anyone who falls somewhere in the middle of the map can be pulled “upward” toward peak flourishing. Strictly speaking, under two-continua models, one could address *mental health* while remaining altogether silent on the matter of mental disorder. Going one step further—although this interpretation goes beyond the original literature—there is a sense in which two-continua models effectively render mental illness *irrelevant* to mental health; after all, “even in the presence of a mental illness,” we are told, “you are capable of flourishing” (U of C, 2016, para. 2).

A second commonly-invoked conceptual device in student mental health documents is the funnel-shaped “framework” reproduced in Figure 5. In this and similar frameworks, tiers of strategic foci are tied to progressively narrower “target student populations” (CACUSS & CMHA, 2013, p. 9): all students, students with concerns about coping, and students with mental health concerns. Each tier is inclusive of the one(s) below it, such that upper-tier “interventions” are presumed to benefit everyone: A rising tide lifts all boats. Not only might upper-tier activities prevent students from slipping further down the funnel, but, complementing two-continua models, “wellness” is assumed to enhance learning for all students.

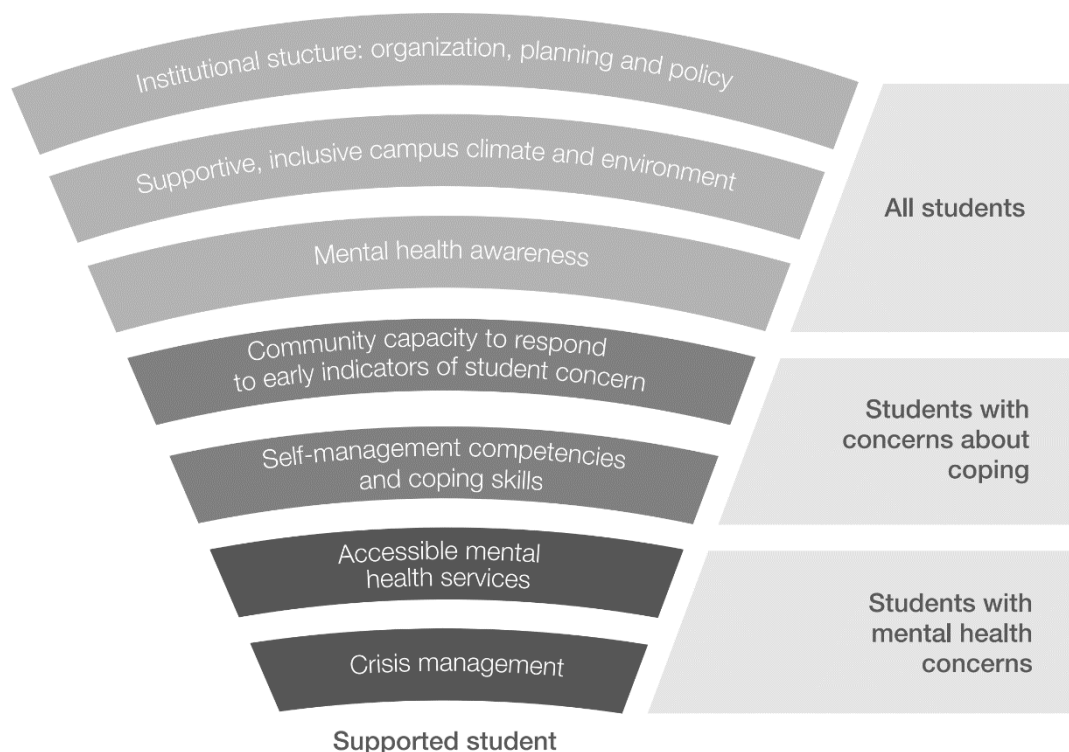


Figure 5. “Framework for Post-Secondary Student Mental Health” illustrating a tiered, systemic approach to student mental health (reproduced from CACUSS & CMHA, 2013, p. 9).

Two-continua models and tiered frameworks, and/or their structuring logics, were broadly taken up in the official institutional documents I studied. Both constructs facilitate and justify a “pivot to wellness”: that is, a foregrounding of broad, inclusive, strengths-focused, health-enhancing, and positive practices. Such a shift allows student mental health to be made and molded not as a problem, but as a site of *opportunity*—for students and institutions alike.

Mental health as an opportunity for students. Constructions of mental health as an asset or property to be stockpiled, maximized, or enhanced abounded in my data. Workshops, webinars, apps, “tips,” and self-tracking tools all promise to help students improve not only their mental health but their grades and *productivity*: to become “comfortable, confident and capable of performing” (U of T, 2014, p. 2). Within such logics, counselling becomes a technology of

enhancement, helping students “fulfill their personal potential in order to maximally benefit from their university experience” (YU, n.d.-b, para. 1). Hearable in these countless “opportunities” to improve or optimize mental health are the self-entrepreneurial logics that have elsewhere been critiqued as part of an increasingly compulsory therapeutic or wellness culture (cf. Cederström & Spicer, 2015; Davies, 2015; Illouz, 2008).

In a similar vein, we find program descriptions that emphasize an activity’s instrumental value: “the art workshop is all about making art in order to relax!” (U of O, n.d.-a); “few people may know that drumming has many therapeutic effects, such as reduced fatigue, anxiety and stress!” (U of O, n.d.-c); “let the therapy dogs cheer you up” (McGill University, 2015, “Therapy dogs”)³⁴; “gratitude is a powerful emotion that does wonders in supporting your brain health and your overall mental health. It boosts both dopamine and serotonin” (UBC, 2016, Say thanks, para. 2). Enjoyable but mundane activities become rationalized: that is, specified, operationalized, systematized, and quantified to yield “effective” strategies in service of a “rational, methodical lifestyle” (Illouz, 2008, p. 275)—specifically, in this case, a mentally healthy lifestyle. Not even comedy is immune to logics of rationalization: Students are urged to “take in a comedy show, watch a funny movie or tell a joke to a friend” not for the fun of it but because “laughter has been linked to healthy blood vessel functioning and ... improves emotional connections and self-confidence” (UBC, 2016, Have a laugh!, para. 2).

³⁴ Dogs are among the few nonhuman animals represented in the student mental health situation. I chose not to extensively analyse their role, though I wrote a memo during my internship about a curious episode in which the counselling centre’s marketing team was compelled to change their advertisements for “puppy therapy” after receiving complaints that the animals in attendance were, in fact, not puppies but *dogs*. Materiality—in this case, a dog’s age—provokes contest in unexpected ways!

Consistent with critiques of wellness culture's neoliberal underpinnings, many campus activities focus on "empowering" individuals to cope with problems that are arguably structural. For instance: "In today's environment of nonstop demands, competing commitments and never enough time, creating balance in our life often doesn't come easily or naturally" (U of O, n.d.-b). The proffered solution is a workshop in which participants learn about "balance," identify priorities, and recognize what they cannot control (which presumably includes "today's environment of nonstop demands"). Another advertisement asks: "Ever have tight shoulders or a crick in your neck from sitting at your desk all day?" (U of O, n.d.-e). Solution: a seminar that will teach you to do yoga at your desk.

As noted in the previous chapter, expert practices that promise to enhance (mental) health and wellness can be understood as technologies of the self (Foucault, 1988a), taken up to fashion a particular kind of valued self: healthy, high-achieving, balanced, independent, proactive, self-optimizing. Being a "good" student in the 21st century arguably involves not only good grades but apprenticeship to a particular emotional style: The ideal student is expressive, enterprising, and entitled (that is, confident and assertive; Martin & McLellan, 2013). As one university administrator enthused:

"There are other traits we hope students have when they graduate. Are they resilient? Do they feel empowered? Can they empower others? By adopting a holistic view on what success means, we start to realise that we need to approach things differently. GPA is great, but so is an A+ in empathy." (Latimer, 2016, "Wellness is a big tent," para. 2)

There is much to appreciate in this sentiment; resilience, empowerment, and empathy are all worthwhile goods. Nonetheless, with her metaphoric reference to an "A+ in empathy," this administrator concretizes a tacit sense that emotional competencies constitute a new metric on which to be graded. Like GPA, excelling at this metric demands work—studying, homework,

seminars—upon the project of the self (Rose, 1998). And, as Illouz (2008) has argued, practices that are framed as *opportunities* frequently grade into *responsibilities*, particularly as middle-class norms of emotional intelligence come to constitute “a new axis of social classification” (Illouz, 2008, p. 205) clothed in meritocratic language. Students who fail to apprentice themselves to increasingly normative postures and languages of emotional wellness may jeopardize their status not only as students, but prospective employees (Boler, 1999).

Mental health as an opportunity for institutions. Addressing student mental health has been positioned as universities’ “moral obligation” (Tamburri, 2012, para. 9)³⁵; institutions are thus under “increased public scrutiny ... to ensure that adequate mental health services are available to their students” (U of A, 2015, p. 4). Although this responsibility is generally accepted (Ng & Padjen, 2019), many universities manage to satisfy it in ways that dovetail with other institutional goals, transforming student mental health into a site of opportunity. Under wellness-focused, systemic, holistic, or “flourishing” models, the scope of activities deemed facilitative of mental health is considerably broadened (cf. “the five key factors of flourishing: playing, learning, connecting, interacting, and helping”; U of C, 2016, How to flourish). As a result, nearly any campus initiative or event—cooking lessons, farmers’ markets, stand-up comedy, drop-in crafts, pop-up choirs, dodgeball, bike rides—can be cited as evidence of the university’s commitment to mental health. Conveniently for institutions, such events might also enhance *student experience*, which has been identified “as an important strategic competitive

³⁵ Although the sentiment is common, Tamburri (2012) reports, intriguingly, that the phrase “moral obligation” was used by the Chair of the Mental Health Commission of Canada (which is federally-funded via Health Canada). The positioning and counter-positioning undertaken by university and government groups would be a worthwhile line of inquiry that I did not pursue in the current study, although I was reminded of the university president who pointed to limited funding from “the state” in accounting for service shortcomings (Awde & Robertson, 2017).

factor for higher education providers” (Tan, Muskat, & Zehrer, 2016, p. 210). As another example, it has been claimed that student mental health is enhanced by “student engagement and connection/belonging to the campus community” (UBC, 2013, p. 10); thus, mental health can be *acted upon* by fostering student engagement and belonging, which have also been found to predict student retention and alumni giving (Kahu & Nelson, 2018; Rau & Erwin, 2015).

My intention here is not to impugn wellness-promoting activities, nor the sincerity of the groups who initiate them. It may be pleasant and desirable to meet fellow students, to learn yoga or meditation, to enjoy well-designed buildings and outdoor spaces, and so forth; in other words, these practices further multiple goods. I simply wish to call attention to how events such as these—fun, positive, appealing to a broad audience—permit an institution to align intrinsic goods with strategic interests. Within this logic, it makes sense to engage as many students as possible, perhaps with the help of “swag bags,” free food, or gamification (e.g., collecting stamps on a “passport”; U of C, 2016). To maximize participation is not only to support (and be perceived as supporting) mental health, but to boost retention, reputation, and other administrative priorities.

Opportunities for branding. In addition to boosting student experience and engagement, mental health can be made and molded in support of a university’s *brand identity* (defined as “the essence of how you would like alumni, prospective students, legislators, and the public to perceive your institution”; Lawlor, as cited in Judson, Aurand, Gorchels, & Gordon, 2008, p. 57). Brand identity is reinforced, for instance, by rhetorically linking mental health documents to a school’s legacy or articulated vision (often with reference to an academic or strategic plan such as *Eyes High*, *Our Time to Lead*, *Dare to Deliver*, or *Place and Promise*). It is no coincidence

that mental health steering committees and task forces often include representatives from Marketing and Communications departments.

Mental health, here, becomes an opportunity to demonstrate the institution's unique innovation or leadership. For instance: "Guided by our University's nine strategic directions for a Next Generation University, Concordia is experimenting boldly to conceive how a world-class education can intersect with health and wellness for a holistic experience" (Arasaratnam, n.d., Going public, para. 3). Even mental health *problems* can be constructed in ways that reinforce a brand (e.g., as the unintended side effect of excellence): "Research-intensive universities create cultures that demand high performance while promoting excellence and achievement, and also carry the risk of stress, stigma, and challenges to mental health" (U of C, 2015, p. 1).

Branding is inextricable from marketing, whose logics, practices, and people all participate in the situation of student mental health. Perceived support for mental health has become yet another factor in the so-called "complex consumer decision" (Judson et al., 2008, p. 57) of selecting a university; the well-known Maclean's Canadian university rankings (Maclean's, 2018) now rank universities according to student satisfaction with mental health services, a metric that, if favourable, can be featured in a school's marketing efforts (see Dakin, 2018). Once again, student mental health is simultaneously a matter of sincere concern and an unambiguous strategic priority. "Providing support services that enhance students' ability to be successful *sends an important message in a competitive market* [emphasis added]," reads one institutional report; "at no time has there been a greater need to maximize our appeal to prospective and current students" (U of A, 2015, p. 12).

Opportunities for "impact." Many institutions' mental health strategies and reports feature a tiered model akin to the funnel-shaped framework reproduced in Figure 5 (above). Such

models, echoing the healthy settings approaches discussed in the preceding chapter (e.g., Dooris et al., 2014), “[extend] the focus beyond the individual and strategies such as treatment, skill building and awareness to the whole campus including its environment, organizational structure, policies and practices” (CACUSS & CMHA, 2013, p. 8). Upper tiers seem to garner special attention in institutional documents; without high-level strategic action, goes the logic, “we will not structurally and systematically impact our community in ways that broadly support mental health and wellbeing for all students” (UBC, 2013, p. 4).

Like two-continua models, therefore, tiered frameworks justify an emphasis on initiatives that benefit *all students*. Education, empowerment, engagement, and health promotion come to the fore; once again, mental health is a site of exciting opportunity. Many institutions, for instance, aspired to develop a for-credit course on mental health; at U of C, students can now pursue an embedded certificate in Mental Wellbeing and Resilience through which to “become a mental health champion, build positive coping skills and resilience, and help us create a community of caring” (U of C, 2019, para. 1).

Demonstrating an institutional commitment to mental health frequently involves not only the striking of task forces and committees, but the creation of new or restructured offices, directorships, and other administrative positions. Student mental health has been a very “successful” social problem; it has been *autonomized* (Latour, 1999), with dedicated infrastructures and bureaucracies that may “assume a life of their own” (Spector & Kitsuse, 1977/2011, p. 151). In other words, it would now be quite difficult for an institution to *stop* caring about student mental health. Many would applaud this momentum; others might wonder if mental health has become yet another proliferator of middle-managers, senior administrators,

and the “student services cabal” (Srigley, 2015, sec. 6, para. 6). Regardless, such positions are considered *necessary* to maximize strategic impact.

Finally, “bold” and high-level action inevitably requires *further research*. One report—in addition to recommending the establishment of a Campus Wellness directorate plus three specific task forces or working groups—concluded that “many of the following recommendations require some study. The University should consider using *all available resources* [emphasis added] ... to study in depth some of the questions that our review raises” (UW, 2012, p. 35). Such study is not the exclusive purview of scientists and scholars, but may be undertaken by administrators—up to and including uppermost institutional leadership:

Recently, a group of university presidents formed a working group that will examine the mental health needs of students. Their report to the Association of Universities and Colleges of Canada will be designed to assist universities and colleges in responding to mental health issues of students in post-secondary education. (UW, 2012, p. 2)

A mental health working group comprised of *presidents*: it is hard to imagine a more top-down undertaking. Such a working group’s recommendations would likely be sweeping, systemic, strategic. They would aspire to *impact*.

Troubling goods of wellness. Plenty of *goods* can be found in what I have described above. Two-continua models lend themselves well to a strengths-focused approach, with resilience and flourishing open to all; tiered frameworks are proactive and holistic. But what are the trade-offs? To answer this, let us peer down the funnel of Figure 5, all the way down to “crisis management.” Relatively few students are involved at this level; crisis management tends to focus on a single person at a time. It is local and specific. While it is doubtless important, its importance tends to be non-transferrable—hardly a strategic use of funds. It is reactive rather than proactive and preventative. It does little for an institution’s reputation and may not have

much of a ripple effect on campus. It sometimes fails to prevent students from dropping out and, tragically, could even fail to save a student's life. In short, on-the-ground crisis management can be risky, messy, and painful, and has little in common with the activities of a presidential working group. But as we intuitively recognize, it carries its own varieties of goodness—not least *specificity*, which, as Mol (2010) argues, is essential to *care*.

At one institution, Figure 5 is used to illustrate a surprising goal. The bottom, narrow part of the funnel is labelled as “where we are: 80% of resources go to 20% of community members”; the upper, broadest part is “where we want to be” such that “80% of resources go to 80% of community members” (Lenton, Brewer, & Morrison, 2017, p. 10). Here, it is implied that diverting resources to upper tiers is not only strategic, but *fair*. Disproportionate resources are currently spent on counselling and crisis management for a small minority of students; meanwhile, *everyone* can benefit from upper-level interventions, just as two-continua models tell us that everyone can enhance their mental health (as one student group put it, although one in five Canadians experience mental illness in their lifetime, “5 in 5 of us have mental health and we all need to care for it”; Arts and Science Federation of Associations, n.d., “Jack.org,” para. 4). Priorities and resource allocations must be revamped, updated to better serve all students—or at least the majority.

To a great extent and at many sites in the situation, this logic has been embraced. And yet, at the heart of sticking points and protests, we often find “old-fashioned” problems. Wait lists. Staff resignations. Budget cuts and physical space shortages. Students who are turned away from services, or who attempt or die by suicide. These are not only “big-picture” concerns; they are granular, specific. They involve illness, suffering, and treatment. They insist that it *matters*

when even a single student does not get the care they need. They insist upon continuing to understand student mental health as a problem, not an opportunity.

Celebration and reckoning. Above, I posited that marketing and branding practices matter in the student mental health situation. In studying the “Waterloo Walkout for Mental Health” described earlier, I was struck by a statement in which one of the student organizers positions branding quite differently:

“We know that [the UW] brand asks students to innovate at all costs because it tells them that their individual worth is bound up in their productivity,” [an organizer] said. “It is bound up in their ability to get the best grades, the best co-op positions, to reach the unreachable deadline. It may not be said explicitly, but it is written in every unrealistic syllabus, every unrealistic deadline, and every harmful narrative that exists on this campus.” (Clarín, 2018, para. 6)

This student skillfully parleys the university’s brand identity into strong critique. By problematizing goods such as innovation and co-op success, which are held forth as unique points of pride *within the university’s own branding*, the argument pre-empts rebuttals that these problems either do not exist or are common to all universities. The student, as a representative of the ad hoc social world that organized the protest, calls upon the university administration to be accountable for the harms caused by its *specific* priorities and practices.

“Campus culture” is widely recognized as influential to student mental health, and yet in my data I found only a handful of references to problems within the culture of a *specific* campus. In an interview, the founder of a student group called The Tipping Point remarked that “there is a glorification of overworking at UBC and I want there to be a culture that celebrates self-care” (Oproescu, 2016, para. 15). At another school, students invoked a campus-specific meme—“Cali or bust”—to epitomize the intense competitive pressure characteristic of their campus (“Cali,” i.e., California, was believed to offer the most lucrative and prestigious co-op internships; Chow,

2018; Students of UW, 2017). For their part, universities seem happy to get specific when celebrating their mental health-related achievements and innovations; when it comes to shortcomings, faults, and failures, things suddenly become much more general.

I have already suggested that specificity is important to good care. But specificity is also important to *reckoning*—that is, owning one’s participation in a problem. Reckoning is essential for accountability and, arguably, for improvement, but fits uneasily with practices of evaluation and marketing that “invite those whom they call to account, to *boast* about their work. ... Look, our indicators are fine, our work is good, they are invited to say” (Mol, 2010, p. 227). Mol (2010) continues:

But improving the practice in which one is engaged, calls for the opposite attitude. Modesty, self doubt. Attentiveness to what does *not* work. Those who want to improve the practices in which they work, should be on the lookout for tensions, frictions, problems. For sites and situations where different *goods* do not easily go together. For clashes and places where it hurts. (p. 227)

“Clashes and places where it hurts” are rarely “aspirational and inspiring” (U of C, 2015, p. 2); they make poor marketing copy, and thus may not be welcomed by some of the social worlds represented in Figure 3 (Administration, Marketing and Communications, Recruitment, etc.). They are sites of silence in formal institutional documents. This may be, in part, what student social worlds are reacting against: not necessarily hypocrisy, although that may be brought up too, but an exclusive emphasis of one sort of good—the optimistic, enthusiastic, celebratory sort—over another sort, one that involves sober and possibly uncomfortable self-assessment. The latter is what I mean by *reckoning*.

Though reckoning is an exceedingly rare stance, in my data I occasionally stumbled across acknowledgment of a *problem*—by which I mean a specific dilemma not immediately redressed by a solution or strategy. In some cases, problems “sneak in.” For instance, one

strategy document (UBC, 2013) features a list of “Opportunities/Action Items,” each consisting of a crisp, verb-led bullet point (review; provide; embed; support; etc.). One such bullet point, relating to enriched educational experiences, is abutted by a curious note. The note has nothing to do with the action item whose bullet point it shares, and (unlike the rest of the list) it is terse and unpolished; I got the sense that it was somehow missed during the editing process. It reads: “Incongruence: Grad st. funding period and ave. time to grad” (UBC, 2013, p. 9). In the midst of “opportunities,” here is a *problem*. No action items are listed to address it. I wonder whether this problem, though it must have been raised at some point during the strategy development process, was supposed to make it into the final document at all.

Incongruence between graduate student funding periods and typical time taken to graduate is a *real* “[place] where it hurts” (Mol, 2010, p. 227). It is one among many real problems related to student mental health, and yet examples such as these were rare in my data. Problems are revised until they become opportunities; if no opportunity can be created, the problem may be edited out altogether. But of course, such editing does not make them go away.

Many institutions express an interest in new sorts of dialogue around mental health, by which they seem to mean dialogues about wellness, flourishing, resilience, and so forth. Institutions devote time and resources to improving wellness, yet some student groups remain unsatisfied. What I am gesturing toward is that their dissatisfaction might relate, somehow, to a sense that *pleasant* and *marketable* goods are being advanced at the expense of uncomfortable, unmarketable goods such as reckoning and specificity: that universities are celebrating their successes without adequate soberness for their failures. If this is the case, then perhaps institutions might consider the possibility of new dialogues around “old” matters: matters of mental illness (not only mental health), of crisis and counselling and waitlists (not only policy,

awareness, and “campus climate”). The newness, then, would come from a public posture of reckoning: a specific “attentiveness to what does *not* work” (Mol, 2010, p. 227).

“Breaking Down Silos”: Integrating Mental Health Services

I began this chapter arguing that a strong current of discourse establishes and enacts a claim that, when it comes to student mental health, campuses are *all in this together*. Within this logic, it makes good sense to pool our efforts: to integrate, consolidate, and/or harmonize campus mental health initiatives and services. Integration, it is argued, facilitates *good service*:

Students expect and require seamless transitions between University services for the learning environment to be truly supportive. ... Recognizing that students require continuity and cohesive services, initiatives have been started to foster links through communication between units, a shared vision, and explore strategic re-alignments. (U of A, 2015, p. 12)

“Seamless transitions” and “cohesive services” are positioned as part of reducing confusion for students looking for support, a way to “simplify the pathway to care” (U of T, 2015, “What will be different”) such that “every door is the right door” (U of T, 2014, p. 24). In contrast, “silos” of practice are problematic, as they “create artificial barriers for students to overcome and navigate” (U of A, 2015, p. 11). In the face of unnecessary confusion, integration promises to advance *goods* of continuity and ease.

Another putative good of integration relates to cost—or, more palatably, *efficiency*. Some institutional documents minced no words about this matter: “Operating parallel or uncoordinated services lacks efficiency, risks duplication of resource allocations, and impedes the delivery of impactful programs and services” (U of A, 2015, p. 18). Resources are part of the situation, both materially and discursively (e.g., a shortage of resources is a common refrain, as discussed in the previous chapter in relation to stepped care). Questions of “managing” resources efficiently or responsibly are always-already steeped in economic logics and practices; such logics may be

extended when, for instance, the director of a newly integrated campus wellness service holds an MBA in Health Industry Management (Hunter, 2016).³⁶

In addition to (customer) service and efficiency, integration is justified by another key good: *consistency*. But *why* is consistency desirable? In my data, “consistency” sometimes indexed fairness: for instance, consistency across departments in accommodating students with disabilities. Elsewhere, consistency is cited as essential to managing risk (i.e., consistency in implementation of established “risk mitigation protocols”; UBC, 2013, p. 21). Here, we learn that integration and harmonization are priorities not only for *services* but for policies and protocols. One university sought to achieve a “coordinated response to the broad range and severity of student concerns” via an “aggregation of data relating to student concerns across departments” (UBC, 2013, p. 21). “Data” itself is already the result of student concerns *made consistent* via standardizing technologies—for instance, the online form fields of an Early Alert System. Such data work to rationalize, that is, elevate to consistency, the implicit *bads* of fragmentation and haphazardness, moving us closer to the *goods* of coordination, consistency, and “best practice.”

Logics of integration orient to any or all of the three *goods* I have just named: service, efficiency, consistency. Such goods are apparently quite compelling at the moment, since many campus mental health services are indeed “harmonizing” and integrating. Some services that were separate when I began collecting data have since been amalgamated; many were already

³⁶ In an article announcing her appointment, the new director models the spectrally corporate language and logic through which she understands her new role:

“Being open to having a non-clinician at the helm demonstrates a mindset where the benefits of complementing the team’s great clinical and practitioner knowledge with new models of delivery and community partnerships can fully realize the desired scale and impact. The complementarity of skills is vital and I look forward to co-creating solutions with my team and stakeholders.” (Hunter, 2016, para. 6)

integrated (e.g., across health, counselling, and sometimes disability-related services) and others have been restructured in new ways. Given that knowledges and practices of student mental health are heterogeneous (as discussed in the preceding chapter), one might wonder whether campus services vary in their understandings of student mental health problems. As readers likely anticipate, such variations may trouble the goodness of integration and harmonization.

Different constructions of mental health. How do campus mental health services (via their websites) describe the problems they address? One sort of description—in my data, most commonly associated with counselling services—is that they assist students with “normal developmental and life concerns” (U of A, n.d., para. 2). Much is carried in this brief phrase: *normal* carries a reassuring sense that such concerns are common, familiar; *concerns* is gentler than alternatives such as *problems* or even *issues*; *developmental* invokes necessary growth.

Another description extends and elaborates similar themes:

From first-year through graduate school, university students often find themselves challenged by a wide variety of stressors—both personal and academic. Whether providing assistance during a crisis, teaching relaxation techniques, or discussing a failed exam or broken heart, the McGill Counselling Service is here to help. (McGill Mental Health Service, 2015, Counselling service)

Here we find the assumption that distress might be provoked not only by personal and relational troubles such as heartbreak but by the student role and academic environment. “University life is exciting and challenging,” reads another centre’s description; “sometimes it’s possible to manage challenges on your own, while other times you may need support. It’s OK to reach out and ask for help if you need it” (UBC, n.d.-a, Reach out, para. 2). Such formulations construct distress as expectable and understandable under many common circumstances. And not only local circumstances: following a terror attack in France, one counselling centre website acknowledged that “these are challenging, distressing and very sad times” and noted the availability of crisis

counsellors for anyone affected by a “recent world tragedy” (Concordia University, n.d., para. 3-4).

Concerns, stressors, challenges, difficulties: everyone encounters them at one time or another. To some scholars and practitioners, these “things” should not be called mental health problems; perhaps we should instead refer to *problems in living* (Szasz, 1960), or “normal sorrow” and “natural anxieties” (Horwitz & Wakefield, 2007; 2012), or try to simply describe each emotional distress in its own, situated terms. These conversations are doubtless alive and well at some sites, on some campuses; in the meantime, the meaning of *mental health* does not remain static. It may be always-already disposed to medicalized understandings, but people can also pull it back toward the normal, the human, the everyday. At one school, “mental health concerns” are roughly equated to anything “interfering with your ability to feel good and achieve your goals” (UBC, n.d.-a, What to speak with a counsellor about). Although it may still rankle those who wish to retire the term *mental health* altogether, a “definition” this broad allows plenty of room to maneuver.

On the other hand, biomedical and diagnostic constructions of mental health are not difficult to find, particularly within medical and psychiatric social worlds. At one campus health centre, for instance, doctors and nurse practitioners can refer “patients” to a mental health counsellor in hopes of addressing “more chronic conditions, such as anxiety, depression, and other mood disorders” (U of O, n.d.-d, para. 1).³⁷ Diagnosis, treatment planning, prescription of medications, screening via symptom checklists: all are going on in the campus arena.

³⁷ Anxiety and depression might represent particularly important *boundary objects* (Star, 2010): Although they can be diagnosed and treated psychiatrically, they are elsewhere positioned as “normal developmental and life concerns” (U of A, n.d., para. 2) or “challenges of university life” (YU, n.d.-b, para. 1) that one might bring to *counselling*—

Biomedical or psychiatric logics are increasingly common in counselling settings (Strong, 2017). In some cases, medicalized language is easily recognizable: for instance, a counselling centre website defined depression as “a very common illness ... [that] must not be confused with ‘the blues’ which occur normally when facing a difficult situation or in reaction to excessive academic pressure” (Student Academic Success Service, n.d.-b, Professors/The student who is depressed, para. 2). Perhaps more prevalent are instances of “spectral” medicalization, in which diagnose-and-treat logics tug counselling practice in medicalizing directions (such logics might also involve rationalizing, standardizing, quantifying, instrumentalizing, etc.). Here is an example. On the website of one counselling centre, students were advised: “The intake specialist determines your triage level by listening to the words you are using in the interview, so it is important to be as detailed as possible during the interview to get an accurate assessment” (UW, n.d.-a, Information about intake appointments, para. 4). The “intake specialist,” here, becomes a robot, an algorithm: *words* go in, “triage level” is *determined*, assessment comes out. The more detailed the input, the more accurate the output. Although assessments are always specialized sorts of conversation, the above passage does not describe a conversation. In a conversation, I listen to my companion; I listen to their story; perhaps I listen *for* certain things they say or do not say. But I do not *listen to the words they are using*.³⁸ Another reading of the passage is possible, one in which the “intake specialist” is not an algorithm but a rarefied expert, an oracle; be as detailed as possible, and this Sherlock Holmes (or Sigmund Freud) of intake will render an accurate assessment. In either case, the student is not qualified to interpret themselves, and must

alongside relational, psychological, social, or developmental issues like relationship/family problems, self-esteem, sexuality issues, and so forth.

³⁸ Perhaps I listen to the words they are using if I am acting as a discourse analyst, but this is not typically the case when I am having a conversation. I doubt the counselling centre is taking a discursive lens here.

humbly submit their words for interpretation by the expert—or processing by the algorithm (De Vos, 2013).

Particularly germane to my inquiry, given my field of study, are sites of uncertainty, negotiation, contest, double description, and so forth—what Strong (2017) has called *medicalizing tensions*. I introduced one side of such a tension in the preceding section, when I quoted a Counselling Services website that frames university life as “challenging and exciting,” sometimes (though not always) requiring support, and concludes that “it’s OK to reach out and ask for help when you need it” (UBC, n.d.-a, Reach out, para. 2) to help you “feel good and achieve your goals” (UBC, n.d.-a, What to speak with a counsellor about). That is one way of narrating (and *doing*, since words also *do*) student mental health.

Elsewhere, in the same institution’s Mental Health and Wellbeing Strategy, we find quite a different narration of the same service: for instance, we read that Counselling Services and Student Health Service “operate a collaborative shared care approach to the treatment of depression consistent with stepped care provincial guidelines” (UBC, 2013, p. 19). Upon investigation, “stepped care provincial guidelines” seem to refer to British Columbia’s Provincial Depression Strategy, Phase 1 Report (Goldner et al., 2002), which frames depression as a chronic disease akin to asthma or diabetes and seeks to achieve “symptom reduction, improvements in function and productivity and prevention of relapse and chronicity” (Goldner et al., 2002, p. 25) through, for instance, the development and dissemination of provincial standards for evidence-based treatment.

As I have noted above, Mol (2002) writes that realities are done in practices. Where there are different practices, there will be different realities; if these different realities do not fit well together, *work* must be done to relate them. Perhaps the work is relatively simple; maybe

“everyone knows” one of the accounts is to be ignored (only to cause trouble when some occasional actor—administrator, student—tries to hold you to the ignored account). If neither of the accounts can be ignored outright, the work may be trickier. Navigating and negotiating and managing may not always go smoothly. It becomes a site of tension (see Strong et al., 2012; Strong et al., 2017).

Pre-empting tensions. Given the heterogeneity of the situation, then, efforts to harmonize or integrate different services may be fraught with tension. As I have already noted, it is difficult to know (via publicly available data) how tension management is done “on the ground” at any of the campuses I studied, including within and between social worlds. I found some hints from student newspapers: for instance, when the Clinical Director of one campus’ newly-integrated counselling and mental health service was suspended with no explanation, a students’ society vice-president noted that the Director had been advocating for staff and student concerns regarding the transition to stepped care (Martel-Desjardins, 2017). A staff member later commented, on condition of anonymity, that “many of the issues regarding the harmonization of Counselling and Mental Health Services and the implementation of the stepped care model were apparent to staff members” (Ng, 2017, para. 10), but that these concerns were “not being heard.”

Other clues come from passages of rhetorical pre-empting and positioning work within strategy documents themselves. Here is one example, which I quote at length to illustrate how positioning is done in the progressive working-up of the account:

Although a number of mental health services are located on each campus, the degree of coordination and collaboration between these services varies greatly due to a number of potential barriers that exist. These include physical, departmental, and professional barriers, as well as the lack of time, resources, or will required to overcome these barriers and foster relationships. Physical distance between services prevents spontaneous communication that could occur if people work in the same space. Departmental barriers exist due to reporting structures and cultures that keep colleagues

apart. *Professional barriers are the most invisible and potentially the most significant obstruction to providing seamless care* [emphasis added]. They stem from differences in training, professional language, theories, expectations, status, power, and compensation. Communication and trust are vital when professionals share the responsibility of caring for vulnerable individuals with mental health problems. (Ontario College Health Association, 2009, p. 14)

Here we find a description of a problem: *colleagues* are being *kept apart* by *barriers*. Each key term could be unpacked at length, but the upshot is that this formulation constructs the situation of apart-ness as unnatural: if only these barriers could be removed so professionals could enjoy the spontaneous relationships *proper* to their status as (natural) colleagues! Ah, but here we come to the more devious problem: *professional barriers*.

Professional barriers, we are told, stem from a series of (material-discursive-practical-social) differences. However, the potential legitimacy (or value) of these differences is quickly curtailed by a trump card: “the responsibility of caring for vulnerable individuals.” This is a disciplining move, one that renders alternative positions morally untenable. To be *professional*, in this formulation, is to set aside parochial “barriers” in service of the greater good. Failure to do so—even on grounds of “status, power, and compensation”—could jeopardize the welfare of vulnerable students.

But the pre-emptive positioning work does not end there. After citing the above passage, one report continues: “The Project Team recognizes that significant elements of this report challenge the status quo and will demand creative approaches to addressing the issues” (UW, 2012, p. 2). The term *status quo* cues up a recognizable dichotomy of conservatism versus progress. In popular culture, sticking to “the status quo” is often glossed unfavourably as a familiar, convenient, and complacent cop-out. Moving beyond the status quo is deemed courageous, if disruptive (“growth and comfort never ride the same horse”; Warrell, 2015, p.

xvii). In campus documents, similar discourse is invoked to frame restructuring as uncomfortable but generative. For instance:

Some departments approach integration in a relatively pain-less (but low impact) way ... others deep dive in efforts to be better than the sum of their parts. When this happens, the commons in the Venn Diagram becomes a vibrant space for innovation. (Arasaratnam, n.d., *Why write about it?*, para. 2-3)

Such accounts simultaneously anticipate *and* neutralize resistance. Staff members who balk at integration, or who worry about how it might impact their work, are merely experiencing the growing pains of innovation. They will come around—or they will be left behind.

Here I must pause and take off my critical discourse hat to convince readers that I am not, in fact, opposed to innovation—nor necessarily to integration, for that matter. Integration may indeed improve care and service, efficiency, and consistency. It doubtless fosters creativity: new relationships always open possibilities for imagining and co-constructing something new together. And, importantly, integration need not entail homogenization: there may be plenty of space to work in preferred ways, and to appreciatively learn from one another. What I *am* pointing out is that logics of integration may obscure, constrain, or even punish the expression of alternative positions and the pursuit of other goods. Individual and collective actors in the campus arena may prefer to remain separate and *unharmonized*, for many reasons. Some of these reasons, to be sure, relate to laziness or pettiness. Others might relate to protecting something valued or resisting something odious, to a political objection, to sustaining pluralism, to respecting others' professional identities. A reason is not the same thing as a "barrier."

Because my data is primarily text-based, I have thus far focused on how integration is constructed in language, although to the extent possible I have tried to discuss the practices that might "go with" a certain linguistic formulation. What I have been less able to show is that

situated language and practices cannot help but be entangled with the material. Integrating services might involve literal walls that must be knocked down, actual distances that must somehow be managed, new material spaces that might be built. Tensions play out here, too: what sort of clothing will the reception staff wear? Those trained as medical office assistants might wear scrubs, and these scrubs become part of the situation. How will notes be managed? If a common software is used, doctors and counsellors can easily view each other's notes; the student's weight and blood pressure may be automatically displayed at the top of the counselling record. One integrated wellness centre planned to design a bespoke Electronic Health Record software to operate differently for each of its three "units" (counselling, health, disability services) but feature a "common visual dashboard" where "the clinician will get a holistic picture of the patient's situation at a glance" (Latimer, 2016, "The first university," para. 2-3)—note the default, here, to more medicalized language. New practices arise from the material arrangements of integration; for instance, at my internship site the possibility was raised that when counsellors wished to conduct a safety assessment or brief check-in rather than a "full" counselling session, we might signal and enact this difference by meeting the student in one of the starkly-lit medical examination rooms (amongst the accoutrements of a medical appointment) rather than bringing them down the usual hallway to our relatively cozy offices. Walls, scrubs, software, examination rooms—these and countless other *things* participate in co-constituting the mental health practices that take place in a given setting.

Other material-discursive-practical questions raised by integration relate to intake procedures. Here, too, tensions must be managed. At one newly integrated Health and Wellness Centre, students seeking counselling (or any other service) were first to be "assessed by nursing staff or a family physician" to "[ensure] that each student receives the right care at the right time

with the right wellness professional, program or service” (U of T, 2015, para. 4). Perhaps anticipating pushback, the website FAQs included the following exchange:

[Q:] If I have a mental health concern, why do I need to see a family physician?

[A:] A number of mental health challenges have a physical basis that needs to be explored or treated before a specialized referral can be made. Meeting initially with a physician or nurse allows for a diagnosis and treatment of any underlying physical causes of mental health issues. (U of T, 2015, FAQ #5)

Although this does not mean that all student concerns would be medicalized, it does mean that concerns would pass *first* through the medical gaze (though students’ own explanations remain in the mix). Particularly in the case of ambiguous or contested problems such as worry/anxiety or sadness/grief/depression, students referred to counselling by a physician or nurse may arrive with interpretations and expectations already organized in more-medicalized ways. How might this arrangement shape counselling practice, particularly for counsellors who work in less-medicalized (e.g., discursive or feminist) ways? Furthermore, how might it change *who* seeks counselling in the first place? As anticipated in the FAQs, some students may be confused by a doctor’s gatekeeping role in their help-seeking for relational, emotional, or spiritual concerns and thus look elsewhere for help, changing counselling practices at the centre even further.³⁹

Changing any element of a situation changes the situation. Integrating campus mental health services is a major change that sparks cascading and refracting shifts, pulls, and flows that cannot easily be predicted, nor classified and evaluated. Eliminating “silos” and “barriers” accomplishes some goods and jeopardizes others; discursively heterogeneous social worlds make uneasy bedfellows. Tensions persist, despite rhetorical efforts to pre-empt or squash them.

³⁹ The “elsewhere” where students seek alternative help will then also be changed—and might push back. On one campus, the Racialized Students’ Collective protested the counselling centre’s alleged practice of referring distressed racialized students to the Collective instead of urgently hiring more diverse counsellors (Kufu, 2017).

Boundaries and limits. As described above, my analysis of institutional texts suggested that mental health problems are constructed in different ways, including medicalized *and* more everyday or psychosocial understandings. This was consistent with my expectations and seemed like good news for pluralistic practice—yet I found myself somewhat unmoved by what I was finding. I puzzled in a series of memos about why this might be: What was leaving me cold about these perfectly nice descriptions of mental health problems as “normal developmental and life concerns” (U of A, n.d., para. 2)?

The following passage finally helped me articulate my misgivings:

Counselling is a confidential service for students who are dealing with temporary life difficulties such as homesickness, relationship breakup, serious illness or death of a family member, academic or financial stress, etc. The aim of counselling is to facilitate a timely return to normal functioning. (Student Academic Success Service, n.d.-a, What is counselling?)

Although this description suggests a variety of developmental, relational, and circumstantial explanations for student distress, it simultaneously makes very clear that such difficulties are expected to be *temporary*. A single goal is endorsed—a “return to normal functioning”—and it is assumed that this return can be expedited. Distress, here, arises from discrete, identifiable causes; although these causes are not necessarily simple, one gets the sense they can be addressed in a systematic fashion.

We learn, in this description, about the kinds of difficulties that qualify as non-medical: those that are concrete (or culturally familiar) and remediable. Where does this leave students whose troubles are more complicated or ambiguous, or whose difficulties are proving not-so-temporary despite the proffered quick fix? Through what resources should they understand and respond to their concern? The website does not say, and I realized that this was what had troubled me. A small variety of subject positions were available: psychiatrically diagnosed

students, students navigating temporary (but contained) life disruptions, and “risky” students. Other kinds of people and problems were a site of relative silence, an unaccounted-for remainder. In other words, less-medicalized repertoires may be reserved for “well-behaved” problems, those that “get with the program” in a timely manner. If a student’s problems fail to do so, perhaps that student should see a doctor for diagnosis and management of their “chronic condition.”

Limiting care. Of course, there are many practices whereby counsellors stretch and bend and tinker with directives that constrain their ability to help people (although “inconsistent,” off-the-record workarounds can themselves yield tensions and dilemmas). One counselling centre wrote that upon intake assessment, students will be placed on a wait list for counselling *if* their “issues can be addressed within our short-term model of six to eight sessions,” as justified by “current research which suggests that most client concerns can be adequately addressed” within this timeframe (YU, n.d.-c, “Individual,” para. 2-3). However, this position is destabilised by a subsequent claim that counsellors “are responsive to the needs of students and therefore work collaboratively ... to determine the length of counselling required” (YU, n.d.-c, “Individual,” para. 3). The *limiting* practices of the first description seem at odds with the *caring* ones of the second. Staff must, presumably, find ways of navigating these tensions (cf. Garfinkel, 1967).

Administrators, too, must navigate tensions. They may be committed to providing good care for suffering students and to validating student grievances, thus extending notions of a caring and unified campus community. On the other hand, their interests may include curbing spending or working within a finite budget while simultaneously forestalling critique. How to balance these interests?

One rhetorical strategy is to construct limitations as *natural* and inevitable. For instance, in one policy we read that “the Committee nonetheless *recognizes the limitations of what can be expected of an educational institution* [emphasis added] in the provision of health and mental health services” (U of T, 2014, p. 8) and that students must therefore be “educated” about “necessary limitations” of campus mental health services (U of T, 2014, p. 21). We encountered a version of this strategy above, in which an administrator explained: “sometimes more specialized assistance is required and we must rely on our provincial health system for these resources” (Laurier, 2017, para. 2). Another possible strategy is to suggest that campus services compare favourably to services elsewhere. For instance, one executive director pointed “to wait times, costs, and quality of care at Ryerson as being more efficient than those in greater society” and questioned “whether this standard is fairly imposed on universities” (Ryersonian Staff, 2015, “Get to the other side,” para. 1). Somewhat surprisingly, given the patchy-at-best mental healthcare system in Canadian society at large, such rhetoric was rare in my data; even the director quoted above was quick to hedge, orienting to the unique pressures and anxieties of the university experience and thus implying that universities *should* meet a high standard of care for their students.

A third and likely most appealing strategy is not to speak of limitations at all, instead emphasizing innovation and student choice. One university boasted of “ideating a new model for a new era—one that draws on stratified care and utilises a variety of treatment options such as group therapy, online modules and wellness programming” (Latimer, 2016, “Wellness is a big tent,” para. 4). Implicit within such discourse is the expectation that students will be “helped” to choose the most appropriate (and least intensive/expensive) intervention. Logics of *choice* and

empowerment facilitate a fitting-together of *efficiency* and *good care*. There is no longer any need to speak of *limitations*.

Of course, limits still make themselves felt, to staff and students alike (recall, from the preceding chapter, the stepped care trainee who learned to “[avoid] the dreaded step 7 (individual therapy)!”; Cornish et al., 2017, p. 435). During my interviews, I did not ask about service limits—yet two of my interviewees referenced the ten-session maximum for counselling sessions at the university Wellness Centre (a policy that appears to have since changed; U of C Wellness Services, n.d.). I had expected to find tensions amongst medicalized and less-medicalized understandings of mental health problems—but tensions related to limitation versus flexibility may be equally salient. These tensions, like everything else in the situation, intersect and refract; like everything else, they are material and political (for instance, medical doctors may be freer than counsellors to provide flexible, longer-term care if they are paid via provincial health insurance rather than student fees or university budgets).

Other possible goods. I began this section by identifying some of the possible *goods* of integrating or harmonizing campus mental health initiatives. Despite the legitimate appeal of these goods (and considerable efforts to rhetorically pre-empt tensions), the discursive terrain of student mental health remains heterogeneous; it may not yield easily to landscaping efforts. Furthermore, and I will conclude with this, we find tensions even *within* administrative social worlds. Good service, efficiency, consistency: yes, these are valued. At the same time, I stumbled upon expressions of other aims, other goods—diversity, localness, tinkering—that may not fit particularly well with logics of integration.

One working group reported that there were “many gaps and a lack of consistency in message and content” (Ryerson Mental Health Advisory Committee, 2013a, p. 4) in the mental

health services and programs available on their campus. How does this fit with the commitment, elsewhere in the same document, to consider “diverse knowledge bases” (p. 2) and to broaden curricular mental health content beyond medical and positivist knowledges (“a small group of educators are teaching critical/structural/Mad positive aspects of mental health,” the report notes, “but they are definitely in the minority”; p. 3)? If we are to accept that mental health “may extend not only to medical conceptions of illness and health but Indigenous conceptions of social, spiritual and community well-being, critical notions of Madness and disability and cultural interpretations of wellness” (Ryerson Mental Health Advisory Committee, 2013a, p. 3), how should we enact the concurrent recommendation to develop “standard, systematic and coordinated education and training” (p. 5)?⁴⁰ Goods of consistency and diversity trouble one another. Efforts to amplify local and minority voices might prove destabilizing to goals of standardizing training or implementing “best practices.” Managing such destabilizing pulls can be laborious, but also generative. Agreements must be worked out in their specificities and become necessarily provisional, subject to ongoing adjustment and re-negotiation.

Occasionally, in my data, I noticed sites in which logics of consistency seemed to hang together with something else, perhaps an expectation of tinkering (Mol et al., 2010). An example from one strategy document related to practices of granting academic concessions for mental health reasons, which were framed as “overly reliant on health professionals’ documentation” (UBC, 2013, p. 7). While the proffered solution turned upon “consistent, clear guidelines and practices,” the hope was expressed that such guidelines would facilitate “transformative student

⁴⁰ Similarly, at another university, calls to coordinate and align programs exist alongside recommendations for “services that have a deeper connection to the local experience” (U of T, 2014, p. 21).

interactions” with instructors or academic advisors that “reinforce student accountability, goal setting and skill development” (UBC, 2013, p. 7). In a possible *demedicalizing* pull (Conrad, 2007), this recommendation seems to shift gatekeeping authority *away* from health professionals and to reauthorize the local relationships pertinent to each student’s situated struggles.

Coordinating diverse social worlds is a messy business; “balance” among competing goods can never be achieved once and for all. I conclude with an extended passage that nicely communicates some of these challenges and commitments in relation to students seeking accommodation for mental health reasons:

In order to ensure inclusion we need to find the right balance between required rigor and standards in the classroom and workplace, and the needs of those who require flexibility, accessibility and accommodation. We need policies and procedures that allow us to find that balance rather than simply indicating which rights and responsibilities “trump” one another. We need to recognize and allow for the time required for problem solving in complex situations and this has to be balanced by realistic timelines for everyone involved. We need to acknowledge that *policy will never cover every eventuality and therefore an important goal of policy is to enable the fair and equitable exercise of discretion* [emphasis added]. We need to acknowledge all of these realities as we attempt to craft creative solutions/accommodations and a supportive working and learning environment for all members of the Ryerson community. (Ryerson Mental Health Advisory Committee, 2013b, p. 3)

Or, more succinctly: “there is no policy in general” (Law & Singleton, 2014, p. 392).

Conclusion

To maintain that campuses are “all in this together” when it comes to mental health belies the political positioning that SA can foreground so effectively. And yet unity, wellness, and celebration are *goods*. Declaring them *fait accompli* can be one strategy by which to advance them; compelling visions may become hyperstitions (Cybernetic Culture Research Unit, 2004) that bring about their own reality. At the same time, they are neither the only goods nor, necessarily, superior to the alternative goods that they overshadow, obscure, or oppress.

As I have discussed, even the most self-evident goods may exist in tension with other goods. By “zooming out,” SA provides the means to represent complexity in a way that does not presume critique. There is room for critique, of course, but in reckoning with the situation it is necessary to recognize that each actor is indeed striving for a genuine good, just like those who position against them. We are not yet in “this” together (and what “this” is remains contested too), and perhaps we should not aspire to be. Tensions, as I have posited earlier, can be uniquely generative. They can keep us awake to the unfinalizability (Bakhtin, 1935/1981) of human problems.

Administrators, counsellors, researchers, advocates, student leaders: everyone wants students to enjoy good lives, but their sense of this goal is shaped by heterogeneous interests and answerabilities. If we are to move forward in a spirit of hopefulness, we must come to terms with the situation’s many sincere and incommensurable goods—goods that defy integration—and the very real and consequential places where they occasion friction, uneasiness, even conflict. To make these tensions explicit, familiar goods must sometimes be made strange. And of course, campus mental health activities must maintain some logical relation to the problems with which students are struggling, or they become hollow and absurd. It is to these problems that we now turn.

Chapter 5: Student Constructions of Mental Health Problems

The sufferer is a poet in search of metaphors adequate to express his predicament.

(Kirmayer, 1984, p. 249)

In the preceding chapter, I explored ways in which student mental health is made and molded as a social problem (Spector & Kitsuse, 1977/2011) in and by the claims-making of heterogeneous collective actors. In this chapter, I invite readers down into a more intimate register, that of students' sense-making in relation to the predicaments that get called "mental health problems." By what idioms and metaphors do students express their suffering (Kirmayer, 1984)? Different styles of sense-making proceed from different assumptions, render different elements salient, and carry different implications for action (Brinkmann, 2014). What sort of problem is this? What should be done about it? What does the problem imply about the student who is experiencing it? Or, as my second research question asks: In what ways do postsecondary students discursively construct "mental health problems" in their lives, and with what implications for self-understandings and responses?

As described in Chapter 2, between August 2016 and February 2017 I interviewed ten University of Calgary students who self-identified as having gone through an experience that they, or others, might understand as a mental health problem. I interviewed six women and four men, ranging in age from 18 to 23: Anthony, Brent, Carl, Charlotte, Chris, Daniela, Geoffrey, Hannah, Mayumi, and Sabrina (all pseudonyms). To enhance confidentiality, I have chosen not to list each interviewee's age and cultural self-identification beyond what arises in the analysis.

After transcribing each interview verbatim, I engaged in close analysis of each document, making wide-ranging notes and memos focused on discursive constructions and self-positioning. As analysis proceeded, I began to juxtapose these constructions and positions to create axes of

discursive variation, and to juxtapose different axes to create positional maps, as described in Chapter 2 and below. While working up these maps, I constantly circled back to the data to substantiate putative positions and their implications, flagging key quotes that epitomized positions of analytic interest. I paid particular attention to sense-making or accounting that struck me as fraught, controversial, tentative, emergent, unusual, or evocative.

As noted in Chapter 2, although students' explanations are eminently local (often private, even secret), they are co-constituted with the "doings, sayings, and relatings" (Mudry, 2016, p. 5) that circulate within a larger social situation of mental health. In SA, data from multiple sites (interviews, documents, etc.) can be mapped together (Clarke et al., 2018), but for this project I created maps specific to interview data in hopes of resisting premature closure and sparking fresh analytics, storylines, and sensitizing insights.⁴¹ It was initially tempting to interpret the data through a pre-existing framework such as Brinkmann's (2014) five languages of suffering (diagnostic, religious, existential, moral, and political), Foster's (2003) dimensions of *location* and *controllability*, or Brinkmann's (2016) model of *having*, *being*, and *doing* psychiatric diagnoses. However, jumping too quickly to familiar understandings risks glossing over the systematic *groundedness* of SA. Clarke and colleagues (2018) are clear that the goal of positional mapping

is to represent all the major positions articulated in the materials on their own terms. These are not the terms of the researcher, but rather the researcher's best efforts to grasp and represent the positions taken in the discourses by those who produced those materials. (p. 166)

⁴¹ Near the end of the chapter, I will diffractively read key discursive tensions in my interview data through selective analysis of awareness campaigns and popular online articles.

Although Clarke (2005b) is sceptical of bracketing, or the notion that researchers can somehow expunge their preoccupations and encounter the data with naïve eyes, she insists upon careful empirical work. Positions taken on basic issues in the data are treated as worthy of curiosity in themselves: What is at stake *for those who take this position*? What affordances and dilemmas might be consequential from *within* this position? The researcher can and should produce critical and theoretical memos but must not prematurely abandon *close* data-grounded mapping.

The maps I have chosen to present in this chapter are not as flashy as some alternatives I considered (cf. Ross, 2019). They are, perhaps, relatively humble: First, I juxtapose biological and biographic discourses of mental health problems, and second, I juxtapose responses that emphasize receptivity with those that emphasize agency. I found myself circling back to these maps because they seemed to get at basic but crucial distinctions in students' sense-making. I also wanted to offer readers a less abstracted account of my knowledge-constructing work. Such work can be painstaking, even laborious, but intentional:

In walking the reader through your positional map in the narrative of your article, the reader looks at the world 'over the shoulder' of each position in the discourse, one by one. Readers can thus vicariously experience some of the stakes in the controversial issues analyzed in positional maps. And they *gain a systematic overview of all the positions articulated in the discourse* on certain issues. (Clarke et al., 2018, p. 174)

Although I permit myself some analytic commentary, I strive to honour the sensibilities of each position. Consistent with SA principles, I have separated actors from discursive positions when constructing the maps, but following each map I offer two “case studies” of interviewees who moved across multiple positions, took up positions in unexpected ways, or encountered “trouble” in their sense-making and had to work up adequate meanings on the fly.

Before introducing my first discursive map, I wish to flag two authorial tensions I navigated while writing this chapter. One relates to a possible distinction between *explanations*

and *understandings*, wherein *explanations* are associated with “quantitative hypothetico-deductive or experimental methodologies based on the biomedical illness model of linear cause and effect from the natural sciences” (Hjelmeland, 2016, p. 50), while *understandings* are interpretive accounts that foreground subjective meanings (von Wright, 1971/2004). Seen this way, my research was designed to generate understandings, not explanations. Nonetheless, anyone reviewing my interview transcripts would recognize the conversational activity of *explaining*: First *this* happened, which resulted in *that*. Cause and effect are elements not only of experimental methods, but of everyday stories. I have, therefore, retained *explanation* in my vocabulary but invite readers to hear it not as an authoritative claim but a culturally recognizable linguistic device (cf. Scott & Lyman’s 1968 analysis of *accounts*, a type of explanation deployed to justify or excuse untoward action).

I encountered a similar challenge related to *causes* and *reasons*. Brinkmann (2014) has suggested that psychiatric discourse relies on *causal* logics: Jack and Jill went up the hill because a signal in their motor neural cortexes triggered a cascade of neurochemical and musculoskeletal sequences. Within such frameworks, so-called behaviours occur “as a consequence of some mechanism (in the brain, genes, or body) that is either working well or in a pathological way” (Brinkmann, 2014, p. 640). In contrast, Brinkmann argues that moral discourses orient to people’s *reasons* for doing things—reasons that reflect intentions and express meanings. In such discourse, we may speak not of behaviours but of *actions* or *conduct*. Perhaps Jack and Jill went up the hill because it was where they first kissed, and they hoped the view would rekindle the spark they have been missing for the past while. The point, in relation to the current chapter, is that speaking of the *causes* of a student’s distress may be different from speaking of the *reasons* for their distress. Although this is a theoretically interesting distinction, in everyday talk (and in

my interviews) things are much muddier. Events that are described mechanistically may subsequently be imbued with meaning; reasons become causes, causes contain reasons. Causes and reasons can blur even within a single utterance—particularly when interviewees were discussing socially meaningful episodes such as a loss or assault. I therefore chose not to fuss over whether I was discussing (in memos or in this chapter) a *cause of* or a *reason for* a student's mental health problem. Nonetheless, I found this theoretical distinction useful for sensitizing me to the mechanistic or moral inflections of various constructions.

Constructing Mental Health Problems: Biology and Biography

Karen: So I'm wondering—when you think about your, uh, y'know, illness, or the bipolar—what kind of a problem do you think it is? Is it something that, um, like what is it—is it a brain disorder, is it a reaction to what was happening in your life, is it some—like, what do you, what's your theory –

Carl: Is it genetic or environmental?

Genetic or environmental? Nature or nurture? Dichotomous tropes like these have come to signify, in the public imagination, the contested origins of mental health problems. It is unsurprising that the interviewee in the extract above, Carl, volunteers this familiar binary. However, as evidenced by my muddy and meandering question, it can be challenging to push beyond matters of etiology to those of ontology: What *is* a mental health problem?

My first positional map (Figure 6) juxtaposes axes of biology and biography (i.e., life experiences), defining a discursive field through which my student interviewees “moved” as they constructed, explained, and accounted for the mental health problems they had experienced. As we will eventually see, interviewees combined and recombined elements of heterogeneous logics in unexpected ways—but we begin at a familiar position, one associated with (bio)medicalized understandings of mental health and illness.

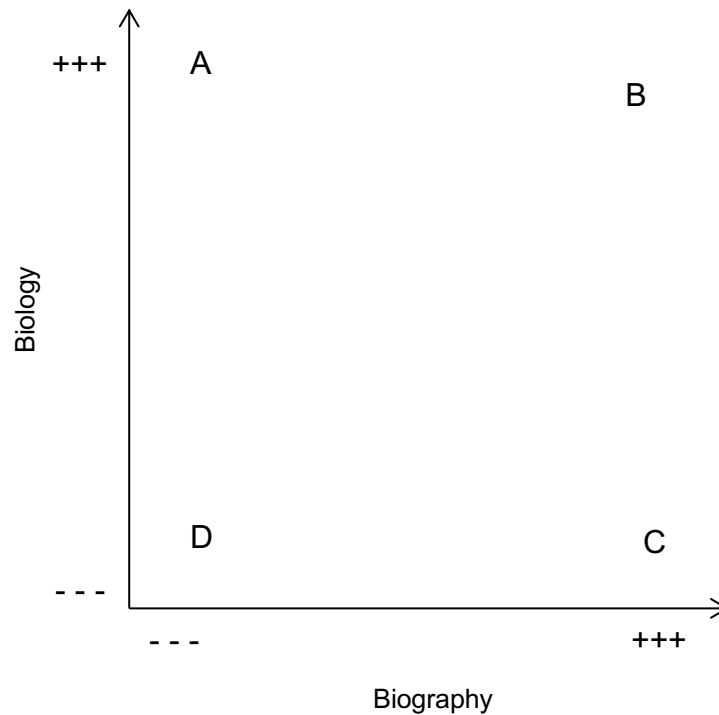


Figure 6. First positional map: Emphasis given to biology and biography (i.e., life experience) in students' discursive constructions of mental health problems.

Position A: Mental health problems are biological. In Figure 6, Position A is characterised by a strong emphasis on biology and limited emphasis on biography. “Chemical imbalance” explanations of depression (see France, Lysaker, & Robinson, 2007) might occupy this position; here, too, we might locate interviewee claims that certain “people are fundamentally different in their brains” and that such differences are “a from-birth kind of thing” that, if not provably genetic, were so early and irreversibly ingrained that they might as well be.

Genetics, of course, go hand in hand with ideas of heredity, of *running in the family*. For several of my interviewees, mental health concerns were a family affair. When family members are already diagnosed and/or taking medication for psychiatric concerns, such knowledge and practices are ready-to-hand. As one interviewee, Brent, explained:

Most people in my family are currently on some sort of medication. Like, my brother and my mom are both on SSRIs [selective serotonin reuptake inhibitors, a common type of antidepressant], my dad is on an SSRI too, I think. ...so when it was my turn, when I kinda came around, [my mom] already—understood what was going on, I think.

Another interviewee, Charlotte, recalled that as a teenager her parents pre-emptively placed her on a waiting list for psychological assessment even before she began to experience major difficulties at school. As she put it: “My younger brother has Tourette’s, my older brother has stuff, my older sister has OCD—so it’s, like, all these different things. So, like, ‘well, you probably have something going on.’”

In such moments, Brent and Charlotte seemed to speak as inheritors of a family tradition of sorts, a tradition in which unpleasant or disruptive subjective states are quickly interpreted as *symptoms*. While older siblings may endure a lengthy and ambiguous period of interpretive uncertainty, their younger siblings’ struggles are always-already poised to be “recognized” through a diagnostic lens. This may not be experienced negatively; on the contrary, culturally *and* familially shared narratives may confer a sense of reassurance and solidarity, perhaps akin to what Rogers-de Jong and Strong (2014) have called *we-ness*. As Brent explained:

The way that my mom has always seen the mental health issues that run in my family is that it’s a chemical imbalance in the brain. ... It’s just something that is different about you. And there’s nothing wrong with that, it’s just—something that needs to be solved with either therapy or medication or something like that.

Brent’s account exemplifies a tension simmering in contemporary neuro-biomedical mental health discourse. On the one hand, Brent posits that certain brains are just “different” and that “there’s nothing wrong with that.” Here, he could be heard as invoking discourses that disclaim assumptions of pathology in favour of descriptions like *neurodiverse* or *neuroatypical* (contra *neurotypical*). However, even as Brent positions his neurological difference as neutral, he reinscribes it as “something that needs to be solved”—that is, as a problem. Pathology is at the

heart of the term *chemical imbalance*: An imbalance presumes and requires a contrasting (healthy, normal, desirable) state of balance. Similar to Brinkmann's (2016) paradoxes of contemporary diagnostic discourse—that mental illness is “just like somatic illnesses” (p. 9) and yet not, that mentally ill individuals are “just like you and me” (p. 8) and yet different—neurological difference is constructed simultaneously as “just something different” with which there is “nothing wrong” *and* as “something that needs to be solved.” Such tensions are unlikely to resolve anytime soon.

Although *chemical imbalance* discourses are widely considered legitimate and sufficient explanations (France et al., 2007), my interviewees sometimes constructed highly biological positions via discursive work that pre-empted or disclaimed alternative, more biographic interpretations. Interviewee Hannah, for instance, explained:

I feel like it's really just something biological with me because, like, I grew up in a great home, like, nothing's ever happened—I've never had to go without something major; my parents are together and happy; there's really no flags there. So—I think it's just something that, like—when I was talking with the doctors, just having first of all low serotonin or something.

Hannah invokes a series of “flags” that could thinkably explain her depression: a bad home, deprivation, parental divorce or conflict. Her conclusion that for her, depression is “really just something biological” has seemingly been reached through process of elimination. By demonstrating that she has duly considered *and ruled out* potential biographical explanations, Hannah pre-emptively defends her biological self-interpretation.

Hannah's self-positioning with regard to biological and biographic positions cannot be understood apart from the occasioning situation, that is, the interview and research project. It was clear from my recruitment materials and interview prompts that I was inviting participants to tell me a *story* about their mental health problem(s) and, furthermore, that I was problematizing the

dominance of biomedical discourse. In another situation or conversation, Hannah might deploy a chemical imbalance narrative with little or no extra justification. Nonetheless, it is analytically relevant to note how interviewees orient to thinkable-but-rejected alternative positions—which, by contrasting with the preferred position(s), co-constitute it. Here is Brent again:

My issues, they seemed to come out of nowhere—it would be flared up by stressors but it would be blown way out of proportion for me. And the medication would almost completely solve it.

Taken pedantically, this statement is puzzling: If a problem has been “flared up by stressors,” did it really “come out of nowhere”? For Brent, though, proportionality is everything. It is the subjective *excessiveness* of his reactions to legitimate stressors that seems to “come out of nowhere”; to him, such emotional intensity is unjustified and nonsensical without explanatory recourse to invisible neurobiological processes.

As an interviewer (who is also a counsellor), I was initially puzzled by Brent’s claim that his issues “seemed to come out of nowhere.” Brent had told me a rich and compelling story: As a child, he moved between public school and homeschooling multiple times, punctuated by bouts of school refusal and bad teachers; around the time of Brent’s first depression, his father had lost his job and moved away to find work; Brent had been stressed about his own future and was exploring existential philosophy and “coming to terms with” his changing beliefs about mortality. I heard in these experiences a plausible “origin story” of mental health difficulties—and yet Brent said his troubles “seemed to come out of nowhere.”

Although Brent continued to treat experiences as meaningful (after all, he shared them during the interview), their explanatory significance was undermined by evidence such as medication’s power to “almost completely solve” the problem. Solutions are commonly expected to map onto the nature and structure of problems; within this line of thinking, emotional

disturbances that are successfully addressed by medication *must* be (largely) biomedical. Such assumptions have been challenged (see Bentall, 2009; Kirsch, 2010), but remain broadly persuasive. If a student notices improvement after being prescribed medication—especially if that student’s parents and/or siblings are already diagnosed and medicated, and/or if the student perceives their emotional reactions as disproportionate to life disruptions—strongly biological constructions of mental health problems may feel not only resonant, but inevitable.

Position B: Mental health problems are both biological and biographic. Of course, biological understandings do not obviate the potential relevance of life history—as evidenced by the ubiquity of *biopsychosocial* and *stress-diathesis* models of mental health in scholarly, professional, and lay publications (see, for instance, Schotte, Van Den Bossche, De Doncker, Claes, & Cosyns, 2006). At Position B of Figure 6, genes and neurochemistry are treated as important, but so too are social-relational-developmental events and circumstances. The relation between these material-discursive elements varies. For instance, as already introduced above, some interviewees positioned biographic events as “stressors” that could “flare up” their underlying (medical) conditions or symptoms. Here is an account from interviewee Hannah:

The end of grade twelve, it hit me really hard. Um ... the way it was kind of coming in was—one of my really good friends, I had a crush on him. And then it didn’t work out and stuff and, like ... I saw myself getting upset and I knew where that could lead—into the worst depression.

To Hannah, *getting upset* (in this case, by an unrequited crush) and *depression* are distinct entities: *Getting upset* is an entry point for, and precursor of, the clinical entity of depression. In this formulation, depression seems to hover, latent, until circumstances give it a “way ... of coming in” to Hannah’s life. A qualitative shift is implied: Depression is a sequela of normal distress, not an intensification of it. In other words, normal teenage upsets increase the *risk* of

depression for those with biological vulnerabilities. Biology retains ultimate or master explanatory status, a hierarchy through which *biopsychosocial* models might effectively slip into “bio-bio-bio models” (Sharfstein, as cited in Read, 2005, p. 597).

That said, other arrangements of biological and biographic elements are possible.

Another interviewee, Daniela, described how one of her diagnoses was explained to her:

And [the medical student] was like, “yeah, you have ADHD! And ... because you have ADHD, and you’re in this highly structured environment your whole life, when you finally started getting a little bit of freedom or ... when you’re starting to figure yourself out, like, you realize you’re not achieving ... and it’s sort of like a downward spiral.”

Here, ADHD is constructed as an objective neurological entity (something she *has* and perhaps has always had), yet biographic circumstances are assigned an essential role in co-constituting Daniela’s difficulties. Changes in her environment, her developmental stage (increased freedom and interest in “figuring herself out”), and her distress over slipping grades: ADHD itself becomes one among a number of intertwining and refracting elements that converge into Daniela’s “downward spiral.”

A third possible relation between biological and biographic discourse was offered by interviewee Carl, who mused: “I think even if it was genetic, it cannot be activated—it could not have been activated or triggered without what I have been through.” In some ways, this utterance resembles stress-diathesis accounts (circumstances “trigger” an underlying illness). However, Carl subtly reorganizes the hierarchy of biology and biography. In this construction, the involvement (or not) of genetics does not particularly matter; it is life experiences that are the necessary (and possibly sufficient) source of mental illness. Here, we find ourselves pulled toward Position C of Figure 6—a position at which biography outweighs biology in explaining

and understanding mental health problems, a position from which Carl can reasonably declare:

“If my dad was understanding from the beginning, none of this would have happened.”

Position C: Mental health problems arise from life experiences that are upsetting, traumatic, or otherwise disorienting. At this discursive position, mental health problems are constructed with reference to biographic events such as traumas, losses, conflicts, dilemmas, double binds, and so forth. One interviewee, Geoffrey, recounted how growing up as a feminine child and then gay teenager in a small town yielded ongoing fears and worries, which often manifested as physical sickness. Like several other interviewees, Geoffrey invoked a hydraulic metaphor of emotion, in which unexpressed emotions become “bottled up” or repressed: “You kind of neglect that trauma more and more. And then neglected trauma becomes where you throw up in public because you’re so nervous [*laugh*].” Geoffrey recounted that soon after leaving his hometown for university he was sexually assaulted and then manipulated into successive abusive relationships. Few people who hear Geoffrey’s story would be surprised that these assaults and abuses resulted in emotional turmoil. From this position, no inner pathology is necessary to understand the emergence of mental health problems; as Geoffrey remarked, “I’m just a normal person that’s had bad things happen to them.”

It might be tempting to conclude that this position treats difficult life experiences as *causes* of mental health problems in a mechanistic sense (cf. Brinkmann, 2014). The term *trauma*, after all, retains implications from its original meaning: a physical injury caused by an impact or blow (cf. McLaughlin, 2012). Nonetheless, causal logics were frequently braided with more meaning-dense *reasons* for the impact of certain events. For instance, Geoffrey described his experience of being assaulted (seemingly by a stranger or strangers) shortly after managing to leave an abusive partner:

It was really defeating. Because it was, like—I finally had the confidence to leave that person; I was happy and enjoying friendships, just to be beaten down again. And I was like—there’s no escape. ... It was really a low point ... I was really spiralling.

Here, Geoffrey makes clear not only that he was (emotionally and literally) “beaten down” by the assault, but that the *timing and circumstances* of the assault carried situated meanings that amplified its effects. The materiality of the attack intertwined with its symbolic significance, such that Geoffrey came to doubt whether he would ever feel truly safe or happy.

Although I have thus far been focusing on Geoffrey, whose obviously distressing experiences would be commonly considered traumatic, more modest but nonetheless upsetting events may also be invoked at this position. For one interviewee, Chris, an unexpected falling out with a family member precipitated a period of turmoil and depression. Chris reflected on her emotional state at the time:

I was certainly sad. Like—and confused, I think is the real thing ... and scared. 'Cause I had an adult that I looked up to accusing me of all kinds of slanderous activities and never actually telling me what the problem was. ... Which spiked all these, like, worries.

Critical incidents may serve as the proverbial straw that breaks the camel’s back; in Chris’s case, she had also spoken about feeling ostracized from her immediate family (after choosing to call the police when her sister was making suicidal threats), about feeling lonely and disappointed that her family did not visit her when she moved away for university, and about dealing with food insecurity and precarious finances. Problems attributed to biographic events are frequently overdetermined: Life and its associated meanings are messy, and multiple stressors, interpretations, and relations may intersect to produce distress.

Moral variation within biographic positions. As I pored over my interview data—noticing, memoing, and testing out different maps—I puzzled over the observation that although biology and biography made sense as contrasting axes, biographic (experience-focused)

positions seemed to vary along a third axis related to the moral significance of mental health difficulties. *Moral*, as I use it here, refers to the *ought*-ness of life (Brinkmann, 2011); moral positions orient to a subject's responsibilities and accountabilities (to themselves, others, moral-ethical codes, etc.). For some interviewees, mental health problems signalled a disconnect between preferred values and current conduct or circumstances; such problems thus constituted a call to change something, to *live differently*. As interviewee Sabrina put it:

That's just my perspective on [depression], is that your body's trying to tell you something. Or your soul is trying to tell you something, or your spirit or who you are deep, deep down is, like, trying to get out, but you're suppressing it.

Unlike Geoffrey's and Chris's constructions, discussed above, in which mental health problems are grounded in upsetting, traumatic, or stressful experiences, here mental health problems are grounded in a *moral* disconnect in one's life. Both positions are biographic, in the sense that they relate to the specificities of a person's life trajectory and narrative; however, they differ along a continuum of moral significance and responsibility. Such variation can be visualized by adding a z-axis to my first positional map, yielding the map shown in Figure 7:

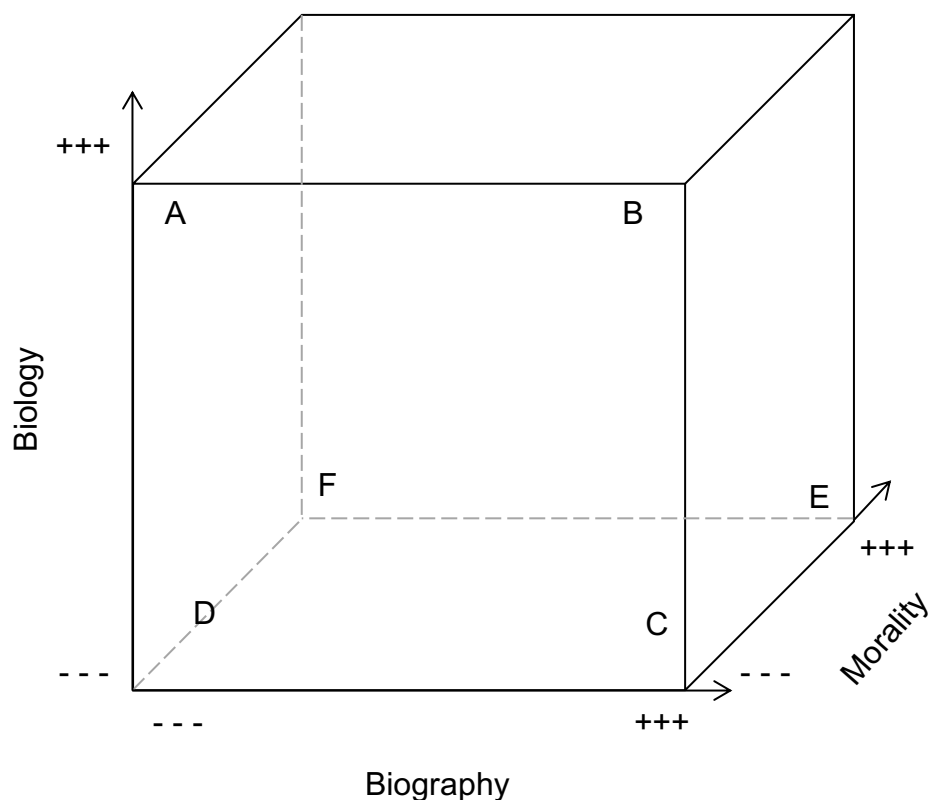


Figure 7. Extended first positional map: Emphasis given to biology, biography (i.e., life experience), and morality (i.e., “ought-ness”) in students’ discursive constructions of mental health problems.

As Figure 7 shows, adding a *z*-axis to my first positional map makes new positions possible; here, I am focusing on Position E (high emphasis on biography *and* morality). This position can be elaborated by a quote from interviewee Anthony, who reflected:

In the back of my mind? I felt like I was feeling miserable because I—I wasn’t doing anything. And I feel like a lot of it was guilt, too. ‘Cause I felt like—like, I’m not going to school; I’m wasting my parents’ money, um, I’m letting my parents down, I’m letting my friends down. ... I felt like I was just, like, a waste.

Some might interpret Anthony’s guilt and shame as artifices of depression (e.g., “that’s just the depression talking”). However, even in hindsight Anthony treats these thoughts with legitimacy: He really *wasn’t* doing much of anything, and perhaps he really *was* disappointing his parents

and friends through his increasing withdrawal and neglect of his responsibilities. In fact, Anthony described a major turning point centred on the insight that “maybe the reason why I feel so down is because ... I’m not living virtuously.” Although life circumstances had contributed to his predicament, his moral self-conduct *within* these circumstances was paramount. In other words, Anthony interpreted his depression as the consequence of avoiding a key existential or spiritual task—that of facing and transforming his fears in order to live “virtuously.” Like Sabrina in the quotation above, Anthony constructed depression as a cue for agentic change—a position whose implications will be discussed further in relation to my second (upcoming) positional map.

Position D: Neither biology *nor* biography are important to understanding mental health problems. An important function of positional maps is to provoke analysis of non-intuitive positions and *sites of silence*. I was initially perplexed by Position D (see Figure 7). Can mental health problems be constructed as neither nature nor nurture? If so, how would such a position show up in students’ accounts? I speculated that it might be possible to take a spiritual or religious position in which emotional suffering is attributed neither to a person’s genes nor their experiences or moral choices, but to supernatural forces acting in somewhat arbitrary ways (imagine the biblical story of Job, in which Job’s suffering stems from a wager between God and Satan). This position was absent from my data; however, the z-axis introduced in Figure 7 creates the possibility that mental health problems could be understood as a subset of morally significant human struggles that are—to some extent—universal (Position F). Although I found no clear examples of this position in my data, Anthony hinted at it—remarking: “I feel like everyone kind of goes through their own, ... their down times. And, like, depending on the person, it could vary—how deep it goes.” Anthony did not specify, nor did I ask, on *what* this

variation depends: on a person's neurochemistry? Experiences? Character? But such questions arguably miss Anthony's point—that there is something quintessentially *human* about seasons of fear and sadness, and that we must each respond as best we can to the existential challenges we are dealt.

From there, I found myself re-considering Position D. I surmised that this position might be characterized as agnostic—grounded in an assumption that we cannot definitively know the cause or nature of mental health problems. I found some evidence of such positions in my data. For instance, when I asked interviewee Charlotte to speak to *why* she experienced mental health problems, she rattled off a litany of biological and biographic possibilities: genetic makeup, premature birth, being bullied and lonely in elementary school, the death of the family dog, sharing a room with her sister, seeing a news story about a child who had committed suicide. However, Charlotte concluded: “For the most part, it’s hard to pinpoint anything. It’s just like—well, this happened; it’s there, so now what do you do?” In a related vein, interviewee Geoffrey remarked: “Some people just are who they are; there isn’t always a mechanism—they’re just like, y’know, I deal with depression. And that just is what it is.” Biological and biographic discourses may not be dismissed outright, but at this position they do not particularly *matter*. I am reminded of a maxim of solution-focused therapy: The facts of the problem may be irrelevant to the facts of the eventual solution (e.g., Berg & de Shazer, 1993; cf. Wittgenstein, 1922/2010).

In the quote above, Geoffrey seemed to be speaking about *others* whose mental health problems have no apparent cause or mechanism. I had assumed that Geoffrey would not include himself in this category, since he had narratively linked his emotional distress to the assaults and abuses that he experienced. However, he elsewhere troubled a straightforwardly causal relation between his traumatic experiences and mental health problems:

I don't think, like, each of those actions caused anxiety, or caused me to have depression or caused me to have *x, x, x*. I think that it's something—that occurs in everyone. And these are things that have heightened it, and things that have lessened it. Not something that caused it.

Here, Geoffrey invokes a possibility that mental health problems—though shaped and intensified by life experiences⁴²—may not categorically differ from *normal* emotional struggles (“I think that it's something that occurs in everyone”). Biological, biographic, and even moral repertoires are diminished, and in their absence we might infer an attitude of mild pragmatism. “It's hard to pinpoint anything,” Charlotte remarks; “it's there, so now what do you do?”

Some readers may be skeptical of the above analysis. Does all this really “belong” at Position D (low emphasis on biology, biography, or morality), or should Position D be instead considered a site of silence? I welcome such critique and dialogue, but maintain that the above section, if nothing else, exemplifies the analytic generativity of positional mapping: Look at all I eventually had to say about a position that seemed, at first, nonsensical!

Multiplicity and Mashups: Touring and Folding the Map

In SA it is *discursive positions*, not actors, that are placed on positional maps. Even when an interviewee is quoted to substantiate one position and not others, the person does not “belong” at that position; it is assumed that they might take up other positions at other times. This “space between” actors and positions (Clarke et al., 2018, p. 173) allows for the analysis of complexities, heterogeneities, and discursive movement or flexibility. Once maps have been created, they can be used to articulate and analyse the shifting positions of individual actors.

⁴² And perhaps biology: Geoffrey elsewhere remarked “I think I've always been predisposed to be emotional ... whether it be in my personality or my genetic makeup or whatever that is, I'm uncertain ...”

My colleagues and I (Strong et al., 2015) have previously argued that “humans are best served by being able to judiciously draw from the resources of multiple discourses, and that problems can emerge when they overcommit to the resources (e.g., viewpoints, explanations, solutions) of a single discourse” (p. 599); we have referred to the latter phenomenon as “discursive capture” (Strong et al., 2015; cf. Massumi, 2011). Carrying this assumption into the current research, I was curious about instances of discursive flexibility and poly-positionality in my interviewees’ sense-making. I found several such instances, and will discuss some presently, but should also note that some participants seemed to have settled quite comfortably within the terms of a single discourse. Far from suffering in a state of discursive capture, their accounts suggested that the resources of their preferred discourse were, at that time, adequate to their expressive and problem-solving needs. I wondered whether this had something to do with my inclusion criterion that at least one year must have elapsed since “the ‘peak’ or most difficult part of the problem” (see Appendix B, screening question #4). Interviewees would have had plenty of time to arrive at a satisfactory, and perhaps stabilized, account of what had happened (often informed retroactively by what ultimately *worked* to solve the problem). Had I interviewed students in the midst of a mental health crisis, their meaning-making might have involved considerably more discursive flux.

Nonetheless, it is important to acknowledge that each interviewee’s meaning-making was creative, even if they remained firmly within a single discourse; these students were certainly not “discursive marionettes” (Hardin, 2001, p. 11) ventriloquizing dominant narratives in a formulaic way. I remained interested in exchanges during which interviewees “moved around the map,” taking up heterogeneous discursive positions or remixing discourses in unorthodox ways. Such instances were rarely obvious, but could be abduced at moments where as an interviewer I felt

taken aback, where I felt something unusual going on: where my expectations were breached (Garfinkel, 1967). I will discuss two examples before moving to my second positional map.

Discursive Multiplicity in Daniela's Account. Interviewee Daniela began her story “at the beginning,” with her parents’ difficult divorce when she was three years old. She recounted a peripatetic childhood, moving within and between South America, South Asia, the United States, and Canada. She described being “heartbroken” when her parents uprooted her life in South America; upon immigrating to Canada, she “found a good friendship circle ... and then we had to leave again.” At one point, she attended an evangelical Christian school where she recalled being told “your whole family’s going to hell.” She also found herself in an intense childhood friendship/romance with a boy who, struggling with his own emotional issues, would frequently threaten to kill himself. Later, in high school, she went through a breakup after which she felt “shunned” by her peers.

In addition to these many and complex spatial-social-relational losses and disruptions, Daniela described a fraught relationship to her body, refracted through family pressures and practices. As a Latina child in the southern United States, she yearned to have blonde hair, blue eyes, lighter skin, and a slimmer figure. Beauty norms were reinforced within the family, with her mother and older sisters undergoing cosmetic surgery. Daniela recalled:

I think that’s when a lot of my real, like, pronounced mental health issues started. ... I remember when I was in grade four this girl said I looked like an Australopithecus and like, I was really upset by that. ... And, um, my mom—she was very hard on me in terms of my weight and dieting and stuff, and that started at a very young age. So, when I was around 10 years old ... I saw myself in a very negative way, and I think that’s probably when I started becoming depressed.

By high school, Daniela said that her mother would weigh her daily, monitor and control her eating, threaten and punish Daniela for gaining weight, and wake her up at 5am to run prior to

morning sports practice. By grade twelve, Daniela recalled that she was isolated, overwhelmed, ashamed, self-harming, taking laxatives, struggling at school, and having thoughts of suicide.

With reference to Figure 7, the narrative I have relayed thus far draws compellingly from Position C (strongly biographic). A “case conceptualization” from nearly any therapeutic school of thought would have no shortage of content with which to make sense of Daniela’s depression and anxiety. I was sincerely surprised, then, at Daniela’s response when I asked her how she interprets the mental health problems that she has experienced:

The best way that I interpret it is just, like, there’s literally something different in my brain. Like—’cause everyone goes through stressful situations and everyone goes through things that makes them sad but, like, I think that my brain chemistry, just as it was, took it to a whole other level.

Here, Daniela’s sense-making falls closer to Position A: Her struggles are attributed not to a *different* (i.e., traumatic) childhood, but to a *different* brain. Within this logic, her childhood ordeals—described earlier with so much intensity—are implicitly downgraded to “stressful situations” such as “everyone” experiences.

How might we interpret Daniela’s position-switching? Illouz (2008) has argued convincingly that therapeutic narratives—those that locate emotional difficulties in a traumatic or damaging history—confer certain advantages to contemporary subjects. To have suffered as a victim (or survivor) amplifies the valor of ultimately overcoming (McLaughlin, 2012). To exhibit resilience becomes honourable, even heroic (Bracke, 2016). Position C offers an appealing and recognizable genre through which to tell one’s mental health story, and it was this story with which Daniela “led” during our interview.

On the other hand, medicalized claims (such as those found at Position A) carry their own benefits: authority and indisputability, for instance (Jutel, 2011). Medicalized discourse is

frequently understood as morally neutralizing, that is, badness (or moral weakness) becomes sickness (Conrad, 2007). Daniela specifically cites this effect:

I feel like that's, for me, an important way to see it. ... It's not that you're a weak person or anything, it's literally that your brain is different; it's wired differently and you're gonna react differently to things than some people might, and you might take things harder.

One possible reading of this excerpt is that brain-based understandings offer Daniela *insurance*, shoring up her biographically-based narrative. If anyone (including herself) doubts that her childhood was “bad enough” to justify or explain her mental health problems (i.e., accuses her of over-reacting, exaggerating, or being “a weak person”), this understanding neatly bridges any gap. If she “takes things harder” than others would, it is because her brain is wired differently.

There are still subtler functions at play. Daniela speaks of medicalized discourse as offering a “way ... to sort of rationalize it to myself, to sort of keep me sane and to not feel, like, sorry for myself.” She immediately offers a correction of sorts:

Not that there's anything wrong with that in, like, certain parts of my story—because, like, there were some parts where I'm like, yeah, like—that was really a shitty experience, and, like, no one should have to go through that.

To some extent, Daniela asserts that feeling sorry for herself (or, perhaps more precisely, for her past self) is justified. Nonetheless, she alludes to something undesirable or unsettling about attributing her mental health problems to her “shitty experience,” however legitimate this discursive move may be. Brain-based understandings are reassuring: They help her “rationalize” her problems, they “keep her sane.” By extension, she implicitly casts the alternative position, one in which her childhood experiences bear the full etiological weight of her problems, as not only self-pitying but (to use current vernacular) crazy-making.

Why might this be? One hint might lie with how Daniela relates to, and understands, her parents. Daniela's parents figure prominently in her story, and (in my hearing) rarely in a positive light. We hear of her mother cutting Daniela's hair as a punishment for gaining weight; of her parents locking snacks in a suitcase, thus amplifying Daniela's obsession with food; of Daniela's stepfather cheating on her mother, to which Daniela attributed her inordinate caution in relationships with boys and men. A counsellor listening to this account might agree with Daniela's assessment that a lot of her distress, at the height of her crisis, "was because of them." However, no sooner had this claim left Daniela's mouth than she began to trouble it:

Or—at least that's what I said when I was a kid. 'Cause after therapy, now I'm like, I understand where my parents were coming from and I understand that what they were doing wasn't the healthiest way. But I understand that they meant well, and, like—my parents had issues of their own growing up, so ... they did the best they could.

Although one can imagine therapy introducing or reinforcing a narrative of "abuse," Daniela's therapy apparently proceeded in a different spirit—one of generous *understanding* via psychological discourse. Of course, the latter is more useful for moving forward in relationship. And—here I am making an analytic inference—a preference to understand her parents as doing "the best they could" may increase the appeal of brain-based interpretations. Medicalized discourse was, historically, hailed as a corrective to the "mother-blaming" of psychoanalytic or attachment-focused theories (Bentall, 2009); perhaps this is a function it (implicitly) serves for Daniela. "I just blamed them, at the time, for everything," she recalled; now she can also draw on the understanding that it is *really* her brain that is to blame. Biological discourses, in addition to alleviating *self*-blame for emotional difficulties, may simultaneously exculpate one's parents.

As Daniela told the story, there were few instances of hearable tension. Generally, she moved seamlessly between therapeutic and medicalized repertoires of sense-making, not tripping

upon possible contradictions or incommensurabilities. This pluralism may be related to her occasional signalling of a pragmatic attitude toward her own account: That is, Daniela did not always present her claims as objective truths but, sometimes, as useful and situated interpretations. For instance, she spoke of a perspective being valuable for “rationalizing” circumstances to herself, and elsewhere remarked “I feel like that’s, for me, an important way to see it.” By specifying that a certain perspective feels important *for her*, Daniela hints at the possibility of multiple valid ways of seeing and feeling. Nonetheless, biological understandings are often bestowed with the declarative voice of scientific truth: “It really comes down to, like, people are fundamentally different in their brains.” Elsewhere, she remarks that her brain chemistry *must* be “a little different—‘cause that’s, like, what basically mental illness is, right?” Daniela tells a psychologically-inflected life narrative in moving detail, proffering plausible biographic *reasons* for her emotional problems. And just as convincingly, she takes for granted that ultimately—“fundamentally,” “basically”—mental illness “really comes down to” biology.

Discursive Mashups in Carl’s Account. Not unlike Daniela, interviewee Carl told a story of intense socio-relational stress that culminated in a series of breaking points. Carl explained that while he was a high school student in the Middle East, he became romantically involved with a girl from a different religion—a hugely problematic difference within their family and regional cultures. Carl spoke at length about the tumult of their volatile and often unhappy relationship, his parents’ intense disapproval, and his ongoing guilt, stress, and confusion as he moved to Canada for university but continued the relationship. He spoke of feeling and acting “crazy,” irrational, and paranoid. At different points of his narrative he

oriented to intolerable pressure, profound loss, heartbreak, and filial and moral duties (e.g., “living in the shadows just destroyed me”).

Intertwined with this relational, emotional, and existential tale runs another plotline: Carl’s quest to recognize, accept, and understand his mental illness. Although I have just called it “another plotline,” Carl seemed to make no such distinction; he invoked biographic and psychiatric explanations in the same breath, never signalling a discursive switch. During the interview, I often found myself scrambling to regain footing after what felt, to me, like a sudden shift of the discursive ground on which we had been standing. As I reflected on my impressions of Carl’s talk, I thought not of discursive flexibility, code-switching, or narrative braiding (Cobb, 2013) but of a mashup, a song created from two or more songs overlaid upon one another. In mashups, elements of the original songs may appear and disappear in unpredictable ways; what felt familiar a moment ago is now something else altogether, and listeners may be unsure when and how the change happened.

I find it difficult to convey this quality of Carl’s talk through quotes and examples, but I will try. Early in our interview, Carl described the stress of hiding his forbidden romantic relationship from his father. He explained:

I couldn’t make the right decision. And now I realize that this was just part of the illness. Part of the overall stress that was occurring to me, for six whole months, that just drove me to make ... irrational decisions.

I recall feeling confused: Are illness and stress the same thing? Will the stress ultimately be constructed as a red herring, masking the effects of an underlying illness? But Carl had moved on, and I did not interject. A few minutes later, Carl was describing a series of utterly miserable circumstances and terrible double binds. When I asked how he interpreted his experience at the

time, he replied: “I just thought I was sad. And after all this was gone, after I travel [to Canada], everything will be okay. I didn’t realize. I didn’t admit depression.”

Talk of *realizing* tends to follow a familiar format: I thought, at first, that it was *x*, but ultimately realized it was *y*. Here is Brent, for instance: “For a long time I thought it was an issue with sleep. ... But then I realized that, uh, or I talked to my doctor, and he said that depression and anxiety can cause issues with sleep.” Carl’s claim follows a similar hierarchy: I thought, at first, that I was just sad, but ultimately realized it was depression. Depression is placed in the truth position, and convention would dictate that biographic or emotional explanations be downgraded accordingly. Carl does not do so. Throughout the rest of the interview, he continues to treat psychiatric and biographic understandings as equally legitimate (and fungible).

My confusion, I posit, was grounded in expectations about thinkable relations between biological and biographic discourses: They can be held apart, they can be used to critique or discredit one another, or they can be integrated in some sort of biopsychosocial or stress-diathesis model. I thought I knew what to expect—the general logic to anticipate—when someone invoked diagnostic or psychiatric discourse. Carl seemed to be doing something different. Late in the interview, he offered the following account:

I was so, so conflicted. In making up my mind. And I think if you don’t make up your mind about something that really, really matters for so long, you can never make up your mind. And, that, I, I say influences the type of mental illness. Which is being bipolar.

“If you don’t make up your mind about something that really, really matters for so long, you can never make up your mind.” To the best of my knowledge, this notion is far from psychiatric canon (see National Institute of Mental Health, 2016); it is also the most poetic account of bipolar disorder I have ever heard. As my colleagues and I have previously written, “relying on a single discourse for understanding something as complicated as anorexia or

depression [or bipolar disorder] might leave us with a sense of ‘linguistic poverty’ (Vico, 1744/1999)” (Strong et al., 2015, p. 606). Rather than relinquishing diagnostic discourse, Carl imbues it with unexpected poetic wisdom (Vico, 1744/1999), rendering it *adequate* to express his predicament. In his use, diagnoses are not (only) symptom checklists, but metaphors.

How might this unorthodox style of sense-making serve Carl? I have already implied that importing poetic meanings into psychiatric discourse creates space within the latter for honouring the specificities of Carl’s moral and relational suffering. But the psychiatric discourse is also useful. Here is an extract from a passage in which Carl is explaining how he concluded that he must have bipolar disorder:

Carl: It’s not normal to have, to have these kind of conflicts. And, it’s—

Karen: Conflicts in, in—

Carl: In the mood. Because, uh, sometimes I love her. Sometimes I hate her. Sometimes I’m good; sometimes I’m bad. And whenever I’m feeling good? I’m feeling extremely good; whenever I’m feeling bad I’m feeling extremely bad. And whenever I’m having both, it’s the hardest time of my life.

In justifying his initial claim that certain conflicts are *not normal*, Carl turns not to psychiatric authority but to emotional experience: In essence, *this is too painful to be normal*. “Normal” languages of suffering (biographic, developmental, romantic, relational, etc.) do not feel “adequate to express his predicament” (Kirmayer, 1984, p. 249). Psychiatric languages—the realm of the extreme, the pathological, the *abnormal*—lend an essential “heft” (Lindemann Nelson, 2001, p. 96) to Carl’s self-interpretive efforts.

A second and more tentative possibility relates to Carl’s background and cultural self-identification. Carl repeatedly emphasized that recognizing and accepting his mental illness was a challenge: that he previously “didn’t believe depression existed” and thought that people who

claimed to be depressed were “just too weak to deal with life.” He asserted that in his culture, mental illness is not talked about, nor does one visit a doctor for non-somatic concerns. Carl presented himself as someone who “was too blind to” the realities of mental illness but has now seen and acknowledged the truth. In demonstrating to me, an interviewer affiliated with counselling psychology, that he has journeyed from denial and ignorance to enlightenment (or mental health literacy; Jorm et al., 1997), overcoming not only his own misconceptions but those of his culture and parents, he may enact a valued self-understanding as independent, cosmopolitan young adult and an enlightened, compassionate, and scientific thinker.

Finally, and perhaps most importantly, medicalized discourse offered Carl new problem-solving responses. Carl first saw a doctor who assessed his physical symptoms, listened to his dilemmas surrounding the romantic relationship, and told him: “You’re just stressed ... you need to make up your mind.” However, Carl remained paralyzed in indecision (“I can’t make up my mind. What is right? I don’t know the right from wrong any more!”) and was unable to end the relationship. He eventually concluded:

No. I need to see a doctor. And I need to get medication. I am depressed. Depression. I did notice, it changed. ... And I have all the symptoms of someone who is depressed, and sometimes I am suicidal ... and I’m going to get help, because I cannot live this way any more.

Bringing this now-definitively medicalized account to a second doctor, Carl was able to get the medication he sought, which brought him some relief.

The fact that Carl’s shift in constructions of his distress yielded different responses raises an obvious point: We are not interested only in how students make sense of their mental health problems, but in what they do about them. This question could certainly be explored via the maps in Figures 6 and 7, given that ontological and etiological positions inevitably carry

implications for responding. Position A will (most obviously) be associated with medication, Position E with self-examination and change. Therapy might be associated with Positions B and C. However, SA encourages analysts to “play with” variations of maps. How *else* might the situation be mapped, and what new insights might emerge? To discuss problem-solving responses, I chose to create a separate map (see Figure 8); although it bears some resemblance to Figures 6 and 7, it is not fungible with them (nor can it be superimposed on top of them). The axes of my second positional map concern the extent to which subjects are (materially-discursively) interpellated as *agentic* and/or *receptive* in overcoming or working through a mental health problem.

Addressing Mental Health Problems: Receptivity and Agency

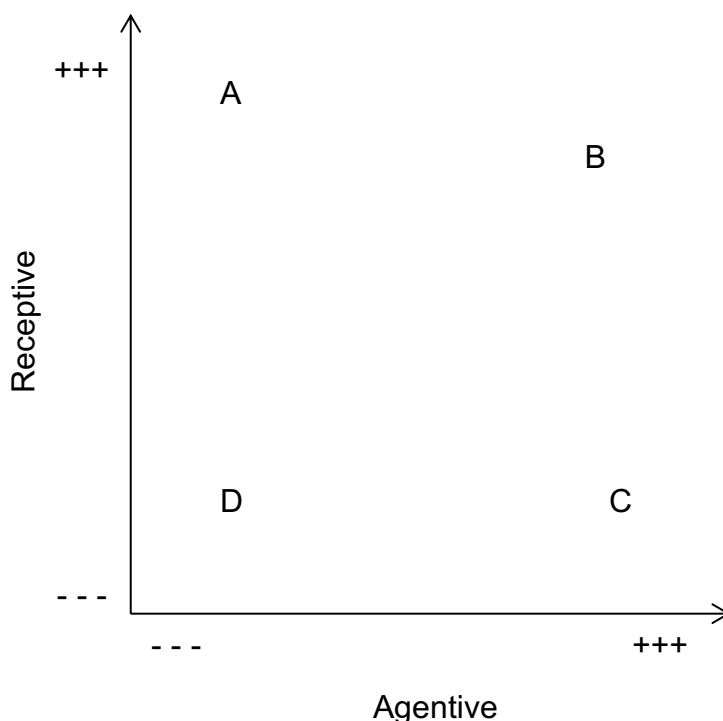


Figure 8. Second positional map: Extent to which subject positions emphasize *receptivity* or *agency* in overcoming a mental health problem.

What *posture* is conducive to addressing a mental health problem? Answers to this question can be mapped along axes of receptivity and agency. By *receptive*, I refer to a posture or style in which one's core duty is to seek and facilitate the ministrations of other actors (or nonhuman actants). To be receptive is not necessarily to be passive—indeed, receptivity may involve considerable action. However, such action is primarily focused on accommodating or facilitating the interventions of some non-self agent (whether that agent be a doctor, therapist, antidepressant pill, self-help regime, etc.). High-receptivity positions tend to involve deference or surrender to an entity imbued with special *power* (authority, expertise, knowledge, technology) to make changes that are beyond the capacities of the individual seeking help. In contrast, highly *agentic* positions are those in which the power to address mental health problems lies (chiefly or even exclusively) within the people experiencing such problems; necessary action and insights will be *self-directed*, *self-generated*. A position's location in this discursive field involves who has authority in deciding on problem-solving strategies, as well as who (or what) will ultimately be credited for change.

Position A: Mental health problems require expert treatment. Position A of my second positional map (Figure 8) resembles the classic *patient* posture: The suffering person seeks out a professional who can assess, diagnose, and treat their ailment.⁴³ Here, the most authoritative and influential agents are professionals (doctor, psychologist, therapist, etc.) and their curative prescriptions of medication, mindfulness, exercise, and so forth. From this position, addressing mental health problems entails presenting oneself to the appropriate experts

⁴³ Although this position fits logically with medicalized discourses of mental health, a receptive posture could also fit within, for instance, religious or spiritual traditions in which an authority figure (an elder, priest, etc.) delivers a pronouncement on the nature of the problem and specifies what must be done to resolve it.

and following their advice and guidance: delivering oneself over (in a sense) for healing ministrations. Such a posture is particularly (though not exclusively) compatible with biomedical discourse, since matters of brain chemistry or genetic makeup exceed the usual purview of everyday problem-solving. High-receptivity postures may also be taken up when someone has become so exhausted and overwhelmed by a mental health problem that they need more directive forms of assistance: for someone else to take control and offer possible (new) solutions.

Interviewee Daniela recalled:

I opened up to [my family doctor] and I was like—"I don't have the means to take care of myself. I need access to, like, whatever Alberta can do for me. Like, an actual psychiatrist ... because I've been struggling with this for so long and I've tried all these methods on my own; I just think I need—like, I wanna see what all my options are, even if it is medication ... like, I need, something."

Daniela's plea involves a putative shift in self-positioning: she has "tried all these methods on [her] own" for a long time and has reached a point where she does not "have the means" to care for herself. Although she retains some language of (consumer) choice ("I wanna see what all my options are"), her overall posture is that of a supplicant: *help me*. She inhabits a posture of receptivity to help from any actor/actant (a psychiatrist, medication, the state). In the medicalized logic of *help-seeking* (discussed in Chapter 3), Daniela has fulfilled her side of the bargain: *open up, seek help* (cf. Parsons' 1964 notion of the "sick role"). She may now (per this logic) relinquish the burden of problem-solving to professionals, who will take over the interpretation and attenuation of her mounting distress.

In her book *Putting a Name to It: Diagnosis in Contemporary Society*, Annemarie Jutel (2011) describes the sense of relief that a medical explanation can confer. The patient brings "a picture of disarray" (p. 4) to the doctor's office and emerges equipped with a narrative that can organize their pain and direct their frustrated efforts. In Hannah's words: "I felt comforted once I

got that diagnosis because then it feels like I can categorize myself. Like, this isn't just random thoughts or making stuff up in my head, it's like—this is a real thing.” Being diagnosed with obsessive compulsive personality disorder confirmed and legitimated Hannah's difference; it offered, in Jutel's (2011) words, “a sanctioned explanation of what makes ... her different from everyone else” (p. 5).

In addition to naming and legitimizing emotional struggles, diagnoses come packaged with actionable knowledge and authoritative advisors. Hannah observed: “That's why I liked having the diagnosis. Just because, it's like—I'm working with someone who knows about it; I know about it now, and we're working through it together.” Notably, shifting the problem from the realm of the everyday to that of professionalized knowledge and care can shut out friends and family who wish to help; indeed, Hannah deployed this understanding to silence her parents' expressions of worry and exclude them from this sphere of her life (“Relax, I got it under control ... I have someone who, that's their job”).

Adopting a receptive posture may also involve deferring to experts on the question of when a mental health problem is “over.” Brinkmann (2016) posits that contemporary diagnostic discourse involves a paradox of chronicity: Although, strictly speaking, diagnoses are labels for clusters of manifest symptoms, it is widely assumed that mental disorders persist even in the absence of symptoms. By this logic, mental disorder is understood as a chronic disease that must be “managed” to forestall relapse. As Charlotte remarked: “Mental health, a lot of times it's ongoing, like lifelong. ... Like, it gets better—but at the same time, it's always gonna be something that could pop up at any moment.” When I asked Hannah, who was taking antidepressant medication, whether she considered herself someone who *has* or *had* depression, she was equivocal. Eventually she ventured: “I would lean towards—I have it, but I'm, like,

asymptomatic? ... Just because they're, like, antidepressants. So ... if I'm taking antidepressants, I'm still depressed, but the medication's doing its job." When I asked Hannah when, if ever, she foresaw discontinuing the medication, she again seemed uncertain: "I kind of leave that up to what my doctors think. ... If they think I'm coming to a point where I'm stable enough to get off them, then I'll follow that path." In other words, Hannah's sense of her own wellness remains subject to expert ratification. The receptive posture persists, months or even years after symptoms have abated.

Position B: Addressing mental health problems requires both agentic action *and* receptivity to influence. At Position B of my second positional map (Figure 8), receptive *and* agentic postures are considered crucial to addressing mental health problems. Problem-solving authority and efficacy are shared between the struggling person and professionals or other helpers; alternatively, problem-solving capacity may be thought to emerge or inhere within therapeutic relationships. Such a position is familiar to many counsellors and therapists, who may work from an assumption that clients are the experts in their own lives, while therapists are experts in facilitating a therapeutic process (e.g., Anderson & Goolishian, 1992). Clients are invited to be active, authentic, and assertive within the therapeutic endeavour while simultaneously welcoming expert recommendations in the form of homework, in-session exercises, and so forth (cf. the influential *stages of change* model; Prochaska & Norcross, 2001). In more collaborative or dialogic counselling approaches, expert intervention may be replaced by notions of transformative dialogue and shared meaning-making. Regardless, active participation of both professional and client are considered essential to the change process.

I found many examples of high-receptivity, high-agency discursive positions in my interview data, particularly among interviewees who had sought counselling for their concerns.

Geoffrey, for instance, emphasized that “being able to speak” about being sexually assaulted was central to his healing process. Importantly, this speaking involved not only revealing a hidden truth to others, but to himself: “You just don’t ever say those words out loud. Right? You just think it’s all fine.” He continued:

I just had repressed so much emotion. So there’s just so, so much to unpack, that a lot of it was just listening—[my counsellor] was listening, helping—um, dealing with anxiety, understanding anxiety, I think, [was] a lot of what she worked on.

In the extract above, Geoffrey initially positions himself as the active *speaker* and his counsellor as the receptive *listener*, bearing witness as Geoffrey unpacked his repressed emotion. However, mid-sentence he amends his formulation to one in which the counsellor also actively *worked* on a psychological object—anxiety—that was impacting him. Focus shifts to the counsellor’s actions—dealing with, understanding—with Geoffrey himself becoming briefly absent from the construction (here it is *she*, not *we* or *I*, who is doing this work).

Therapeutic talk may be constructed as involving separate functions for client and counsellor, as above. Alternatively, “being able to speak” may be understood as a relationally emergent capacity, one that inheres in the *joint* dialogic work of counsellor and client. In Geoffrey’s words:

We also worked on, just, methods of language. How to speak—uh, not necessarily how to speak—but, I just learned it as we spoke about it; kind of the language that helps me convey what I’m feeling in a way that’s not this explosion of emotion [*laugh*]. So, just working on, like, um—a more factual langu- I shouldn’t even say factual. But just, like a language that makes you feel comfortable and that makes you feel like you can explain some of the more intimate details of your life.

Geoffrey’s repairs in this passage (that is, moments when he interrupts or corrects himself) suggest that he is articulating an idea that is relatively unfamiliar, one for which there is not a readily-available cultural understanding. He twice discards constructions that would confer a

sense of expert or objective practices (“how to speak,” “a more factual language”) in favour of more tentative constructions. “I just learned it as we spoke about it,” he says; rather than didactically *teaching* Geoffrey communication skills, we might infer that his counsellor engaged him in new sorts of conversation, through which new ways of speaking about his feelings became possible. When characterizing this new style of speaking, Geoffrey retracts *factual* in favour of a more pragmatic description: it is language that *allows him* to tell his story comfortably in ways that can be heard by others (he had previously talked about “flooding” his friends with details of his assault and overwhelming them with his intense distress). In my reading, Geoffrey is at pains to avoid giving the impression that his counsellor supplied him with generically “correct” language, although she contributed certain terms and ideas, such as *survivor’s guilt*, that he found helpful. He seems more interested in emphasizing that their *joint* efforts worked up forms of expression that were useful for his (local, relational) purposes.

For Geoffrey, coming to terms with what had happened to him was truly *coming to terms*, that is, moving from *linguistic poverty* (Vico, 1744/1999) to language that permitted new and healing self-expressions. Such self-expression was not pursued for its own sake, but for how it mattered *in relationship* with others who could witness Geoffrey’s story. Both Geoffrey and his counsellor were indispensable to this process whereby he became newly “able to speak.” Such emergent self-expression unfolded alongside other therapeutic “work”: Geoffrey’s work of expressing repressed emotion (invoking a hydraulic metaphor; Solomon, 2007) and the counsellor’s professional work upon psycho-epistemological objects such as anxiety.

Position C: The power to address mental health problems lies with the person experiencing them. At Position C of Figure 8—high agency, low receptivity—a person’s own actions, choices, and insights are central to addressing mental health problems. At this position,

professional expertise and intervention become optional, irrelevant—even counterproductive. As interviewee Sabrina put it: “Whenever I’ve been depressed it’s like, ‘you need to change something; you’re not going in the right direction ...’” As discussed above, morality-focused discursive positions construct emotional pain, in Sabrina’s words, as a *signal* that “something’s wrong. And you need to figure out what it is and remove whatever—or add whatever—will help.” This position shares territory with existential perspectives that emphasize human choice, however dire the circumstances (e.g., Frankl, 1963). Indeed, some have suggested that choosing and attempting action, even in the face of uncertainty and fear, constitute core human responsibilities (Grelland, 2006). As Anthony described:

The biggest thing, for me, was deciding that, um, that I should live more virtuously. ... And I also decided at the time, too, that—um, since I didn’t know what I was doing, in terms of career goals and stuff like that, I figured that if I at least worked towards these virtues, these virtues would align me to a career path that would hopefully be in line with [them]. ... And I think that’s when I started to turn things around.

The image that arises is one of a person “waking up”—that is, realizing that *his choices* (e.g., skipping classes, avoiding family and friends) are causing his suffering and making a commitment to live differently.

Similar to Anthony’s admission that he had suspected “in the back of [his] mind” that his suffering was self-perpetuated, interviewee Chris spoke of a “self-realization” of something that she, in some sense, “knew the whole time”: that her “self-destructive” enactments of pain and depression may have been informed by cultural stereotypes such as the dramatic forms of emotionality romanticized in the *Twilight* novels and films (cf. Kokkola, 2011). Chris reflected:

I think I felt guilty for it—like, I felt like I was pandering reactions from others ... so that I could feel validated in what I was feeling. And I think at some point I was just looking at everything—the way everything was going—and I was like, “I need to stop worrying about that! Like, I can feel sad and not have others validate that; I can feel lonely and not

have others validate that. I don't have to act out on these emotions to feel them. I can just feel them and that's okay."

Being able to "step back" and consider her actions in a more detached way allowed Chris to recognize the costs and consequences of how she was *doing* depression—in practices such as drinking and self-isolating, which might be understood as culturally recognized "pain practices" or "depression practices." Through her urge to demonstrate the extent of her suffering, Chris elicited others' concern but enacted a problem-saturated, problem-constrained version of her life. Exhortations to *express one's feelings to others* lie at the heart of the therapeutic ethos; for Chris, this logic became enacted within an intensifying interpersonal pattern (cf. Tomm, St. George, Wulff, & Strong, 2014) whereby feelings *must* be expressed, *must* be acknowledged, *must* elicit concern. To interrupt this pattern, Chris needed to challenge the (culturally reinforced) impulse to *publicly* express and demonstrate her emotions, learning instead to "relax" and "feel things" privately until she had "slowly decompressed everything and pushed everything out."

Professional help at Position C. Position C is distinguished not only by its emphasis on individual choice, self-understanding, and agency, but by a minimal role ascribed to professional guidance or help—placing this position in tension with dominant mental health discourse.

Regarding his experience of meeting with a counsellor, interviewee Anthony noted that he "just felt really disconnected." When I asked him to elaborate, he explained:

I felt like I was ... laying things in a certain frame. As opposed to being completely open. ... I think there's certain, like, feelings and stuff like that, that you just can't describe with words. ... There was no way I could explore it, outside of my own mind. And so ... there was, like, this disconnect—and I couldn't express everything that I needed to. ... I just felt like it was, just shallow.

For Anthony, counselling appointments produced a sense of alienation or *disconnect*, not only from the counsellor but from his own experience. In the therapeutic encounter, he found himself

“laying things in a certain frame” that felt false, *shallow*. Something was lost in translation. While Anthony attributed this inadequacy to the transition between *inner* (mind) and *outer* (words), we might also wonder about the therapeutic “frame” into which Anthony was interpellated. Counselling proffers particular narratives within which problems become legible and amenable to therapeutic solutions; struggles presented to a psychoanalyst will become very different *problems* than those presented to a behavioural therapist. Certain modalities, most prototypically solution-focused brief therapy, invite only cursory discussions of problems (Berg & de Shazer, 1993); other short-term models such as Acceptance and Commitment Therapy (Harris, 2009) or cognitive behaviour therapy (Beck, 2011) devote less attention to rich exploration of the client’s story than to the teaching and application of skills and techniques. This is what allows such approaches to be easily standardized and manualized, yet they can be critiqued for relying upon problem descriptions that are “thin” (Geertz, 1973)—or, in Anthony’s language, “shallow.” For Anthony, counselling simply amounted to rehashing his own thoughts in more limited ways—and he concluded that he “might as well explore things on [his] own.”

Not only did Anthony himself find counselling unhelpful, but he troubled the broader assumption that people can be *taught* how to overcome emotional struggles. At Position C of Figure 8, overcoming mental health problems is a personal, moral, spiritual, and/or existential task. Rather than receive ready-made solutions from experts, therefore, Anthony suggested that people must “stumble upon” their own responses. He elaborated:

If you try to teach someone that, they won’t fully grasp that meaning until they learn how to do it themselves. ... If someone told me straight up, like—what to do, exactly how to do it, and ... just gave me, like, an instruction manual? ... I don’t think it would be as valuable to me, as opposed to me kind of building it on my own.

At this position, the *content* of solutions matters less than the *process* of arriving at them. This assumption stands in tension with logics of psychoeducation and mental health literacy—logics wherein pathology can be prevented in groups or populations via mass dissemination of rationalized knowledge and practices (e.g., mindfulness; stress management; cognitive strategies; etc.). Such logics underlie countless campus mental health initiatives including for-credit wellness courses, informational campaigns, and self-help apps or websites (such as those featured at lower “tiers” of stepped care; Cornish et al., 2017). In the position Anthony constructs above, such psychoeducational content cannot replace the hard-won insights of self-examination and agentic struggle. As another interviewee, Sabrina, remarked, however much encouragement and support is offered to someone struggling with their mental health, “at the end of the day ... it’s kind of their work to do.”

At Position C, personal agency is central to moving through and beyond mental health problems; however, recovery need not be a self-absorbed or hermetic process. When I asked Sabrina if she sought any assistance during her depression, she reflected:

I think it’s just people who inspire me, uh, who helped. People who live a kind of life that’s closer to the ones I want to live. Or believe in things ... that kinda open up my world and make it bigger. Those were all of the people that really, like, inspired me and kept me going, and made me see the value in life and more of, like, a purpose.

Depression has been characterized as a phenomenological shrinking and calcifying (of the body, of the self, of imagined futures; Fuchs, 2005). People who “open up [our] world and make it bigger” can become a counterbalance against such shrinking. Rather than offering therapeutic help (which tends to focus narrowly on the unwell person’s life, body, or psyche), such people serve as figurative lifelines to resonance, passion, purpose—in short, to the realm of the living.

In a related vein, Anthony described a transformative moment that arrived in the most mundane of ways. At the nadir of his misery, having succumbed to increasing fears and withdrawal, he happened to watch a music video on YouTube featuring people going about their daily lives in a city:

I remember just seeing, like, all these people—and they were all doing their own thing but they’re all, like, working communally. And—and everyone just looked normal. ... And I compared that to myself—here I was, I was doing nothing ... I was just here laying in my bed, and—I wanted to just be a part of that. Like, I didn’t wanna be alone, I guess. I just wanted to be doing something.

The music video imagery resonated powerfully with Anthony, who experienced a sudden crystallization of his desire to “be part of this big machine that is, like, society” rather than to “just ... rot away.” Notably, he did not seek to rejoin society *in order to* alleviate his suffering (an instrumental logic); rather, he felt an *intrinsic* pull toward shared experience: “If I’m gonna suffer, like, I might as well, um, be with the others, y’know. I don’t wanna just suffer alone in here.” Anthony later added that he was also motivated by a desire to be “worthy” of the affections of a young woman he admired, a fellow student whom he perceived as more actively engaged in the world.

In constructions offered by both Anthony and Sabrina, useful self-knowledge demands interrogating one’s place in the world. This may be why psychotherapeutic or medical support became irrelevant to their problem-solving. In the following passage, Anthony begins in familiar therapeutic territory but, mid-sentence, articulates a meaningful twist:

So if you’re suffering ... kinda like really explore it, like, exactly what you’re feeling, and why you’re feeling it, and learn more about—not yourself, but like, your relationship with things around you and, like, how they kinda all just, like, mix together.

In this construction, exploring one’s feelings is valuable but so too is learning about “your relationship with things [and presumably people] around you” and how they “mix together”—

that is, exploring one's situatedness. To embark upon this journey, one does not need a professional (or a mental health course or webinar). It is an expansive, presumably lifelong task; it is up to you.

Tensions of agency and responsibility. Before moving on from Position C of Figure 8, I wish to linger a while longer with matters of agency, responsibility, biology, and control. Although such issues are not widely discussed or debated in the student mental health situation, I posit that they constitute an important fault line of tension that may be all the more powerful for being unspoken. Thus far, this chapter has focused on the words of my interviewees, whose rich accounts and unexpected constructions could spark endless analysis (and indeed, a great deal has been “left on the cutting room floor” in the interest of length and readability). In the following section I will juxtapose interview extracts with selections from media data (specifically, awareness campaigns and popular online articles). Consistent with SA, my goal in the following analysis is not to marshal an argument toward definitive conclusions, but to work *against* simplification and premature closure. Agency and responsibility have long been messy issues; I ask readers to quash any hopes that they will be neatly resolved by the end of this discussion!

On “toughening up”: The fraught possibility of choice. In a campaign video for Bell Let's Talk (Bell Canada, 2015), two men—factory workers—converse about a third man, perhaps a co-worker. “He says he gets anxiety attacks,” remarks the younger man, to which the older man scoffs: “He should toughen up.” This scene replays, identically, three times, before playing a fourth time with a revised response from the older man: “My sister gets them. It's very tough. I'll—I'll call him.” The younger man nods his approval, and the text “Educate yourself” appears on-screen.

What is the logic of this scene? An account is introduced (*he gets anxiety attacks*) and two alternative responses are modelled. The video's structure implies that the first response is common, habitual, or familiar (suggested by its repetition) as well as outdated, warranting replacement. The final response—in which the account of anxiety attacks is accepted and met with sympathy—is positioned as *educated*, that is, correct and enlightened. By contrast, the first stance—that a person could *toughen up* to overcome anxiety attacks—is retroactively marked as *uneducated*, that is, ignorant and incorrect.

A similar logic is at work in a popular BuzzFeed post (boasting over 1.3 million views when I accessed it in March 2016), “How People Treat Mental Illness Vs. How They Treat Physical Illness” (King & Park, 2015). In this post, a series of colourful cartoons imagine how responses to the same utterance might change depending on whether the speaker is referencing a physical or mental illness. The imagined responses to physical illness are compassionate, concerned, and legitimizing; responses to mental illness are (arguably) dismissive and minimizing. For instance, the remark “I finally feel like I’m making progress and getting better” is met with either “I’m so glad all the treatment has been working” (physical illness) or “I’m so glad you’re looking on the bright side again!” (mental illness; King & Park, 2015, #7). Similarly, a character who declares “I feel like I’m dying” is met with alarm in the context of physical illness (“We need to get you to the hospital ASAP”) but not mental illness (“Just try and remember a lot of people have it a lot worse!”; King & Park, 2015, #6). Another character apologizes to her friend: “I’m sorry I couldn’t make it. I didn’t feel well.” Her apology is accepted unreservedly in the case of physical illness, but only grudgingly in that of mental illness (“It’s OK, but you’re such a flake sometimes!”; King & Park, 2015, #5). Each response to mental illness (but not physical illness) is morally inflected; each assumes that the suffering person has

some capacity to *choose* differently in relation to their distress. The post invites a reading of such responses to mental illness as inappropriate, insensitive, or even outrageous.

With reference to Figure 8, the BuzzFeed post described above normalizes a *receptive* posture (i.e., Position A): Just like physical illness, mental illness requires treatment, medication, hospitalization, and rest. While mental health advice for a general (non-diagnosed) audience often foregrounds voluntary change—for instance, BuzzFeed’s “23 Things To Do To Improve Your Mental Health in 2016” (Borges, 2015) instructs readers to “complain less” and “make your bed every day”—texts concerning mental *illness* frequently pre-empt the possibility of overcoming such problems on one’s own. “Anxiety [is] an illness,” asserts one online article; “you can’t just get over mental illness” (McGlensey, 2015, #19). In a compilation of tweets, “21 Depression Truth Bombs Nobody Ever Drops,” we read: “#TheWorstPartOfDepressionIs having the drive and ambition to get stuff done, and the brain chemistry that wastes your whole day” (Hopkins, 2015, #17). Within this logic, brain chemistry *overrides* agency; exhortations involving will or choice (i.e., Position C of Figure 8), such as *toughen up* or *look on the bright side*, come to seem ignorant and stigmatizing.

Given that popular media frequently reinscribes high-receptivity positions (Positions A or B of Figure 8), I was curious about whether interviewees described or enacted any tensions when articulating high-agency, low-receptivity positions (Position C). When I asked Anthony how he thought other people’s experiences of mental health problems might compare to his own, he initially reflected:

When my friends are feeling down or something ... I just wanna tell them to, like, “toughen up”—like, “you can get through this, you just need to do these things,” y’know, and ... it’s very hard to, like, get people to do something that they need to do.

When I asked what sorts of things people might need to do, Anthony introduced the metaphor of a sword that must be sharpened through ongoing habits and practices. He explained, “you have to do things that might not seem comfortable, but ... it’s to sharpen you, right? And I feel like a lot of people, like, they just—they choose not to.”

Having articulated a strongly moral position (people *choose* against the uncomfortable work of self-improvement), Anthony immediately troubled it:

And then there’s the other side of me that’s more compassionate ... that thinks that, like, well, I don’t know what they’re going through, so they probably—like, they can’t sharpen their sword, y’know? And so, um—that one I, I honestly don’t know.

In the longer passage from which these quotes are drawn, Anthony shifts back and forth between what he calls the “harder” and “softer” sides of himself; his ambivalence is obvious and unresolved (“I honestly don’t know”). It is the notion of *luck* that eventually brings him closest to a settlement, as he remarks: “I think that some people are just really unfortunate, in that sense. And that can lead them to make poor decisions ... so yeah, I just consider myself lucky that I was able to get out of there.” In Anthony’s construction, *decisions* remain central to recovery—but the decision-making playing field is far from level. Luck plays a role, for better or worse.

Interviewee Sabrina enacted similar multi-positionality around matters of responsibility and change. At one point, she ventured:

Whenever I see other people in depression, um, especially people who have been in a very routine life their whole life—they don’t know how to get out of that routine. Um, so they’re kinda just stuck. And they think that it’s, I dunno, maybe they’ll have all these little excuses as to why it’s happening, or maybe they don’t even have an explanation at all. And they don’t even try to think of an explanation—they think it’s just, like, some disease that just caught them.

Some disease that just caught them: in this evocative phrase, Sabrina embeds medicalized interpretations within a posture of passivity. For Sabrina, medicalized understandings do not

qualify as explanations. They are, instead, superficial stand-ins invoked in the absence not only of a meaningful explanation but of the *effort required to search for one*. In contrast, Sabrina said of herself: “I always try to think of, like, the root cause of everything. So I’m always thinking, well, what’s the root cause of this? And, like, how do I make changes accordingly?”

Nonetheless, like Anthony, Sabrina worked to attenuate the position of moral superiority hearable in the preceding construction. When discussing her mother and sister (whom she constructs as relatively passive—“the kind of people who, if they’re depressed, they stay in bed all day”), Sabrina mused:

I think the difference, though, between them and myself was that they kind of grew up with very, very low confidence. ... I think that confidence has a lot to do with actually getting yourself up and just kind of making changes. Because if ... you don’t have confidence you’re always in fear, and I think that holds a lot of people down.

Where Anthony invokes bad luck (resulting in poor decisions), Sabrina cites upbringing or perhaps disposition (resulting in low confidence and fear). In both variations, overcoming depression requires *choosing* and *changing*, but not everyone is equally equipped for these existential tasks. Nonetheless, there is no getting around agency; in Sabrina’s words, each person has “their work to do.”

Any discussion of “toughening up” on campus—at least in 2016 when I collected my data—would be remiss to exclude *The Atlantic*’s widely-shared article “The Coddling of the American Mind,” alternatively titled “How Trigger Warnings are Hurting Mental Health on Campus” (Lukianoff & Haidt, 2015). Arguably, the basic premise of this article is that practices such as trigger warnings, policing microaggressions, and disinviting “offensive” speakers are reinforcing distorted ways of thinking. Drawing on principles of cognitive behaviour therapy, the authors suggest that all students—even those who have experienced trauma—would be better-

served by being exposed and thus habituated to, rather than protected from, uncomfortable and potentially upsetting stimuli. In other words, rather than “coddle” students with mental health problems, we should expect them to face and overcome their fears. I am reminded of Anthony’s remark, quoted above: “You have to do things that might not seem comfortable, but ... it’s to sharpen you, right? And I feel like a lot of people, like, they just—they choose not to.” Perhaps they are too coddled or disempowered⁴⁴ to choose otherwise.

Despite the flurry of public commentary sparked by Lukianoff and Haidt’s (2015) article, its anti-infantilization ethos was all but absent from the institutional mental health policies and program descriptions that I gathered. Much could be written about this discrepancy, but I wish to circle back to my interviewees’ careful hedging of high-agency discursive positions. Although they had successfully overcome mental health problems “on their own”—whether by moving overseas (Sabrina), taking up boxing (Anthony), or independently managing painful emotions (Chris)—these interviewees were reluctant to generalize from their experiences. As discussed above, they oriented to exceptions: situations wherein people may be *unable* to overcome a problem themselves. Failing to offer such disclaimers, we might surmise, puts an actor at risk of seeming sanctimonious or elitist. High-agency positions might thus be an uneasy fit for campus policies or documents, where exceptions are harder to express and explain. It may be that positions celebrating hard choices, active changes, and “toughening up” are acceptable only for *self*-understandings; applied more broadly, they rankle.

⁴⁴ Apparently, one of the authors of “The Coddling of the American Mind”—now a book of the same name—has said that he would have preferred to characterize students as *disempowered* but conceded to the publisher’s preference for the more provocative term *coddled* (Warner, 2018).

On biology and choice. Running throughout the above analysis are questions of self-determination: to what extent do people hold the power to overcome their own mental health problems? To what extent do people in mental distress *choose* how they act? Relatedly, can they be held morally and interpersonally accountable for their actions—is it legitimate, for instance, to accuse someone with mental illness of being a “flake” when they cancel plans (King & Park, 2015)? Who is calling the shots—the person, or the illness?

One way of discursively managing questions of responsibility is to separate persons from their mind, brain, or illness. “My mind is my enemy,” laments one contributor to the “31 Secrets of People Who Live With Anxiety” (McGlensey, 2015); interviewee Charlotte characterized mental health problems as “a whole battle inside your brain.” Interviewee Daniela, recalling her angry reaction to a friend who was trying to support her, reflected:

I don’t think it’s because I was inherently, like, just a mean person who liked to push people away. I think it was just, like, my depression sort of speaking in itself. ... It’s very much like a dark shadow that sort of clouds all of your thoughts.

Here, depression operates as a ventriloquist, bypassing the person’s “inherent” nature, or as a dark shadow overwriting the person’s own thoughts. In this construction, a person’s odds of being able to intentionally resist depression seem slim indeed. When I asked Daniela about her sense of agency within depression, she remarked:

When I was in that really depressed mind-state ... I don’t think I really had a choice at the time. I think it was only after that I was able to ... think a little bit more with a clear head and ... be honest with myself and have that, like, expert insight [from] my therapist or whatever. ... From that point onwards, how I see myself and how I see, like, whatever states I go through and not go through, I think that makes it a choice to me.

At the heart of this fairly mundane passage lies a remarkable transformation: the restoration of compromised agency, the shift from *no choice* to *choice*. In Daniela’s formulation, this change is made possible by new ways of thinking (to “think with a clear head”), new ways of relating to

the self (to “be honest with myself”), and new ideas or interpretations (“expert insight” from a therapist). These new practices constitute a new way of *seeing* herself and her emotions, a way of seeing through which she can *choose* how to speak, relate, and act regarding these emotions.

How might we understand this new way of seeing and thus choosing? Interpreted critically, Daniela’s account might exemplify apprenticeship to the *psy* gaze, as articulated by De Vos (2013):

By saying, *look, this is the homo psychologicus you are*, psychology splits the subject into the one who gazes *and* the one who is gazed upon. In other words, the subject is hailed into a kind of proto-psychologistic position from where it, *together with the experts* [emphasis added], weighs up its psychological double. Psychology’s *this is what you are* creates a vantage point from where the human subject is called upon to look at itself. (p. 9)

Through this lens, Daniela’s newfound sense of agency might be fraught with governmentality—that is, “choosing” to manage her emotions may be part of a repertoire of self-management practices that reproduce and extend dominant norms, values, and interests. *Now that you know better*, goes the logic, *you can make better choices*—“healthier” choices, heavily inflected by psychological, biomedical, and therapeutic expertise (Cederström & Spicer, 2015). Although many people embrace therapeutic *technologies of the self*, authors such as Illouz (2008) have argued that *psy* practices do less to increase free choice than to instantiate new and ongoing obligations.

However, more appreciative interpretations of Daniela’s account are possible. Family therapist Karl Tomm has postulated that intentionality develops via a series of recursions—that is, distinctions that are drawn upon distinctions. With increasingly sophisticated recursions, a person becomes an Observer (who is aware of the distinctions they are making), then an Explainer (aware of sequences and associations among distinctions), and finally a Free Agent

(able to choose among options to enact a particular sequence; K. Tomm, personal communication, November 28, 2013). Stepping back and reflecting upon one's sense-making, as Daniela may have learned to do, increases awareness that *things could be otherwise* and introduces possibilities for choice and change.

Self-awareness can take many forms. Daniela spoke of relational and emotional self-awareness before circling back to *neurological* self-awareness, concluding: “my brain is different; it works in a different way. If I let myself be like this [negative and irritable] for too long, like, my brain's gonna screw me over.” Although Daniela ascribes considerable power to her brain, she retains space to maneuver against its machinations. The use of neurological discourse discursively separates Daniela from the problem in a manner akin to the externalizing conversations of narrative therapy (e.g., White, 2007). She is thus empowered to take strategic action *against* her brain's intentions to “screw her over.” Although Daniela described a helpless or exhausted (and thus highly receptive) posture at the nadir of her depression (“I don't have the means to take care of myself”), her biomedical self-understandings at the time of the interview featured active self-awareness and relational accountability.

Critics of (over-)medicalization have lamented that diagnostic discourse permits abnegation of responsibility for one's actions (in one *New Yorker* cartoon, a woman tells her friend: “Evan has a syndrome where he cheats on me and does a lot of recreational drugs, but I forget the medical name for it”; Smaller, as cited in Frances, 2013, p. vii). Some interviewees denounced the use of biomedical discourse to excuse bad conduct; nonetheless, tensions lingered around the boundary between legitimate *reasons* and illegitimate *excuses*. For instance, Charlotte disapprovingly described how her brother handled his anger: “He would say, ‘Oh, well I have this or that [disorder]’—and I'm like, you can't—like, that doesn't count. Right? ... If you have

a feeling, you have to own that, regardless of what it is.” She elaborated on “owning” one’s feelings:

I think that’s another big thing that I’ve learned is ... if I get stressed, I—even if I’m anxious and I, like I get angry or whatever? I can’t. Because ... it’s my responsibility to get that in check. So when other people don’t, it bugs me.

She immediately added: “But at the same time it’s like, what’s going on—like, why can’t they do that?” Once again, a morally agentic position claimed for oneself—“it’s my responsibility to get that in check”—comes with an asterisk when applied to others (though, perhaps, not to brothers).

Another complex example comes from my interview with Geoffrey, who was telling his story of leaving an abusive relationship. After a violent episode,

I told him I was leaving and he, like, cried and told me it was ’cause his medication was wrong—’cause he has [a chronic medical condition]. And so he used my sympathy for mental health against me—to basically say, I have this condition, and it’s affecting my brain to be able to, to build these—and of course that was correct on, like—the medication can cause that, if you stop taking it. And he had stopped taking it ... so his body wasn’t making certain chemicals. And ... so he used the, um—so that became a form of, y’know, and then I accepted it; it became a legitimacy. Right?

What can we make of this passage? On the one hand, we hear Geoffrey retrospectively challenge the legitimacy and sincerity of his ex-partner’s account (“he used my sympathy for mental health against me”). On the other, Geoffrey confirms the “facts” of the explanation (“and of course that was correct ... his body wasn’t making certain chemicals”). I later asked Geoffrey to clarify, upon which he acknowledged a tension around this matter. Ultimately, he seemed to object to the mechanical nature of his ex-partner’s explanation: A medical condition is affecting my brain, thus *causing* my abusive actions. Geoffrey mused about a hypothetical alternative: “I’m experiencing depression and therefore I’m lashing out.” The crucial difference, here, is that *lashing out* is the action of a person, not a brain. A person—an emotional agent—is inserted at the locus of action, opening space for the possibility of apology, accountability, and change.

Depression itself, in the alternative explanation, is pluripotent: it may be construed as a mechanistic cause, a meaningful reason, or perhaps both.

On medication and selfhood. As hinted above, interviewees variously constructed mental health problems as both *self* and *not-self*: sometimes *who I am*, sometimes *part of who I am*, and sometimes *not who I am* (interestingly, anxiety was more often accepted as *who I am*—a variant of normal human experience—while depression was separated out as a discrete pathology or condition). We might ask similar questions of psychiatric medication: what is its relation to the self? In other words, if a medication seems effective, who or what is acting upon the problem, and how is the self positioned in this exchange?

One construction attributes agency fully to the medication, overwriting something important about the person's selfhood. As interviewee Anthony reflected:

I don't have anything against actual, like, pharmaceuticals. But for me ... I think it's my stubborn side. It's just that, like, I'd much prefer to, to suffer and go through it than to kind of, um—take things into ... places where I would feel like I'm not in control.

Similarly, although several people in interviewee Mayumi's family had taken antidepressants, she herself was hesitant. She explained:

I think I found ways to cope where I don't need the medicine. Um, and it's kinda scary, like, I know a lot of people—my sister had tried it ... and she was kind of like a zombie. And I don't wanna be like that.

Mayumi does not specify in what sense her sister was “kind of like a zombie,” but the comparison is evocative. Zombies are animate but insensate; they cannot exercise human volition, driven instead by blind compulsion. Zombies are, to put it mildly, no longer themselves. If medication carries a risk of zombification, no wonder Mayumi finds it scary.

In his article “Neurochemical Selves,” Rose (2003) has argued that psychiatric drugs “embody and incite particular forms of life in which the ‘real me’ is both ‘natural’ and to be

produced” (p. 59). This duality was a site of tension for interviewees who wondered, as Brent did, “whether ... the medicated me is the real version of me, or the unmedicated me is the real version of me.” Brent navigated this question in at least two ways. One tactic was to rhetorically limit the incursion of the medication upon the self—we might call this a minimizing discursive strategy. When discussing his initial misgivings about medication, Brent asserted:

I’ve since realized that it doesn’t ... change the way my brain functions, it changes the way my brain *interprets* things. So I’m still the same person, I’m still very logical, it’s just that—it tends to make me see the more positive aspect of things.

Taken literally, this justification is somewhat baffling: are *the way a brain functions* and *the way a brain interprets things* not intertwined, if not identical? But to quibble is to miss the point:

Brent is claiming that yes, medication has changed *something*, but it has not changed *him*.

Echoing Brinkmann’s (2016) paradoxes of diagnostic culture, Brent is still the same person—and yet not. As Rose (2003) theorized, the “real me” is both natural and pharmacologically produced.

A second, alternative rhetorical strategy is hearable in Brent’s sense-making. Here, he explains why he briefly stopped taking medication in high school:

I guess I was kind of struggling with the fact that I was taking medication to make myself feel normal. Like, it was—it kinda felt weird to me. And I mean, it still feels a little weird to me. But ... I try not to think about it ’cause I’m just happy where I am.

This approach does not attempt to explain, resolve, or minimize the “weirdness” of taking medication to change one’s subjectivity. Instead, we might characterize it as pragmatic: what ultimately matters is whether the medication is *useful* in living a good life. Brent himself connected this approach to the nihilistic philosophies with which he loosely self-aligned:

If nothing matters then I might as well just do the things that make me happy, and that includes taking medication. ... I think that, deep down there is no real us, it’s just kind of what we do that makes us who we are. And if taking medication makes me a happier person, then so be it.

Brent's account troubles not only the mythic *real* self but the moral supremacy of "the natural" over "artificial" interventions such as medication. Here we find ourselves in the realm not of zombies but of cyborgs: hybrids of organism and technology, "creatures simultaneously animal and machine, who populate worlds ambiguously natural and crafted" (Haraway, 1991, p. 149). Haraway argues that we have all become cyborgs, assemblages of cultural texts and information and technological systems. Agency arises in a distributed fashion amongst the actors and actants (humans and things) that comprise "us" at a given moment (cf. Latour, 1988). For at least one interviewee, Hannah, relinquishing control to medication constituted an agentic act. As she explained:

I would always fight against wanting to help myself, kind of. Like, in the bad times. So—just having medication has been able to, yeah, take that control away. Which—like, I always like control over everything. So, then, taking that, is better for me.

For Hannah, to take medication is indeed to relinquish control (as Anthony, quoted above, feared); however, for her, *giving up control* is an intentional choice. She *chooses* to ingest medication in strategic anticipation of future impulses. Her will has become shared, distributed between the self who ingests medication and the medication that insures her preferred ways of acting during "the bad times." This arrangement is not "natural"; it could be seen as cyborgic. For some, such hybridism is haunted by specters of pharmaceutical dependency and exploitation (e.g., Kirsch, 2010); for others, it may hold creative and emancipatory potential (cf. Laboria Cuboniks, 2018).

There is no easy or appropriate way to summarize the above discussion. Agency, control, choice, will, biology, selfhood, responsibility—for many students, these matters remain open sites of discursive *tinkering* (Mol et al., 2010), places where meanings remain improvised, uncertain, and unfinalized. Although some tensions were hearable, interviewees clearly

demonstrated that both receptive and agentic postures can serve valued self-understandings and the active pursuit of preferred futures.

Position D: Neither receptivity nor agency are important to addressing mental health problems. Similar to my response to the analogous (low x /low y) position in my first positional map, I initially thought Position D might constitute a site of silence. After all, what is left if neither receptivity to intervention (from without) nor agentic change (from within) are deemed relevant to overcoming mental health problems?

One possible way of understanding this position is as a “line of flight” beyond individual treatment or change efforts to collective or structural responses (such as the “healthy settings” approaches discussed in Chapter 3). Another interpretation is that this is a position in which even disruptive or painful mental-emotional states are accepted and accommodated rather than treated or overcome. In other words, a low-receptivity, low-agency position might reject the premise that mental health “problems” need be solved at all (echoing certain forms of critical disability discourse, also raised in Chapter 3). Hints of such a position are hearable when interviewee Geoffrey problematizes the “expectation that you should achieve happiness—y’know, you’re ill, and then you’re better.” Elaborating on this expectation, he explained:

Even though there’s so many people supporting mental health, there’s still also this [sense of] destination ... “well, Geoffrey, like, why are you depressed—you’ve been depressed for eight months.” Y’know, like—“why aren’t you better.”

Not only did Geoffrey critique normative trajectories and timelines (from ill to better in a timely fashion), but the binarization of “completely unwell and completely well,” suggesting that society must become more comfortable with the many people whose lives include heterogeneous, overlapping, and ongoing experiences of wellness *and* unwellness.

Relationally Situating Mental Health Sense-Making

“People do not acquire the languages needed for self-definition on their own.” (Taylor, 1994, p. 32)

Self-interpretation is not a solitary endeavor. As Taylor (1994) trenchantly observes, we are introduced to languages of self-understanding by people who matter to us. Such languages and meanings, including those related to mental health, are never finalized (cf. Bakhtin, 1935/1981) but continually negotiated in open-ended dialogue with the countless actors and actants that comprise our situation(s). Before concluding this chapter, I explore how the *social* flux of relationships, answerabilities, and position calls (Drewery, 2005) is made present in the accounts of two interviewees, Mayumi and Chris—and with what implications.

Meaning-Practice-Relationship Packages in Mayumi’s Account. The epigraph and guiding refrain of this chapter come from Kirmayer (1984): “The sufferer is a poet in search of metaphors adequate to express his predicament” (p. 249). While this formulation is elegant, we must not imagine this search as “shopping” for new meanings, picking up various expressions from a shelf and examining them for their perceived adequacy and usefulness (cf. Strong & Knight, 2012). Rarely do sufferers consciously search for *metaphors*; primarily, they search for *help*. Such help involves not only articulating their predicament to themselves but expressing it acceptably to others who may provide a caring response (whether intervention, advice,

sympathy, etc.). In other words, sufferers search not for meanings in isolation, but for *meaning-practice-relationship packages*.

This entanglement of meanings, practices, and relationships was particularly well illustrated in Mayumi's story.⁴⁵ Mayumi recalled approaching her family doctor as a teen, looking for "validation" of her amorphous, inexplicable sadness. She said that she hoped a diagnosis of depression would help explain her (invisible) experience of unwellness to others, concluding that it would be nice to have "a name for things." Mayumi did not explain how she had learned that sadness could be interpreted as depression, but it seems likely that this understanding was available within her family: she noted that both her father and grandmother take medication for depression (although Mayumi's mother, a first-generation immigrant from South Asia, responded to difficult feelings in decidedly non-medical ways).

In Mayumi's recollection, her doctor's response was noncommittal: "She was like, I can't really do anything for you ... 'cause I can't prescribe you drugs, um, but I can give you, like, a therapist, but that's it." Mayumi later elaborated on the significance of this moment. She had *wanted* a diagnosis—that is, an authoritative pronouncement—but was met with ambiguity. She had made a bid for the patient position, but her doctor failed to take up the corresponding doctoring position of authority, concern, and prescription. Mayumi's social expectations had been breached (Garfinkel, 1967).

⁴⁵ In working up my analysis of Mayumi's narrative, I needed to guard against certain "positivist recalcitrancies" (Clarke, 2005b, p. xxi): specifically, a temptation to analyse the events Mayumi described as *historical events* rather than as features of an account (an account worked up in a research interview with me, at a certain point in time, occasioned by my questions and preoccupations, etc.). I have attempted to remain discursive in my analysis—exploring how Mayumi positions herself and others in her account, and with what (narrative) effects—while still assuming that we can infer something meaningful about how others might have (historically) participated in Mayumi's evolving understandings of mental health problems in her life.

Following this disconcerting doctor's appointment, Mayumi recalled: "I kinda just let myself deal with it on my own." "Let myself" is an interesting formulation, invoking permission for something previously disavowed; perhaps Mayumi saw approaching the doctor as the *proper*, necessary, dutiful response. When the doctor breached her expected terms of engagement (take my concerns seriously; advise me on a course of treatment), Mayumi was released to explore not only alternative responses to her suffering (e.g., practices of self-care and self-assertion) but *alternate relationships in which to understand it*: in her case, through online communities such as Tumblr. To reiterate, this practical and positioning shift did not happen intramentally, but in relationship.

Later in the interview, Mayumi reflected that failing to receive a diagnosis at that time "was kind of distressing [*laugh*], right, when I was like, 'I don't know what I am ...'" The implicit promise that diagnostic systems can tell us *what we are* (cf. Brinkmann, 2016) might be especially tantalizing to a teenager. Although Mayumi said that she was "okay not having that label now," the certainty of medicalized discourse continued to exert a pull. She spoke of wondering recently whether she might have bipolar disorder rather than depression and acknowledged that "it would be kinda nice to have that reassurance [of diagnosis]." When I asked what stopped her from seeking diagnosis now, she invoked the previous breach:

I think it always goes back to, going to my doctor, and her being like "well, you can take medicine, or:: you don't have to take medicine; it's kind of your, your [choice]." Um, and—I just kinda ... my doctor's far:: [*laugh*] from where I live, and I don't wanna go there just to have her to say that. Where I can just kind of ... cope with it myself.

Again, it is not exactly the legitimacy of medical-diagnostic discourse that has been undermined for Mayumi, but its exclusivity and urgency. She no longer considered her doctor a definitive authority on emotional matters. Even in the advent of new "symptoms," Mayumi took a position

of relative indifference toward medicalized discourses and experts; she seemed content to look elsewhere for responses that suited her (and were closer to home, in multiple senses).

Another meaning-practice-relationship package that Mayumi introduced in her story was psychotherapeutic. She recounted that in junior high and high school she had few friends and was self-harming, depressed, and suicidal. According to Mayumi, when her mother and sister found out that she was cutting, they “kind of dragged me from therapist to therapist, but I didn’t really like it.” She described feeling like the therapists were “looking down on me” or judging her, and as a result she would “automatically get defensive” and become reticent. Mayumi identified a particular line of therapeutic reasoning that would instantly threaten any rapport:

[*Laugh*] Um, I’m very protective of my family. And so as soon as [counsellors] start attacking, like, “oh, well, d’you think it’s your mother? That’s why you’re like this?” Like, “or is it ’cause of your father or your sister and that’s why you’re like this,” and I don’t like—like, don’t talk about my family! [*laugh*] Like, I love them, and ... there might be some issues there but, um, I don’t wanna blame them. I know they’re trying as hard as they can to help me, an’, throughout life, just to be as best as they can be. Like, they’re not who I want to be focused on. Um, and, like, feel like I have to defend.

Mayumi recalled seeking support at a campus counselling centre and feeling like the counsellor was “attacking” her and her cultural background (e.g., her large multigenerational household), hijacking Mayumi’s priorities with the counsellor’s own agenda:

It felt like I was trying to talk about one thing and then, when I mentioned something that branched off of that—she, like, took it and ran with it. When that’s not what I wanted to talk about or, like, what I needed help with.

All too often, it seems, Mayumi experienced counsellors as adopting an expert, investigatory stance that she found alienating, particularly when an inspecting gaze was cast upon her family. Once again, this was not some abstract, *a priori* objection to the meanings and practices of counselling (e.g., psychodynamic theory; practices of assessment and case conceptualization).

Rather, Mayumi's rejection of certain meanings and practices became salient in her situated and specific *relationships* with particular counsellors.

I do not wish to give the impression that Mayumi was “resistant” or impossible to please.

On the contrary, she had a clear (and reasonable) formulation of she might have wanted:

I think it's what all teenagers want? Is just to be listened [to] and to feel like ... what you're feeling is normal and, um, okay and valid and that it's gonna get better. Um, 'cause I really thought that things weren't gonna get better, and that life was gonna just, like, stay shitty [*laugh*]. Um, but it's not shitty any more. So, I think I just needed, like, some confirmation—someone saying, like, “it's okay, like, you just need a hug” [*laugh*].

Here and elsewhere, Mayumi aligned herself with a discourse that I might call “normalizing self-love,” in which mental health problems are dimensional (i.e., located on a spectrum of emotional experience; Cromby, Harper, & Reavey, 2013) and most fundamentally require compassion, connection, and flexibility. Seen this way, turning points may not involve professional intervention, but attunement to one's emotional needs and values as a situated, relational being.

Switching high schools was one such turning point for Mayumi, which she described in this way:

I think I was just so fed up with feeling so sad and gross and ... I like being around positive people and I like being positive, but that was just impossible to do there. And I was like ... I can't do this. It's either stay in this school and feel sorry for myself and, like, worst comes to worst, like, commit suicide ... or, I'm gonna live my life and live it in the best way that I could. And ... I chose the light, I guess you could say [*laugh*].

All this said, Mayumi did ultimately find a counsellor with whom the constellation of meanings, practices, and relationship proved an excellent fit. This counsellor, Mayumi said, listened in ways that made her feel comfortable, “like talking to yourself in a mirror”; rather than digging for root causes, he taught Mayumi to notice and name symptoms of anxiety and helped her observe how day-to-day events in her life connected to her mood. Perhaps counterintuitively, Mayumi was best helped by a professional who paid little attention to her systemic context

(specifically her family dynamics) and instead worked in what sounds like a relatively short-term, skill-based, psychoeducational fashion.

A final observation about Mayumi's talk is that, perhaps more than other interviewees, she signalled some critical distance from her sense-making, occasionally treating her meanings as contingent or pragmatic rather than as straightforward truths. For instance, she oriented to a passage in my informed consent document (see Appendix C) in which I mentioned "running in the family" as an example of discourse that could be deconstructed (though not necessarily delegitimized). Mayumi reflected:

It's easier to say that it's depression I kind of—viewed it like that. 'Cause my grandmother and my dad and now me and, like, to some extent my sister, um, all deal with these things. So ... it makes it easier to not fully blame myself, for these feelings that I'm having. Which is kind of nice to have a scapegoat [*laugh*].

Here, Mayumi seems to orient to the *authenticating* capacities of hereditary or medicalized discourse, that is, its usefulness in establishing the subjective truth of one's identity to oneself (West, 2019). She later adds its *legitimizing* functions (West, 2019), that is, its power to sanction her occasional bids for the sick role (Parsons, 1964):

I kinda need that label to kind of explain why I feel sad for no reason. Or, like, feel this need to not wanna get out of bed every so often. Um—to just say that is kind of easier. And as mental health is getting more attention and becoming more normalized, I think it's easier to say that I need a mental health day. I need a day to just like, watch Netflix all day [*laugh*].

Mayumi presents her sense-making as both socially and historically occasioned ("mental health is getting more attention and becoming more normalized") and pragmatic ("to just say that is kind of easier"). Nonetheless, she continues to treat her self-understandings as valid, even if they are contingent and unauthorized. Having failed to find a (relational) foothold in medical or

psychological discourse, Mayumi had discovered a discursive community in which mental health identifications and needs can legitimately be *self*-asserted.

Positioning and Counter-Positioning in Chris’s Account. As noted earlier, some of my interviewees seemed relatively stabilized in their understandings of mental health concerns (e.g., they were caused by a chemical imbalance; they were an impetus to change). However, there were also moments in which interviewees seemed to be sense-making “on the fly,” perhaps expressing something novel or tricky. Chris was an interviewee whose self-positioning seemed a little less settled; her understandings of past and ongoing emotional difficulties remained underdetermined, pluripotent. Chris’s “trying on” of different meanings during our conversation was not a hermetic cognitive exercise; her interpretations emerged in dialogue not only with me, but with internalized others (Tomm, 2014) to whom she ascribed both welcome and unwelcome positioning moves.

After I began our interview in my usual open-ended fashion (cf. Appendix D), Chris unexpectedly oriented to the phrasing I had used in my recruitment and informed consent materials: “something that you (or others) might consider a mental health problem” (see Appendix A, para. 2). She mused:

I was thinking—like, a lot of the stuff that people’ve told me, I just—I disagree with. I’m like, no, I’m completely fine in that regard. And then I’m like—okay, maybe I’m biased? And this has actually started something that I would consider [*small laugh*] actually is a problem, and that people have noticed—is I’m like, extremely anxious all the time.

She explained that her increasing worry about how people might perceive her—for instance, worry that they might perceive her physical mannerisms as odd—creates a vicious cycle in which her mannerisms become amplified, as does the attendant worry.

One person Chris implicated in this amplificatory loop was her mother. Chris recalled negotiating meanings and subject positions with her mother:

I didn't think it was a problem; I thought, okay, everyone's just ... like, I'm just being analytical. Um, and then my mom kinda stepped in and was like, "you:: need to calm down"; ... she said I seemed anxious, and I was like—to me, anxious is, like, jittery and stuff, right? And she's like, "No, no, I mean like, psychologically, like—you're anxious, like you're in a cer-, a constant state of being anxious of things."

Although Chris initially rejected her mother's attempt to position her as anxious (pointing out that she was not "jittery and stuff"), her mother doubled down on the initial positioning effort, putting forth a revised, psychologized definition of *anxious* that presumably better matched Chris's mien.⁴⁶ Although Chris does not wholeheartedly endorse her mother's positioning attempt, neither does she fully reject it; throughout the interview, she returns repeatedly to a mode of ambivalent second-guessing around the question of how to interpret her ways of being in the world—and, by extension, herself.

Chris described similar interpretive tensions with her boyfriend, with whom she had recently moved in. Her account offers evidence that, in situations of conflict, diagnoses can be deployed and experienced as accusations. After an argument during which Chris's boyfriend had yelled at her and she had responded dispassionately,

He said all my responses were formulaic and robotic. And he was like, "I think you have sociopathic tendencies ... you can't empathize with other humans and register with them." And then I thought about it, and—that thought didn't make me feel [*laugh*] sad or happy or, confused; I just didn't really think anything of it. And then that worried me. I was like ... should I not feel upset that someone's telling me that I can't empathize with other human beings? Why don't I feel that way? And then—I, like I couldn't sleep last night, because I was ... just going through all these things.

⁴⁶ Chris reported that her mother had spoken to her own doctor, who pronounced: "I can't diagnose anyone without talking to them but it sounds like your daughter has high-functioning social anxiety." This opinion, disclaimed as diagnosis but nonetheless carrying the weight of expertise, may have bolstered Chris's mother's confidence in her positioning efforts.

Although Chris subtly resisted her boyfriend's right to position her in this way (elsewhere, she sarcastically remarked that this was "really sweet of [him] to say"), she was nonetheless disturbed, losing sleep over whether her reaction to his accusation was *normal*. She had initially rebuffed his positioning attempt, but not without being changed by it. Humans (of which Chris is certainly one) are interactive kinds (Hacking, 1999); we *respond* to efforts to classify us, particularly by people whom we care about. Chris's options are unenviable: accept her boyfriend's bid to pathologize her (and what then?), strongly reject his bid (potentially straining the relationship), or hover in an undecided discursive space, searching for other possibilities. Chris summarized her predicament thusly:

I think he's used to people being really ... passionate, maybe. And I'm more reserved. So—
[*laugh*] ... But yeah, he, he thinks I'm a sociopath [*laugh*]. I think I just ... worry a lot. Which my
mom attributes to anxiety. So, [*laugh*] yeah.

Chris finds herself at a discursive impasse: a three-way *differend* (Couture & Strong, 2004). Her laughter might mark the situation as absurd, or perhaps signal that she has no idea how to resolve it. When describing yet another proto-pathologized characteristic, a repetitive arm movement when she is socially uncomfortable, Chris noted that she herself had been concerned about this unusual quirk, although this concern existed in tension with her observation that "it's not hurting me or anything" (her boyfriend, on the other hand, had been "quite persistent that it's a problem"). Chris expressed worry that psychiatric assessment could reveal "some kind of underlying strange problem" like Tourette's, which she reasonably feared would mark her as "weird" (compared to increasingly socially acceptable diagnoses like depression or anxiety). I asked her about the opposite possibility: what if a doctor "diagnosed" her arm movement as simply a strange habit that she had fallen into, but nothing diagnosable or concerning? She responded, "I don't think I could feel reassured [*laugh*] even though it's a medical professional telling me," explaining, "Any time I did it, I think ... [my boyfriend] would still consider it strange. And then I would be thinking, 'okay, maybe, maybe this is a misdiagnosis, like,

maybe I am weird; maybe there's something, going on.'" In other words, Chris's anticipation of her boyfriend's persistent concern shapes her own sense of what explanations she could accept; in no scenario could this odd but harmless habit remain unclassified and anonymous. Once the pathologizing gaze has been invoked, it is difficult to shake.

In some ways, we can imagine that Chris might find it easier to simply accept the diagnostic positioning bids of her mother and (perhaps) her boyfriend. Shared discourse can *settle* matters, and such settlement can make life easier. Chris was not (yet) prepared to do this, at times mounting spirited resistance to others' efforts to pathologize her:

I think people should butt out. [*laugh*] But, I get it, they're concerned. But it's like—y'know. I'm, I made it this far. And I think I'm doing okay. And, sure, I have days where I can't function, like, because I'm just too—I guess anxious is the word, like, to leave the house ... and so I agree [*unclear*] with my mother, maybe in that regard, maybe I do have some kind of anxiety. But—other things, I'm, like, y'know—I still do get out of the house, and I still live my life; like, I'm paying my bills, I'm doing my job, I'm happy sometimes—and maybe I'm sad sometimes too, maybe sometimes I don't feel anything. But I think they're just trying really hard to diagnose [*laugh*] the human condition, and they're not really ... uh, is anyone really qualified to do that?

Given my sympathy for critiques of (over-)medicalization, this could be a powerful note on which to end my discussion of Chris's account: a rousing stance against psychiatric totalization, a bid to embrace the human condition in its full complexity. But to end on such a resolute speech feels disingenuous, knowing as I do that Chris did not linger in such convictions; true to form, she stepped back into tensions.

We might more appropriately leave Chris where we first encountered her: testing out and talking through meanings within a messy, discursively pluripotent, material-relational *situation*. Chris explained that her self-understandings can change depending on the circumstances in which she finds herself. For instance, if she receives a bad mark that seriously affects her final grade, she might feel that she "can't ... get past, like, these labels of mental health issues and that

... I am indeed, like, someone living with this kind of problem.” In such moments, she might conclude that “everyone’s right, like, I should just go get help first and then come back, and ... take a mental health break, ’cause I clearly need it—like, I can’t function properly.” If, on the other hand, she does poorly on an assignment that has less impact on her final grade, she can usually maintain an even emotional keel, associated with a different self-interpretation:

I’m like, y’know ... I’m doing fine. Like—and maybe I do have those issues, but I’m able to overcome them and continue. So I think it does definitely affect my outlook of who I am as a person and how I react to other people. So—I’m not sure if it—yeah. I’m not sure if it’s, um, concrete yet.

Given that people in her life express their concern for her via medicalised discourse, Chris remains answerable to it. At the same time, she continues to find ways of articulating a more normalized sense of who she is in the world. This tension may not resolve into something “concrete” for some time; perhaps it does not need to.

Conclusion

In this chapter, I mapped ways in which postsecondary students discursively construct mental health problems in their lives, as well as discursive postures from wherein students respond to said problems. The juxtaposition of biological and biographic discourse and agentic and receptive postures create a range of heterogeneous positions, which—whether understood with reference to SA (Clarke, 2005b) or to positioning theory (Davies & Harré, 1999)—carry resources for self-understanding (authenticating) and self-assertion (legitimizing; West, 2019). For interviewees who settled into particular discursive positions, these resources generally worked well. If the resources did not work so well, the interviewee was likely to position themselves elsewhere.

Sometimes, one discourse “sticks” over an equally plausible discourse. For instance, Hannah, who cited antidepressants as indispensable to her recovery, offhandedly mentioned that she started medication just as she moved across Canada for university, putting her “in a completely different environment than when I was back home.” Conversely, Sabrina, who credited a semester abroad with dissolving (Anderson & Goolishian, 1992) her depression, happened to mention that she became depressed around the time she started taking birth control. Shrugged Hannah: “It’s kind of like I started medication as I started a different part of my life.” Shrugged Sabrina: “Eventually I just, like, stopped [taking birth control]—around the same time I left for Italy, actually, so I don’t know if that correlates or not.” Each young woman treats the alternative explanation as plausible but extraneous. Mental health problems have been called over-determined: “A single observed effect is determined by multiple causes at the same time (any one of which alone might be enough to account for the effect)” (Cromby et al., 2013, p. 351). A discursive perspective might add that a single observed effect can be constituted via multiple discourses at the same time, any one of which alone may feel sufficient to account for the effect (cf. Lock & Strong, 2012).

Consistent with tenets of SA, interviewees were not pinned to a particular discursive position, allowing analysis of movement around the maps. With thanks to Daniela, Carl, Mayumi, and Chris, I demonstrated, first, that students move across and mash up biological and biographic positions and, second, that students undertake self-interpretation not in the abstract, but through packages of meanings, practices, and—crucially—relationships. Particular sites of trouble, on both positional maps, involved the relation of mental health problems to morality, agency, and personal responsibility. As we will see in the next chapter, these quietly controversial concerns constitute sites of near-silence within institutionally produced documents.

Chapter 6: Relations and Conversations between Situated Elements

“Do research things like this actually influence the university’s decisions? ... ’Cause I al-, always find there’s a disconnect between what is actually, like, [what] the people in charge are doing, and what the students are complaining about. ... If they’re in the same environment you’d think there would be, almost like, at least a little bit of similar mindset? But sometimes it’s, like, so far off.” (Charlotte, interviewee)

In many ways, the preceding two chapters offer markedly different stories about student mental health. In Chapter 4, I explored how different logics are enacted in campus social worlds. Inspired by Mol’s (2008, 2010) organizational ethnographies, I posited that some goods may be less marketable or rationalizable than their dominant counterparts, but nonetheless matter in the situation. An individual or collective actor’s pursuit of alternative goods—goods of dissent, of reckoning, of multiplicity, of *care*—may bring them into tension with campus-level imperatives of community, wellness, strategic impact, or standardization. At some times, such tensions lead to advocacy and protest; at others, they simmer as an inchoate sense that something important is being lost or obscured.

In contrast, in Chapter 5 I shifted “downward” to the specifics of students’ local self-interpretations: Through what discursive positions do students make sense of distress and emotional disruptions in their lives? Here, I was thinking with a different set of theoretical influences—for instance, Brinkmann’s (2016) cultural psychological study of how people use diagnoses in relational and self-interpretive activities. At first blush, my interviewees’ deeply specific accounts of suffering and struggle seem to have little to do with the flurry of campus activity around *student mental health* as an institutional priority, challenge, and opportunity. As interviewee Charlotte muses in the epigraph, there is a disconnect.

It might be tempting, at this juncture, to dutifully report what my student interviewees were “complaining about” in relation to campus mental health (and, indeed, there were some

complaints). Although such reporting may have been what Charlotte had in mind, a realist record of “what interviewees said” would flout the interpretive epistem-ontological framework in which I have been working. In SA, the “disconnect” itself demands careful study. Analytic *work* must be done to relate different levels, actors, and elements. In this penultimate chapter, I will sensitize readers to several new tensions derived from the juxtaposition of my literature-, document- and interview-focused analyses (Chapters 3, 4, and 5). What might students, institutions, and experts or researchers be *saying to each other* through these chapters?

To produce the analysis that follows, I returned to my situational maps: messy, freeform depictions of any and all elements that co-constitute the situation. Using one of my data-informed situational maps, I undertook a series of relational analyses (described in Chapter 2) by drawing lines from one element—*students*—to other elements and memoing about the relationship represented by the lines (illustrated in Figure 9). Informed by my prior analytic work and my data, I considered what different elements might “have to say” (Clarke, 2005b, p. 103) to and about one another: how they construct, alter, and stabilize one another (Mathar, 2008).

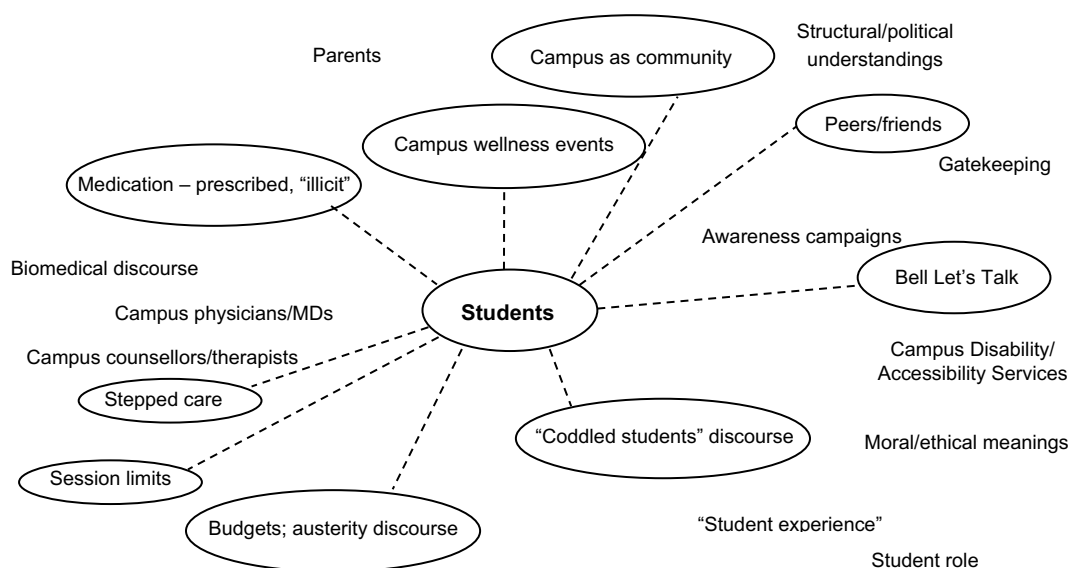


Figure 9. Demonstration of a messy situational map informing relational analyses.

As Mathar (2008) points out, relational analyses carry the risk of misleadingly rendering “elements” monolithic and monologic. As should be clear from Chapter 5, *students* cannot be treated as a discursively homogeneous group, nor can my 10 interviewees be taken to represent the positions of all students. For this reason, I consider relational analysis a generative and sensitizing activity rather than a representational one. When considering the lines between *students* and other elements, I did not ask how *all* students, nor even all students I interviewed, related to that element. Instead, I memoed *different* ways in which my interviewees related to that element, attending preferentially to sites of divergence or tension. From this empirical and analytic work, I selected four lines of variation (and possibly tension) that I deemed newsworthy, that is, potentially consequential for variously situated actors and stakeholders. Is student mental health a public or private concern? Is the university central or peripheral to student problems? Are student problems personal or political? Should helping be spontaneous or structured? My goal is not to answer these questions, but to identify and substantiate them as sites of unsettled multiplicity, sites that may demand ongoing negotiation and tinkering (Mol et al., 2010; Oute & Rudge, 2019). I conclude by discussing a possible site of silence in campus documents—the moral domain—and suggesting that even students who do not take up explicitly moral languages are engaged in “projects of moral becoming” (Mattingly, 2014, p. 20).

Student Mental Health as a Public or Private Matter

As its name suggests, the Bell Let’s Talk mental health awareness campaign revolves around “talking,” a word whose meaning is variably constructed within campaign texts. In some materials, “talking” and “starting a conversation” are implicitly located within specific interpersonal relationships and, crucially, also involve listening (plus kindness, sympathy, helping, and “simply just being there for people you care about”; Bell Canada, 2017, Listen and

ask). Elsewhere, “talking” and “joining the conversation” are rendered functionally equivalent to tweeting, texting, or posting the #BellLet’sTalk hashtag—arguably a severely emaciated (not to mention corporately self-serving) understanding of *conversation*.⁴⁷ Regardless of how *talk* is understood, Bell Let’s Talk has taken up and extended a logic wherein mental health problems *must* be talked about—and wherein the alternative to talk is “silence,” which the campaign discursively equates to stigma, shame, and suffering (Bell Canada, 2017).

This logic was taken one step further by the 2016 CMHA Mental Health Week—funded, in part, by Bell Let’s Talk—via its slogan “GET LOUD” (CMHA, 2016). Once more, campaign materials offer multiple articulations about what it could mean to “GET LOUD for mental health.” Some recommendations dovetail intuitively with an ideal of *loudness*; for instance, citizens are exhorted to petition their elected representatives for more and better mental health services (“Don’t stop at seeking help. Demand it”; CMHA, 2016, #5). Other constructions strain the metaphor: for instance, “Now’s the time to Get Loud with your family doctor” (CMHA, 2016, #4), or “Get Loud and be that friend” (CMHA, 2016, #3). In the latter case, the image of *loudness* seems particularly at odds with the advice that follows: “Be that friend who opens up the conversation. You can start by simply asking ‘How are you, really?’ Offer to listen without judgment. And offer to do what you can to help” (CMHA, 2016, #3). The intimate and gentle quietness of this scene is sacrificed to the imperative of building a cohesive campaign brand: “GET LOUD.” In some campaign materials, the phrase is entirely untethered from meaning and content: One video (CMHA National, 2016) consists exclusively of “on-the-street” clips of

⁴⁷ Consistent with industry conventions, such tweets, texts, and shares are somewhat euphemistically called “interactions,” “engagements,” and “messages of support,” although interaction and engagement *with whom* and support *for whom* remains unspecified.

diverse pedestrians exclaiming “Get loud!” or “Get loud for mental health!” ad absurdum (35 times, by my count). Unlike *talking*, which at least presumes the possibility of conversation, *loudness* is the domain of shouting, announcing, insisting, demanding: the domain of one-way, and necessarily simplified, monologue.

At the risk of belabouring the point, to the terms *talk* and *loudness* I will add one more putative good: *noise*. Jack.org, a youth-focused Canada-wide organization whose “vision is ‘*No More Silence*’ on the subject of mental health” (Jack.org, 2017, para. 4), organizes an annual conference called “Unleash the Noise” (Jack.org, 2017, Our history, para. 8). One campus Jack.org chapter stated their intention “to create a sustained, year-round noise for mental health in our university” and “to engage everyone in the conversation on mental health through loud, positive, and fun initiatives” (Arts and Science Federation of Associations, n.d., “Jack.org,” para. 1). Here we find a very specific normative vision of how mental health should be done on campus: loud, positive, and fun. Although I do not wish to caricature the group—of course they are making claims about mental health, not simply screaming—the foregrounding of “noise” advances a sense that truths of student mental health, having been established beyond question or debate, must simply be *heard* by those who are not paying attention. The goal of “a sustained, year-round noise” constructs mental health as a properly *public* social problem (Spector & Kitsuse, 1977/2011), one that must be brought out of the silence and into the open.

At this point, I invite readers to take a deep breath and mentally re-locate to a small, quiet meeting room on the U of C campus, where I am nearing the end of my interview with Charlotte. She is trying to express her thoughts on certain campus mental health activities. Here is an excerpt from our conversation:

Charlotte: I've always hated those weeks where they're like, "We're doing a week about mental health"—I always have hated those. Or, like, [*overlapping speech*] I remember we used to have, like—

Karen: [*overlapping speech*] Can you clarify what, what you hate about them?

Charlotte: I think that they try to be heard? They're tryna shove information in a week. But it's, like, it's an ongoing thing. ... They try to showcase it in a way that will catch attention, one that will be understandable, but, like, mental health isn't easy to understand. It's not something to catch attention.

Later, Charlotte muses: "I think, just, their approach, they—they basically do it so loud, almost."

Loud, easy-to-understand, attention-grabbing: To Charlotte, this bombastic style has little to do with the subtle heterogeneities of day-to-day mental health struggles. She went on to express concern that splashy, highly visible initiatives, despite good intentions to normalize and destigmatize mental health problems, may be missing the mark of students' actual needs. As to what those needs might be: Charlotte recalled once noticing, in a bathroom stall, small cards printed with mental health resources. "It's the bathroom," she remarked appreciatively; "It's private, you just grab one, no-one knows." Read through dominant mental health discourse, a preference for secrecy and "silence" reflects an underlying shame that must be challenged. However, an alternative reading of Charlotte's account is that students might legitimately understand mental health concerns not as shameful, but as *private*.

In some ways, of course, campuses treat mental health problems as eminently private. Conversations with counsellors or doctors are protected by formal confidentiality arrangements. However, universities have good reasons to distinguish between privacy (framed as professionally managed confidentiality) and what they might consider *secrecy*, that is, choosing to keep one's suffering to oneself. The latter carries risks: perhaps chiefly, that the university could be unaware of a student who is considering suicide. One viral online article I analysed,

“Split Image: Instagram account of University of Pennsylvania runner showed only part of story,” emphasizes the possibility that students’ happy self-presentations can hide “the reality of someone struggling to go on” (Fagan, 2015, para. 1). Within the logic advanced by this tragic story, outer appearances and even the student’s own reassurances cannot necessarily be trusted; secret and potentially lethal emotional pain could be hidden within any student’s subjectivity. Faced with this spectre, it is little wonder that campus discourse urges students to “go public” with their distress, at least to their doctors.

Despite the insistence of such messages, students may have other ideas about whether they can be trusted to manage distress on their own terms. One interviewee, Hannah, remarked: “When I decide I want something to be personal, I don’t like to spread that at all.” She elaborated:

Media representations, like, when they try to spread awareness about it, ... they kind of represent it in this one stereotypical way—where it’s, like, a cry for help. Whereas I didn’t want the help. I just wanted it to be my own thing.

Conventional (and professional) wisdom would suggest that Hannah was neither able nor entitled to decide that she did not want help, given that at the time she was describing, she was a minor who was self-injuring. However, during our interview Hannah did not retroactively frame her teenaged preference for privacy as misguided or uninformed. Indeed, by her account, she sought help when it was necessary—by her own standards—and not before. She positions herself as someone who, even as a child and teenager, was relatively “literate” in mental health knowledge but did not feel particularly beholden to its imperatives.

In the Healthy Minds Study referenced in Chapter 3, “I prefer to deal with issues on my own” (Eisenberg et al., 2018, p. 78) is students’ most commonly-endorsed reason for not seeking mental health treatment. As I have noted above, this preference is frequently dismissed and

invalidated, sometimes from a position that “people with mental health problems may not be in a position to make rational decisions about help seeking” (Eisenberg, Hunt, & Speer, 2012, p. 223). Hannah’s self-positioning suggests that some students might experience such assumptions as paternalistic and intrusive, even if, like Hannah, they *do* ultimately seek treatment. The same students might resent imperatives such as “regular, automatically scheduled emotional wellness check-ups” (Eisenberg, Speer, & Hunt, 2012, p. 713), no matter how well-intentioned. In pointing this out, I am not advocating for universities to simply leave students alone, nor to (re-)adopt an attitude that their coping is, as Furedi (2017) huffs, “a personal matter” (p. 55). I am merely suggesting that goods of openness and privacy remain contested and that some students, if exhorted or commanded to talk (not to mention to get loud and make noise), may shrink in the opposite direction.

In a related vein, it is increasingly valorized not only to speak publicly about mental health, but to tell one’s own mental health story, thus “finding one’s voice” (cf. Small, 2013, para. 1) or becoming a “mental health champion.” “Speaking out on mental illness” makes you “a total badass” (Holmes & Williams, 2015, para. 1-2); an online article dubbed the late actress Carrie Fisher, who often spoke publicly about her diagnosis of bipolar disorder, an “O.G. Mental Health Hero” (O.G., an abbreviation of “original gangster,” is a slang term signifying respect for a pioneer or early leader; Holmes & Williams, 2015). Beyond an increasing cultural appetite for confessional and therapeutic modes of public self-narration (Illouz, 2008; McLaughlin, 2012), such storytelling is enshrined within mental health logics as central to peer-to-peer and contact-based education (Jack.org, 2017).

Going public with one's struggles, loud and proud, may be lauded as courageously resisting the "spoiled identity" (Goffman, 1963/1986) that is definitive of stigma. One interviewee, Mayumi, quietly gestured toward this logic:

I don't wanna be ashamed ... 'cause it is something that is so part of me. ... I wanna be proud of who I am. And if depression is a part of me—it's not that I wanna be proud of my depression, but it's something I don't wanna hide.

A slightly different, though not incompatible, position is articulated by interviewee Hannah. Discussing how she represents herself and her psychiatric diagnoses to friends, she concluded: "For the most part I just, I don't mention it. Not because I'm embarrassed, but it's like—you wouldn't go, 'Hi, I'm Hannah, I have diabetes.' Like, it's [*small laugh*], it's not something they have to know."

For all the concern that medicalized discourse might stabilize and essentialize pathological identities (Avdi, 2005; Barker, 2002), Hannah—who drew strongly on biomedical discourse and responses—seemed disinclined to feature her diagnoses in public self-presentations. As she explained:

I think ... since I am so much better than I was? It's kind of like I almost just forget about what happened. Like, it's in the back of my mind but ... it's not something I choose to make vivid memories of.

As I reflected on Hannah's sense-making, I was struck by a unique affordance of privacy. To declare oneself publicly as someone living with a mental health condition is to anchor oneself to a particular label or narrative. Generally speaking, the broader the audience with which one shares the narrative, the more stabilized or persistent it will be (cf. White, 2007). In contrast, therefore, keeping one's emotional difficulties close to the chest might permit a greater degree of flexibility in self-understandings and self-presentations.

To support this claim, I share another anecdote from Hannah, this one from her childhood (grade five). She had been telling me about what she understood as an early bout of unhappiness or depression, which ended following a turning point at a school dance. In brief, Hannah said she realized at the dance that she was not having fun—consistent with her self-understanding as miserable—but that because her classmates had not noticed her misery, she could do something spontaneous and joyful without raising questions or attracting inspection. In her own words:

I kind of had a view of what my personality was like, but inside my head. And so, other people didn't know that; they just saw me for, like,what I've always been. Kind of like, [an] extrovert and stuff. Um, so I was like, "It's not like they're gonna be like, 'Oh, Hannah's changed.'" So I was like, "just do it."

In Hannah's story, keeping sadness private was what ultimately allowed her to let it go. Her account subverts a common plotline of mental health discourse, in which positive expectations about a person (that they are extroverted, happy-go-lucky, etc.) can result in a burdensome "false front" behind which suffering is hidden. The normative arc calls for the reveal and validation of the authentic, suffering, hidden identity. Because of Hannah's intense preference for privacy, this arc seemed to hold little appeal to her; by her account, keeping her feelings to herself permitted her to experiment behind-the-scenes with different ways of being in the world.

Although Hannah was particularly keen to keep her own counsel, other interviewees also oriented to the freedoms of flexible self-understandings. Reflecting on his journey through and beyond depression, Anthony remarked:

I think a lot of [what] was holding me back was just this idea that I was, like, something rigid. And so now, um, I'm more open. And that helps me adapt to problems better, I feel like. Like, ... when I was getting over it, I had to let go of who I thought I was. 'Cause I used to view myself as, like, this shy person, and ... after kinda, like, re-wiring myself, I figured that, like, who I am is actually a really fluid concept. So, I can decide who I wanna be, whenever I wanna be. ... The way I view myself now is that, ... instead of, like, a rigid rock, I'm more like Play-Doh and I can just be moldable in different ways that [are] suitable for me.

To talk is to commit oneself, however temporarily, to a particular version of reality; to talk publicly or loudly is to amplify this commitment. But, as Anthony suggests, there may be value in noncommitment, that is, in openness, emergence, and unfinalizability. Even as universities embrace loud, fun, declarative modes of mental health activism, it may be worth keeping in mind that quieter and less definitive modes of engagement, while ill-suited to slogans and chants, may offer worthwhile goods of their own.

The University as Central or Peripheral to Student Mental Health

For *student* mental health to exist as a social problem demanding targeted action, claims-making activities must distinguish it from the *general* social problem of mental health. Much of the scholarly, institutional, and popular discourse on student mental health thus foregrounds characteristic concerns of the student role: pressure, perfectionism, competitiveness, debt burden, loneliness, and so forth (e.g., Scelfo, 2015; Walker, 2015). According to one widely-shared article, “Over half of students are wrestling with the ‘*what-if-I’m-not-good enough, ’ nail biting, running scared and no-room-to-breathe kind*’ of stress (Costa, 2015, para. 2). When the NCHA reports that in the preceding year nearly 90% of students felt exhausted or overwhelmed by all they had to do (ACHA, 2016), there is a tendency to interpret these claims in relation to studenthood (a term I borrow from Warmington, 2002). Additional claims-making focuses on sub-types of students deemed particularly vulnerable, at heightened risk, or strategic targets for intervention, such as first-year and transfer students, indigenous students, international students, and sexual and gender minority students (U of A, 2015).

Given the understandably student-centric nature of discourse on student mental health, I was struck by how peripheral the tasks and pressures of studenthood seemed to my interviewees’ narratives. Studenthood was certainly present—exams were failed, scholarships were lost,

majors were questioned, parental disappointment was dreaded—yet none of my interviewees seemed to be telling a story of *student* mental health problems. Their status as students was part of their situation, but generally not its crux.

In some ways, this is unsurprising; no-one would expect individual stories to conform exactly to a stock narrative about student stress and distress. Nonetheless, it is worthwhile to consider the extent to which the defining features of my interviewees' accounts would be left out by interventions designed to “target” them. Interviewee Carl, for instance, had recently arrived in Canada from the Middle East. If he were to attend a mental health workshop for newly arrived international students, he might learn some useful tips about managing culture shock, perhaps even in relation to parental expectations; however, such tips would hardly match the agony and ambivalence of his forbidden, fraught romantic relationship. If interviewee Chris had perused online psychoeducational resources about homesickness and loneliness, she may have found them interesting, but they would not speak to the anguish of being suddenly ostracized by a trusted family member. Creating standardized narratives unavoidably prunes a thick experience into a thin one that is, in Geoffrey's words, “easily digestible.” The first details sacrificed may be those that seem less definitive of the *student* experience. As a result, stakeholders can forget not only that students are dealing with much more than academic pressures, adjustment, and normative challenges of young adulthood, but that even these “common” forms of suffering arise in utterly unique and situated ways for each person who endures them.

Students' emotional problems are not always about school. However, schools are increasingly concerned with making students' emotional problems their business. Institutions stake a claim to “the whole student experience, including the physical, socio-economic, emotional, spiritual, political and cultural aspects of life and learning” (U of T, 2014, p. 33),

coming to resemble *total institutions* (Goffman, 1961) that envelop all facets of students' lives (Fitz Gibbon, Canterbury, & Litten, 1999). A growing range of campus services have come to be considered "essential," encompassing housing, health, meals, financial aid, and counselling, plus cultural enrichment, community-building, entertainment, recreation, and so forth (Ciobanu, 2013). Such services are not only considered a crucial "differentiator in today's higher education marketplace" (Murphy, 2015, Key Takeaways, para. 1), but supportive of students' "academic, emotional and social connection with the institution at cultural level" (Ciobanu, 2013, p. 170). Increasing the university's perceived or actual relevance to multiple aspects of students' lives may translate to "engagement" and thus retention and alumni giving (Kahu & Nelson, 2018; Rau & Erwin, 2015). More critically, Bousquet (2012) echoes the notion of a total institution when he observes:

The smoothly functioning campus is a post-Fordist company town, with a churning pool of self-subsidizing cheap labor that takes loans to spend in the company store, voluntarily poses for company marketing materials, pays for the privilege of serving as a "brand ambassador" for the campus, and so on. (p. 65)

My interview data suggests that, at least in relation to mental health, this aspiration is less completely realized than institutions might hope. Many non-student identities, relationships, and commitments remain relevant to students, and their distress may or may not pass through the purview of campus services. Even if it does, such services may prove a poor fit: Both Anthony and Mayumi found their sessions at the campus counselling centre alienating and turned to alternative strategies. Distressed students may direct their focus elsewhere, whether inward or off-campus, and, like several of my interviewees, may begin to question whether studenthood is right for them.

All this said, it is abundantly clear that many students—including a subset of my interviewees—use and value campus mental health services, from accessibility services to counsellors and doctors. No interviewees mentioned attending self-improvement or “wellness” programs, but neither did I ask about this. What did come up is that unpredictable features of campus life can become resources in navigating and overcoming mental health problems. For Mayumi, the structure of attending classes made a difference. For Sabrina, it was the opportunity to complete a semester abroad. It may not be possible to predict what (if anything) will constitute the “difference that makes a difference” (Bateson, as cited in Tramonti, 2019, p. 132).

To make this point and conclude the section, I wish to zoom in on a tiny moment in Anthony’s story, one he mentioned purely as an aside. I had asked him about how boxing played a role in his recovery, and whether boxing continues to be meaningful in his life. He launched enthusiastically into a description of training, coaches, and competitions, but noted: “I had to stop last year because of school ... and also because, um, I slipped on ice and, like, I chipped one of my teeth. So I was out for a bit.”

For Anthony, it was not only the demands of studenthood that interfered with his boxing, but also a more humdrum matter: ice. I am certainly not going to blame the university for Anthony’s injury; ice is common in Calgary, and Anthony did not specify whether he fell on campus or elsewhere. But I wish to make a point about what is, and is not, considered germane to students’ recoveries. Removing ice from stairs and sidewalks has probably never been named as a mental health priority, nor am I suggesting that it should be. But I am hoping to remind stakeholders that systemic and holistic frameworks can be extended downward to the humble tasks that simply make students’ lives *better* on a mundane, day-to-day, local basis. Removing ice may not win any wellness innovation awards or result in measurable strategic impact. It is

unlikely to strengthen students' connection to the campus or investment in their student identities; done well, it may go more or less unnoticed. It is a humbler good, demonstrating thoughtfulness for how students move about their daily lives. But for institutions to sincerely care about student wellbeing, little things could end up mattering a great deal.

Student Mental Health as Personal or Political

In Chapter 3, I discussed literature grounded in collective or structural approaches to student mental health, both medically-inflected (e.g., socio-ecological or healthy settings models; Dooris et al., 2014) and socioculturally-focused (e.g., critical theoretical or critical disability scholarship; Peake & Mullings, 2016; Price, 2011). In Chapter 4, I demonstrated that Collective/Medical sensibilities are widely incorporated into institutional strategies' emphasis on campus culture, campus community, and aspirations to broadly enhance wellness for all students. In comparison, the critical approaches that I classified as Collective/Sociocultural are more adversarial toward status-quo systems, framing student distress as “a structural and relational condition, symptomatic of the stressed and anxiety-ridden environments in which we live and work” (Peake & Mullings, 2016, p. 259). Perhaps understandably, such positions are less commonly represented in institutional documents, although they are invoked by more politicized student groups and campus newspapers (e.g., McWhinney, 2018; Simon Fraser Public Interest Research Group, 2019). Because of my own interest in critical, political, and/or structural understandings of mental health, I was curious to discover how my interviewees might take up such positions.

The short answer is that critical discursive positions were rare in my interview data, at least in an overt sense.⁴⁸ Only one participant, Geoffrey, engaged in a sustained way with politically-inflected positions. Geoffrey's talk in this "genre" had an emergent, unpracticed, somewhat jumbled quality, as though he was working through his arguments as he was articulating them. He often spoke at length (e.g., several pages of transcript to develop a point) and jumped amongst premises, making it difficult for me to confidently summarize his positions and their possible relation to the Collective/Sociocultural concerns highlighted in Chapter 4. Nonetheless, I wish to appreciatively share some of the discursive work through which Geoffrey connected student mental health problems to structural and political matters. In so doing, I substantiate a single thread of relation—partial and situated, as all relations must be—between students (in this case, one student) and critical literature on student mental health.

Sanitizing and homogenizing effects of mental health discourse. Geoffrey expressed a sense that dominant narratives of mental health on campus have a constraining effect, whereby painful emotions are expected to conform to a "singular" and "linear" trajectory, a normative arc from illness to wellness mediated by approved treatments (therapy, medication, exercise, etc.). This normative trajectory works to discipline or silence references to *ongoing* effects of trauma or other unruly and persistent emotional struggles, although Geoffrey reflected:

In university campuses, there is some discourse around there—like, especially when you look at, like, women's studies and very, like, critical women's studies, I've—that's where I've experienced it. Where I've been fairly empowered to talk about [it]. But—there isn't really a, a place where raw experiences are welcome.

⁴⁸ Working abductively, I could have found much fodder for discussion of, for instance, neoliberal imperatives of self-improvement. However, for the purposes of this SA project I was more interested in articulating tensions and relations to which I could point *within* my data rather than relying too strongly on theoretical frameworks with limited uptake beyond the academic literature that I studied.

Similar to Charlotte, who criticized efforts to “showcase [mental health problems] in a way that will catch attention, one that will be understandable,” Geoffrey observed: “When we’re having big organiza-, big events on campus, it isn’t—y’know, I don’t find it inclusive to all experiences; it’s inclusive to the ones that are easily digestible.”

Geoffrey also protested the de-historicizing and depersonalizing tendencies of prevailing discursive practices, whereby *specific* incidents of harm (e.g., an assault that caused distress and deterioration) tend to be subsumed within generalized phenomena. In his words:

There’s this, this conversation we don’t like to have ... where there’s a person that’s harmed somebody—and it’s very overt in these kinds of stories, that there are people harming people. And I think when we’re telling stories, and we’re talking about mental health, or assault, things like that, [it’s] as [if] there isn’t somebody being hurt—like, it isn’t a person, it’s a, it’s a cultural thing, it’s an education thing ... we like to take the person out of it.

Extending this complaint, Geoffrey noted that our society seems much more comfortable *empowering* survivors than *blaming* perpetrators (he also mentioned the necessity of “sociocultural blame,” but unfortunately I did not ask him to unpack this). In my reading, Geoffrey’s critique was levelled at shallow, celebratory understandings of “empowerment” in which suffering is positioned as temporary and resilience as universally attainable for those who desire it. Such modes, he seemed to suggest, not only exclude experiences of ongoing impairment and elide the responsibility of people (or perhaps sociocultural systems) that have caused harm, but gloss over *how* this allegedly universal resilience will be attained:

Like, with the “It Gets Better Project”⁴⁹ too—I have a hard time with it because it’s, like, ... implied that there’s gonna be a horrible experience in your life, and ... implied that there’s a better. And it’s like—how are we gonna get there? There’s no mechanism!

⁴⁹ The “It Gets Better Project” is a non-profit group and campaign that seeks to prevent suicide among LGBTQ+ youth by having adults share their stories and communicate that “hope is out there, and it will get better” (It Gets Better Project, 2010-2018, para. 2).

Geoffrey advocated for a move away from binaries of health and illness towards a spectrum of “emotion and capacity and depression,” as well as a move to legitimize and respect people’s right to articulate ongoing and variable emotional needs; regarding trigger warnings, Geoffrey took a strong position that people who have endured trauma “shouldn’t have to have this thick skin, to just exist in the world.” Much of what Geoffrey said seemed consistent with the critical theoretical and critical disability scholarship that I had reviewed, and he identified intersectional feminism as an influence on his thinking. He did not use academic keywords like neoliberalism but critiqued rigid and “un-human” ideals of health, advocating for institutions to make space for a wider range of human experiences:

You’re not ... ill or not ill, you’re just a person. Y’know? You’re a person experiencing emotions and feelings each day. And sometimes it can be overwhelming, sometimes they can be great, right? And – it’s, shouldn’t be dictated by business, y’know what I mean?

“It shouldn’t be dictated by business” is the closest Geoffrey came to an economic critique of the student mental health situation.⁵⁰ Nonetheless, if he continued in the discursive traditions in which he self-positioned at the time of the interview, it might only be a matter of time.

Masculinity and mental health. Gender receives some attention in scholarly literature on student mental health; for instance, it is noted that men are less likely to seek help with mental health problems (e.g., Eisenberg, Hunt, & Speer, 2012) and women suffer under cultural norms of perfectionism (Schrack, Sharp, Zvonkovic, & Reifman, 2012), sexism (Hurst & Beesley, 2013), and gendered/sexual harassment and violence (Eisenberg, Lust, Hannan, & Porta, 2016). However, gender was a site of relative silence in both my institutional and interview data. Again,

⁵⁰ Few other interviewees mentioned economics; Daniela took a more pragmatic, arguably austerity-inflected position: “If you are going through like a particularly sad time, and you might not be depressed, it’s always helpful for you to, like, have someone to talk things out with, right? ... And obviously, like, it’s not viable to get everyone that opportunity because like, I mean, money is a thing too, right.”

someone taking an abductive approach would likely find much to say about how my interviewees' self-positioning was shaped by gender roles and norms; however, I want to limit myself to mentioning two overt and notably different references to masculinity by interviewees Geoffrey and Anthony.

Geoffrey raised the topic of masculinity in relation to a campus initiative called ManUp for Mental Health that, according to Geoffrey, organized an event that involved “working out in the middle of the square” to raise awareness and funds for mental health issues. Although Geoffrey hedged by noting that he had limited knowledge of the group and acknowledged the logic of using weightlifting to appeal and relate to men, he was critical of how the initiative might extend normative repertoires of “hyper-masculinity.” As Geoffrey pointed out, exercise (perhaps particularly weight training) is already highly valorized and socially acceptable for men. Foregrounding exercise as a response to mental health problems (“oh, you should just work out, it'll get the dopamine going”) extends the seductive belief that “if you just work hard enough, [the problem] will be gone,” and that overcoming emotional problems need not challenge one's masculine self-sufficiency. “If that works for you, that's wonderful,” Geoffrey allowed, but what about men for whom hitting the gym is *not* a solution? He expressed concern that exercise has “historically been a way to ... delegitimize medication and all these other forms that people take to care for themselves.”

While Geoffrey problematized ideals of masculinity, Anthony expressed a more ambivalent positioning related to gender norms:

I think it did play a role in me not wanting to get help. ... Like, with masculinity, obviously you wanna be, like, macho ...; you wanna just, like, tough things out, right? Um—so it's ... kinda detrimental. But at the same time, ... that [desire] to not get help ... I feel, like, makes an individual stronger. Because now you're kind of forced to, like, bite the bullet; like, you have to get through it on your own.

The latter thread of Anthony's reasoning runs counter to much prevailing discourse about men's mental health, in which a macho enactment of "toughing things out" or "biting the bullet" is framed as damaging and dangerous (CMHA, 2007). Of course, we cannot generalize from Anthony's experience; after all, a discourse of disciplined self-improvement *worked* for Anthony, and he acknowledged that it may not work for everyone. Nonetheless, Anthony's sense-making sensitizes us to the possibility that one man's liability may be another man's resource (gendered language intended). Not only did Anthony associate masculinity with values of strength and grit, but he indicated that exploring his masculinity "added more meaning" to his commitment to live more virtuously, offering him "guidance towards a path" and "something to work towards." In other words, Anthony turned to masculinity as a moral framework; I will briefly return to this point near this chapter's close.

Distal and proximal horizons of power. I confess that I was somewhat disappointed that structural and political elements were not more prominent in my interviewees' sense-making. As demonstrated by Figure 7 (see p. 181), interviewees understood mental health problems in their lives as biological, biographic, and moral, but not strongly as matters of oppression or injustice. But this disconnect sparked some critical reflection about tensions shaping the practice of campus mental health practitioners such as counsellors.

The late clinical psychologist David Smail (1999), in his book *The Origins of Unhappiness: A New Understanding of Personal Distress*, articulates an "environmental approach to distress" (p. 227) in which persons are understood as embedded within fields of power. Smail (1999) argues that

the most likely pattern is for extremely powerful distal events—political or economic perhaps—to reverberate through a network of influence and interest until they work

themselves out in the proximal relations which make up the context of the individual's personal life. (p. 75)

According to Smail (1999), it is distal events and structures that are most responsible for our emotional suffering; however, in a cruel paradox, the causes we can most easily perceive are those in our proximal or local lives. The explanations that *feel* most plausible, therefore, are those involving our day-to-day relationships and circumstances, amplified by “an inarticulate (ideologically determined) sense of personal inadequacy and guilt” (p. 75). It is these proximal explanations that students are likely to present in counselling, not the shadowy, untouchable, and much more powerful distal causes.

As a profession, counselling has long articulated a commitment to social justice (Kennedy & Arthur, 2014). However, I have been struck by how slight or toothless this commitment often feels in practice: how rarely counsellors undertake truly disruptive political advocacy. There are doubtless many reasons for this, including problematic logics of neoliberal self-responsibility and healthism arguably baked into the very premises of our profession (Loewenthal, 2015). Reflecting on my interviews, however, I wondered whether we campus counsellors might remain preoccupied with individual-level interventions because *these are the stories students bring to us*, stories that are compelling and plausible. Even if we suspect that students' struggles are, in fact, social problems masquerading as medical or personal ones, our primary job is not to consciousness-raise; it is to help. As Ann Cvetkovich (2012) observes in her book *Depression: A Public Feeling*:

Moving to an even larger master narrative of depression as socially produced often provides little specific illumination and even less comfort because it's an analysis that frequently admits of no solution. Saying that capitalism (or colonialism or racism) is the problem does not help me get up in the morning. (p. 15)

Seen this way, even students with a keenly developed critical and political consciousness might be inclined, when deeply suffering, to take up an account that foregrounds the proximal; their pain is too great to rely on the slow and uncertain fight for structural change.

Structured and Spontaneous Caring

Across the situation, actors broadly agree that student mental health problems require *care*. Campuses aspire to be, for instance, “a community where we care for each other” (U of C, 2015, p. 2) or “an environment that can nurture instead of waiting for the crisis to happen” (YU, 2013, p. 12). What remains unsettled, however, is what care means and how it should be practiced or expressed.

I begin this section with two different portraits of *caring*. The first comes from my interview with Mayumi, from her account of the nadir of her distress during which she was “crumbling” into anxiety and alienation. When I asked if anyone had noticed what was going on for her, she replied:

My sister and I are really close, and at the time, she was travelling abroad. And so she kinda wasn't here, um, in person to help me. Um—and I kind of kept that quiet ... 'cause I didn't want her to worry So—she texted me one day, and I was actually in the library, and I was on the quiet floor, and she said—“Everyone is texting me saying that they're worried about you,” like, “Are you okay?” And I remember just, like, seeing that—'cause I don't like my family worrying about me. 'Cause I—there's much bigger things to worry about. Um, I just read that and I started crying, like, really bad ugly crying in the middle of the library. And like, um, just feeling so guilty that it was starting to affect them And that's when I thought, like, ugh, I can't, I can't deal, I can't keep on going like this; I need to see someone, I need to talk about this, 'cause it's affecting—it's bigger than me now.

There are multiple layers of refracting and intersecting care in this account. Mayumi's older sister, who has always cared for her, is overseas; Mayumi cares about her family and does not want them to worry; Mayumi's family cares about her, and (presumably consistent with their established ways of relating) expresses that care not to Mayumi, but to her sister, who acts as

emissary of the family's collective worry. Ultimately, Mayumi's commitment to seek help with her suffering was intertwined with her realization of how it was affecting her loved ones. These relationships long predate Mayumi's studenthood; she has always-already been deeply embedded in and co-constituted by them. The care may not be perfect—some might raise an eyebrow at Mayumi's sense of guilt for worrying her family—but it clearly *belongs* and makes sense within Mayumi's life.

Here is a second example of care on campus. After five young people were killed at a party near my university (see Tucker & Hixt, 2016), the campus counselling centre solicited qualified volunteers to offer temporary 24-hour crisis support. The tragedy occurred just prior to the final exam period, so several campus buildings (such as the library) were open around-the-clock to allow for “flexible,” all-night studying. When I arrived for my late-night shift, I learned that in addition to being available for telephonic or walk-in support, volunteers were to roam the campus in pairs looking for students who seemed emotionally distressed. Upon identifying such a student, we were to approach them and gently inform them of available mental health resources (including the counselling centre). I was unsettled by this request; it felt intrusive, not to mention bizarre, to roam the libraries inspecting students' body language for signals of distress (and what, exactly, were we looking for? Tearfulness? Agitation? Holding one's head?). It was, quite literally, surveillance. And yet this, too, was an expression of care—one that differs in many ways from the care in Mayumi's account.

In the latter logic, caring arises within practices of “therapeutic surveillance” (Moore, 2011, p. 255) that trouble familiar dichotomies of care and control. Such benevolent surveillance assumes not only that students may be unfamiliar with available resources, but that they may not realize that their distress *warrants care*. It assumes that, ultimately, students will not interpret

such interventions as intrusions, but as welcome expressions of support. Yet at least one interviewee—to whom privacy mattered a great deal—directly troubled this assumption.

Regarding her emotional suffering and self-harm, Hannah remarked:

I wouldn't want someone else to find out before I decided that I wanted to tell them. So I didn't mind talking about it with my friends, because I made that decision. But for someone to notice? And be like, "I noticed something was wrong, like, what's going on?" I'd be like, [*small voice*] "no:::", like, "not your business."

Hannah's position sits uneasily alongside officially valorized ways of relating to friends and peers with suspected mental health difficulties. In mainstream student mental health literature, peer-to-peer initiatives that "capitalize on students' natural inclination to assist their peers" (Kirsch et al., 2014, p. 1) are touted as a relief measure for overburdened professional mental health services. Students thus become "a plentiful, often-untapped *resource* [emphasis added] that extends the reach of mental health services on campus" (Kirsch et al., 2014, p. 1). The *primary* aim of such programs is not to empower students to comfort their friends, but to train them to identify and refer distressed peers to campus resources and professionals (Ng & Padjen, 2019).

Upon close examination, dominant logics of campus mental health construct *helping* in a very specific way. At one campus, *helping* is identified as one of the "five factors that help you to flourish" (U of C, 2016, What is flourishing?) and is initially defined inclusively, if tritely: "See someone in need? Help them! Helping can be anything from contributing to society or holding a door for someone with their arms full" (U of C, 2016, How to flourish, para. 5). However, closer inspection reveals that the only two activities classified under the *helping* factor both revolve around benevolent surveillance: Bystander Intervention Training and the Question, Persuade, Refer suicide-focused peer gatekeeper program. At another campus, students are

invited to “give back to the McGill community” via the medicalized helping practices of Mental Health First Aid (MHFA): “Just as physical first aid is administered to an injured person before medical treatment can be obtained, MHFA is given until appropriate treatment is found or until the crisis is resolved” (McGill, 2015, “October 21,” para. 1).

In addition to logics of surveillance, campus mental health programs often construct helping and caring as rationalized *skills* that require expert knowledge and practice. Interested students can learn “How to Support Someone with a Mental Illness” (“How can I help my friends without burning out?”; McGill, 2015, “October 16,” para. 2). Another workshop promised to teach attendees “how to be the most supportive friend you can be” via “new listening skills and ... a greater understanding of empathy” (McGill, 2015, “October 21,” para. 2). In an advertisement for one peer support program, through which students provide “suggestions, referrals, and support” to “an individual who is struggling” (UW, n.d.-b, “MATES,” para. 3) prospective volunteers are reassured: “Not to worry ... training and resources for each meeting will be provided to you in advance!” (UW, n.d.-b, “MATES,” para. 3). That resources *for each meeting* can be decided in advance gives the impression of a curriculum rather than a dialogic relationship; nonetheless, the phrasing suggests that without this structure, volunteers would worry that they might “get it wrong.” Such worry is reinforced by claims that “when it comes to mental illness, education is key. Having the right tools, knowing the right words to use and *understanding how to correctly speak* [emphasis added] with someone experiencing a mental illness can make all the difference” (Bell Canada, 2017, Educate yourself).

Although DeFehr (2016) has articulated a strong critique of MHFA, Illouz (2008) has theorized the rise of emotional and communicative rationalities, and Aubrecht (2012) has

discussed how wellness publications incite students to self-surveil, I have found no published critiques of the rationalization of on-campus helping or the rise of peer surveillance. Fortunately, one of my interviewees had something to say on the matter. Here is Charlotte:

They give out these cards and, like, “Look for your friends!” Like, “If they’re—are they always tired, are they always complaining about things, are they not eating—” ... and then I think, like, people start getting paranoid [*laugh*]. And like, “Oh no! Like, you did this and you did this,” it’s like, “You have something!” ... They wanna force feed you, like, “You can figure out your friends’ problems”—but a lot of times, that’s not your job. Like, you’re not supposed to inspect your friends!

Charlotte continued, describing how she reassured a friend who was getting panic attacks. The friend apparently valued this support, because she called Charlotte again during her next panic attack. Charlotte emphasized:

But that wasn’t from a pamphlet. That was just from, either from my experience, or just from her hearing that it was a normal thing. It’s not like, [*affected voice*] “So, I have this card here? And it says that, if you have these things, then I think I should help you out.”

Inspecting your friends, relying on a card or pamphlet to tell you how and when to help out:

Something in these common practices struck Charlotte as perverse. Elsewhere, however, she described expressing concern for a friend via medicalized mental health frameworks (“I’m like, ‘But you’re saying this. Like, these are symptoms. And I’m like, listening to you, they’re causing you distress. So, technically, it’s something that should be taken care of’”), suggesting that the appropriateness of rationalized caring remains a site of ambivalence and possible tension.

I have quoted three interviewees, each suggesting a different nuance in constructions of care: Mayumi and the power of relationally networked, historical, and situated care; Hannah and the aversion to surveillance, Charlotte and scripted versus spontaneous care. As I have suggested, each of these positions—while far from universal or even common—constitute a possible site of tension with prevailing sensibilities. My analysis does not discredit such sensibilities. After all,

not everyone has a loving and attentive family like Mayumi; not everyone is possessed of Hannah's sound judgment regarding when to seek help; not everyone has Charlotte's confidence in reassuring a friend suffering a panic attack. Nonetheless, and at the risk of sounding like a broken record, I have sought to sensitize readers to possible alternative goods and priorities to which students may orient in such situations.

Moral Languages of Suffering on Campus: A Site of Silence

I conclude this chapter with one of the few sites of silence in my data. Of the three discursive axes from which my interviewees constructed mental health problems in their lives, biological and biographic discourse are abundantly represented both in scholarly literature and in campus documents (although, as noted in Chapter 4, biographic discourse on campus may carry implicit ceilings of intensity and persistence, beyond which problems are shunted into medicalized discourse). The third axis, that of moral discourse, is much harder to find. In Chapter 5, I defined moral positions as those related to the *ought*-ness of life (Brinkmann, 2011): to duties, character, virtue, and ethics. Within such discourse, experiences that might elsewhere be labelled as "symptoms" constitute *meaningful* signals of something amiss in one's conduct. Here, suffering happens for a reason: it may result from living in fear, suppressing one's true self, or failing to enact one's values.

To an extent, moral discourse can be found in the student mental health literature, largely in what I have classified as Individual/Sociocultural stances and, more narrowly, the "coddled students" genre. Whether disdainful or sympathetic, such positions imply that students' suffering is amplified by their fearfulness of it, and that they must be expected or supported to develop forbearance and grit to weather the vagaries of life. As noted in Chapter 5, such positions were generally absent from my data; however, I have heard student services professionals complain,

behind closed doors, of entitled attitudes among a minority of students who “expect us to solve problems for them, rather than taking responsibility for themselves” (a phrase I jotted down in a memo after one such conversation). In a particularly gracious and compassionate variation on such themes, Biesta (2017) has posited that “the educational task consists in arousing the desire in another human being for wanting to exist in and with the world in a grown-up way” (p. 7). Such a task can be considered moral in a broad sense, with studenthood a dedicated time during which young adults “come to a greater understanding of who they are, who they want to be with, and where they are headed in life” (U of A, 2015, p. 8).

In a second broad sense, campus mental health texts and practices are deeply moral to the extent that they constitute technologies of the self (Foucault, 1988a), setting forth normative practices and principles by which people may achieve a good life. Under an increasingly hegemonic regime of healthism (Cheek, 2008; Crawford, 1980), a good life and a healthy life are one and the same. “Live well to learn well” (UBC, n.d.-b), students are exhorted; “if you take some easy preventative measures you can keep yourself healthy and save your energy for studying and other fun activities” (U of T, n.d., para. 1). If you do find yourself depressed, anxious, or otherwise unhealthy, you must make the choice to enact the necessary lifestyle changes, including treatment, through which you may restore yourself to health. Although such logics are moral in the prescriptive sense, they typically stop short of claiming that students become depressed or anxious *because* they have not been living well, because they have neglected the necessary precautions. Mental health discourse tends to remain strategically agnostic about moral *causes* of suffering.

Moral causes and effects can certainly be inferred from diverse therapeutic frameworks, from cognitive behaviour therapy (you suffer because you have not mastered your distorted

thinking; Beck, 2011) to Acceptance and Commitment Therapy (you suffer because you are fused with your thoughts and pain; Harris, 2009). However, in the campus document data I reviewed I found no explicit constructions of student suffering as an existential signal or a meaningful consequence of moral choices and conduct. Contrast the narrowly psychological, healthist, and atomistic versions of moral subjectivity described above with Sabrina's account of the emotional turmoil occasioned by the complex mangles of poverty, tourist economies, and colonialism that she perceived during her travels in Southeast Asia: "I never knew what to do, I never knew ... how to treat situations; I didn't know what was right, what was ethical, what was wrong. ... The whole time, there was just a lot of frustration and anger." Upon returning to Canada, Sabrina continued to wrestle with her own ethics and potential hypocrisy:

I was also pointing out all the things that other people aren't doing, but I wasn't doing anything either. So it was, like, that protection of things I don't wanna have to admit to myself. ... I was very insecure, too, but I didn't wanna show it. Because I was very confident before, so then it started to turn into really, really cocky, and ... Like, tryna make myself feel like I'm still this person—but yeah, I wasn't really doing anything that, like, aligned with the values I claimed to have or the things I seemed to care about.

This moral reckoning painfully unsettled Sabrina's assumptions about herself, her place in the world, and her studies. It was grounded not in idealised moralities of health, but in Sabrina's situated and material sense of conscience, values, and *social* responsibilities. And, as I noted in Chapter 4, reckoning demands attention to *specific* "clashes and places where it hurts" (Mol, 2010, p. 227).

What kinds of mental health services might be useful to students who make sense of their suffering through moral discourse? Counselling is one possibility, but dialogically co-narrating ambiguous ethical and existential meanings requires time (or, at least, a sense of spaciousness and liberty to take the time that *may* be needed). How would this way of working fit within rigid

short-term models of care, or stepped care approaches that firmly (re-)conceptualize one-on-one therapy as intensive, specialized, and evidence-based *treatment* suitable for students at moderate to high risk (Cornish et al., 2017)? As Rosenbaum and Liebert (2015) observe, “it can be difficult to withstand the urge to flatten client contacts and pursue interventions essentially focused on problem solving, especially in the face of overwhelming caseloads and record numbers of students in significant crisis” (p. 191). I am reminded of interviewee Anthony’s assessment of his campus counselling sessions: “I just felt like it was, just shallow.” Students who self-interpret via moral or existential discourse may crave deeper dives.

As I reflected on how and where else moral and ethical self-exploration might take place on campus, I recalled that during my internship at a campus counselling centre in 2017-2018, several of my student clients expressed interest in the work of Jordan Peterson, a Canadian psychologist who rose to prominence in 2016 after railing against “political correctness” and criticizing a bill that would extend anti-discrimination protections to gender identity and expression (see Beauchamp, 2018). I find most of Peterson’s public statements personally and politically odious, so I was surprised and somewhat dismayed that several clients, all young men dealing with various emotional difficulties or mental health problems, were so curious about what he had to say. My clients expressed appreciation for Peterson’s efforts to articulate moral and ethical principles in a clear, accessible, and actionable way. Peterson is associated with an online writing program called the Self Authoring Suite that promises to “help you understand and rectify your personality faults” as well as “understand and develop your personality virtues” (Self Authoring, 2019, para. 3); he has published a bestselling self-help book, *12 Rules for Life: An Antidote to Chaos* (Peterson, 2018). Regardless of the legitimacy and quality of Peterson’s

scholarship, there is clearly an appetite for his overtly moral advice and opinions, especially among young men (Bryant, 2018).

Here I briefly return to the matter of masculinity. When masculinity is invoked in mental health discourse, it is often as a liability: machismo and stoicism are thought to inhibit men's emotional expression and treatment-seeking (Canadian Institutes of Health Research, 2014; CMHA, 2007). Bids are made to redefine masculinity—for instance, in the image of what Illouz (2008) calls the “New Man” who exhibits “a sense of uniqueness, individuality, and self-confidence as well as the emotions, needs, and desires of the psychological self” (p. 235). Messages encouraging men to be vulnerable, engage in self-care, and seek help when struggling (e.g., ManUp for Mental Health, 2017) may well save lives and productively trouble status quo masculinities. However, few such messages extend beyond medicalized priorities of mental health promotion and primary prevention. Although a full exploration of this possibility is beyond the scope of this dissertation, Anthony's account (and my clients' interest in Jordan Peterson) suggests that students may be interested in broader conversations about the meanings of contemporary masculinity, including its implications for ethical or virtuous self-conduct. At our historical moment, so-called assaults on masculinity (an idea advanced by Peterson; Bowles, 2018) and “men's rights” have become dog whistles or outright refrains for misogynist and violent enclaves that may appeal to young men who are suffering (Romano, 2018); conversations about masculinity cannot be relinquished to the political right. From moral vantage points, matters and meanings of gender are always already entangled with questions of distress, self-interpretation, and problem-solving.

Given that only a minority of my interviewees used moral discourse to interpret their problems, these considerations may fall in the realm of provocation rather than recommendation.

But SA is interested in amplifying quieter voices and illuminating sites of silence, so I linger in this provocation a moment longer. Alongside programs and curricular content teaching students coping skills, mindfulness, and mental health literacy, could student mental health programming include workshops in virtue ethics (see Harrist & Richardson, 2014) or self-guided resources exploring the philosophical question of *How should one live?* Alongside chaplains who offer valued spiritual guidance, could ethicists or moral philosophers be made available for non-religious students to seek guidance on dilemmas and existential angst in their lives? To take such possibilities seriously might require new ways of speaking about student distress and emotional suffering. *Mental health* carries considerable medicalized and psychological baggage, even when it is discursively distanced from mental illness and rebranded as wellness, flourishing, or thriving. To help students in new ways, more indeterminate understandings of “the good life” may be necessary.

On the other hand, perhaps the preceding three pages miss the mark altogether. Perhaps moral discourse should remain outside of the rationalized purview of student services, and instead find organic expression in the many *commitments* that students make, whether on campus or off. Students test and tinker with virtues, values, and the good life in women’s and LGBTQ centres, advocacy and activist groups, racialized students’ collectives, political parties, cultural organizations, and boxing gyms, not to mention classrooms, friendships, and families. According to Mattingly (2014), such everyday spaces

can become the unlikely grounds for moral experimentation and the creation of transformative experiences. These emergent and fleeting *moral laboratories* [emphasis added] provide vantage points on familiar or prior ways of seeing, acting, believing that are actively brought into question. They are also experiments in hope and possibility. They suggest possible futures even while taking place in some all-too-real, and often quite ordinary, present. The actions themselves may seem mundane enough, but they may

also function in this experimental way, as actions within possible narratives of transformation, moments in possible lives. (pp. 14-15)

Seen this way, each of my interviewees—whether or not they took up moral discourse—was telling me a story of “the struggle for a good life” (Mattingly, 2014). They had fallen into depression, anxiety, and other forms of suffering and confusion, and experimented with meaning-practice-relationship packages to spark lines of flight (Deleuze, as cited in Winslade, 2009) out of despair; they strove for “the ‘best good’ within the particularities of circumstances” (Mattingly, 2014, p. 55). During our conversations, many of them articulated little manifestoes about how they intend to live life, going forward, in light of their mental health struggles. “Everything, in the end, is utterly meaningless,” ventured Brent, “so you might as well just do what makes you happy.” Sabrina cited a quote from Instagram—“I dive into the darkness just to find a way out”—to explain that “even though all those bad times sucked, ... when I’m out I can show others the way.” When I asked Carl how his experience shaped his sense of the future, he replied:

How I see the future is—I’m gonna deal with this. Um, I, I like the fact that this happened to me. Uh, now that I’ve gone through it, obviously, not—not back then [*laugh*]. ... But I like that this happened to me. It proves something. Proves that I could endure this type of pain. And it’s something I would not wish upon anyone. ... But I’m going to build myself a lot stronger than I was.

Chapter 7: In Lieu of a Conclusion

No one wants to be a bad or compromised kind of force in the world, but the latter is just inevitable. (Berlant, 2012, p. 177)

While writing this dissertation, I often felt betwixt and between social worlds. I was riveted by principled critiques of *psy* expertise, therapeutic culture, wellness imperatives, and the neoliberalization of institutional and mental health logics (e.g., Davies, 2015; Denzin & Giardina, 2017; Esposito & Perez, 2014; Illouz, 2008; Rose, 1998). Yet during my year-long internship at a campus wellness centre, the *psy*-medicalized-therapeutic knowledge and practices about which I had become deeply ambivalent proved *helpful* to students who were floundering and suffering. I worked alongside colleagues who sincerely wished to improve students' lives through health promotion and psychoeducational outreach, and student volunteers who wholeheartedly embraced *health* as a guiding virtue of the good life on campus.

I often longed for the simplicity of aligning my research with one camp or another. My research was not (as some campus colleagues assumed) producing an ambitiously integrated model of student mental health with modernist maps charting new paths toward wellness. Neither was I writing a manifesto against insidious forces at work within status quo mental health practices, sounding a call to replace such practices with some superior, perhaps political, interpretive framework. I had produced a document that was difficult to summarize, whether to conventional mental health audiences or critical scholars. I knew I had done a lot of work, but for whom? To what end? As Lauren Berlant (2012) writes in the epigraph, I often felt like a “compromised kind of force in the world” (p. 177), regardless of where I self-positioned.

In some ways, this should have come as no surprise. My aim, stated in Chapter 1, was to study variations, complexities, contradictions, and tensions; I could hardly expect to avoid

feeling their effects. As Clarke (2005b) promises, SA replaces “modernist unidimensional normal curves with postmodern multidimensional mappings” (p. 25), mappings that may not fit neatly together. Rather than attempting to tell *the* story of what is going on in student mental health, I zoomed in at sites of material-discursive “trouble” and articulated my analytic observations. These observations are linked not by the sturdy planks of theory, but the looser ties of provisional theorizing (Clarke et al., 2018). I produced not “prescriptions of what to see” but *sensitizing concepts*: “directions along which to look” (Blumer, 1969, p. 148). The student mental health conversation is tripping along, yet I sought (in some ways) to trip it up: to look in new ways, to notice the cracks in matters upon which “we all agree” (cf. Potter, 1996).

Review of Findings

With preliminary, abstract situational maps like Figure 1 (see p. 46) as touchstones, I dipped into the student mental health situation at multiple sites, including scholarly literature; university mental health strategy or policy documents; descriptions of campus programs and services; documents produced by student unions, clubs, and campus newspapers; Canada-wide awareness campaigns; widely-shared or “viral” online articles on mental health; and social media (which I excluded from the current analysis). My mapping and memoing unfolded episodically over several years, during which I pursued many lines of inquiry that are *not* reflected in these pages. From this wide-ranging analytic work, I selected the storylines associated with the positional and social worlds/arenas maps in Chapters 3, 4, and 5.

I began Chapter 4 by troubling visions of campus as a unified “community of caring” (U of C, 2019, para. 1), suggesting that a campus can alternatively be understood as a political arena involving differently positioned actors with legitimate and divergent stakes in the situation. Emphasizing togetherness can build momentum but may obscure the priorities and complaints of

less-powerful groups, which can in turn expose institutions to accusations of hypocrisy. In a related vein, I discussed prominent constructions of wellness as an *opportunity* for student self-enhancement and institutional branding, contrasting celebratory goods with those of *care* during crisis or illness and of *reckoning* with shortcomings and failures. Finally, I explored goods of integration—good service, efficiency, consistency—and possible tensions with other goods such as epistemic diversity, localness, and tinkering.

In Chapter 5, I mapped how students take up biological, biographic, and moral discursive positions and receptive and agentic postures to construct mental health problems in their lives. The chapter showcases discursive multiplicity in student sense-making and shows that such heterogeneities can occasion ambiguity and subtle tensions, for instance, related to responsibility and agency. My interviewees demonstrated creativity in fitting meaning-practice-relationship packages to their struggles, but not without dilemmas and mismatches along the way. For some interviewees, these dilemmas had been satisfactorily (if provisionally) “settled”; for others, such as Chris, both private and relational negotiation of self-understandings and problem-solving practices was ongoing.

It would be traditional, in a concluding chapter, to position my findings in relation to extant literature. Given that I treated the literature as part of the situation to be analysed, I have alluded to such connections throughout the document. Knowledge claims that I classified as Collective/Medical are strongly represented in mental health strategy documents: Health promotion, primary prevention, and healthy settings logics undergird discourse about campus culture, community-building, and the cheerfully health-focused activities I characterized as a “pivot to wellness.” Individual/Medical literature, with its focus on the identification and treatment of diagnosable psychiatric disorders, is consistent with institutional priorities related to

efficient and effective treatment, as well as students' self-interpretation through biological discourse. As noted in Chapter 6, the critical and political positions I classified as Collective/Sociocultural are present but infrequent in my student interview data. Certain meso-level campus social worlds, such as the "Discourse of Dissent" class behind the walkout described in Chapter 4, take up critical disability, critical theory, and/or intersectional feminist positions on student mental health. It remains to be seen what claims and pulls such actors will make on healthist, individualist, depoliticized mental health discourse moving forward—how they will continue, like the student groups quoted in Chapter 4, to demand accountability. Finally, positions I described as Individual/Sociocultural, from which student distress was variously constructed as meaningful, developmental, and/or unnecessarily amplified, were rare in my document data but hearable in interviewees' moral self-understandings and agentic stances.

At this point, I hope it is obvious that there is plenty going on with regard to student mental health. Very little of what goes on is ill-intentioned or disingenuous; most people are seeking to accomplish something good. Some claims-making efforts pull the situation in systemic and holistic directions; others pull toward technological solutions, Big Data, and maximized efficiency (cf. Gardner, 2019). Some pull toward political activism, advocacy, critique, and resistance. A few tug "backward" toward putatively traditional understandings of challenge, character, and grit. Rather than attempt to distil or synthesize these disparate activities into "best practices," I have suggested the possibility that there are multiple good practices, each advancing a particular vision of the good life on campus. Troubling the self-evidence of "best practices" would force us to be more intentional in our negotiations; we might need to accomplish cooperation without consensus (Star, 2010) or co-establish other ways of

“respectfully going on together” (Verran, 2002, p. 754). We might need to experiment (Mattingly, 2014) and to tinker (Mol et al., 2010).

On Being Stuck: Reflexive Suffering as a Student and Researcher

During the course of this study, I became a student with mental health problems. My suffering, like that of my interviewees, was exquisitely situated and co-constituted by material-discursive relations. I struggled to find “metaphors adequate to express [my] predicament” (Kirmayer, 1984, p. 249). I was told that “everyone” struggles with their dissertation as I watched my colleagues defend and graduate, one by one, months and years ahead of me. I was told that I was dealing with imposter syndrome or perfectionism, formulations that bounced right off; perfection and legitimacy felt laughably distant when I was staring at a blinking cursor for hours, my chest filled with empty anger or fluttering terror. I could not bring myself to quit, but sitting down to work felt like anathema, like death, like an impossibility. I was trying to think through sand, through heavy sludge. Nothing made sense. My life made no sense; my future made no sense. The wires of resonance that previously connected me to my work, to the world, fell silent (Rosa, 2019). Or, to borrow from Vonnegut’s (1961/2009) novel *Mother Night*,

What froze me was the fact that I had absolutely no reason to move in any direction.
What had made me move through so many dead and pointless years was curiosity.
Now even that had flickered out. (p. 232)

Elements of the situation about which I was writing became salient in new and painful ways. I had moved away from my university, and as far as I could tell there were no student counselling services offered by videoconferencing or telephone. I clicked, with a forced-open mind, through some of the chipper self-help webinars on the Wellness Centre’s website; I tried to implement some of the “tips and tricks.” I phoned my partner’s employee assistance program and was given a videoconferencing appointment with a counsellor who spent a great deal of time

explaining the tenets of mindfulness, despite my interjections that I had just led a mindfulness-based group for anxiety, and glossing over any specifics of my despair. After the video call, I sobbed; later, I cancelled the follow-up appointment. I felt too financially stressed to consider a private practice counsellor or psychologist, and was ashamed of my failure to capitalize on years of relatively decent funding (I recalled, ruefully, my analysis in Chapter 4 of the problem that snuck into a list of “Opportunities/Action Items”: “Incongruence: Grad st. funding period and ave. time to grad”; UBC, 2013, p. 9).

I had accessed counselling at the campus Wellness Centre once, sometime in the first year of my PhD. I remember the psychologist expressing great enthusiasm about my potential in the field and urging me to persist in the program. I did not know how to politely convince this psychologist that I was having serious doubts about the value of our mutual profession and my future within it, so I nodded along, thanked her, and did not return. Years later, as my emptiness intensified and I cast about for options, I bitterly recalled that initial appointment. If a service is unhelpful once, it can be difficult to imagine that it will be helpful in the future. Nonetheless, when visiting Calgary I did phone the Wellness Centre; however, upon learning that prior to a counselling appointment I would need to attend an intake appointment with someone called a Student Support Advisor, I balked (out of pride, perhaps, or hostility toward what I perceived as a jargonistic shift toward stepped and regulated care).

After declining the intake appointment, I dropped in to see a doctor instead. I sat in her office and sobbed, and she gently asked if a PhD was really necessary to my career goals. I told her I had no career goals left. She was kind; she asked me questions from the PHQ-9 (a common depression screening tool; Kroenke et al., 2001) as well as other specific, thoughtful questions. I sobbed more. She directed me to take two weeks off and visit my family doctor when I returned

to Vancouver. Two weeks later, I dutifully kept my appointment with my doctor, who was rushed and running late. She asked me the same PHQ-9 questions, typed a few keystrokes, and printed out an SSRI prescription. I filled the prescription but did not take it; online reviews said the medication makes you tired, makes thinking foggy and muddled. This seemed like exactly what I did *not* need, so the pills sat untaken. Unlike a counsellor or psychologist, the cost of the pills was fully covered by my extended health benefits; they were easy and quick to obtain. I ground on with little relief, compartmentalizing in ways that preserved some happiness but amplified my avoidance.

Among my saving graces during this time have been what Sara Ahmed has called *companion books*, that is, “books that make me feel less lonely” (Mehra, 2017, para. 14). In my upset, I could only tolerate the mental company of women; I leaned heavily on Annemarie Mol (e.g., 2010) and Cheryl Mattingly (2014). Most of all, I clung to Ann Cvetkovich’s (2012) *Depression: A Public Feeling*. Cvetkovich *saw* me. She articulated what I was feeling:

Academia seemed to be killing me, a statement that seems very melodramatic given the privileged nature of my professional status and the specialized task of writing a dissertation or book, the stakes of which are often ultimately only personal. But to feel that your work doesn’t matter is to feel dead inside, a condition that is normalized for so many. (p. 18)

Since Cvetkovich (2012) knew how I felt, I clung to her insights. “Sometimes saving the day is all it really takes to save a life,” she wrote. “If you can hold the despair at bay for just a little bit longer, there’s a chance that something will come along to change things” (p. 50). I kept putting one foot in front of the other, trying to save one day at a time. Somehow, I am now writing the final chapter.

This is not an autoethnographic dissertation, but along the way its subject matter became acutely personal to me. Doctors, counsellors, accessibility advisors, coaches, fellow students;

medications, self-help and wellness advice, mindfulness, productivity apps; money, family, office space, aspirations, geography. Amongst the co-constituting relations of these and countless other elements, I struggled to identify meaning-practice-relationship packages that fit. I admit that I did not exhaust all avenues of potential help, not out of “stigma” but out of an inability to put words to what was wrong or what sort of help I might need. I had a sense of being stuck in a constraining choreography (Aronsson, 1998; Strong et al., 2015), an untenable way of relating to myself and my work, but could not seem to find the right material, relational, or discursive levers with which to interrupt it—the elusive lines of flight (Deleuze, as cited in Winslade, 2009) through which I might find myself suddenly elsewhere.

Even as I struggled to write about my interviewees’ self-interpretive efforts, I was tacitly learning about discursive satisficing, about *making do* with less-than-perspicuous understandings and responses. I was tacitly learning to test biological, biographic, and moral discursive positions as if they were blocks in a game of Jenga, poking here and there to see what might move today that would not move the day before, what might be workable to “save the day.” I was tacitly collecting jumbles of idiosyncratic maxims, skeleton keys to try when shadowy inner doors slammed shut: for instance, the notion that curiosity is impossible without love, and love is impossible without curiosity. If one is nowhere to be found, try restoring the other, back and forth until you have bootstrapped yourself out of the pit into which you have fallen.

Learnings, Limitations, and Open Curiosities

As I approach the end of this project, I find myself much better equipped to begin it. I have come to a deeper understanding of SA; in hindsight, I can point to misunderstandings and missteps that made this project more difficult than strictly necessary. As noted in Chapter 1, I began this study with a vague intention to expose and critique biomedical mental health

discourses on campus, with my initial funding proposal titled “Psychiatric discourse and self-understanding: Young adults’ identity construction in a biomedical era.” Although I had proposed to use SA, I did not yet appreciate how thinking as a situational analyst might differ from thinking as a discourse analyst. I share some of my reflections in hopes they may be useful for other researchers planning to use SA.

First, when beginning this project, I did not fully grasp the centrality of *meso-level* analytics: of focusing deliberately on the situation as a whole. I was well into my analysis before realizing that my research questions, centred on discursive constructions of student mental health, failed to align with the outcomes that Clarke and colleagues (2018) identify as “core to a good SA” (p. 206): *relational ecologies* of the overall situation, the collective situation, and the major debates in the discourses of the situation. Such relational ecologies, I now believe, are where I should have begun, resisting the temptation to zoom in for “close-up shots or cameos” (Clarke et al., 2018, p. 209) until I had achieved a sense of how the big picture “hangs together.” It was not only my research questions that distracted me from such priorities: because of my experience with discursive psychology and discourse analysis, I fell into close analysis of turns of phrase, even single words, devoting considerable time, energy, and attention to such memoing. This resulted in a reversed dynamic through which I was attempting to piece together a meso-level portrait *from* close-up shots, an exhausting and inefficient way to work if a meso-level outline has not been at least empirically sketched out beforehand.

A second and related misstep was my choice to identify in advance the data I would gather for my analysis. Although this is a common convention of funding and candidacy proposals, it is (I have now concluded) ill-suited to SA. In my case, the data I had proposed to gather (mental health texts from 11 campuses; popular online articles plus reader comments;

awareness campaigns; social media; student interviews) proved massively overwhelming in quantity, particularly given my *too-close too-soon* analytic habits. As a result, I could hardly imagine collecting *more* data, and the theoretical sampling that I now recognize as essential to SA became daunting. I now take much more seriously Clarke and colleagues' (2018) advice to begin with an abstract situational map and identify data *as needed* to substantiate the relations between major elements. This process relies more heavily on the researcher's interpretive and abductive sensibilities than many students may be used to; part of learning to use SA well is learning to trust your own curiosities while also committing to take "a peek" (Clarke, 2015b, p. 101) at all significant elements and relations in the situation.

Third, aside from the student interviews, all the data I planned to gather were publicly available. This may be perfectly adequate for studying topics that are actively contested in public forums such as media and government, such as a novel anti-abortion technology (Clarke & Montini, 1993) or the cloning of endangered animals (Friese, 2013). Unlike these situations, however, "major debates" in student mental health are not immediately obvious; the topic is not openly controversial. Indeed, at face value, there is considerable consensus on problems, priorities, and goods. As noted in Chapter 4, the establishment of such consensus likely requires considerable work (negotiation, suppressing opposition, etc.) to which I was not privy. This became particularly clear to me during my internship at a campus counselling centre, where I witnessed plenty of tensions but had no authorization to use these privileged experiences as data; I was there in good faith as a counsellor, not an undercover researcher. To truly understand the debates and stakes, I would need access to budgets, organizational charts, task force minutes—documents that might help me interpret the veiled hints of dissent I was gleaning from front-facing data.

Fourth, I had conceptualized the situation of inquiry as postsecondary student mental health in Canada, and accordingly collected institutional mental health data from 11 large universities across the country. However, I have come to see this as a strategic error. There are certainly many situations whose social worlds and arenas are national or international in scale, including the aforementioned studies of abortion technologies (Clarke & Montini, 1993) and cloning practices (Friese, 2013). In such situations, national and international actors interact in a public, shared arena in observable ways. To study Canadian student mental health in an analogous fashion would have demanded greater emphasis on national debates, stakeholders, relations, and events (e.g., key legislation; landmark conferences and policy documents; etc.). The data I gathered, produced by specific institutions, focused primarily on their own campus or campuses; allusions to specific other universities were rare, and references to national events or bodies tended to be generalized and apolitical. My institutional data thus offered limited insight into the relational structure of a *national* situation of student mental health. In retrospect, I could have chosen to proceed more ethnographically, studying how student mental health is done on a single campus through the actions and interactions of that campus's specific social worlds (collective actors). Such an analysis would doubtless include national or international stakeholders, but allows for empirical specification of their interactions, analogous to Alonso-Yanez's study of the social worlds and arenas in the situation of a single biosphere reserve in Mexico (Alonso-Yanez, Thumlert, & de Castell, 2016). Just as "there is no policy in general" (Law & Singleton, 2014, p. 392), there is no situation in general.

Finally, I wish I had been better able to adapt my inquiry once it became apparent that my proclivity for close analysis in combination with the breadth of available data would lead me into a quagmire from which I would struggle to escape. *Student mental health* is a vast and

amorphous topic; my preliminary situational maps included hundreds of elements, and all seemed to matter. I have suggested above that I could have adopted a more disciplined focus on meso-level relational ecologies (which would have been facilitated by more flexible data collection strategies and a more locally focused situation). Another tactic might have been to zoom in on a hot-button sub-situation. Stepped care (Cornish et al., 2017), for instance, could be studied as a situation unto itself; so too could mandatory leave policies (cf. Roy, 2018) or early alert systems and other tactics of mental health surveillance (cf. Gardner, 2019). It is possible that my recognition of the above problems was delayed because I had learned to describe SA as “messy” (Mathar, 2008). There is a difference, however, between “messy” and chaotic; as it happens, I believe Clarke’s updated edition of her seminal SA text (Clarke et al., 2018) does a much better job of clarifying the tasks, structure, and priorities of SA than the first edition (Clarke, 2005b) to which I had access upon beginning this study.

Lingering behind the above learnings is the question of whether it is possible (or desirable) to use SA mapping techniques in studies that bear little resemblance to the stated goals of SA or the prototypical exemplars featured repeatedly in Clarke’s oeuvre. That is, perhaps it is perfectly legitimate to use SA mapping techniques as an analytic strategy for addressing discursively-inflected research questions, letting go of any expectation to theorize the meso-level relational situation. In support of this possibility, several examples listed in the appendix of Clarke’s latest textbook (Clarke et al., 2018) feature SA ideas and maps but do not attempt situation-level relational analyses (e.g., Gagnon et al., 2010; Salazar & Öhman, 2015). It is not clear whether situation-level analyses were undertaken behind-the-scenes but excluded from the articles in question; this ambiguity makes it difficult for neophyte researchers to understand what features are definitive of SA. It may be worthwhile, as the method evolves, to theoretically

distinguish between *doing* SA and *using* SA mapping strategies; to my knowledge, no such distinction has yet been articulated.

Limitations and possibilities for future research. Perhaps the most significant limitation of the current study was my choice to exclude Student-at-Risk policies, duty-to-care legal precedents, and other suicide- and violence-focused texts. Suicide and “risk” are heavily weighted elements in the situation of student mental health; their influence is spectrally hearable in all other mental health documents. In a sense, “risky” student mental health constitutes a shadow situation always-already present within the peppy wellness-forward vibe of the primary situation. I could see no way of adequately addressing both within a single dissertation and thus chose to foreground the latter; however, *risk* constitutes a key area for future study.

Another limitation lies in my choice to interview students who considered themselves to have successfully overcome the worst of the problem. None of my interviewees were in crisis at the time of the interview; none were at risk (though some reported that they had previously been suicidal). To my knowledge, none of my interviewees had come under campus surveillance for crisis intervention and/or risk management. I also chose not to screen students for severity of mental health problem. Although I stand by this choice, remaining skeptical of the truth value of such screening efforts (cf. Frances, 1998), it means that I do not know whether my interviewees’ problems would have been deemed “mild” or “non-clinical,” “moderate,” or “severe” by standardized measures or qualified professionals. It is not only possible but likely that I would have generated different results had I interviewed different students. Some readers might question whether any interviewees had experienced clinically severe mental disorders, and I acknowledge that I do not know; all I know is that some had been diagnosed, and many described their experiences as intense, prolonged, and devastating. None of my interviewees

described major psychotic breaks, nor addictions; none described being hospitalized. In short, many possible experiences were *not* present in my data. My analysis is thus “modest and partial” (Clarke et al., 2018, p. 55), and not intended to be generalized except as a *sensitizing* narrative offering “directions along which to look” (Blumer, 1969, p. 148).

A third limitation of the study is my relatively solitary analysis of the data. I did not have the luxury of an analytic working group, as recommended by Clarke and colleagues (2018). Although I discussed my emerging analysis with my supervisor and presented preliminary findings for discussion at conferences, I was effectively the only one with “eyes on” my data. Others who studied the same data would almost certainly have made different “cuts” (Barad, 2007), mapped the data in other ways, and been intrigued by different storylines. This is to be expected with interpretive SA mapping, which (as noted in Chapter 2) involves no aspirations to “objective” representation. As a consequence, the claims in this dissertation are open to challenge. I have cited passages to exemplify the data in which my claims are grounded, but of course there are other claims that could be made, supported by passages that I did not quote. The legitimacy of my analysis is tied to its plausibility among situated audiences, who will decide whether my constructions can “be trusted to provide some purchase on some important human phenomenon” (Lincoln & Guba, 2000, p. 179). Regarding trustworthiness, I orient to what Lather (1993) describes as “a kind of validity after poststructuralism in which legitimation depends on a researcher’s ability to explore the resources of different contemporary inquiry problematics” (Lather, 1993, p. 676). If my findings are challenged, the ensuing dialogues can be considered part of the work’s purpose.

Clarke and colleagues (2018) describe SA results as “modest and partial but serious, useful, and provocative” (p. 55). What I did not anticipate was how painful this partiality would

be. Many of the stories I was unable to tell would be rich and worthwhile areas for future research. I noted several above: stepped care, early alert programs, and mandatory leave policies all warrant in-depth study. I also itched to delve deeper into corporate influences on campus, such as the on-campus activities of Bell Let's Talk or the outsourcing of campus mental health services to private employee assistance programs. An institutional ethnography (Smith, 2005) could investigate how institutions attempt to manage access to campus mental health services, whether via outsourcing, stepped care, or more mundane technologies such as intake and wait list policies. Frontline practices would likely reveal both reproduction and resistance of the *ruling relations* (Smith, 2007), that is, the processes, knowledge, and interests that are delivered from "higher up" with an expectation of compliance.

A possibility for future research in a more positivist or quantitative vein relates to the relation between health promotion efforts and demand for mental health services. As discussed in Chapter 3, primary prevention logics tend to assume that successful population-level health promotion and psychoeducational initiatives will reduce the demand for acute mental health services, namely, one-on-one counselling or medical appointments. An alternative possibility is that such initiatives will instead serve as an advertisement for psychologized and medicalized interpretive frameworks of stress and distress, thus potentially *increasing* the demand for campus mental health services. Given the considerable energy put into campus health promotion alongside dire concern about meeting service needs, this dynamic warrants further study.

When I began this study, I had read Mol's (2002) book *The Body Multiple*, but I had not yet encountered her additional books *The Logic of Care: Health and the Problem of Patient Choice* (2008) or her co-edited volume *Care in Practice: On Tinkering in Clinics, Homes and Farms* (Mol et al., 2010). It was later still that I learned of what appears to be a sub-genre of

organizational ethnographies focused on studies of care work (cf. Oute & Rudge, 2019). I have come to appreciate the deep ethnographic leanings of SA, and—particularly during my internship—recognized the missed opportunity of an ethnographic study of care on campus. I attempted to bring Mol’s sensibilities into my analysis of *goods* in Chapter 4, but the current study was not set up to investigate

the messy process of practicing care that encompasses the multiplicity of ‘doings’ in the midst of competing political requirements, commercial concerns, professional discourses or humanistic views of what is at stake and needs to be done in any care organization. (Oute & Rudge, 2019, p. 249)

I was not well positioned to document the local tinkering and situated creativity that goes on in campus mental health services. Such an inquiry might prove both fascinating and hopeful.

Strengths of the Current Study

I have discussed at some length the current study’s missteps and limitations. What, then, are its strengths? What have I done that is unique or worthwhile?

First, I have introduced SA as a tool for exploring campus as a complex and multiply co-constituted arena. It has become commonplace to assert that student mental health demands a systemic, comprehensive, and/or holistic approach (CACUSS & CMHA, 2013; College Student Alliance, Ontario Undergraduate Student Alliance, Colleges of Ontario, & Council of Ontario Universities, 2017; ICHPUC, 2015). SA complements this assertion by offering an interpretive theory-methods package through which to critically and empirically specify relations amongst various elements, “levels,” and stakeholders of the campus system.

Second, I have demonstrated the value of analytic attention to *tensions*, which are rarely explored except as problems to be mitigated. In treating tensions as meaningful—signal, rather than noise—I have constructed student mental health as a political issue, contested by

differently-positioned stakeholders with heterogeneous and valid priorities and interests. I have complemented this inquiry by incorporating students' local voices and sense-making, revealing that multiple *languages of suffering* (Brinkmann, 2014) remain useful and legible on campus. Such workable multiplicity might raise uncomfortable questions for premises of mental health literacy (e.g., Wei et al., 2015): namely, literacy in whose language?

Finally, I have sought to take a stance of sincere curiosity—of braided generosity and critique, suspicion and faith (Josselson, 2004)—toward campus mental health actors/ practices. I have found Mol's (2010) notion of *goods* useful in this endeavour. Furthermore, I believe this notion beautifully complements the SA commitment to representing social worlds and discursive positions “on their own terms” (Clarke et al., 2018, p. 166), that is, documenting with integrity (though not always endorsing) their “terms of legitimacy” (Cobb, 2013, p. 14). I am aware of only one other study, a dissertation focused on kindergarten mealtimes in Denmark (Hansen, 2016) that brings Mol's notion of goods into Clarke's SA method. Therefore, the current project might further advertise these theoretical resources to other researchers, particularly those who are invested in simultaneously critiquing and working within situations of care.

Sensitizing Implications for Policy and Practice

Mental health is often treated as though it is a coherent epistemic object (Danziger, 2003), a single social problem (Spector & Kitsuse, 1977/2011). At the same time, we are taught that “mental health means striking a balance in all aspects of your life: social, physical, spiritual, economic and mental” (CMHA Toronto, n.d., para. 1). A curious doubling is at work: *mental* is listed as one aspect of life, yet *mental health* somehow contains all aspects of life. In the NCHA (ACHA, 2016), a single heading for “Mental Health” encompasses items about psychiatric diagnosis and treatment alongside questions about arguably common emotional experiences such

as loneliness, sadness, overwhelm, and anger. Even more broadly, it includes questions about whether any life areas have been “traumatic or very difficult to handle” (p. 15), including academics, finances, family problems, personal appearance, health issues, and sleep difficulties. Mental health, it seems, can include everything and anything. On campus, as I have described, it has been invoked in relation to a huge range of activities, from earnest self-optimization and lighthearted group bike rides to socio-political self-identifications and legal accessibility claims to deep, life-threatening despair and alarming breaks with reality.

In many ways, mental health appears less as an object than as what Berlant (2007) calls an impasse, that is, “a singular place that’s a cluster of noncoherent but proximate attachments that can only be approached awkwardly, described around, shifted” (pp. 434-435). Although Berlant is writing about sex, her descriptions are strikingly trenchant to how I have come to understand mental health. Borrowing her theorizing, we might say that student mental health

is not a thing, it’s a relation ... it’s an experience of becoming disorganized that, at the same time, can be lived through, assimilated, talked about, tracked (noticed, fetishized, historicized, genealogized), and forgotten, while also being a threat to well-being and to fantasies that in the good life people ought to be protected from being too chaotic, unstable, ambivalent, or enigmatic. (Berlant, 2007, p. 435)

Berlant (2007) notes that “to substantiate this cluster of phrases in a way I can live with takes work” (p. 435). This is the implication toward which I am gesturing: that policymaking in relation to the *impasse* that we call mental health might be enhanced by a posture of tentativeness, of “conversing, reading around, rephrasing, listening, nitpicking” (Berlant, 2007, p. 435). I have no doubt that most researchers and policymakers will continue to orient to solution-focused consensus; this is one form of good. I hope to have raised another possibility, that we might take a stance of curiosity toward tensions and alternative goods that might be at stake, rather than relating to them as threats or inconveniences. We might also do well to

acknowledge the complex and ever-shifting nature of the situation, and to be humbler in our ambitions. We do not always have solutions at hand.

Regarding implications for counselling or other professional mental health practice, the positional maps in Chapter 5 could be used as sensitizing devices when working with students: How does this student take up biological, biographic, and/or moral discursive positions in making sense of their mental health struggles? How do they position themselves as receptive and/or agentic with regard to problem-solving? The maps could even serve as in-session prompts for dialogically working up language that is fitting and adequate to the student's predicament, with the added effect of sensitizing students to the possibility of multiple understandings. Counsellors often choose to enter into, or join, student clients' meaning-making and theories of change (cf. Duncan & Miller, 2000). Positional maps remind us that if a client has exhausted the resources of their current discursive repertoire, that is, if they seem to be discursively *captured*, counsellors can venture alternative possibilities for sense-making and responding through processes of "braiding" or discursive supplementation (cf. Strong et al., 2015).

Given what I have both read and experienced about stepped care and efforts to "manage" services at campus counselling centres, I recognize that the dialogic and collaborative ways of working described in the preceding paragraph may be a vanishing luxury at some centres. We might, therefore, consider designing counselling groups or even self-help resources informed by a range of discursive positions. Perhaps websites could feature an interactive infographic resembling a positional map; students could explore self-guided content associated with varied discursive constructions of mental health problems. Given the current appetite for "innovative" mental health services (that is, services that are less expensive than one-on-one counselling), there may be possibilities for innovating in ways that protect and advance discursive multiplicity.

That said, I also hope my analysis has sensitized readers to the contested nature of the student mental health situation. For campus counsellors or other student services professionals who find themselves at odds with dominant or compulsory constructions of mental health (or austerity logics), my analysis may serve as a reminder that the construction of resistance as parochial, unrealistic, and so forth is a *political* strategy. Collective and individual actors in a political arena may choose to resist the positioning assigned to them, and to assert an alternative self-positioning. Of course, doing so typically involves trade-offs; it may jeopardize other goods, such as relationships with colleagues and, possibly, ability to help students within existing structures. I reiterate Berlant's (2012) maxim: "No one wants to be a bad or compromised kind of force in the world, but the latter is just inevitable" (p. 177).

The final sensitizing implication I will highlight comes from my analysis in Chapter 6. Students are not *only* students, nor are they isolated individuals. However, my analysis of campus mental health services suggests that family therapy is rarely advertised, perhaps consistent with assumptions that young adulthood should be a time of individuation (cf. Mattanah, Hancock, & Brand, 2004). This site of silence might constitute a significant missed opportunity for helpful and enduring change, given the number of students living with (or otherwise in ongoing meaningful relationships with) family. Extending this line of thought, perhaps we are missing opportunities for fresh approaches to systemic therapy on campus. Residence floormates, roommates, peers in a small academic program, and friend groups may all significantly co-constitute a student's habitus (Bourdieu, 1990) and relational self. Any or all such people might participate in the problematic or healing interpersonal patterns (Tomm et al., 2014) by which mental health problems are sustained or (potentially) interrupted. To my knowledge, the possibility of systemic therapy with "chosen family" or "voluntary kin" (Baugh,

2015; Blair & Pukall, 2015) remains unexplored. For students with more disruptive or troubling concerns, we might imagine variations on an open dialogue approach (Seikkula & Olson, 2003) in which a student's community is recruited to participate deeply in planning for healing, recovery, and managing crises. More broadly, I wish to raise the possibility of moving beyond models of individual therapy to imagine how healing might be undertaken in and with communities—operating not from standardized curricula and psychoeducational logics but from responsive dialogical work with situated narratives, meaningful relationships, and local practices (cf. Pizzini & Gremillion, 2017).

In Closing

In 2017, I attended the conference *Social Pathologies of Contemporary Civilization*. One of the keynote speakers, Hartmut Rosa, introduced his notion of *resonance*, an ambitious theoretical formulation of the good life. In brief, Rosa describes resonance as a mode of being in the world in which we are both *affected* by the world and experience self-efficacy to *move toward and affect* the world. Resonance is transformative, Rosa posits, and “unseizable,” that is, emergent and unpredictable. Resonance can neither be guaranteed nor experienced on demand. In “constitutive moments of resonance,” he writes, “our *wire to the world* begins to vibrate intensely, ... our relationship to the world begins to breathe” (Rosa, 2019, p. 15). Its inverse, alienation, is a state in which these wires fall silent, in which people “experience the world as flat, mute, cold, and hollow, no longer capable of affecting them ... subject and world lose their color and sound in equal measure” (Rosa, 2019, p. 180). Rosa posits that burnout and depression constitute extreme and prolonged forms of alienation.

I invoke resonance and alienation to end this dissertation on an expansive note. We all want students to live good lives. The construct of mental health, as I have demonstrated, contains

multitudes—and simultaneously limits our imaginations, keeping us confined to the domain of *health* and its analogues of wellness, thriving, and so forth. Playing with new vocabularies through which we might understand suffering and “the good life” might help spark unexpected insights and possibilities. “*A better world is possible*,” Rosa (2019) insists, “and it can be recognized by its central criterion, which is no longer domination and control, but listening and responding” (p. 459). Although I have spent an entire dissertation troubling general principles and universal truth claims, I feel content to endorse *listening and responding* as safe bets for building better worlds, on campus and beyond.

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Appendix A

Social Media Recruitment Announcements

Recruitment was primarily accomplished via paid Facebook/Instagram advertisements in the form of a) “promoted” pages/posts and b) “boosted” posts. These posts used the following text, accompanied by one of three photos (with no identifiable faces) of the U of C campus and downtown Calgary:

“Are you a U of C student, aged 18-25? Have you gone through something that you (or others) might consider a mental health problem? By sharing your experience, you can help us better understand the many ways that people get through real-life difficulties.”

Advertisements were linked either directly to the study webpage or to the study’s Facebook page (“Research Study: Ways of Understanding Mental Health Problems”), which featured links to the study webpage. I created the study webpage as a nested sub-page within my student profile webpage, which was itself nested within my primary supervisor’s University of Calgary faculty webpage.

The following additional posts were shared within the aforementioned Facebook group, with a “Global/Everyone” setting so they could be easily and widely shared amongst friend networks:

- a) “Are you a U of C student, aged 18-25? Have you gone through something that you (or others) might consider a mental health problem? By sharing your experience, you can help us better understand the many ways that people get through real-life difficulties. Click here to learn more: [webpage link]”
- b) “Please share! I’m studying students’ experiences of emotional difficulties or mental health problems – looking for U of C students willing to share their stories with me :) Thanks!” [accompanied by webpage link]

Appendix B

Screening Email Template

I used the following template to respond to prospective participants who contacted me by email as a result of posters, social media announcements, or website views. Specific wording was tailored to the prospective participant's email inquiry, but covered the following key points:

Dear _____,

Thank you for your interest in my study on how postsecondary students understand and experience emotional difficulties or mental health problems. The formal title of my study is *Postsecondary students' self-understandings and problem-solving in a "mental health" era*. With this research, I hope to help counsellors, administrators, and policymakers better understand the many ways in which real students get through emotional difficulties and life challenges, including those that are considered mental health problems.

I have attached a Letter of Information and Informed Consent with more details about the study and what participation would entail. Please take a look – if you have questions about anything (big or small), do not hesitate to ask me.

I have six screening questions that I ask of anyone who is considering participating in this study:

1. Are you currently a student at University of Calgary?
2. Are you between the ages of 18 and 25 (inclusive)?
3. Have you gone through an experience that you, or someone else, might consider a mental health problem? (Note that you may agree, disagree, or partially agree with interpreting the experience as a mental health problem).
4. Although I know that these sorts of difficulties can be ongoing, would you say that the "peak" or most difficult part of the problem took place at least a year ago (but no more than five years ago)?
5. Are you currently having thoughts of harming or killing yourself, or harming or killing anyone else?
6. Do you feel like you have adequately "gotten through" the difficulty/challenge/mental health problem that you experienced? In other words, do you feel as though you are "doing okay now" with regard to this problem?

[If the prospective participant had already addressed some of these questions in their initial email, I acknowledged this information in an appropriate way—for instance, "Thanks for the details in your email; it seems like you've answered some of these questions already, and if you decide to participate I look forward to hearing more about your experience. However, I still need to directly ask these six screening questions of anyone who is considering participating in my study."]

If you are interested in participating (after reviewing the attached Letter), please e-mail me back with answers to the six screening questions. If you're eligible to participate, we can schedule an interview. If you would rather discuss these questions by phone, I can be reached at (xxx) xxx-xxxx (we can also meet in-person, if you prefer). Your emails and our phone or in-person conversations will remain confidential (unless I have reason to believe you pose an imminent risk to yourself or others, or if a child or dependent adult is at risk).

Thank you, and I look forward to hearing from you again soon!

Best regards,

Karen Ross, MA
PhD Candidate, Counselling Psychology
Werklund School of Education
University of Calgary
[email and telephone contact information]

Appendix C

Letter of Information and Informed Consent

**Researcher:**

Karen Ross, MA, PhD Candidate
Werklund School of Education
[email and telephone contact information]

Supervisor:

Dr. Tom Strong
Werklund School of Education
[email and telephone contact information]

Title of study: Postsecondary students' self-understandings and problem-solving in a "mental health" era

Sponsor: Social Sciences & Humanities Research Council of Canada

This consent form is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study.

Purpose of the study:

I am interested in learning about how young adult postsecondary students (aged 18-25) make sense of, and respond to, the emotional difficulties or emotionally significant life challenges that arise in their lives. It is common for emotional difficulties to be interpreted as mental health concerns (e.g., depression or anxiety) – an interpretation that fits for many people. However, some scholars have argued that there are many legitimate ways of understanding these types of problems – and many diverse and creative ways of working through them.

In an earlier phase of the study, I analysed how mental health is written about in online articles, in awareness campaigns, and in university policy documents and program descriptions. By now turning to students themselves, I hope to create detailed "maps" of how postsecondary students' mental health is understood – in different ways and by different groups of people.

What you are being asked to do:

I will be interviewing 10-12 students about an emotional difficulty or emotionally significant life challenge that they experienced – an experience that they *or others* might understand as a mental health problem. Although emotional difficulties often ebb and flow – or have some lingering or ongoing effects – in order to participate in this study the ‘peak’ or most difficult part of this difficulty or mental health problem must have been at least one year ago (but no more than five years ago). The interviews will take somewhere between 45 minutes and 1.5 hours.

I will be asking questions about the nature of the mental health problem/emotional difficulty/life challenge, how you felt or made sense of the problem at the time, and what you did to work through or cope with it (if anything). I will ask who or what else helped (or tried to help) you respond to the problem, in any way (including professionals *and* non-professionals). I will ask if anything changed in how you understand the problem as you look back on it now.

Although I am trained as a counsellor, I will not be acting as a counsellor in the context of this interview. For this reason, I am only accepting people to this study who feel they have adequately “gotten through” the problem/difficulty/challenge that they choose to discuss. This will mean different things to different people. The bottom line is that you need to feel as though you are “doing okay now” with regard to this problem. If you are still feeling pretty distressed or upset about the problem, and especially if you have any thoughts of self-harm or ending your life, the study won’t be a good fit for you – but you can still contact me if you need suggestions of where you could look for help/support.

Your participation in this interview is voluntary. You are free to choose not to answer certain questions, or you may choose to stop the interview at any point. Withdrawing will not adversely affect you in any way.

A note about my approach to data analysis:

When I analyse the transcripts of these interviews, I will interpret them both “at face value” *and* critically. This means, for instance, that I will sometimes consider *where* people’s ideas might have come from and what effects these sorts of ideas have in society (this approach is sometimes called *deconstruction*). I come from the assumption that we don’t invent the knowledge or language that we use to make sense of our lives – it comes from *somewhere*. Sometimes people use language or ideas that have implications that they’ve never considered – the language carries unintentional “baggage.” My role as a researcher is to critically think and write about some of these implications or baggage. If I do, this *doesn’t mean that I am criticising you*.

For instance, someone might say, “Depression runs in my family.” In my analysis, I might interpret this statement as reflecting an idea about “depression” as a distinct entity/“thing” that can be hereditary (perhaps genetic or biomedical). I am not making any claims about whether or not this statement is true – just that it can be seen as part of a certain way of talking about an experience that gets labelled “depression.” I also am not making any claims about how the participant *intended* the statement – only that such statements may be interpreted in a particular way by others in society. I will work to treat your narrative with respect, even when I look at the

“baggage” that might come along with your language. If you have any questions about this, please ask me.

What personal information will be collected? What happens to the information I provide?

When you contact me, I will have your name and e-mail so we can correspond. However, once we conduct the interview, I will invite you to choose a pseudonym that I will use in subsequent work with your interview transcript. I will ask you some basic demographic questions such as your age, gender, and cultural self-identification.

I will be audio-recording our interview so I can transcribe it later. When I transcribe it, I will remove or disguise any names or identifying information. I will email you a copy of the anonymized transcript to ensure you’re satisfied with how I’ve disguised the identifying details. Please review the transcript within three weeks of the sent-date of that email. If I do not hear back from you within three weeks, I will assume it is okay to proceed with analysis.

My analysis of these transcripts will be used for academic purposes such as my dissertation, journal articles, book chapters, conferences, and other forms of academic knowledge dissemination.

If you decide after the interview that you want to withdraw your data, please contact me within three weeks of when I send your anonymized transcript. If you have concerns after this point, please contact me and I will make every effort to withdraw your data; however, this will not be possible once the first draft of analysis/results has been completed.

I will securely store the audio-recording and signed consent form (the one with your real name) in a locked cabinet in my home office. This information will be destroyed after five years.

Why is this research important?

We’re seeing a lot more attention paid to mental health these days. However, we don’t know whether the language and assumptions used in mental health policies, campaigns, and media is reflecting how young people actually make sense of their emotional concerns. I come from an assumption that having *more* ways of understanding complex emotional difficulties is better than having *fewer* ways, and that there’s no one *right* way to understand human emotional pain or life challenges. Because of that, I want to call attention to a) how media and policies can shape our ways of understanding emotional or mental health problems and b) how young people make sense of emotional challenges – both in mainstream and alternative ways.

Are there risks or benefits if I participate?

I do not anticipate that you will experience any risks, harms, or inconveniences as a result of participating in this research. However, because I am inviting you to discuss a past difficult experience, there is a chance you could start to feel upset. If this happens, please let me know. We can stop the interview, take a break, or switch topics. It is important to me that by the end of the interview you feel as good, or better, than when we began.

This research offers you the chance to contribute to scholarly and professional understandings of the complex and resourceful ways in which people get through difficult emotional experiences. Some people enjoy sharing their story with a researcher, and/or come to new insights about their experience as a result of our conversation.

Signatures

Your signature on this form indicates that 1) you understand to your satisfaction the information provided to you about your participation in this research project, and 2) you agree to participate in the research project.

In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time. You should feel free to ask for clarification or new information throughout your participation.

Participant's name: (please print) _____

Participant's preferred pseudonym: _____

Participant's Signature: _____

Date: _____

Researcher's Name: (please print) _____

Researcher's Signature: _____

Date: _____

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Karen Ross, MA, PhD Student
Werklund School of Education, University of Calgary
[email and telephone contact information]

or

Dr. Tom Strong
Werklund School of Education, University of Calgary
[email and telephone contact information]

If you have any concerns about the way you've been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, University of Calgary at [email and telephone contact information].

A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form.

Appendix D

Semi-Structured Interview Guide

Age:

Gender:

Cultural self-identification:

1. Tell me about the experience (“the problem”) that you would like to focus on for this interview – the one that could be considered a “mental health” concern. What happened? What led up to it?
2. How were you making sense of [*interpreting/understanding*] your experience at the time?
 When did you start understanding it as a problem?
 What do you think contributed to you making sense of it in that way?
 Were there any changes in your understanding of the problem as you went through it?
 (Prompt: What contributed to these changes?)
3. How did you respond to or deal with the problem – at first? As time went on? What was helpful, neutral, or unhelpful?
4. Who else got involved in your efforts to deal with the problem? Did they understand the problem the same way you did? Did your understanding of the problem change because of them? Did you get them involved intentionally, or did they volunteer (or impose) their involvement/help?
5. Did you seek any professional help in response to the problem? What sort? What role did that play in your efforts to deal with the problem? Did you explore any other resources (e.g., self-help books, online information?)
6. Looking back now, how do you make sense of the problem? (Prompts: how do you define it? Do you understand it as having any meaning or purpose? What do you think caused it?). Has the problem had any lasting or ongoing effect on your life? What’s your relationship to the problem now? Is there anything you still do with relation to the problem?
7. Do you think others struggle with similar problems? Do you think they understand it in similar ways to you, or different? Why? What advice might you give others with a similar problem?
8. Where do you think you’ve gotten your ideas or knowledge about mental health? Have you heard/read anything that shaped how you understand emotional difficulties or mental health problems? (Prompts: different types of media, online articles/websites, campaigns, talking to friends or professionals. Prompt for specific sites, articles, films, messages.)