Talk, Body, Performance: Mental Health Rhetoric in Corporate, Government, and

Institutional Settings

By

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I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

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Abstract

Rhetorical studies in health and medicine often point out the ways in which medical empiricism is structured as an arhetorical entity. This dissertation delves into a rhetorical analysis of psychiatric illness through a study that considers how rhetoric informs how mental health is viewed, treated, and embodied in the present-day Canadian context. This study uses a combined methodological approach, merging classical concepts of rhetorical analysis from Aristotle with more contemporary conceptual theories by Kenneth Burke to Michel Foucault, within a disability studies framework. This approach is applied to examine how mental illness is rhetorically structured in corporate, government, and institutional settings. The major campaigns informing this study include the Bell Let's Talk campaign, the Government of Canada's E-Health initiative, Better Health Together, the institutional response to student suicide at the University of Waterloo, and Queen's University's Jack Talks campaign. By bringing together various mental health campaigns that purport to end stigma, treat mental health, and work towards a mentally "healthier" society, this study seeks to formulate a framework that students and teachers can use to rhetorically assess mental health discourse without resorting to what Robert Crawford would call 'healthist' assumptions while concurrently encouraging the formulation of non-discriminatory practice. This dissertation argues that the mental healthcare campaigns call forth very specific forms of "talk," performativity, and embodiment that shape, limit, and constrain the ways in which psychiatric disability is treated within a Canadian context. Through a rhetoric of self-care, healthcare is depoliticized and individualized; a constrained conceptualization of "good" mental health is shaped through corporate, government, and institutional campaigns.

This study considers the lived experience of people with a psychiatric disability, and merges this disability studies framework into a discussion of how people with mental disabilities are represented in healthcare campaigns. The analysis uncovers common disabling tropes and myths such as overcoming, disability as tragedy, and disability as (bodily) erasure.

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Table of Contents

List of Figures

Introduction

On Monday, October 1st, 2017, a shooter opened fire from the 32nd floor window at the Mandalay Bay Hotel. Below, people scrambled for cover at a country music festival. A total of 58 people were killed, and 515 people were injured. This attack is, to date, the largest mass shooting in United States history (Scott). Almost all media reports covering this tragedy focus on the mental state of the shooter. A Canadian national news source quotes a sheriff, who states, "I can't get into the mind of a psychopath" ("58 Killed"). A *USA Today* news article quotes Olympic Gymnast, Aly Raisman, who asks "why is it so easy for crazy people to get guns?" ("Sports World Reacts"). Most other articles simply refer to the shootings as "so crazy." Multiple reports paint a picture of a shooter who just mentally "snapped." In one report, FBI profiler Jim Clemente suggests that a "psychological autopsy" is necessary to determine if "a neurological disorder or malformation" ("Las Vegas") is present in the shooter's brain. Clemente extrapolates the idea that mental disorders lead to violence when he explains that "genetics load the gun, personality and psychology aim it" ("Las Vegas"). As has been the case in other mass shootings in the USA, mental health is framed as the cause for the violence. In North American society, deviance is pathologized in myriad diverse ways, mental illness being one of the markers used to individuate, separate, and isolate people who fail to act according to expected norms. The normative position is often white, middle to upper-class, male, western, heterosexual, able-bodied, and mentally non-disabled. Media reports often reflect a normative position. Acts of violence are attributed to people who deviate from expected norms. People who are deviant are classed, raced, or marked with a disability that differentiates them from the norm. Mass murders are often, if not always, said to be "crazy." Mental illness is framed as the reason they kill; and it is, further, the characteristic that marks them as "other" in society. In her

1

book *Mad at School,* Margaret Price outlines the rhetorical construction of mental illness in America by exploring how shooters are framed as dangerous, violent, and mentally-ill lone wolves. After reading Price's book, I began to think about how the rhetoric of mental illness manifests in a Canadian context; moreover, I began to turn my attention away from constructions of mental illness in film and the media towards campaigns that purport to help people with mental illness. I began to wonder how mental illness is rhetorically framed by these helper campaigns. I wondered if negative connotations of mental illness were so deeply ingrained within our society that the very campaigns established to raise awareness about mental illness would, inevitably, reflect and disseminate problematic disability stereotypes. The disability studies perspective that informs this study first and foremost views mental illness not as a deficit or a biological flaw, but as a rhetorical entity that changes according to social and cultural ideological constructions. I wish to consider what types of experiences people with psychiatric disabilities may face when accessing help through various mental health care campaigns. I further want to query notions of mental illness in the Canadian context. To achieve this, my research first asks what is the rhetoric of mental healthcare and further questions if mental healthcare campaigns perpetuate negative stigmatizing representations of mental illness.

This dissertation study questions social, cultural, and individual subject-shaping implications by examining major mental healthcare helper initiatives initiated by corporate, governmental, and institutional organizations. It is my belief that a rhetorical analysis of these health care initiatives is necessary to disrupt the highly celebratory discourse that these campaigns employ and also disrupt the acts that these campaigns call for by guiding consumer behaviour—which is, inevitably, citizen behaviour.

Methodology

Following Judy Segal and Patricia Kelly, this dissertation approaches the rhetorical analysis of health care by applying a neo-Aristotelian methodology. These rhetorical health scholars merge an Aristotelian framework of speech production into an analysis that examines how these speeches can be received. Aristotle's theories are used as a conceptual framework for examining the elements that exist between the speaker, audience, and expressive modes of delivery. While Aristotle's notions are useful for conceptualizing a rhetorical framework for analysis, many critics point out that classical rhetoric has its limitations when applied to contemporary texts. As a response to contemporary analyses of health and medicine, this dissertation employs a hybrid methodology that blends theoretical applications. Aristotle informs this work, as rhetoric is "an ability in each particular case to see the available means of persuasion" (Aristotle qtd. in Warnick, 25). Guiding neo-Aristotelian principles will underlie and frame each analytical chapter. Aristotle's rhetorical principles frame the chapters, while more contemporary rhetorical scholarship, such as that of Kenneth Burke, is brought into the discussion where suitable.

Kenneth Burke and Health Rhetoric

The premise engrained in the field of health rhetoric is that rhetorical study, the study of persuasion, is an excellent means by which to study, frame, and recast questions essential to our health. In Western contexts, health most often means well-being as it is treated within the medical framework. This study isolates health rhetoric produced within the western framework of medicine in North America. While persuasion may not be an overt element in the field of medicine, health rhetoricians work to uncover persuasion as a central element embedded within many medical contexts. Kenneth Burke's theories are foundational to the field of Health Rhetoric.

Health rhetoric is born out of the rhetoric of science movement. Jack Seltzer, in *Understanding Scientific Prose*, writes rhetorical analysis of science or health would have been impossible to imagine had it not been for thinkers like Kenneth Burke, whose theories lead to the critique of scientific belief—previously thought to be a truth free from rhetorical influence. Since the 1970s, health rhetoricians have worked to document the modes of rhetorical appeals embedded with healthcare. Theorists Kenneth Burke and Thomas Kuhn (among others) represent two key theorists whose theories lead to rhetorical analysis of healthcare. Burke's notion of scientific discourse as a shared, communal, formative discourse based on identification works if paired with Thomas S. Kuhn's model of science, which states that knowledge communities generate scientific knowledge by communal language, "an explanatory theory, rules of practice, puzzles, instruments, and standards of instrumentation" (Kuhn qtd. in Segal 12). According to Randy Allen Harris, Kuhn "provides a kind of touchstone for rhetorical inquiry because he actually uses the word persuasion to talk about how scientists are won over from one 'disciplinary matrix' to another" (Harris qtd. in Segal, 12). By making rhetoric a fundamental feature of scientific production and scientific meaning making, Kuhn notes that persuasion is a key element in the discourse of science, which is a fundamental tenant to health rhetoric scholarship.

Two specific modes of analysis, taken from Burke, established the field and continue to be utilized for the rhetorical study of health and medicine. Device number one is "identification." Segal notes that "first, Burke's attentions are seamlessly both traditional and 'new rhetorical'. According to Burke, 'the key term for the old rhetoric was persuasion and its stress was upon deliberate design. The key term for the new rhetoric would be identification, which can include a partially unconscious factor in appeal" (quoted in Segal, 11). The "new"

rhetoric formulated under Burke uses identification as a primary appeal to an audience by a speaker, including both overt identifications and unconscious ones.

The second aspect from the Burkean lexicon utilized by the field of health rhetoric is, according to Segal, "inclusiveness" (12). Everything in the world, especially science and health, can—according to Burke—be analyzed rhetorically. In Burke's words, rhetorical scholars must "realize how ubiquitous 'oratory' is today, particularly in written forms that often pass for sheer 'information', 'knowledge', 'science'" (Burke qtd. in Segal, 11). Rhetoric is the art of influence, the art of persuasion in which the rhetorician and the audience form an "identification" on mutual grounds, in order to establish meaning making in the fields of science, knowledge, and sheer informative grounds. The rhetorician is not simply an "agent" in Burke's terms, but also an "agency" for knowledge discourse already in circulation. Specifically, Burke's theory of co-substantiation, which refers to a rhetoric that enacts social cohesion via one party identifying, or aligning, with the other party based on a shared set of values, is adapted to be applied to online material throughout this discussion. I will argue that corporations and government sources cosubstantiate with a customer base through sharing, tweeting, and posting online in mental health campaigns which works to standardize mental health discourse in very specific ways.

In this dissertation, I will specifically interrogate the "identification" called for through "healthism." The term "healthism" is a neologism first defined by Robert Crawford. According to Crawford, "healthism" is a "the preoccupation with personal health as a primary focus for the definition and achievement of well-being… healthism treats individual behaviour, attitudes, and emotions as the relevant symptoms needing attention" (368). Healthism locates both the disease and the cure as problems that an individual is solely responsible for. By focusing on 'individual behaviour, attitudes, and emotions as the relevant symptoms needing attention,' healthist

5

ideology removes the responsibility for good health from the social institutions providing healthcare. In the social struggle for good health, healthism turns good, social health and well-being into a privatized venture where the individual bears the sole responsibility for their wellness. I will focus through this dissertation on the embodied identification and consubstantiation that this specific rhetoric of health demands in our culture.

Disability Studies

While this dissertation is situated as a health rhetoric analysis, multiple readings in this dissertation draw upon a critical framework rooted within disability studies. Disability studies is highly critical of the medical model of psychiatric disability, as the field seeks to examine, recast, and read psychiatric disability using alternative frameworks. Often, the medical model casts psychiatric disability as a biological deficiency. Disability scholars seek to complicate the idea that disability is an impairment requiring a cure; instead, considerations of a social and historical nature inform the discussion. Disability critic Jay Dolmage uses questions of a rhetorical nature in his consideration of a disability aesthetics. In his book, *Disability Rhetoric,* disability theorist Jay Dolmage argues for the critical link to be made between rhetorical study and disability studies. Dolmage writes that "rhetoric needs disability studies as a reminder to pay critical and careful attention to the body. Disability studies needs rhetoric to better understand and negotiate the way that discourse represents and impacts the experience of disability" (3). By situating disability as rhetorical, Dolmage reclaims the disabled body in rhetorical history, reminding scholars that considerations of the disabled body must include rhetorical considerations of persuasion and meaning making. This study inserts considerations of the body into mental health discourse to show how images of physically broken bodies are taken as proof of disordered and sick minds.

Talking about personal narratives of mental illness is a matter addressed by disability scholars who recognize the necessity of adding personal narrative perspectives on mental illness, in a way that illuminates and diversifies the standardized notions of psychiatric disorder. Identity politics is a foundational component of disability studies scholarship. As a political movement, disability studies is about reclaiming, defining, and representing disabled identity through lived experiential narratives (Linton; Dolmage). Personal narratives are incredibly important additions to theoretical conversations surrounding disability politics because they provide voices that counter the often disabling ideological constructions of illness. Theorists such as Margaret Price, Andrea Nicki, Anne Wilson, and Peter Beresford have written on the need to widen the scope of disability studies in order to include psychiatric disabilities under its theoretical umbrella. To perform such a complex endeavor, Price notes that researching writings by persons with psychiatric disabilities should be used to illuminate and expand our understanding within the field of disability studies. However, this does not mean that disability memoir narratives should be taken wholeheartedly as the "truth" regarding mood disorders. Instead, these texts must be examined using literary and rhetorical criticism in order to assess the strategies employed via memoir, as well as to consider the wider implications of these representations. For example, several critics note that a problematic aspect of disability autobiography is that the author's narrative often follows the generic conventions of a heroic tragedy. According to disability theorist Margaret Price, heroic tales conventionally feature a protagonist who overcomes great misfortune. This disability narrative trope heightens the author's "otherness" or difference, while the non-disabled reader revels in their "normalness" ("Pronouns", 16). Thomas G. Couser also engages in this debate by similarly arguing that rhetorical patterns employed in disability memoirs often conform to an expected script. He notes

that disabled bodies are often called upon to account for their disability with a story. Moreover, those stories are expected to "relieve their auditors discomfort" (604) by (re)inscribing negative cultural expectations of disability. These writings tend to follow standardized rhetorical forms of generic convention that both shape and reflect (negative) cultural discourse.

Amid negative social notions of disability, disability activism is an integral, foundational, and essential component of disability studies scholarship. Academic studies in the field began to question the disabling effects of the environment itself. Dolmage notes that the protests that prompted the passing of the Americans with Disabilities Act often articulated the sentiment that "exclusionary structures at least partially created disability" (Disability Rhetoric, 95). Adrienne Asch echoes this statement when she writes that disability scholars should "question how to modify the environments so they are not disabling" (16). Entangled within the divide between identity activism and disabling environments is the idea that disability is both a material identity and a result of cultural ideas and environments. To fully understand mental disability, disability scholars must embrace the idea that disability is both a material psychiatric condition and a result of constructed cultural conditions. By embracing both realities, a more nuanced picture can begin to emerge that challenges static conceptions of mental illness.

Social Constructivism

A movement known as the "social model of disability" rose to prominence in the 1980s in disability studies. A social model of disability looks at how underlying social factors could be generative of a disability. In this model, societal inclusive practices are preferred to the cure-based fixed approach used in the medical model. However, the social model suggests that disability is a pure social construct. As a material theorem, the social model has drawbacks in that disability as a bodily impairment and socially oppressive values concerning disability are

8

both real, tangible issues, but the social model exclusively focuses on how society is the major oppressive force. This theory divides bodily impairment and social impairment, leading critics to articulate more nuanced theorizations of disability as an embodied ontology, which also considers questions of cultural disablement.

From the "social model" arose the idea of cultural constructivism, a postmodern way of viewing disability. Looking in such a way follows Asch's comment that "saying that disability is socially constructed does not imply that the characteristics are not real or do not have describable effects of physiological or cognitive functions that persist in many environments" (18). A postmodern way of looking does not diminish the fact that disability has concrete circumstances. Dolmage further explains that interrogating the environmental and cultural constructions of disability has value if we shift the way we think about disability as a lack, and further consider how to manipulate and change the environment to minimize disabling effects. A transformation of both environmental and linguistic representations of cultural constructions of disability could allow for a new vision of disability to be formed that is transformative and regenerative. To this effect, postmodern theory is often applied in disabilities scholarship in order to deconstruct biosocial cultural notions of disability. Some disability rights advocates and theorists warn that the postmodern view of social constructivism removes the concrete lived experience and political activism necessary to argue for disability rights. Theorizing disability as a construct removes agency from individuals who must assume essential group identity when this group is being denied essential human rights. The social constructivist view disrupts the binary between lived experience and cultural conceptions of disability, complicating notions of agency used by postmodern theorists. Shelley Tremain suggests that a Foucauldian analysis of power relations disrupts the social model, a model she calls a "chimera" (10). Tobin Siebers also advocates for a

social constructionist view of disability, but warns that such a view can erase the realities of the disabled body.

In light of the complex theoretical considerations, theorists Jay Dolmage, Len Barton, and others suggest a "cultural turn" (100) in disability studies, and it is within this movement that this particular study engages in post-modern critique of disability rhetoric. By engaging with post structuralist ideas that take up linguistic representations of disability that work to exclude and oppress, this focus on cultural representations does not neglect "how bodies, minds, senses, and things relate" (Schillmeier, 2). Dolmage explains that "cultures and their expressions can be studied for their role in making bodies, and bodies and their expressions can be studied for their roles in making cultures" (100). The cultural turn in disability studies melds considerations of both the environment and bodily experience, disrupting the false binary created by the social model of disability in ways that lead to generative and more nuanced understandings of disability in our culture. Foundational French theorist Michel Foucault contributes to this work with his theories of governmentality and biopower, which consider how bodies are subject to power relations through discourse—always circulating, always negotiating, always dependent on subjugation and dominance in the cyclical nature of power negotiations. All considerations of rhetoric, in this dissertation, are brought back into conversation with Foucault's theories, to which this work is greatly indebted; and all considerations of rhetoric always engage with the "cultural turn" in disability studies, while respecting the lived realities of disabled people.

Chapter One

Chapter one approaches the question of the rhetoricity of mental health by analyzing the widely publicized charitable initiative entitled "Bell Let's Talk Day." This corporate initiative is read through a disability studies lens to consider how mental illness is rhetorically contextualized

through charity. Bell Let's Talk Day is a charitable initiative run by Bell Canada, a major

Canadian telecommunications and media company. This event is held annually one day in late

January.[1] This initiative runs on the principle that "talking is the first step" towards ending the

stigma surrounding mental health ("End the Stigma"). This highly corporatized initiative sends

out messages such as "turn that frown upside down" (Shafi) and "add your voice to help build a

stigma free Canada" ("Mark Your Calendars"). This day encourages Canadians to "join the

conversation around mental health" ("Mark Your Calendars"). It would appear, at least on the

surface of this charitable initiative, that the stigma surrounding mental health is ending, that

people are having constructive conversations online about psychiatric disabilities, and web-based

therapies are curing patients through the sharing of narratives in online communities.

This chapter applies Kenneth Burke's theories of co-substantiation and terministic screens

in an analysis of Facebook posts, campaign commercials, and biographical speakers, to show

how rhetorical influence manifests online. The section entitled "Heroes" applies Aristotle's

theory of Epideictic rhetoric to campaign commercials. These commercials praise "heroes" of

mental illness for their ability to overcome disability well enough to communicate by using very

specific mannerisms. Furthermore, this "Heroes" section concludes that there is a problematic

privileging of "talk" in the commercials that is both ableist and socially exclusionary. The

second section of this chapter extends the reading, showing how epideictic rhetoric works to both

exclude and include socially acceptable values through the "Faces of Mental Illness" narratives.

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[1] Established in 2011, the campaign started by donating 5 cents from every telephone call and hashtag
generated on or around January 27th to ending the stigma surrounding mental illness (Shafi). This
initiative has raised over $79.9 million as of December 2016 (Major Grants, Bell) to support various
organizations such as the Canadian Red Cross, multiple university Psychiatry Departments, government
mental health initiatives, and the Centre for Addiction and Mental Health (CAMH). Bell Let's Talk
grants further aided various community mental health programs such as the Grand River Hospital in
Waterloo, ON, and Wilfred Laurier University in Waterloo, ON, to support student mental health as well
as increase awareness of the stigma surrounding mental illness (Major Grants).

This chapter finds that the rhetorical presentation of talk and the body promotes problematic disability stereotypes. Specifically, the rhetoric promotes stereotypes and messages based on healthist ideological principles that turn good health into something that can be attained through participation in the Bell Let's Talk initiative.

Chapter Two

This chapter suggests that Bell *re*politicizes mental healthcare in a neo-liberal corporate consumer environment by making good health an individual pursuit. This chapter further demonstrates how the company persuasively shapes and calls forth a very specific subjectivity, based on healthist ideological principles and problematic disability stereotypes, by analyzing online social media posts according to Burke's theory of co-substantiation.

By rhetorically positing mental illness as the enemy, a tension is created in this mental illness campaign as it offers a forum for people for people with disabilities, while simultaneously excluding them as well. Instead of helping people with mental illness, Bell Let's Talk day in fact perpetuates problematic disability stereotypes. The campaign shapes subjectivity in harmful ways that ignore the lived experience of those with psychiatric disabilities. The campaign material speaks to a caregiver audience and not people with real disabilities. The campaign attempts to co-opt psychiatric patient discourse online and erase the possibility of radical "talk" of a critical nature that is so necessary to initiating change in mental healthcare services.

Chapter Three

Chapter three questions the rhetoric of a government health care campaign by critiquing Digital Health Week, which is an annual public awareness program held annually from the 14th to the 20th of November. This campaign was launched in 2014 by the Canadian government. The main goal of this week is to promote the Government of Canada's e-health services, touted

as offering progressive, empowering, and innovative mental health services.[2] This chapter takes

the position that Digital Health Week is highly rhetorical. Optimistically, the Digital Health

Week partners claim that online services can replace traditional health therapies. A tweet on the

Digital Health Week website announces that "E-Mental health services can be as effective as

face-to-face therapy" ("E-Mental Health"). Digital Health Week thus suggests that online health

care is *as good as* traditional therapy; in addition*,* online access to digital health care is growing

and the new patients are being framed as empowered.

Using an Aristotelian sensibility that organizes this argument into three sections, entitled

"Logos," "Pathos," and "Ethos," this chapter analyzes the rhetorical arguments made in the

Government of Canada's E-Health campaign as they relate to mental health. "Logos" unpacks

linguistic terms of commodification through Burke's notion of terministic screens (analogies of

e-health as shopping, e-health as technological rebirth, and patients as doctors). This section

argues that the linguistic terminology of commodification problematically advances the notion of

technology as progress, which works to promote healthist stereotypes. Theories of healthism are

read mainly through Petr Skrabanek in this chapter. The second section, "Pathos," applies

Burke's theory of terministic screens to show how patient stories promote problematic disability

stereotypes. In the section titled "Ethos," ethical considerations guide the analysis of government

media as propaganda. This chapter concludes that government materials attempt to lead subjects

to act, through a reading of governmentality and biopower as conceptualized by Foucault.

A disability studies perspective informs this chapter, which questions how e-health could

affect the lives of people who have psychiatric disabilities. This chapter argues that the Digital

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[2] Digital Health Week is supported by organizations such as the Mental Health Commission of Canada, Patients Canada, Canada Health Infoway, and Ontario E-Health. For a full list of supporting government and health organizations see www.betterhealthtogether.ca

Health Week campaign is highly rhetorical, structuring e-health as a consumer event (shopping is used as an analogy in the campaign) that is highly progressive, healthy, and independently accessible for patients/consumers. The aim of this chapter (as is the case in the first and second chapters as well) is to trouble the acts called for in the discourse by disrupting the highly celebratory rhetoric of the campaign.

Chapter Four

The fourth chapter, "Institutional Rhetoric," uses the rhetorical concepts talk, body, and performance as guiding principles through a comparative essay that examines the rhetoric of mental health in the setting of two university environments. Canadian universities are currently facing what the media reports as a "mental health crisis" (Maclean's). Media coverage following university student suicides is extensive. Reports frame student mental health as a crisis for the university and an increasing burden in terms of government mental healthcare costs. This chapter explores the rhetoric of mental health by analyzing institutional responses to student suicide on campus. The practice of upholding prized speakers whose bodies "talk" and "perform" in very specific, stylized ways is critiqued in this chapter, to disrupt a current strategy that would promote common disabling myths such as "overcoming." These campaigns hail what Joseph calls a "super-crip" performance. This chapter employs the disability studies framework by conversing with foundational studies: the work done in *Academic Ableism* by Jay Dolmage and *Mad at School* by Margaret Price. This chapter finds, following the conclusions reached in the previous two chapters, that institutional responses to mental illness are based upon and steeped in rhetorical principles that are healthist in nature.

In an aim to disrupt the acts encouraged by institutional mental health care campaigns— that people with mental disabilities speak publicly about their mental illness—this chapter

14

situates the rhetoric within a discussion that ties the business of corporate and government healthcare campaigns together with the business of higher education. This section concludes with a discussion of how representation shapes subjectivity in these campaigns and what types of subjectivity are shown as desirable, and it postulates that these campaigns may not be beneficial for students with psychiatric disabilities.

In the conclusion to this dissertation, I draw connections between corporate, government, and institutional mental health strategies to reiterate my argument that the ways in which mental health is rhetorically presented in mental health strategies are steeped in healthist ideological principles that perpetuate problematic disability stereotypes. This conclusion re-states and re-frames the many ways in which this standardized discourse (read through talk, the body, and performance) affects people with psychiatric illness in corporate, government, and institutional settings. The campaigns purporting to help people with mental illness inevitably culturally (re)inscribe disabling disability stereotypes; moreover, these campaigns prevent the alternative, critical discourse necessary to reform or revise the troubling manner in which psychiatric disability is manifested in discourse in the Canadian cultural environment.

At the time I am writing this, the date is Wednesday October 4th, 2017 at 12:00 p.m. My Facebook newsfeed is filled with news reports of the Las Vegas shooter. Reports range from discussing the "psychopathic" nature of his disordered mind to showing pictures of the Las Vegas shooter's girlfriend, who is Filipina descent. This woman is pictured in the reports more often, it seems, than the shooter himself. Media reports frame mental illness and race as markings of deviance and otherness. Margaret Price's words are apt, as she observes, "although mental disability is the primary form of deviance marked in the case studies of [the shooters] lives, it is important to note that these writings also stigmatize other aspects of the men's lives,

15

including race…" (149). Marking of race, mental disability, or other variances from the norm

are ascribed to the shooter to reinforce to the target audience that he is not like you/*us*—he is not

us, nor are *we* responsible for him.

Likely, readers saw these reports on their own news feeds. Some reports on our feeds

call for increased gun control in America in response to the shooting. Other reports call for

increased mental health care services. Statistically, people with mental illness are more likely to

be victims of a crime than perpetrators. A 2011 study by Harvard Medical School reports that

60% of Americans believe people with severe mental illnesses like schizophrenia were highly

likely to commit violent crimes ("Mental Illness and Violence"); however, the study reports that

"public perception does not reflect reality. Most individuals with psychiatric disorders are not

violent" ("Mental Illness and Violence"). I return to the example of the shooter because it

reminds us just how rhetorical mental health can be. This example highlights how the rhetoric of

mental health isolates the problem within an individual rather than considering the systemic

forces at play. The rhetoric surrounding the shooter reflects a hyper-vigilant need to diagnose

the shooter with a specific illness, and the very lack of information surrounding his mental state

dominates and frustrates the media at present. News reports focus on the lack of information as

to his mental state as the problem, as there is a need (a requirement even) to frame this shooter as

mentally ill. The problem must be isolated as an individual event, an individual failure, because

otherwise, socially, we would need to take responsibility as a collective. In the absence of a

concrete diagnosis, some reports call for increased mental health services, assuming mental

illness to be the problem. And it is regarding this last point—the call for increased mental health

care services—that I believe this rhetorical study makes a contribution to the contemporary

discourse of mental health. This dissertation aims to answer the following questions: what does

it mean when citizens call for increased mental health care services? What are people asked to do in these campaigns? What segment of the population is being targeted by these mental healthcare campaigns? What are the rhetorical elements of these campaigns and by what forces are they shaped? What is the discourse of mental illness in helper campaigns? This study addresses these questions from a disability studies framework by questioning the nature of talk, examining the bodies representative of psychiatric disability, and exploring how mental health affect is enacted in a variety of corporate, government, and institutional campaigns. These critical questions contribute to our understanding of the ways in which mental health care helper campaigns both construct and reflect cultural notions of psychiatric disability.

Chapter 1

Corporate Rhetoric

Let's talk, in this chapter, about the social and ethical implications of Bell, a major

Canadian telecommunications corporation, leading a widespread mental health campaign. Let's

analyze the strategies of persuasion used in these online advertisements. Let's question who is

being persuaded and to what end. Let's ask to what effect the corporate rhetoric may influence

other areas of mental health discussion, research, or policy. Let's speak especially about how

mental illness is represented in the Bell Let's Talk campaign, one day in January intended to

raise mental health awareness and funds through a five-cent donation from every talk, text, and

tweet shared online by social media participants.[3]

There has been an explosion of people writing and conversing about their mental

illnesses online in the past decade. Online forums, health sites, and YouTube have provided the

technological means for people to discuss their illnesses and diagnoses in an alternative medium.

In face-to-face professional interactions, disclosing a psychiatric disability could potentially

result in negative consequences. Going online to discuss psychiatric disabilities has and

continues to provide an area where users can speak about their illnesses using their own terms,

seemingly outside of stigmatizing social forces and limiting medical labels. The Bell Let's Talk

campaign attempts to end stigma by encouraging people to have discussions about mental illness.

The Bell Let's Talk website states that "stigma can often prevent those struggling with a mental

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[3] It is important to note in the very first sentence of this chapter that there is an ableist assumption behind the very notion that talking about an illness is possible. Many people with psychiatric illnesses do not have the ability to speak or pronounce their experience of psychiatric disability in the forms of speech acceptable to this campaign—or even those acceptable socially. People with dissociative disorders may be unable to formulate the sort of speech this campaign calls for. Speech that is incoherent or that does not follow a logical thought progression is dismissed. Moreover, some people may not be able to physically produce words to narrate their experience. It is highly problematic and ableist to privilege speech as the Bell Let's Talk campaign does.

illness from seeking the help they need" ("Thank you!"). The sheer magnitude of tweets, shares, and Facebook posts on this day appears to indicate that the conversations surrounding mental illness are helping people with mental illness. Yet the issue is more complex, and there are still very real consequences when one discloses a mental illness in the workplace.

Karen Ho, a contract employee at Bell, writes about how her high-stress position with the company led to mental health issues. Moreover, as a contract employee, she did not have access to the benefits that would have given her mental health days or access to mental health care. She writes that the Bell corporation "[fails] to acknowledge how it participates in the systemic problems affecting the mental health of its own staff" ("Let's Talk About"). According to Ho, when she was employed with Bell, she covered traumatizing and difficult events without support, worked long hours, and experienced harassment, low-pay, lack of sleep, all in a toxic work environment that contributed to and caused mental health issues—specifically, anxiety and depression. Another Bell employee, Maria McLean, also publicly shares the story of her negative experience with Bell. On January 12th, 2017, this radio host was fired from her afternoon show at K93FM, a station that is a subsidiary company of Bell Canada and which is based out of Grand Falls, New Brunswick. She was fired just one hour after disclosing her mental illness to her employer and requesting just two weeks off (with a doctor's note) so that she could adjust to her new medication. The day prior to being fired, Maria McLean was promoted from the afternoon show to the morning show, nor had she ever been reprimanded for inadequate job performance. After hearing she was fired, McLean told her boss that "[she] can't believe [she's] being fired right now for asking for mental health leave" (Weldon). While McLean's supervisor denied her mental health was the reason for the dismissal, no other reason was given. Paradoxically, the very same element that consumers celebrate Bell Let's Talk Day

for (speaking about mental illness) is specifically what is problematic about the campaign. While the Bell Let's Talk campaign urges people to speak out about mental health in the workplace, the campaign fails to acknowledge that speaking out is not going to help if there are no protections in place for those who do speak out.[4]

The following analysis attempts to untangle how mental awareness campaigns speak socially about psychiatric disability and further questions who can speak about mental illness, as this is a problematic concept outlined in disability studies scholarship. Medically, mental illness is regarded as an illness governing the brain and, as such, people lose credibility, respect, and rhetorical agency when mental disability is publicly disclosed. Jenell Johnson argues that disclosing a mental disability is a constitutive rhetorical act in that the discloser is constructed as someone bad, or lacking morality. A meta-ethnographic 2012 study by Elaine Brohan et al finds that job applicants with disclosed mental health problems were rated remarkably lower by employers than applicants with no known disability. This study further finds that "54% of employers would never/occasionally employ someone who was currently depressed, [and] 66% would occasionally/never employ someone with schizophrenia" (Brohan). Speaking publically about a mental disability could result in someone being dismissed from their job, or losing social support, and the Bell Let's Talk campaign fails to acknowledge the serious social repercussions

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[4] The social demand for public disclosure is incredibly pervasive. Various other campaigns employ a similar strategy to the Bell Let's Talk campaign's call for people with mental illness to 'talk' publicly about their disability. For example, from April 2017 to December 2017, the Centre for Addiction and Mental Health (CAMH), a government clinical health care agency based in Toronto, Ontario, implemented a campaign entitled "Nominate a Difference Maker." The campaign calls for Canadians to nominate 150 mentally ill people who are "making a difference in mental health" (Nominate, CAMH). This campaign will choose 150 heroes of mental illness who are making a "contribution" (Nominate, CAMH) to mental illness as a "leading Canadian" (Nominate, CAMH). The call for people with mental illness to publicly profess how they heroically overcame their mental illness (to rejoin society) is entrenched within the discourse of mental health in Canada. Additionally, the Canadian Mental Health Association started a social media campaign entitled "Get Loud" that encourages Canadians with mental illness to "speak up on social media" (Get Loud, CMHA) during CMHA Mental Health Week from May 1-7, 2017. It is noteworthy that Bell Canada is the sponsor of the Get Loud CMHA webpage.

that can follow. While it is commendable that this campaign attempts to raise awareness and

funds for mental health issues, the campaign may rhetorically silence mental health discussion of

a more critical nature.

Problematic healthist assumptions underlie many of the ads in the Bell Let's Talk

campaign. Corporate rhetoric interpellates an online audience whose identity is constituted by

consumerist, healthist ideology[5]. As mentioned, the term "healthism" locates both the disease

and the cure as problems that an individual is solely responsible for. According to Robert

Crawford, "healthism" is a "the preoccupation with personal health as a primary focus for the

definition and achievement of well-being… healthism treats individual behaviour, attitudes, and

emotions as the relevant symptoms needing attention" (368). Good health, furthermore, is

heavily corporatized. Julianne Cheek observes that health has reached "sacred status" (974) in

Western consumer society. Tying the rise of healthism to neo-liberal capitalism, Cheek quotes

Susan Sontag, who comments that "what has followed in the wake of 1989 and the suicide of the

Soviet empire is the final victory of capitalism, and of the ideology of consumerism, which

entails the discrediting of 'the political' as such. All that makes sense is private life.

Individualism, and the cultivation of the self and private well-being—featuring, above all, the

ideal of 'health'—are the values to which intellectuals are most likely to subscribe" (Sontag qtd.

in Cheek, 974). Health rose to an "ideal" status, leading individuals to constantly strive to

improve their health or seek out good health. Cheek notes that the search for health mirrors the

search for the fountain of youth, and governments and individuals promote wellness, living well,

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[5] French Marxist theorist Louise Althusser contributes to this analysis with his theory of interpellation,
acts through which a subject is hailed into existence ("Ideology", 11).

and good health as the primary objective in life. Most importantly, Cheek writes that embracing good health means embracing a range of surgeries, technologies, and services in the search for good health, which would not have otherwise been embraced within a free market enterprise. The boundaries of what constitutes good health are continuously shifting according to the neo-liberal capitalist ideology that raises health to an "ideal" status, allowing corporations to profit off of individuals during the continual (and impossible) search for wellness.

This chapter contributes to a disability studies project by arguing, through rhetorical analysis, the following four broader critiques of the campaign: one, the campaign restructures stories to fit formulaic hero narratives in which the limitations of the genre erase the very real consequences of disclosure; two, the campaign erases the complexities of racial identity and considerations of how intersectionality impacts experiences of stigma and discrimination; three, the campaign paradoxically increases stigma by suggesting that caretakers, as opposed to people with mental health disabilities, should be the ones initiating the conversation; and four, the campaign dismisses any potential for radical dialogue about mental health by co-opting patient narratives and further shaping this discourse in very specific ways.

Hero Narratives

While literary and historical critics dispute the origins, and shaping historical factors of many of the tropes and stock characters common to charitable campaigns, theorist Paul Longmore approaches charity specifically through a disability studies lens. For this reason, Longmore's study informs the charitable campaign section of this work, as I wish to isolate disability as a focus through which to observe historical tropes. He observes that late in the 1960s, Jerry Lewis and the Muscular Dystrophy Association changed the way that disability-related telethons operated in North American society. This national telethon event collectively

22

screened to about "quarter of a billion people in the United States and Canada" at it zenith

(Telethons, 11). Outwardly, to telethon supporters, donating to people with disabilities seemed a

worthy cause; however, Longmore notes that the issue of giving and receiving charity is a

complex issue. Charitable givers were depicted as having the traits of "neighborliness,

generosity, and altruism" (16) by donating to those who were "afflicted" (15) and "less

fortunate" (15). Charitable giving became a spectacle run by big business. The Easter Seals, for

example, paraded two disabled children on television to elicit sympathy and donations. The two

disabled children became known by the monikers "Timmy" and "Tammy"; however, these are

not their real names, nor are the children consistently the same children. According to the Easter

Seals, "the concept of 'Timmy' was borrowed from Dickens' *A Christmas Carol*, in which

Timmy is depicted as child with a physical disability who has indomitable spirit" ("History").

This spectacle was indeed typical of the big-business tactics that charitable organizations

engaged in beginning in the twentieth century. As the nature of charity shifted to a business

mentality in the first half of the twentieth century, campaigns went to extraordinary lengths to

stage spectacles, such as the Warm Springs Foundation which, in the 1930s, launched The

President's Birthday Ball "to pay tribute to [President Roosevelt] who overcame a great affliction

to rise to the highest position" (Longmore, 43). President Roosevelt, who was partially

paralyzed from polio, was celebrated for specifically "overcoming" his disability. He was

lauded for being successful despite not being able bodied. Many well-established charitable

tropes such as "overcoming disability" were implemented during this era. This era ushered in

stock gimmicks, such as big checks, corporate sponsorship, and "high-pressure public relations

techniques," as commonplace charitable fundraising elements (45). Longmore argues that the

stars, pomp, and celebration introduced yet another stock character into the telethons: "the

corporate executive as community moral leader" (48). Under the guise of charity, altruism, and respectability, corporations, according to Longmore, "reinforced the legitimacy of the existing system of status and power" (48). Charities became, in short, a means to celebrate and reinforce normative value systems by reifying symbols of status and political power.

While a telethon is now largely a campaign of the past, our modern-day equivalents still operate on the very same principles that Longmore observes. Massive corporate power structures, in the words of Longmore, "reinforce their own legitimacy of the existing system of status and power" by becoming moral leaders through a problematic portrayal of disability. People with disabilities are excluded from the social sphere because they are objects of the "medical gaze" which places them under the scope of a clinical gaze that ascribes to a medical model, according to Foucault. In this model, the paradigm within which disability is structured situates it as biological defect and object of study. Disability is defined as either a physical or psychological defect, or a lack deriving from an illness or injury located within the body of the individual (Telethons, 10). In this paradigm, medical professionals approach disability with the intent to cure the individual of their disability. Longmore states that the attempt to integrate people with disabilities into society through curing them is an "a-historical approach [that] not only medicalizes disability, it also makes individual and private what is in fundamental ways a social and political problem" (Telethons, 10). Alternative ways of viewing disability, not as a lack or medical problem, are not valued within our society because disability is always viewed within a medical framework.

Specifically, Foucault writes about the medical gaze as a detached observership. The cold, clinical, silent gaze "has the paradoxical ability to hear a language as soon as it perceives a spectacle" (Birth of the Clinic, 108). The medical gaze, for Foucault, denotes the separation of

the patient's body from the patient's identity, and the ensuing conscription of the body into medical language occurs through detached observership. In this modern way of seeing, the body is flattened into a surface that is subject to the observations of the medical gaze. By entering the body of medical knowledge through the detached medical gaze, the body further becomes an object that is subject to power manipulations. The all-knowing clinical gaze is perceived by society as having the ability to treat, cure, and understand the body through diagnosis. The idea that we can know a person by knowing what disease they have and what cure their body requires is practically omnipresent in our contemporary imagination. A diagnosis of the body cuts off all other discussion of a person's identity. Foucault posits in his theory that the surface of the body is an individual site upon which discourse is routinely redistributed, as upon a "face," and it constitutes its objects with preformed identity. In "The Discourse on Language," Foucault perfectly summarizes what he intends to disrupt in his theoretical musings on the clinical gaze. He states that "we should not imagine that the world presents us with a legible face, leaving us merely to decipher it; it does not work hand in glove with what we already know; there is no pre-discursive fate disposing the world in our favour" (Archeology of Knowledge, 25). Here, Foucault is writing about language, but his statements can also be taken as a reaction against the change in medicine in the nineteenth century. Foucault observes that the medical gaze was able to discern on the epidermis—on the surface—of the body what was previously unknowable. There was a firm link drawn between what can be seen on the surface of the body and what can be discerned or said about this body in terms of medical knowledge.

Modern medicine changed its structure in the nineteenth century when the relation between the visible and the invisible shifted, as doctors were able to discover, through the gaze, what was previously invisible, prior to inventions such as the microscope and advances in

pathological examinations. Medical doctors became all-seeing sages who could abolish illness

through medical intervention. The medical eye became a powerful instrument for medical

knowledge, and the gaze reached sage status in society. As sages, doctors not only made

powerful observations about the body, but these observations also informed a person's identity

by extension. By penetrating the epidermis, or the surface of the body, the doctor could arrive at

conclusions regarding the person's identity or soul.

An analysis of the ways in which corporate rhetoric constitutes mental illness shows that

we have not, as a society, emerged from the epistemological system described by Foucault.

Subjects are still constituted through the gaze, as faces are presented as sites to attach

epistemological significance to. The section Hero Narratives speaks to how the "face" is

arbitrarily imposed upon a pre-determined identity. Foucault writes of the epistemological

structures that precede and order the subject from the outside. These epistemological structures

indeed subjectivize faces with a pre-ordained order of knowing. Medical perception, as

formulated by Foucault, focuses on an epidermis, a surface, or a face. This face functions as a

site through which the epistemological foundations operate as artificial ways of seeing, limiting

subjectivity.

Faces of Mental Illness

Let's talk about how the four subjects who are featured in the Bell Let's Talk campaign

are reduced to mere "faces." The first webpage of the Bell Let's Talk annual mental health

fundraising campaign lists these four names under a category entitled the "Faces of Mental

Illness." In 2017, Bell added these four new "faces of mental illness" to be featured on the Let's

Talk website, replacing the four faces in the year 2016. These "four faces" are nominated yearly

by the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) for their annual

Faces of Mental Illness campaign. These "faces" are people with mental illness who appear

alongside celebrity spokespeople in the Bell Let's Talk commercials. These faces are

additionally tasked with advocating for mental illness and making appearances and speeches

regarding their mental illness. For the 2016-2017 Let's Talk campaign, biographies of four new

faces are featured on the Bell Let's Talk website[6]. While the Faces of Mental Health Campaign

is run by CAMIMH, one of the stipulations of being "a face" is the duty to participate in the Bell

Let's Talk Campaign, as Bell is the primary sponsor of the CAMIMH.

The following four biographies featuring the "faces" suggest the increasing attention paid

in recent years to personal illness narratives, specifically as used in health initiatives as a counter

discourse to biomedicine. Biomedicine, or biopsychiatry, is associated with the *Diagnostic and*

Statistical Manual of Mental Disorders, which offers categorical, measured, and quantified

descriptors of mental illness. Narrative has exploded as a counter-point to such limiting and

quantifying descriptors of mental health. When Bell uses personal narratives in an attempt to

"talk" or open the discussion about mental health it is, outwardly, a seemingly humanistic

impulse on the part of the corporation to destigmatize and discuss mental illness using "real"

people and "real" stories to humanize psychiatric disorder.

While the Bell Let's Talk day outwardly appears to address the necessity of giving

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[6] I have chosen to anonymize the "Faces of Mental illness" in my analysis by using pseudonyms. My
reason for this is twofold. One, these biographies are written by Bell Canada and hosted on the Bell
Canada Let's Talk Website. I don't wish to attribute material produced by a corporate campaign to any
individual identifier such as a name. My critique is specifically limited to the ways in which Bell Canada
rhetorically constructs mental illness and I do not wish to confuse my critique of the material to a critique
of the actual individual behind the face. Also, I believe the individual faces behind the campaign are in
fact important people doing excellent work that is necessary to change the ways we view and treat mental
illness in society. I do not wish to diminish the fact that the Bell Let's Talk campaign rightfully
celebrates these people for the contributions they are making to mental health. My analysis does not
directly critique any individual associated with the campaign, as the campaign does benefit mental health
services as well as publicly acknowledges great work in the field. This analysis limits the scope of the
critique to the rhetorical effect of the Bell campaign's materials and not specific individuals.

psychiatric patients a forum in which to speak their experiences, an analysis of the campaign

shows that the rhetorical design runs contrary to a disability studies project. The rhetorical

presentation of patient discourse in the Bell Let's Talk campaign is in fact a problematic

antithesis to the humanistic efforts of disability scholarship. The biographies of the Faces of

Mental Illness, for example, are presented in a way that silences patient discourse and hails, or

calls forth, a proper mode of discussing mental illness. Health rhetorician Judy Segal notes that

"patients speak—they compose their stories and even live their experience—in ways guided by

textual culture…genres write stories" (61). Segal isolates a key distinction here that patient

discourse or patient stories (of mental illness) are influenced by the genre in which the patient

articulates their tale. People articulate diseases according to the ways in which disease narratives

are generically constructed and they tell their stories in established, formulaic ways. When

patient discourse is manifested in the genre of a corporate health campaign, the rhetorical

presentation of these stories tends to operate according to certain socially discursive shaping

principles.

      The sheer magnitude of the Bell Let's Talk Day campaign makes this day a relevant case

study for epideictic rhetorical examination. Bell Let's Talk day is a highly celebrated Canadian

initiative that has donated over 93.4 million dollars to Canadian institutions in the form of grants

("Impact"). This large scale telecommunications company funds academics, multiple hospitals

and healthcare institutions across Canada, local government wellness programs such as in

Nunavut, library programs, as well as funding leading mental health centres in the form of a 10

million dollar donation to the Centre for Addictions and Mental Health (CAMH) in Toronto,

Ontario. Queen's University, for example, benefits from a 1 million dollar grant to fund the Bell

Canada Mental Health and Anti-Stigma Research Chair. Bell also funds numerous mental

healthcare initiatives across Canada, such as a 400 thousand dollar donation to the Montreal

General Hospital Foundation to acquire a new Transcranial Magnetic Stimulation (TMS) device

("Impact"). TMS is a brain modulation treatment for depression that uses electric currents to

stimulate the brain. The Bell Let's Talk campaign has a direct effect on how people speak about,

research, and treat mental illness in Canada. Speaking about mental health in Canada has

become almost synonymous with the Bell Let's Talk Campaign and the numerous initiatives the

campaign funds.

Segal's observation that we "praise people for embodying what we value, and we blame

them for embodying what we deplore" (61) is relevant for this campaign, which is immensely

popular in the Canadian public imagination. On this day, and on the days leading up to this day

in January, buses are adorned with Let's Talk advertisements, tall buildings are papered with

Bell messages, and the Let's Talk commercials, tweets, and message shares from the public

occur on a massive scale. On this day, mental health, through the campaign, is culturally

pervasive and unavoidable. On this singular day (and the week leading up to this day), Bell

Canada, a company that holds a near monopoly in the Canadian telecommunications sector, turns

mental illness into a spectacle.[7]

According to Larry Law in *Images and Everyday Life*, which follows spectacle theory as

outlined by Guy Debord, "spectacular business helps develop the culture, philosophy, and

morality of the spectacle. And the morality of spectacular business becomes the morality of the

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[7] This dissertation uses the term spectacle following Guy Debord who outlines his use of the term in his 1967 book, *Society of the Spectacle*. According to Debord, society is a mediation of mass media that uses images to convey to subjects what they should desire. Critic Larry Law, following Debord's theory, discusses the detachment and commodification that occurs in spectacular society: "We live in a spectacular society, that is, our whole life is surrounded by an immense accumulation of spectacles. Things that were once directly lived are now lived by proxy. Once an experience is taken out of the real world it becomes a commodity. As a commodity the spectacular is developed to the detriment of the real. It becomes a substitute for experience" (Law, 8).

community" (25-26). This spectacle occurs on such a massive scale that Bell Let's Talk Day ads

are nearly unavoidable for most Canadian citizens during this campaign. The spectacle informs

the "culture, philosophy, and morality" of the Canadian environment, which then becomes the

"morality of the [Canadian] community." Standing in stark contrast to this singular day in which

mental illness becomes a Canadian spectacle sanctioned by a media empire, there is the fact that

on every other day of the year there is silence surrounding mental illness. And not just any

silence, but an uncomfortable, heavy silence that speaks volumes about how citizens and any

other entities are not able to converse about mental health issues on any other days in the year. In

Canada, Bell is praised for turning mental illness into a socially acceptable spectacle the public is

comfortable with. Many media personalities in the campaign valorize mental illness through

charity; in our present day medical model, a depiction of mental illness as anything other than

something requiring charity is highly unconventional and always couched in negative

terminology.

There is a highly regulatory value system of praise and blame rhetorically expressed in

the campaign material that serves to limit, silence, and control the way mental illness can and

should manifest in the spectacle of the campaign. I would suggest that there is an epideictic

rhetoric of patient representation in the campaign. The Faces of Mental Illness embody a proper

rhetoric of values that constructs a mentally ill person as both a sufferer, outside of normative

value systems, and a hero, for overcoming their illness in an appropriate manner. The Faces of

Mental Illness standardize and outline an acceptable generic mode that others can and should

respond to in kind, via the online campaign tools. Bell Canada celebrates the following four

Faces of Mental Illness as embodying the values acceptable for someone with mental illness, and

by doing so it advocates a normative value system of psychiatric illness.

Jack

This biography is anonymized using the pseudonym Jack:

> Jack is an engaged leader and advocate since a young age. Jack's journey
>
> towards recovery began during university. Since his early childhood, Jack noticed that
>
> he was constantly worried by big questions that no one else his age could relate to. Then
>
> after moving from rural New Brunswick to Ottawa and facing the high expectations from
>
> university, scholarships and peers, Jack became more aware than ever that he may be
>
> living with a mental illness. He subsequently sought treatment for a generalized anxiety
>
> disorder. Today, he uses tools and techniques to keep his anxiety manageable and
>
> continues to maintain an active and engaged life. Drawing from social and cultural
>
> experiences as a linguistic minority and gay man, Jack combines professional
>
> and personal experiences to deliver powerful messages and fight stigma, while
>
> carrying out his projects with confidence. He highly values his family and friends who
>
> feed his spirit and motivate him to evoke change and promote mental health and recovery
>
> for all. ("Faces of Mental Illness")

Hero or quest narratives embody conflict, struggle, and suspense, and the Bell Let's Talk

biographies do not fail to disappoint the reader. Most importantly, this is a hero quest and not a

first-person account because the face is a hero and not the narrator. Jack is a hero and heroes are

valued and venerated in society. For a mental health narrative to be prized, or shared in the

campaign, the psychiatric disability must give rise to heroic conflict and struggle.[8] Moreover,

the disability is othered in the biography, as is the face itself. The narrator tells us that, as Jack is

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[8] Disability studies scholar Joseph Shapiro calls the protagonist who overcomes disability through heroic conflict and struggle a "super crip".

a "linguistic minority" and a "gay man," he experiences otherness. He further feels othered as he "notices that he was constantly worried by big questions that no one else his age could relate to." His disability is structured as something other, something that is outside and different, as his "constant worry" about not being able to relate to others is rhetorically structured as a negative value associated with mentally illness. In order to fix his otherness, and his mental illness, which is valued as abnormal, Jack "uses tools and techniques to keep his anxiety manageable and continues to maintain an active and engaged life." He is praised for using "tools and techniques" of intervention. Foucault, speaking of the power model of psychiatry, writes that the mantra of psychiatry is, "I direct, I praise, reward, reprimand, command, constrain, threaten, and punish every day" (Psychiatric Power, 174). Psychiatry directs behavior through the psychiatric "tools and techniques" Jack uses that are designed as self-governing tools. Jack's use of "the tools and techniques" of psychiatry (and healthist organizations by extension) supposes a pre-existing market for these tools. Corporations capitalize on this market. Bell Canada offers Jack's "tools and technique" guidelines on their Let's Talk website. This toolkit is available for customers to download, so they can read it and adjust their speech and actions based on the recommendations outlined in the toolkit. Here, Bell promotes the value system that it is the face's personal, independent responsibility to self-manage his or her illness by using "tools," as good health is an individual pursuit. The message emphasized here is that the person can overcome their otherness by seeking independent treatment on his own. Not only does Jack overcome his disease by seeking treatment on his own, but he does so with a heroic set of values. The man who manages his own health is the hero in the story, a "confident," "powerful" "fighter" who not only overcame adversity through self-care health management but also encourages others to do the same, as he "promotes mental health and recovery for all." As a hero, the text rhetorically values

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Jack as a prized interlocutor; he is constructed both as standardizing a practice of mental health care—seeking tools to independently manage his own health—and enticing others to seek similar tools in order to recover from mental health issues.

Jane

The following biography also constructs a specific value-laden system in which a hero rises to personal heights by being both a prized interlocutor and a highly successful individual. This face is given the pseudonym Jane.[9]

> Jane was diagnosed with Bipolar Disorder at the age of 25 and she suffered deeply with psychosis, mania and depression resulting in two hospitalizations. She experienced a very serious suicide attempt, but over time, Jane accepted her illness and found hope in sharing her personal story with others. In 2009, she created the ___ Project and ___is now the Founder and Executive Director of the __ Society, formerly the Bipolar Disorder Society of __. She is also co-founder of the __ Program and the Society's Task-Force is excited to make __ the first stigma-free city in Canada. She has presented her story to over 12,000 people, including youth in schools and numerous organizations across __. Jane has received great recognition for her work as the 2015 Courage To Come Back Award Winner from ___, 2015 Top 20 Under 40 Award for ___, 2013 Mel Cooper Citizen of the Year in ___, and the 2013 Award for Youth Mentorship from the National Council for Behavioural Health, ___. Jane shares her personal message far and wide that "No matter what our challenges, we can all live extraordinary lives. ("The Faces of Mental Illness")

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[9] Awards and location are redacted in the interest of preserving anonymity even though Bell does not anonymize these "Faces."

As a hero, Jane overcomes a very serious illness to reach personal heights of success. Social

awards and recognition measure success and praise, and Jane has achieved remarkable success.

This biography highlights the enormous success this face became after her hospitalizations and

suicide attempts.[10] By praising her awards and success, the text situates succumbing to her

illness with hospitalizations and a suicide attempt, rhetorically, as blameworthy. When Jane

"accepted her illness, and shared her personal story with others" she becomes an active hero in

the narrative, for her ability to be a prized interlocutor in a discussion about a standardized

diagnosis and for her active role in her own health management.

Simon

The following biography follows a similar structure, insofar as the narrative establishes a

clear heroic path, from sufferer to prized interlocutor who is valued as a successful speaker. This

face is anonymized using the pseudonym Simon:

> For Simon, talking about mental health was never something that was openly
>
> discussed. Having grown up living in various countries with a single father, he
>
> found himself repeatedly as someone who didn't fit in because of what he looked
>
> like. That, along with a traumatic incident at a young age would follow him into
>
> university. Simon's mental health struggle came to its peak when he tried ending

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[10] Since ancient Greece, the concept of "overcoming" in epideictic disability rhetoric has been omnipresent. In *Disability Rhetoric,* Jay Dolmage outlines how the rhetorical reception and retelling of the Demosthenes myth serve to emphasize and reinforce the concept that one must overcome a disability to attain success. Demosthenes, an orator from Hermogenes's *Art of Rhetoric,* is given rhetorical worth in rhetorical history as a speaker who, despite physical disabilities such as a lisp as well as an effeminate manner, became an important orator. Demosthenes is further mythologized by Debra Hawhee in *Bodily Arts* (2005) as a figure tasked with walking up mountains with rocks in his mouth in order to "overcome" both his stutter and his soft nature. Dolmage isolates these mythological constructions as problematic, as the "rhetoric is disabling" (121). He notes, along with Brenda Jo Brueggeman, that, "disabilities can allow speakers to make their points even more persuasively as a compelling antispectacle against perfection" (121). Far from being a characteristic Demosthenes must overcome, Dolmage notes that "there are other historical accounts that argue this speech pattern was rhetorically effective" (121) and even Aristotle was said to have spoken with a lisp.

his life in his 3rd year of school. Being diagnosed with depression and facing

homelessness, Simon wondered why no one talked about mental health in his

community. This would lead him to disclosing his battle through the school

newspaper. Since then, Simon has helped organize awareness events,

presented a Tedx talk, spoken at summits, universities and high schools and

shared his story at a session of the World Bank and WHO in Washington D.C.

He's now working on a project called ___ that looks to get youth dancing for

hope, perseverance and recovery. Simon lives with Dysthymia and Generalized Anxiety

Disorder. ("The Faces of Mental Illness")

The biography quoted above illustrates how the conventions of the biographical genre erase

complexities in the narrative. On the one hand, the biography fits into the genre of hero

narratives. Simon is also a hero figure who overcomes (negative) mental health "struggles" from

a disadvantaged childhood, as a single father raised him. Framing mental health as something to

be overcome is highly problematic. What is additionally notable about this biography is that the

narrative erases difference. In a complex and confusing erasure, Simon's race isn't mentioned

directly in the text. The biography vaguely states he is "someone who didn't fit in because of

what he looked like." Someone "who didn't fit in" is a sort of euphemism for his race, as he is of

African descent and not white like the majority of the other Faces and celebrity spokespeople

featured in the campaign. While the Bell Let's Talk advertisements include racially diverse

actors to represent mental illness, the biographies offer the heroic message within a simple value

system. Deeper concerns regarding race and disadvantage or perception due to race appear to be

much too messy and complex for the genre—in which case, race is simply erased. The

problematic erasure of someone's racial and cultural background—an erasure of even the

mention of race—highlights the oversimplification inherent in a genre that operates according to epideictic rhetoric. Racism is a systemic and social issue that cannot be boiled down to the individual, as the narratives do here. The campaign's rhetoric is an oversimplification of a complex issue aimed at valuing specific notions and rejecting others. Any complex discussion of social injustice, racial prejudice, or racially diverse experiences is wholly rejected by the campaign, which is problematic for a campaign that claims it is ending stigma. Simon's heroism lies in his ability to overcome his illness, on his own accord, and becoming one of Bell's prized interlocutors. This "Face of Mental Illness" promotes the idea that by talking about mental illness you can learn to "live with" the disease. Simon's ability to "talk," "share," and "organize" suggest an active, independent pursuit of mental health that not only cures his own generalized anxiety disorder and dysthymia, but also encourages others to independently manage their mental illness by simply sharing their stories through the Bell Let's Talk campaign. Their stories, notably, must adhere to the specific conventions of biographical genre that erase complexities in individual narratives.

Genre

When I use the term "genre" in this discussion, I am relying on Carolyn Miller and Ashley Kelly's definition of genre as a rhetorical concept following "a kind of pragmatic tradition that understands genres as products of discourse communities" (Kelly and Maddalena, 293). Kelly and Miller view genre not as a classification system but as codified discourse that sets and creates further discourse that is shaped and molded by the standardization of the genre and generic codes. Within the health and rhetoric field, similar work on genre examines the reshaping of patient discourse to fit with a standardized set of generic codes (Ferrara, 1992; Berkenkotter, 2008; P. Kelly, 2012, 2014). Not only does patient speech become a jointly built

discourse within therapy, as Ferrara shows in a clinical study using discourse analysis, but this reshaping occurs in other discourse arenas—as the Bell Let's Talk campaign exemplifies in this case study. Moreover, the standardization sets a new generic model that proliferates the standardized discourse. As is argued in a later section of this chapter, the rhetoric of the Bell Let's talk online campaign operates to silence patient discourse by standardizing a set of generic codes which then influences other users to respond online in the same manner. As Charles Bazerman writes, "as these solutions become familiar, accepted, and molded through repeated use, they gain institutional force. Thus, though genre emerges out of contexts, it becomes part of the context for future works" (Bazerman qtd. in Kelly and Maddalena, 291). By understanding and defining genre as, first, a standardization, and second, a process of rhetorical reshaping and influence, this chapter moves past Aristotle's classical understanding of generic conventions. This contemporary definition allows us to conceptualize how genre operates in rhetorical arguments, which is integral to any analysis based on questioning how online or technological media influence mental health discourse.

Sally

A look at how epideictic rhetoric operates in the last of the "Faces of Mental Illness" finalizes our opening biographic case study concerning the standardization of patient discourse in the Bell Let's Talk campaign. Like the other three biographies, the epideictic rhetorical features in this biography work to standardize the ways in which mental health discourse is perpetuated through specific generic value systems. This face is given the pseudonym Sally.

This year marks the 15th anniversary of Sally's recovery from bipolar

disorder. Before receiving her diagnosis, she was hospitalized on two occasions

for depressive and manic episodes that included psychotic elements. In order to resume

her activities and the pursuit of her dreams, Sally reached out for professional help

with respect to medication, psychotherapy and music therapy. She also turned to

community resources which helped her better self-manage her symptoms. The presence

of her family and loved ones, together with her employers' support, were also key to her

recovery. She leads a fulfilling life despite having to manage some residual symptoms.

In addition to having led a great career as an actuary, she has travelled the ocean with

her husband and son aboard their sailboat. Recently, she put aside her actuarial career

to join ___, a non-profit organization, with a mandate to make their mental health

self-management workshops available to all. Sally's story demonstrates that no

one is immune to mental illness, and that everyone can aspire to recover from it. ("Faces

of Mental Illness")

Like the previous faces, Sally is introduced with a clear temporal marker in the very first

sentence to cue us to the trope of overcoming disability. Sally is, as the text introduces,

celebrating her "15th anniversary" of "recovering" from Bipolar disorder. And her recovery is a

result of her own, we are told, excellent consumer behaviour. Sally "recovered" because she

became a consumer of health products. Bell writes that Sally deserves our praise specifically

because she "reached out" for professional help with respect to "medication, psychotherapy and

music therapy." Her heroism intrinsically lies in her ability to "self-manage her symptoms" by

seeking out her own resources to (self) manage her mental health. She is also praised for

disclosing her mental illness publicly, for we are told that she has the full support of her friends,

family, and employer as she strives to manage her psychiatric disorder. By highly praising a

value system of complete and open disclosure, the epideictic rhetoric operates problematically,

as very real material circumstances are ignored. Notably, Sally could afford to disclose her

mental illness because she is seemingly wealthy enough to choose to voluntarily leave her career as an actuary, and thus she is not at risk of being fired for her disclosure. As discussed previously, disclosing a mental illness can have profound consequences. In the introduction to this chapter, I note that radio host Maria McLean was fired from her afternoon show at K93 FM, a subsidiary company owned by Bell Canada. Unlike Sally, who is presumably wealthy enough to choose to leave her career, Maria, by contrast, calls her firing a "nightmare" (Weldon). There are very real negative material consequences associated with publicly disclosing a psychiatric disability. The Bell Let's Talk Faces of Mental Illness celebrate full public disclosure (which could be detrimental) and also the heroism of people who overcome their psychiatric disabilities (which is harmful and unrealistic).

Disability scholars such as Margaret Price, David Mitchell, and Sharon Snyder warn of the dangers of heroic narratives. As they caution, "such narratives often reify the dominant script of disability as an individual tragedy (and potential source of triumph when overcome)" (Mad at School, 178). Heroic narratives reinforce the audience's normalcy while reveling in the author's disability or otherness. The ability to overcome is celebrated and disability is negatively constructed as a lack, as undesirable. The faces are only valuable speakers because the narratives promote the idea that "everyone can aspire to recover" from psychiatric illness. By only valuing the speakers who recover from or succeed despite their disability (and not those who exist, in Margaret Price's terminology *with and through* their disabilities) the Bell Let's Talk campaign's rhetoric perpetuates the idea that disabilities are a tragedy. And this is, above all else, a harmful rhetoric. Any campaign dealing with mental disability should adhere to a framework of psychiatric illness that views disability not as a tragedy but as a normal state of existence in all its myriad and complex forms. Viewing mental illness as such would allow the

39

campaign to make realistic policies that effect change and be inclusive of everyone.[11] The hero

narrative perpetuates a genre in which people speak about and view illness as a negative.

Moreover, the individual must conquer their mental disability through self-help and self-care,

and this is highly problematic because this framework ignores the very real situational

consequences of both revealing a mental illness and living with a mental illness. The highly

celebratory framework of Bell Let's Talk fails to deliver on the promise that simply talking

about mental health will end the stigma ingrained in psychiatric illness discourse. The campaign

arguably results in more stigma, as epideictic rhetorical values only praise those who have

recovered from psychiatric illness.

Disability as Alienation and Isolation

The following section looks at how the Bell Let's Talk campaign standardizes the

discourse of mental illness through commercial media. I examine how persuasive elements in

the campaign commercials standardize patient narratives, using a combined methodological

analysis that melds rhetorical elements from Kenneth Burke with epideictic rhetorical features.

The epideictic value system apparent in the 2014 Bell Let's Talk commercial campaign

negatively values mental illness as an alienated and isolated social state, as a functional rejection.

This negative social state—characterized by isolation and alienation—stands in contrast to the

hero campaign. In this campaign, rhetorically valued, prized interlocutors overcome mental

illness by sharing their story with others (who also are also encouraged to overcome). By setting

up a value system equating mental illness with alienation and isolation, the 2014 Bell Let's Talk

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[11] Margaret Price notes that the "proliferation of stories" about mental illness offers proof "of two important truths about disorderly minds. First, such minds show up all the time, in obvious and not-so-obvious ways; and second, recognizing their appearance is not a yes-no proposition, but rather a confusing and contextually dependent process that calls into question what we mean by the 'normal' mind" (Mad at School, 30).

campaign rhetorically positions the state of being "mentally ill" in society as unwanted, inappropriate, and undesirable.

In a chapter entitled, "Archive and Anatomy of Disability Myths," Jay Dolmage outlines disability stereotypes that contribute to discrimination. Two of these myths, "disability as an object of pity and/or charity" (35) and "disability as isolating and individuated" (35) inform the critical reading of Bell Let's Talk commercials in this section. Dolmage notes that in the former stereotype, "people with disabilities are represented as sad and impotent, a problem that can be solved via charity" (35). In this section, commercials are analyzed for rhetorically producing psychiatric disability as a sad subject in a state of alienation, in an attempt to provoke a sentimental, charitable response from the viewer. This, in Rosemarie Garland-Thomson's term, "sentimental" depiction of disability is highly problematic (63). For Garland-Thomson, the image of a sad suffering individual "produces the sentimental victim or hapless sufferer needing protection or succor and invoking pity, inspiration, and frequent contributions" (63). Paul Longmore, discussed earlier in the Hero Narratives section, also writes on disability as charity.

The second disability stereotype informing this analysis is the myth that disability is an isolated experience. In *Cultural Locations of Disability*, David T. Mitchell and Sharon Snyder note that disability is equated with biological deviance, and hence mainstream early twentieth eugenics policies were implemented, such as sterilization and institutionalism, that sought to remove disability from mainstream society. As a result, disability became equated with isolation, as people with disability were expected to withdraw (or were forcibly withdrawn). Not only was the isolation mandatory, this state was regarded as a tragedy worthy of pity (and charity, as discussed above). As critics Barnes, Mercer, and Shakespeare state, "to have impairment was regarded as a 'personal tragedy'—a conclusion which united service providers,

41

policy makers and the wider public" (10). While disability is structured as a "personal tragedy"

worthy of pity and charity, the public sphere became a space where disability was excluded.

Tanya Titchkosky writes how even the designs of spaces at the University of Toronto were

established with the intention of excluding those with disabilities. Isolation is a key component

in the stereotypical disability narrative. As Dolmage notes, "people with disabilities in film and

literature most often live in hospitals and institutions, as though those are their natural habitats—

they rarely have romantic relationships or enduring friendships, and often are left alone at the

end of the narrative" (43). The myth that disability is or ought to be isolating also serves to, as

Dolmage points out, "justif[y] the 'warehousing' of people with disabilities in institutions,

segregated classrooms, sheltered workshops, and so on" (43). In the Bell Let's Talk campaign

commercials, psychiatric disability is constructed as an object of pity, experienced by subjects

who are sad and alienated, and disability is an isolated state. This problematic depiction further

constructs harmful disability stereotypes through the rhetoric of mental disability.

The first example of a campaign commercial to be used for contextual analysis is entitled

"Suffering in Silence." This Bell Let's Talk commercial is dark—almost film noir in its

cinematographic effect. The scene opens with a dark-haired man who is clothed in dark

clothing. He is ringing the bell of a townhouse in the evening darkness. The lights are turned on

inside the home, and the man peers into the windows looking for a sign that someone is home.

Inside, a blonde man seated in a white leather chair and clothed in a dark green patterned shirt

hunches over his knees, staring at the floor in silence. The dark-haired man outside takes his

cellular phone out of his jacket pocket and sends a text. The man inside sees the text, slowly

reaches his hand out, and switches off the sound on the phone. The messages "Millions of

Canadians Suffer from Mental Illness in Silence" and "On January 28th, Let's Talk" appear on

the screen for approximately 3 seconds each, while the man sits still and alone in the background, his head hunched over, his hands clasped together, and his elbows resting on his knees ("Suffering in Silence"). While there is no speaker in this commercial (the mentally ill man is silent, still, and alone) the overall rhetorical appeal in the images uses pathos to appeal to the viewers' emotions, which is Aristotle's rhetorical appeal based on eliciting the appropriate emotional response from the audience. The mood is gloomy, dark, and the blonde man's silent suffering—his staring at the ground, his refusal to answer a text or the knock at the door—plays out as sort of a quasi-film noir or silent horror film. The viewer does not see the man who is knocking at the door, as the viewpoint of the commercial identifies with the outside visitor—the screen shows the outside visitor's view. The viewer is trying to catch sight of the man inside the house, just as the outside visitor is. The viewer identifies with the frenzy and confusion of the visitor knocking on the door and not with the silent sufferer inside. In fact, the commercial elicits an emotional response of frustration and annoyance when the man fails to answer the door or respond to the text. There is mounting frustration in the silence of the commercial which emphasizes his inability to act. His lack of response at his friend's attempt to communicate is presented as dark and deplorable. This commercial performs an epideictic genre function in that the viewer identify with what society praises and dismisses what is presented as deplorable. The outside viewer is confused and frustrated at the self-isolation imposed by the mentally ill man; the commercial denigrates the experience of being "mentally ill" as being in an isolated and alienated state.

Not only is this man living in isolation, but he is also further othered as physically disabled. He sits hunched over, silent, and unable to move. He appears weak—his head hangs— and he is silent. As Dolmage notes in *Disability Rhetoric*, "disability studies needs rhetoric to

better understand and negotiate the way that discourse represents and impacts the experience of disability" (3). Dolmage reminds us of the embodied nature embedded within all rhetorical processes. The visual images of disability in the Bell Let's talk campaign represent all psychiatrically disabled actors who can speak in the genre of acceptably valued terms—using the hero narrative, speaking to caretakers, promoting self-care—as able-bodied. People experiencing mental illness are depicted as physically disabled in that they are hunched over, appear weak, and do not move or speak. They are physically disabled by their emotional disability. These types of representations are shown in this commercial, "Suffering in Silence," and the next commercial to be analyzed, entitled "Missing Work." By representing psychiatric disability as physical disability, the campaign prizes able-bodied individuals and perpetuates negative stereotypes of physical disability by subscribing to a normative value system.

Missing Work

A 2014 Bell Let's Talk commercial entitled, "Missing Work," appeals to audiences' emotions in an attempt to secure an emotional rejection of mental illness as an experience of alienation and isolation. In the opening scene, the viewer is introduced to the sight of the back of a woman's dark-haired ponytail and the back of her shoulders. She is wearing a suit and speaking on a cellular phone. In the background, grey, fuzzy windows are opaque. The woman speaks immediately with a pleasant, professional tone into the telephone: "Hi, you reached the voicemail of Lori Freeman. I will be out of the office all day." The screen changes to show the speaker: she is an attractive, professional looking woman around 30 years of age. She continues, "For emergencies, please contact Dianne at extension 342…Thank you….and have a nice day." The screen pans out to show the background setting in detail and the woman is standing in her kitchen, at home. Decor in the home is upper middle class in nature, with stainless steel

appliances and dark wood counters. "If you are satisfied with your message, press one" can be heard as the woman stares at the phone in her kitchen. The words "Everyday 500 000 Canadians Miss Work Due to Some Form of Mental Illness" and "On January 28th, Let's Talk" flash on the screen for 3 seconds each. As the words flash on the screen, the woman is pictured from behind, leaning over the kitchen counter with her head down in seeming psychological pain. She can be heard softly crying and whimpering. In this commercial, the professional woman's failure to attend work—as everyday 500 000 Canadians miss work due to mental illness—is framed as a social problem. The self-inflicted isolation she imposes on herself by calling in sick to work and failing to answer her work voicemail is specifically an economic matter. Significantly, besides inhabiting a well-designed and impressive home, the woman is well-dressed and appears professional. She is well-spoken. Her tone is pleasant, professional, and measured. Her crying and whimpering in isolation are not only a stark contrast to the professional image she presents in the opening scenes, but they are also threatening to middle-class values. Her mental illness is alienating, and this prevents her from working and, more importantly, from contributing to the economy. If 500 000 people fail to attend work every day due to mental illness, as Bell Canada claims, the alienation and isolation created by mental illness is a threat to the economy.[12] And who has more interest in driving the economy than a major Canadian corporation?

Problematically, the commercial campaign values mental illness negatively as a threat to the economy and a threat to social connectivity. The man in the "Suffering in Silence" commercial refused to answer the door and refused his friend's texts, and the woman in "Missing

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[12] A Global News Article written on May 5, 2017 picks up on the idea of mental health as a threat to the economy. The article reports that "a new poll finds 40% of Canadians report their mental health has disrupted their lives in some way over the past year. Nearly one in five missed work or school….the costs to the Canadian economy are staggering…Overall, this costs the Canadian economy $50 billion a year" ("Canadians Miss Work").

Work" refused to take her calls and refused to go to work. The alienation and isolation that

mental illness supposedly imposes—at least that is how mental illness is represented here—is

rhetorically valued as a threat to citizens performing their proper role as ideal workers and

consumer. If mental health prevents workers from socializing, texting, calling, and working, this

would be—above all else—a threat to the communication that drives sales of communications

products. In actuality, there is no evidence that mental health issues would threaten a

communications company's sales, but implanting the idea in an advertisement, that if you are not

communicating then you are mentally ill, is a persuasive push to drive people to communicate

via text, telephone calls. Not calling and/or not texting is positioned as unhealthy, suggesting the

individual is isolated and alienated. Calling and texting are valued as healthy pursuits. Since

citizens value health and the pursuit of better health, these commercials inscribe, along with the

message of good health, the message that consumerism, communication, and speaking on the

phone and texting combat the alienation and isolation of mental illness. What leaves the viewer

so helpless and dissatisfied at the end of this commercial is the fact that the woman fails to talk,

she fails to confess her illness. Her failure to confess her illness is an affront to the viewer, who

demands confession.

Confession

The viewer is left so dissatisfied and upset at the end of this commercial because mental

disability, in our society, must be confessed. The demand, "Let's Talk," a demand to disclose a

mental disability, is incredibly pervasive in our society. Foucault writes, "western societies have

established the confession as one of the main rituals we rely on for the production of truth"

(History of Sexuality, 56). The rise of the connection between discourse and truth telling via

confession arose with the confession techniques used by the Christian Church. According to

46

Foucault, "the confession became one of the West's most highly valued techniques for producing truth. We have singularly become a confessing society… When it is not spontaneous or dictated by some internal imperative, the confession is wrung from a person by violence or threat… Western man has become a confessing animal" (59). However, this confession has been rhetorically structured not as a constrictive power but as something that sets us free. Foucault writes that "the obligation to confess is now relayed through so many different points… that we no longer perceive it as the effect of a power that constrains us" (60). The desire to talk, to confess, is so normalized that the power structures complicit in the act of confessing are invisible. When this woman fails to talk, she is also defying a long history that establishes the necessity of her confession. While this confession is depicted in the commercial as cleansing— she must confess to cleanse her soul of her malady as per Christian doctrine—it is not simply something that will set her free. The confession is, in Foucault's words, the "effect of power that attempts to constrain." Confessing becomes a socially protective act. In confessing, the mentally disabled person discloses which psychiatric label they have been diagnosed with. Confessing a psychiatric diagnosis allows the audience to determine how much danger the psychiatric illness poses to society, depending on the severity of the psychiatric illness. A diagnosis of depression, for example, is relatively minor. A diagnosis of a personality disorder, however, is regarded with more horror and social rejection. As psychiatric disability is feared and rejected in western society, confession becomes a socially protective principle.

The social order demands confession, and in not confessing her mental diagnosis, the woman in the commercial poses an unknown threat. In the "Genre" section of this chapter, I discussed Miller and Kelly's definition of genre as discourse that is shaped and molded by genres as they become standardized. Rhetoric is influenced by past responses in similar

situations. Types and actions become expected responses as situations become typified and codified. In this way, genre is a social action, as audiences and rhetors establish expected communication based on previously standardized communication. There is a contrast between the confessions so readily given in the "Faces of Mental Illness" biographies—indeed, even their diagnosis is given—and the failure to confess in the commercials. The confessions of the "faces" generically codifies, frames, and structures the appropriate social act in this instance—when one is mentally ill, one must cleanse one's self by confessing one's psychiatric label. The commercials deviate from the codified norms in the "Faces" biographies to provoke viewer frustration. The commercials play on the dissatisfaction and frustration that the viewer experiences when expected communicative norms are violated. The woman's refusal to confess her illness is a refusal to conform to generic codes, and this makes her a threat, as we are uncomfortable with hidden flaws. We expect the disability to be voiced, so we know which evil the speaker possesses. Unless the speaker cleanses herself, as the "Faces" do, the disability is a threat. While the "faces" represent a metaphorical branding of "appropriate" stigma on one who discloses their psychiatric disability in acceptable generic codes, the woman's refusal to disclose her psychiatric condition leaves the audience unable to metaphorically brand her with the "appropriate" response based on her disclosure. As psychiatric disability cannot be seen, there is an increased need for speech to create and maintain stigma, so that the audience can brand those they most fear in society. The confessions of the "faces" must standardize the generic communicative act in order to influence those who follow to offer appropriate responses as a protective social measure.

The Caretaker Audience

This section considers two more recent commercials from the 2017 campaign. These commercials feature a person speaking for a person with mental illness, effectively shifting the discussion on mental disability away from patient speech toward a caretaker audience. Patient discourse is effectively silenced in these new commercials, which is a problematic rhetorical feature in a campaign that purports to give those with mental illness a platform. A commercial entitled "Husband" features an attractive white woman with red hair, around 40-45 years of age, who looks tired, with visible lines on her face. Her hairstyle is conservative, with hair pulled back from the front of her face and long, soft, loose curls. Her blue suit jacket indicates that she is an upper class working professional. She speaks in a low, sad tone as she gently shakes her head back and forth in a gentle "no" mannerism, and the look in her eyes indicates a wild desperation as she begins her speech, the only sound in an otherwise silent commercial. The woman narrates the following: "Depression is hard. It's been getting to me at night. I can't stop thinking about it. It's heartbreaking, and most people don't understand. But, [woman breaks into a smile] now I feel better because he feels better. [A happy jingle begins to play in the background and woman turns head to left, still smiling.] We found a great psychologist and we're getting through it. Together." The camera pans out as the woman speaks the last sentence, showing an attractive Indian man, around 35-45 years of age, who appears slightly younger than the woman. He has youthful, chin-length, slightly curly hair and a beard. He is wearing a blue dress shirt without a tie and a brown suit jacket, with his head and upper body shown. He is sitting, smiling at the woman, with his head turned to the right, facing her. The man is silent and does not speak, but smiles back as the woman speaks. He slightly nods his head as she says, "we're getting through it. Together." After speaking, both the woman and the man face the

49

camera smiling, and a white screen with the words "Mental Health Touches Everyone. Join the Conversation. Bell Let's Talk" appear on screen ("Husband").

In this commercial, the wife's husband is the silent, racial other who looks trustingly at his white, upper-class wife who speaks his narrative. Interestingly, however, the narrative is about her, as her body delivers the message. Her facial expressions and tone of voice convey how hard it has been for her to experience his mental illness. We do not hear about his symptoms, we hear about how she was kept up at night due to his illness. We see the lines of pain on her face. We see the wild, desperate shake of her head as she conveys to the audience that no, she did not wish this, nor does she want this. Her body language conveys her utter and abject horror at facing her partner's disability. And the rhetorical responsibility to speak for mental illness, in this depiction, falls upon the wife's shoulders. The viewer sympathizes first with the wife who is speaking (without her husband in the frame), but the sympathy doubles when the viewer realizes she is burdened with a mentally ill partner. Her husband is a burden as a "depressed" man. His illness is only palatable to the viewer after the happy jingle comes on to indicate that he "gets through" his mental illness and is recovering. The message is simplistic, patronizing, and reduces a complex discussion to a trite jingle and a message that closes off any further discussion. Moreover, the shift in the campaign commercials from the autobiographical confessional to a patronizing caregiver speaking for someone else completely erases individual patient narratives. In fact, speaking for a mentally ill person is preferable specifically because a commercial elicits more sympathy when someone is shown willingly making a sacrifice in association with a condition portrayed as horrible. The audience's emotional response is increased in a caretaker narrative because two emotional frameworks are in play. First, the shift in perspective results in an emotional jolt when the viewer realizes that the person speaking is in

50

fact a caretaker and not a mentally ill person. What was initially a sympathetic reaction on the viewer's part increases to shock and horror when they realize that this person has been saddled with the horrors of mental illness by proxy. Second, the viewer's emotional response changes from shock and sympathy to one of respect and awe. The commercial "Husband" is highly effective emotionally. However, what is so problematic about this commercial, in terms of the mad studies scholarship framework outlined in the next paragraph, is that the advertisement rhetorically argues that people with mental disabilities are incapable of speaking for themselves.

Since antiquity, psychiatric disability has been equated with the failure to speak reasonably. People with psychiatric disability have been (and continue to be) stripped of rhetorical agency. Plato famously claims that "no mad or senseless friend can be a friend of God" (Book II), and by this he means that no truth telling can originate from someone who is mentally ill, because God is what is truthful and good. Aristotle's concepts also discriminate against "mad" behaviour. His belief that we must find the mean between passions, and maintain moderation between emotional extremes, persists today in North American society. Rationality is the marker of sanity and the pinnacle of being "sound of mind"; being mad is thus contrary to the rational, the logical, and the paradigmatic grounding belief that all thought is ordered and linear. Mad studies originated to take back the rhetorical agency stripped from those with psychiatric illness. Brenda LeFrancois writes about how mental disability is equated in our society with a failure to speak with reason: "For many practitioners of the psy professions, and for countless others who subscribe to conventional models of mental distress as biogenetic 'illness,' to invoke madness is to flaunt deep-seated beliefs about the nature of sanity and reason, and about the condition of being psychiatrically 'sound' or 'unwell'" (11). Here, LeFrancois notes how a psychiatric disability label is used as grounds to invalidate the rhetorical legitimacy

51

of someone diagnosed with a disorder. Due to the nature of psychiatric disability (irrational beings are incapacitated and unable to argue rhetorically on their own behalf) this commercial promotes the idea that mentally ill people require other people to speak on their behalf because they are irrational and not capable of rhetorically arguing for themselves. The shift in perspective in this commercial to a caretaker speaking is especially problematic due to the fact that people with psychiatric disabilities are dismissed in society as being irrational and incapable of reason, and thus as incapable of rhetorically arguing for their own autonomy as subjects. The idea that mentally ill people are irrational, non-dependable, erratic, and therefore incapable of speaking for themselves, is in fact a common idea that results in mentally ill individuals being stigmatized in society. This Bell Let's Talk commercial adheres to the same disabling myths about mental illness that result in significant fear, misunderstanding, and stigma within society.

Another commercial entitled "Mother" from the Bell Let's Talk 2017 campaign problematically shifts the perspective from a patient narrative to a caretaker narrative, again removing rhetorical agency from people with mental illness. This second example features a serious, introspective, and attractive 30-year-old woman (set against a white screen background) who stares into the camera intently. Her hair is pulled back and braided. Her braid falls over her right shoulder. She is wearing a jean jacket and a black shirt with polka dots on it. She wears large pearl earrings in her ears, and minimal light pink make up on her fair complexion. She is freckled, with slightly strawberry blonde hair and blue eyes. She starts speaking without any other background noise: "dealing with anxiety is hard, but it's even worse when people think you're faking it, or that it isn't real... [slightly shrugs shoulders] so you keep it to yourself [stares at camera] but there is nothing worse than suffering in silence ["suffering in silence" words drawn out by actress]." The actress' countenance changes from sad to happy, and a happy jingle

comes on in the background. The actress starts smiling as she looks to her left, takes a deep

breath, and says her next line: "That's why, I…talk to her about it and give her my complete

support." The video then pans out and shows a somber, almost embarrassed, silent, conservative-

looking woman around 45-55 years of age with shoulder-length brown hair, a black suit jacket,

and a grey dress shirt. She is staring at the (slightly) younger woman smiling with apprehension.

The younger woman delivers the last line as she pats her mother's knee and smiles at her with

the pride of a parent, as the mother's gaze flickers from the camera to the younger girl, but the

mother stays silent and does not speak. The younger woman concludes, "You're doing great!

I'm so proud of you!" After the speech, both mother and daughter smile at each other and a

white screen with the words "Mental Health Touches Everyone. Join the Conversation. Bell

Let's Talk" appear on the screen ("Mother").

While this commercial ends with the statements 'join the conversation' and 'talk about

mental health' scrolling across the screen, problematically, this ad actually has the opposite

effect, in that it silences any alternative narratives. In the commercial, viewers are shocked at the

role reversal of a child having to speak up for an infantilized mother.[13] Our emotional response

is to the caretaker and not the mentally ill mother, who is valued negatively. Not only is she

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[13] The "eternal child" is a common disability stereotype well noted in disability studies. According to
Jennifer L. Stevenson, Bev Harp, and Morton Ann Gernsbacher, "adults with disabilities in general, and
those with developmental disabilities in particular, have long been treated like childlike entities, deserving
fewer rights and incurring greater condescension than adults without disabilities. The stereotype of the
'eternal child' has burned a disturbing path through history and continues to wreak havoc in areas ranging
from employment discrimination to forced sterilizations" (Infantilizing Autism, Library of Medicine).
The authors note that the infantilization is often evoked to drive, in Stevenson's terms, "fear-based",
donations for charitable organizations. In the Muscular Dystrophy Associations Telethon, notes
Longmore discussed earlier in this chapter, the poster children "Timmy and Tammy" became the
infantilized embodiments of the disease. In Autism awareness, autism charities and awareness campaigns
infantilize the disability, preventing the well-being of all people with autism. Jennifer L. Stevenson, Bev
Harp, and Morton Ann Gernsbacher write that social depiction of autism as a childhood disability is a
threat to autistic people of all ages. In their words, "autism is so predominantly considered a childhood
disability that some autism 'advocates' claim that autistic adults do not even exist" (Infantilizing Autism).

silent and child-like, but she is also at fault for causing an abnormal family structure by being

mentally ill and a burden. She burdens her daughter, who must speak and care for her. The

mother is unable to act as a parent or protect her daughter because she is mentally ill, which

renders her as a silent, meek infant. In the ad, the mother appears sheepish, embarrassed, slow in

her bodily movements, and, most importantly, silent. She fails to speak. Instead, she smiles

meekly at her daughter who speaks for her and (like a parent) the child encourages her mother

that she is "doing great!" and she is "proud" of her. Up until the reveal (when the scene shows

the mother and the daughter), the viewers feels sympathetic; after the reveal, like in the

commercial "Husband," the viewer's emotions change from sympathy to shock and horror at the

abnormal familial structure. By representing a mentally ill mother as an incapable parent, the

commercial argues for a removal of rhetorical agency; the ad justifies taking away the mother's

voice and giving voice to the daughter because the mother cannot perform her proper social role

of parenting and therefore has no subjectivity. The perspective shift in the campaign

commercials, from mentally ill patients to caretakers, reinforces the idea that people with mental

illness are incapable of speaking on their own behalf and arguing for their own rhetorical agency.

In fact, this commercial argues that mentally ill patients do not deserve rhetorical agency, as their

mental illness renders them infantile and abnormal.

Chapter Two

Let's Talk Online

Burke's observation that identification is the key means of persuasion is quite applicable to online rhetorical analysis. Bell Let's Talk persuades online users by responding according to the principle of identification. Critic Barbara Warnick links Burke's concept of identification to online interactivity. Warnick defines interactivity as "communication that includes some sort of reciprocal message exchange involving mediation and occurring between a group (the campaign) and users, between users and the site text, or between users and other users" (Rhetoric Online, 75). This chapter relies upon Warnick's definition of interactivity as a "reciprocal message exchange" with various Facebook users on the Bell Let's Talk public campaign page, and it examines how interactivity operates as a form of rhetorical identification.

To more specifically elucidate Burke's theory of identification, consider the following explanation. Human beings form selves or identities based on symbols that could be physical objects (i.e. phones), occupations, activities, beliefs, friends, or value systems. As human beings identify or form identity through symbols, they ally with other humans who share the same symbol-value system or identification; conversely, they ally against others who differ from their symbolic value system. This allying for or against is what Burke terms "identification" or, synonymously, consubstantiality. In this dissertation, I use the terms "identification" and "consubstantiality" interchangeably, as does Burke. Most importantly, identification and consubstantiality result in persuasion. According to Burke, "you persuade a man only insofar as you can talk his language by speech, gesture, tonality, order, image, attitude, idea, identifying your ways with his" (Rhetoric of Motives, 55). Using Burke's definition of rhetoric as persuasion through identification facilitates a more thorough conceptualization of how rhetoric

operates as a process of change in the audience. In his words, persuasion occurs as a joining of

symbolic identities; it is "only insofar" as the speaker can speak the language of the other that

persuasion occurs. According to critic Sonja Foss, Burke expands the notion of rhetoric as a

field with his concept of identification, which is the key elemental distinction of his rhetorical

theory. In her words, "Burke expands the notion of rhetoric so that it is a change in attitude or

action through identification" (Contemporary Perspectives on Rhetoric, 190). The following

section examines the rhetorical process that Foss defines as "a change in attitude or action"

through various online responses in the Bell Let's Talk online campaign. This process of

persuasion through identification that creates change occurs throughout Bell commercials, online

interactions, website information and links, as well as through online health materials that Bell

Canada directs users to.

In the Bell Let's Talk campaign, the public is encouraged to end mental health stigma by

responding online and sharing their mental health stories through Facebook and Twitter. This

campaign celebrates the idea that the public sharing of individual mental health stories will end

stigma when individuals "bravely" self-disclose. While disability scholars note the importance

of adding personal narrative to academic considerations of psychiatric disability, this section

complicates the celebratory framework of the online Bell Let's Talk personal disclosure genre to

argue that corporate identification operates to silence truly unique and individual narratives—the

opposite of the stated effect of the campaign. The following section examines how the rhetoric

of identification operates in the Bell Let's Talk online media campaign, a campaign that asks

consumers/users to respond with their own mental health stories. It is interesting to note that the

feedback option on YouTube for the campaign commercials analyzed are deactivated, preventing

user feedback. Online feedback through Facebook forum feeds is shaped in very specific ways

in the Bell Let's Talk campaign. as spontaneous or unmonitored feedback is prevented or limited online. Bell TV commercials persuasively interpellate proper responses to psychiatric disability, whilst social media simultaneously hails and shapes appropriate performative subjectivity from among the target client population.

Danielle Landry writes that "[we should] talk about why it's not okay that we have to rely on corporate sponsorship to sustain our mental health system. Let's ask if corporate influence serves to deter (or co-opt) the kinds of radical approaches and critical thinking that are essential for challenging the mental health system to improve and innovate" ("Ok, Let's Talk"). This section responds to Landry's call to "ask if corporate influence serves to deter (or co-opt) the kinds of radical approaches and critical thinking" necessary to "improve and innovate" mental health services, by showing how Bell uses identification as persuasion to "deter and co-opt" the kind of critical thinking necessary to change the stigmatized way that mental health is treated and viewed in our particular social system. Methodologically, four rhetorical features based on Burke's concept of identification frame the discussion. As a guiding principle in this analysis, various nodes of cosubstantiative encounters are regarded as a useful litmus test with which to examine wider, more deeply held assumptions embedded within a community. In the same theoretical vein as Burke, rhetorical critics Chaim Perelman and Lucie Olbrechts-Tyteca write that "for argumentation to exist, an effective community of minds must be realized at a given moment" (14). The conditions in a community—language, speech, image, attitude, idea—reflect wider rhetorical assumptions. The three principles in Burke's theory of identification, according to Foss, consist of the following three (brief) categories: one, identification must be used "as a means to an end" (190); two, identification must be united against a "common enemy" (190); and three, identification must be "unconscious" (191).

57

Identification (or rhetoric) operates as a means to an end. According to Burke, "insofar as their interests are joined, A is identified with B" (20). Identification occurs with A and B being united for a common goal. By this, Burke means that insofar as A (the rhetor, in this case a corporation, Bell Canada) speaks a common language with B (the audience, or customers/potential customers in this case) by sharing their speech, tone, language, and ideas, A is united with B for a common goal. The Bell Let's talk campaign uses technology to emulate the speech, language, and ideas of the audience in pursuit of a common goal. Using Landry's terminology, Bell "co-opts" speech using technology. The idea that social networking can be used to influence an audience introduces, through Burke, a consideration of the role of technology in rhetoric. The technological form, it is important to note, is also used by Bell for the end goal of profit. For Burke, "form and content cannot be separated" (Goodheart, 424). The function of rhetoric is through the form, and form cannot be separated from a consideration of the persuasive content as well as its reception. Through form (the interactive media of Facebook posts and responses in this case) Bell identifies with its intended audience to achieve a common goal.[14] Bell speaks the language, tone, and represents personalities of the audience through social media; this is important because the form of the message influences its persuasive effect upon the audience. In fact, the technological form influences and promotes action on the audience's part, as they are encouraged to share Bell's message to achieve a common goal. Critic Lev Manovich states that "interactive media asks us to identify with someone else's mental structure" (Manovich qtd. in Warnick, 95). If Manovich's statement is accepted, that

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[14] A discussion of technological form and content cannot justifiably occur without a respectful nod to Canadian media theorist Marshall McLuhan, who coined the phrase "the medium is the message" in the mid-1960s. In this influential phrase, McLuhan encapsulates the notion that the form in which a message is conveyed influences the message's delivery and reception.

"through interactive media we identify with someone else's mental structure," then Bell Canada, a corporation, co-opts and assumes the identity of a person online whom other people can identify with. This corporation is, moreover, presented in social media as compassionate, generous, caring, helpful and—most importantly—mentally healthy.

Endorsement

The Bell Let's Talk Campaign generates audience participation using Facebook, Twitter, and other highly influential social media platforms. Through the interactive technological platform itself, users are encouraged to go online and share a post, tweet, or photo. Through the very action of sharing on social media, the user identifies with the corporation. A shared identification between a corporation and a customer who is donating to charity is highly valuable to any corporation. The strategy is simple: "For every text, call, tweet and Instagram post, Facebook video view and use of Snapchat geofilter, Bell will contribute 5¢ more to mental health initiatives. So let's work together to create a stigma-free Canada!" ("Today, Let's Talk!"). The online initiative of January 25, 2017, for example, raised $6,585,250 with a total of 131,705,010 overall interactions ("Today, Let's Talk!"). The campaign is massively successful, mainly due to its Facebook and Twitter strategies. By partnering with celebrity representatives for the Bell Let's Talk campaign, the Bell corporation accesses a large number of online followers through Twitter, commercials, and profiles on Facebook and Instagram. On the Let's Talk twitter feed, Clara Hughes has 50 000 followers and 9 377 tweets for 2017 ("Hughes"). The Bell Let's Talk corporate Twitter feed has 148 000 followers and a total of 6000 tweets for 2017 ("Bell"). Another spokesperson for Bell Let's talk, Howie Mandel, has 748 920 followers ("Mandel"). Serena Ryder has a total of 65 796 followers ("Ryder"). These celebrities reach a diverse online media audience. Serena Ryder is a famous Canadian musician who has won

multiple Juno awards, appeared in music videos, and performed at major ceremonies, such as the Pan Am Games with Kanye West. Clara Hughes is the national spokesperson. As a six-time Olympian in both speed skating and cycling, Hughes figures prominently in the minds of Canadians as a figure of health, determination, national pride, and success through hard work. In 2014, Hughes biked "Clara's Big Ride," a 110-day bike tour of every Canadian territory and province to promote talking about mental health, and appeared at over 235 events. Bell identifies with a wide audience by associating with Hughes—an inductee of both Canada's Walk of Fame and Canada's Sports Hall of Fame—and notions of good health, sports, success, and national pride.

From a disability studies perspective, it is highly problematic to only identify with celebrities who "beat" mental illness. Celebrity narratives in the campaign follow the same, troubling hero narrative found in the Faces of Mental Illness and commercials discussed earlier in this chapter; these narratives inevitably create more stigma and misunderstanding by situating mental illness as a negative social value. Only success stories are disseminated through massive technological means. Celebrity, however, is linked to form because celebrity is used as a two-fold strategy to increase social media exposure. This large amount of social media exposure is a large part of the campaign's success. Users can share and tweet a post by, for example, Olympian Clara Hughes, to identify with health, success, sports, and national pride in addition to identifying with the charitable aspect of the campaign. Users identify both with the celebrity and the positive association encapsulated within that particular image. Users *feel good* about performing a compassionate act by donating to the "needy." Moreover, the participatory element is embedded in the very technology of social media. People want to share their best selves online. Most stories that involve sharing mental illness online follow the success narrative.

Self-Care

A 2017 commercial entitled "Self-care" features celebrity speakers talking about their illnesses. The commercial begins with a front facial shot of Michael Landsberg, host of TSN's Off the Record. His head and shoulders are featured against a grey background. He is clothed in a grey blue suit jacket with a white, checkered dress shirt with a collar. There is no background music. He says, looking directly at the screen, "I have not learned how to beat my illness. I have not learned how to cure my illness. But I have learned how to LIVE with my illness." The screen cuts to a head-and-neck shot of 24-year-old mental health advocate Dexter Nyuurnibe, appearing against the same grey background. He is wearing a black suit jacket with a grey v-neck t-shirt. He says, "we live in a world now where it feels like we just always have to be on". The screen cuts back to Landsberg who says, "I have learned to cope with my illness by saying OK. It will pass." The screen cuts back to Nyuurnibe, who says, "The little victories come from understanding that it is perfectly fine [happy jingle music starts and continues throughout the rest of the commercial] you have every right to take care of yourself, to take a day off." The screen cuts back to Landsberg, who says, "It may take a day. It may take two days. But it will pass. Similarly, I have learned to celebrate a good day." The screen cuts back to Nyuurnibe, who says, "Do things that make you happy, things that set your soul on fire. You know, things that you love." The screen cuts to a head-and-neck shot of Concordia student and mental health advocate Alexis Lahorra against the same grey background, wearing a black suit jacket and pattered blouse, who says, "I love tea. So tea, for me, is my self-care time so I have some tea. I disconnect from the Internet. I call a friend up. I call my family. I pet my cats, or I run outside." The screen cuts to a head-and-shoulder shot of Olympian Clara Hughes wearing a black suit jacket and blue and white striped shirt against the grey background who says,

"Movement is my medicine. For me, moving every single day. Being in nature. Getting outside moving in my body is something that triggers a different chemical response. And when I am feeling like things are getting dark, when I don't understand what's going on in my own head I know the best thing, the first thing I can do is get outside and go for a walk. It seems really simple, and it is not going to fix things. It is not going to completely heal me, but it is a big step for me every single day to keep my mental wellness in check." The screen cuts back to the head-and-shoulder shot of Landsberg, who says, "I have learned how to not make a bad day worse. I cherish a good day without worrying what happens if tomorrow is not a bad day. And that is an acquired skill. You have to learn to live for the moment live for the day. And don't fear tomorrow." The screen finally cuts back to Nyuurnibe who says, "ultimately you need to take care of yourself… you… you have to love yourself." The message and logo "Bell Let's Talk" then appears on the screen for four seconds with background music.

In the commercial entitled "Self-care," celebrities first utilize the singular first-person pronoun "I" while identifying with the audience about their mental illness; however, the pronoun shifts to "you" by the end of the commercial, as the effects of "illness" are framed in universal, humanistic terms aimed at the audience. Cliché advice is used to identify with the audience, such as "live for the moment," "cherish a good day," "it will pass," "take care of yourself," "do things that make you happy," "take a day off," or "do things that you love," and "don't fear tomorrow." By speaking in trite clichés, these speakers identify with customers from an upper-middle-class background. By speaking in this way, Bell is telling its customers that their interests are aligned; the Bell corporation co-opts the discourse to assume the identity of an upper-middle-class humanist intent on "having a good day" and "not fearing tomorrow." When the pronoun shifts from the first-person singular "I" to the use of the second-person singular

62

"you," the pronoun shift marks a co-substantiation involving the corporation Bell and the customer. Trite clichés become trite advice, with the customer being told that "living for the moment" and "loving themselves" are appropriate measures with which to manage their mental illness. The advice ranges from "drinking tea" as an appropriate action to going outside to be in nature and engage in physical activity. By speaking in clichés, these speakers minimize the effects of psychiatric illness. The audience is not someone with a serious mental illness. The audience is working, upper-middle-class social media users from privileged backgrounds. Problematic issues aside, clichés help guarantee that upper-middle-class online users will share, tweet, and post messages from the campaign. Speaking in clichés to an audience who is produced by and produces these cliché terms co-substantiates the corporation with the customer, as they are joined in humanistic, healthy, simple, and seemingly solid lifestyle advice. By couching the identification in healthy lifestyle jargon, A is identified with B because both are invested in raising money and promoting mental health management. Overly simplistic terminology erases the complexity of individual mental health narratives, problematically, and instead corporate and customer identification is joined in the rhetoric of self-care.

Self-care, as a concept, is the identification principle largely driving the online component of the campaign.[15] The idea behind self-care is that individuals are solely responsible for their own health. In this reasoning, a lack of good health, by extension, is a result of individual failure. The first part of this chapter explores the rhetoric of individual health

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[15] While this analysis looks at self-care in a healthist context, framed in a very specific healthcare social setting, it is important to note the political history of the term self-care. Self-care, as a concept, has been used by women of colour in a political context as a reaction against gendered and racial injustice. Audre Lorde, for example, wrote: "Caring for myself is not self-indulgence, it is self-preservation and that is an act of political warfare" (A Burst of Light: Essays, 1988). Lourde argues that "self-care" is a radical act, as she values her own existence in an oppressive system. It is important to note that self-care, in the context of Bell, is a completely depoliticized term. In the context of the campaign, the gendered, racial, and class-related histories of the term are left unacknowledged.

responsibility in the Faces of Mental Illness and campaign commercials in more detail; here, self-care as a concept is explored as a rhetorical device linking users with technology. Bell co-substantiates using the rhetoric of self-care to drive the online campaign. However, the idea behind self-care is an issue because it depoliticizes health from being a social concern to viewing it as an individual responsibility. The idea that an individual is solely responsible for his or her health takes health out of the public arena, masking external causes of ill health.

The shift towards putting the responsibility for good health on the individual depoliticizes areas of health that should be of a social and political concern. By shifting the responsibility to the individual, various players that may profit from the ill health of society are able to prevent real policies from being implemented that could restructure or improve health services. The rhetoric of self-care, with its cliché simplicity, cuts off any complex discourse about improving health services. Self-care, as a corporate rhetoric, is highly influential speech with which to convince employees that any ill health is a result of individual failure. For example, the corporation Arcelor Mittal Dofasco posted the following message on its Facebook and Twitter feeds on January 25, 2017:

> Today for Bell Let's Talk we're focusing on "self-care." We all have mental health that needs consideration and nurturing. It's important to recognize when you are not feeling yourself and do something about it. That can be anything from contacting an employee helpline to, as some of our colleagues shared, grabbing a book. ("Arcelor")

This response exemplifies how A unites with B through technology, based on the rhetoric of self-care. Attached to the above social media post entitled "self-care" are 12 pictures of 12 employees holding signs downloaded from the Bell Let's Talk Website. These signs emulate the Bell Let's Talk commercials, with suggestions like "play hockey," "shop for size 5 shoes," "run

at the beach," "work out daily," "do laundry (I know it's weird)," "work-life balance (time for family and friends)," "read," "call my friends," and "walk the dog" (Arcelor). In these images, Archelor employees hold pre-made Bell Let's Talk 8" by 11" framed blank pages, which are downloadable from the Bell Let's Talk website. Users are directed to go online, print out these blank pages, then write their own self-care tips to photograph and share on their personal social media accounts. These posts are shared and through the act of social communication, via technological means, A is joined with B with the shared goal of promoting self-care. The rhetoric of self-care bonds the corporation with the client. And it is specifically through the act tweeting, or making a social media post or a phone call, that the client is interpellated into the ideology that individual self-care is a response to a social issue. The act reifies the belief. Through social media posts, shares and tweets, the idea of self-care is perpetuated and obscures the political and financial gains that Bell, as a corporation, makes from the campaign—which is the end goal of uniting A with B.   Self-care costs a company nothing, and at the level of co-substantiality there is a division or disconnect between the company and a consumer who is not participating in their socially communicative environment. The company is telling the customer to take care of their individuals needs themselves, in isolation, until they are well enough to return to the company and healthy enough to be an active consumer who can participate in the social system.

If donations from the various tweets, shares, and posts are examined as a potential end goal of the campaign, let's examine the various organizations that Bell funds. The donations from the campaign financially support various university, government, and corporate initiatives. The common goal of the co-substantiation process in the campaign is not to fix mental illness in society as it is posited, but for Bell the corporation to become more powerful and more profitable

65

by raising the company's profile under the guise of a humanitarian effort. On the main page entitled "Today, on January 25, 2017, the Bell Canada website advertised three testimonials about the benefits of Bell Let's Talk Mental Health donation funding. Sharon Wood, President and CEO of Kids Help Phone, attests to the fact that 'in the last year alone, Bell has funded 720 hours of telephone and online counselling hours, which means more than 6500 one-on-one counselling sessions were accessible to young people nationwide'" ("Today, Let's Talk"). These numbers indicate that each counselling session would have been incredibly short in length, just a little more than 5 minutes each. Lucy Warren, Assistant Director of Programs, Eastern Region, Newfoundland and Labrador English School District, states that "as a result of the Bell Let's Talk Funding, 65 schools comprised of 18 000 students in the Newfoundland and Labrador English School District now have a trained mental health support person on-site" ("Today, Let's Talk). And Rodd Laing, Director of Environment, Nunatsiavut Government, states that, "Thanks to Bell Let's Talk's donation to Aullak Sangillivalianginnatuk ("Going Off") suicide rates of young people have been reduced in the people of Nain" ("Today, Let's Talk"). To recap, the testimonials on the Bell Let's Talk page originate from a major charity (Kids Help Phone) with a high profile that is very well funded, an entire School District of Newfoundland and Labrador, and the Nunatsiavut Government. Various other medical and higher education programs are funded by the campaign as well. Users tweet, post, and share through social media knowing— indisputably—that the 5 cents raised with every share funds worthy charitable organizations. But the drawback of a major corporation taking responsibility for mental health initiatives is that the discourse of mental health is directed at an upper-middle-class client base; the discourse becomes simplified, cliché, and packaged as individual pursuit to remove any real sense of social responsibility from the corporation's concerns. Donations are earmarked for high-profile

charities like Kids Help Phone that raise the company profile by providing further media exposure. Moreover, there are ethical considerations that originate from a major corporation funding school, research, and university health initiatives. This gives too much political power to a private company while obscuring the government's responsibility to provide social services.

The Silencing of Individual Narratives

To further complicate what is often a celebratory technological framework applied to the Bell Let's Talk campaign, let's talk about how the campaign's social media campaign silences individual narratives of mental health through identification. According to Burke, a second type of identification involves uniting two opposing forces against a common enemy. He uses the example of the United States and Russia, who joined forces against Germany in World War Two despite the two countries being opposing forces (Foss, 191). Our concluding section of analysis for this chapter will map how identification functions online through Bell's social media Facebook posts to silence individual narratives. This process is two-fold: first, social media posts align Bell alongside a caretaker audience by situating mental illness as the enemy, and second, Bell's social media responses to individual narratives online create an association with the hospital, distress, 911, and other medical organizations, which projects to both the poster and the wider social media audience that disclosures of distress are not welcome in the campaign. This secondary association is not always obvious, and instead this association works, as Burke notes, in a more covert (or subconscious) manner. By responding positively only to caretakers or to positive messages about mental health experiences interpellated into subjects by the campaign, the technological arm of the campaign extinguishes the sort of speech that is necessary to enact criticisms of the shortcomings embedded within our societies' mental health services.

The sort of speech necessary to enact real social change is extinguished through a process of identification that unites Bell and consumers against a common enemy. The Bell Let's Talk social media posts co-substantiate the corporation Bell with a caretaker audience by creating a terministic screen against mentally ill people as the enemy. By directing the speech in the campaign via technological means, through links and posts, Bell co-substantiates with caregivers and not with people with mental illness. This co-substantiation sets up a false dichotomy based on an identification between Bell and the healthy caregiver, or healthy audience, uniting forces against an enemy, which is framed as mental illness (or someone who is mentally ill).[16] A Facebook post with the tagline "Is there someone in your life that positively supports your mental health? Tag these champions to say thanks!" ("Tag these Champions") urges posters to respond on Bell Let's Talk day by tagging and publicly thanking a caregiver in their lives. One poster writes on the Bell Let's Talk Facebook page:

> My mom [person tagged removed] who has supported and cared for me and our 2 dogs
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> in every conceivable way for the last 2 1/2 years with no support of any kind. She will be
>
> 85 next month. She has been fearless and compassionate in helping me face the pain and

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[16] This study has been approved through Office of Research Ethics at the University of Waterloo ORE #23006. All participants were contacted with the following message:

> Dear (Poster), I am writing because I a researcher doing a PhD in the English Literature Department at the University of Waterloo. One of my dissertation chapters analyzes the rhetoric of mental illness in the Bell Let's Talk Campaign. In my discussion, I reference interactions on the Bell Let's Talk Facebook page. One of your postings came to my attention as relevant to my discussion, and I wish to use it in my chapter. My first step is to make the postings anonymous, but if your desire is to be cited directly in my dissertation please authorize me to do so as these postings are publicly available. My dissertation will be published online upon its completion and I will not be able to redact identifying information once it is published. My preference is to anonymize all of my posts. If you object to me analyzing the interaction and your posting please let me know and I will leave this material out of my dissertation. I have attached an information letter fully informing you of your rights as a participant, and I would request a response after reading the information letter confirming if you would like to participate from the study. Any additional questions are welcome and encouraged. Thank you, Quinn Powell

trauma of my youth and adult life. It has been the most difficult time in my entire life. I

wouldn't have survived this without her and love her so very much. ("Tag these

Champions")

Bell responds positively, telling the poster, "Wow, this is so touching. Thank you so much for

taking the time to so bravely share your story. Your mom sounds incredible and we wish you

strength as you continue to get through this difficult time" ("Tag these Champions"). The

problem is, the poster's story has not been shared as Bell claims. By directing posters to "tag a

[caregiver] champion," the campaign co-substantiates with the caregiver against mental illness as

an enemy. By giving the caregiver electronic legitimacy, the post erases the actual experience of

the original poster. What is notable about this particular post is that the user responded privately

to my request to use her material. She confessed that she was too scared to post her thoughts and

experiences online for fear of negative repercussions from insurance companies and social shame

from friends.[17] The poster stated that she never posts online, but did so this time because the

narrative deflects to a caregiver. Problematically, users are not safe disclosing mental illness

online, and the rhetorical co-substantiation process perpetuates the negative stigma associated

with mental illness as an enemy; the campaign does not offer a safe forum where users can

discuss mental illness as a lived experience.[18] Instead, the conversation shifts acceptable

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[17] Further ethnographic research into the area of mental health and online communities would be a relevant, useful, and timely addition to my rhetorical examination.

[18] This poster responded to my request for permission to use her online Bell Let's Talk post with the following message. I requested and obtained permission to also reproduce this message in a footnote as I believe it is relevant to this section, as this poster was comfortable posting to "thank a caregiver" but not comfortable posting personal information on a social media platform for fear of negative repercussions, such as losing insurance and social shame. Please note that putting this feedback in footnote form is not meant to diminish the value of this information in any way. This is not secondary information, but important, critical speech that is being silenced and pushed to the periphery by the Bell Let's Talk campaign. The value of this speech is precisely why I wish to include the following message here, to

discourse towards caregivers. Another Facebook user questions how they can get a struggling person to speak up about their mental illness. Bell Responds with a form letter:

> Hi ___ Thank you for reaching out to us and attempting to help someone else in need. Having a family member or friend with a mental illness can be very stressful and often times, very difficult to understand. To learn more about what your loved one is going through and how to access the proper support for them, please visit this resource from our partners at The Canadian Mental Health Association (CMHA)…Please don't hesitate to reach out to us or to CMHA   if there is anything else that we can do to help you through this difficult time – Hailey. ("Prince William")

In this post, Bell forms an identification with the caregiver by thanking them for "reaching out and attempting to help someone else in need." Bell aligns itself with the caregiver in seeking a common goal. The post further co-substantiates the caregiver with Bell in an expression of sympathy, making the caregiver the primary subject of the conversational alignment. Bell and the caregiver are fighting mental illness, the enemy, which is, moreover, an experience that Bell constructs as "stressful," "difficult to understand," and deserving of sympathy. By aligning Bell

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mark the types of discourse that should be front and center to any discussion surrounding mental health in our society:

> For what it's worth, bell let's talk day is actually one of the worst days of the year for me. I have spent 25 years trying to get well and have only recently received the proper diagnosis. Trust me when I say it hasn't been for lack of trying. I lost everything and by that I mean my career, my friends and financial stability So while I realize we need to start somewhere, I have no one to talk and no access because of where I live now. I moved here because my doctors told me I needed to leave the city in order to get well. Stupidly I believed them. So when Bell says let's talk, my question is, to who? Because anybody who is suffering does not want to reach out and dump their shit on somebody else and when you're feeling better you don't want to talk about how bad those days are because you just want to enjoy the moment that you have feeling good. So this is why I struggle AND the fact that I have been repeatedly misdiagnosed for 25 years! I've had to take out a loan in order for get the help I need. While I realize I am fortunate to be able to do that, (there are many people who can't) it's still puts be farther in the hole at a time in my life when I should be getting to retire or at least thinking about it. Ontario health care for the most part has not been my friend.

and the caregiver against the enemy (caring for someone who is mentally ill), any discourse from the person with a mental illness is erased. By uniting against an enemy, the discourse divides those who are "donating" to mental illness through shares and texts and those who are (suppressed when) disclosing illnesses through personal narrative. People with mental illness are situated as grappling with the enemy of illness, and conversely, charity cases to be pitied and treated as children. Mad studies professor Danielle Landry writes that the campaign problematically situates mentally ill people as "charity cases through a nickel-for-every-text campaign" ("Ok Let's Talk"). The process of co-substantiation uniting actors against a common enemy—mental illness—aligns Bell with a caretaker audience by situating mentally ill people as charity cases.

By problematically situating mentally ill people as charity cases who require caregivers to help them, narratives from people with mental illness are not given any weight or value in the campaign. In fact, the responses from the Bell Let's Talk campaign work to limit and silence any real discourse that points out flaws in the mental health care system. Bell doesn't simply hail clients in this campaign; Bell hails charity cases. Bell takes the medical structure of confession and transforms disabled people into conduits not necessarily for direct care, but conduits through which donations flow. This transformation serves corporate interests, but not the interests of people with mental disabilities. Landry states, "Let's talk about universal access. Let's talk about the importance of community. Let's talk about our rights" ("Ok Let's Talk"). Landry's point (and mine as well) is that the Bell Let's Talk campaign fails to make space in the campaign for speech that addresses real social justice issues related to mental health concerns. A woman with the pseudonym Karen responds to a Facebook post entitled "Prince William calls for End to Stigma on Mental Illness" with the following post:

I have tried to tell my family, doesn't help when they don't listen and the ones that did now have a reason to be pissed at me because I can no longer do stuff for them. Three months waiting for help only to be called the week before my Dr. appt. and told it was cancelled; how much longer do you think I can wait? I needed help in November, work thinks I should accommodate a sexual offender, yes that was their solution to help me return to work, I won't have to deal with a man who assaulted me. Great work there don't you think, doesn't even address any of my problems, thanks for that, so glad I gave them the last 20 years of my life. No one treats you the same ever again, they don't know how to deal so they just complacently walk out of your life! I am not being silent, everyone else IS. ("Prince William")

This post highlights the fact that real speech that criticizes institutions that uphold systemic injustice are not given any weight or value within society (or by the campaign, as discussed below regarding Bell's reply). This woman posts that a man at work sexually assaulted her and when she complained her employer did not take any action and tried to get her to "accommodate" her assailant. This post highlights gender inequality, sexual assault, and the fact that many systems (in the workplace, education, or the justice system) do not effectively prosecute or address sexual assault in our society. Many times, women are forced to endure harassment in the workplace and are told to simply deal with it, as they are either not believed or the institution wishes to preserve the reputation of prominent men within the organization. Additionally, since Karen did tell people about her experiences, she says that "no one treats her the same" and they all just "walked out of her life." Speaking up did not help Karen. This woman further experienced, according to her, a three-month wait for help when she tried, through her physician, to access relevant services. Karen's post relays concrete problems that

speak to systemic issues that should be addressed within any campaign dealing with mental

health services. This post highlights extremely concerning and problematic practices within our

social systems, and Bell responded with the following post:

> Dear Karen, thank you for being brave and opening up about your experience. I'm sorry
>
> to hear about what you are going through and I want you to know that you are not alone.
>
> Please reach out to someone you trust who cares about you. There are also organizations
>
> out there that can provide assistance…If you find yourself in crisis, please reach out to
>
> your local distress centre or call 911. Additionally, if you can send us a message with
>
> your best contact number, we can arrange for a support counsellor to reach out to you.
>
> Wishing you strength during this difficult time –Hailey. ("Prince William")

Karen does not respond to the post—many posters do not respond to this form letter from Bell—

as the poster likely realized her voice was not being heard in this campaign.[19] The identification

process fails in this post, as the campaign does not engage in critical discourse. Instead, the reply

attempts to limit this type of discourse. Bell directs Karen to speak to "someone she trusts who

cares about her" after Karen posts that after she spoke up about her sexual assault everyone

"walked out of her life" and "no one treated her the same." When Karen spoke up about her

distress after her sexual assault, no one helped her—not even the very campaign purporting to

raise awareness about these issues. While Bell successfully identifies with caregivers, when

people try to speak up against systemic injustices, their concerns are dismissed. The reply

tactically shifts the perspective from a social concern to an individual concern. Karen is told to

personally "reach out to a local distress center or call 911." This reply from Bell is an affront to

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[19] When this poster replied to my request for use of her material, she responded (my paraphrase) that she
hoped people would begin to see this campaign for the profit-driven business venture it is (in her opinion)
and not as a mental illness awareness campaign.

the honest disclosure that Karen made about her experience of being placed on a long wait list when trying to access appropriate medical care. Karen is not making a cry for help. She does not require 911. She is calling attention to the fact that she did try to access help and was not helped. The conversation should thus be focused—as Landry argues—on the rights of citizens to access adequate mental health services and not only stop-gap emergency measures (such as hospitalization) that ignore long-term and systemic social causes of emotional distress.

Unconscious Identification

The second aspect of identification is that it works subconsciously. Bell social media responses craft identification between psychiatric illness and crisis, the hospital, and 911 emergency services. This identification projects to both the poster and the wider social media audience that disclosures of distress are relegated to alternate spaces. Bell directs these bodies to go to the hospital or to call 911 immediately. On the first page of the Bell Let's Talk website, on January 25, 2017, a message instructs users, "if you are in crisis, please go to your local hospital or call 911 immediately" ("Today, Let's Talk!"). Bell posts this message on social media conversation threads as well, reinforcing the idea that mental health is a crisis. The subconscious association between the hospital and mental health narratives creates a self-regulatory silence. In short, people fear disclosing mental health struggles when they are unconsciously aware that their voices, their electronic social media bodies—insofar as personal social media Facebook pages are a representation of the actual body—do not belong in the Bell Let's Talk campaign

On social media, where bodies are metaphorically represented in personal profiles, the actual physical bodies of posters who profess mental distress are directed to take themselves to

the hospital, removing them from the online conversation in the campaign.[20] Instead of an

identification with mentally ill individuals, the campaign operates to (dis)identify with those

individuals by referring them to hospital. While the campaign has been lauded for opening a

conversation about mental health, on social media any critical questions or non-campaign-

normative disclosures are directed to a distress centre or told to call 911. By subconsciously

associating people who have real mental illness with a hospital, or 911, co-substantiation

eliminates psychiatrically disabled bodies from representation on social media (by relegating the

body to the psychiatric ward or another form of institutionalization) and cuts off the

conversation. Furthermore, the subconscious association through identification frightens other

patients and prevents them from disclosing their psychiatric disability for fear of the negative

association it will give rise to. On a post on the Bell Let's Talk Facebook page, a user writes,

"Mental health is failing my son and me. Stay strong for how long forever?" ("P.E.I."). This

poster discloses, online, that "mental health is failing" her and her son, but she does not go into

further detail. She also states that she is "staying strong," a cliché strategy espoused by the Let's

Talk campaign, but questions "how long" she can simply "stay strong" in a "failing" situation.

Bell responds with the following post:

> Dear ___, Thank you for being brave and opening up about your experience. I'm sorry
>
> to hear about what you and your son are going through and I want you to know that you
>
> are not alone. Please reach out to someone you trust who cares about you. There are also
>
> organizations out there that can provide assistance. If you're interested in learning more
>
> about organizations that can help, you can find the information here: http://

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[20] Please note that my position here is not that mental distress should not be treated immediately at a hospital crisis center. In fact, I would advocate for increased mental health services. My argument is limited to the rhetorical agency of the psychiatrically disabled body.

letstalk.bell.ca/en/get-help. If you find yourself in crisis, please reach out to your local

distress centre or call 911. ("P.E.I.")[21]

Bell's response is a form letter that allows a Bell employee to fill in and customize certain parts

of the response. This letter does not encourage any further discourse. Bell doesn't request further

information from the posters. All responses are designed to shut down further discourse from the

poster. While the corporation tells the poster that she is "brave" and thanks her for "opening up

about her experience," the post directs the user to the online presence of mental health

organizations.[22] By responding to disclosures of psychiatric disability with a link to hospital and

mental health resources, Bell's response silences any real discourse about how to improve mental

health services. The above post raised a relevant point about the failure of our mental health

services. The post is, in fact, a valid question that arguably deserved an answer and discussion.

However, further discussion about this issue was drowned in the link between crisis and

psychiatric disability.

By consubstantiating crisis and disability on social media, the corporate campaign limit

discourse of a critical nature. A woman who requested that she be identified as a 48-year-old

female named Aurora (not her real name) posts, in response to an article entitled "1 in 7

Canadians have suicidal thoughts," that "They are just coming to this realization now? I have

had a plan since I was 12 years old. There is no money in psychiatric research nor treatment"

("Suicidal Thoughts"). Bell responds to this post with the same response given to all posters who

either disclose psychiatric disability or critically comment:

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[21] All of the organizations listed on the "Get Help' weblink are all largely funded by Bell donations from the Let's Talk campaign.
[22] Figure 1.1

76

___ thank you for being brave and sharing your experience. We are sorry to hear about

what you have gone through and we recommend that you to reach out to someone you

trust who cares about you. There are also organizations out there that can provide

assistance. We encourage you to reach out to your local CMHA branch at

1-866-531-2600 (toll-free) or by visiting...http://www.cmha.ca/.../understanding.../

anxiety-disorders/ to learn more about resources that will be able to assist you. If you find

yourself in crisis and feel like you need immediate assistance, please reach out to your

local distress centre or call 911. ("Suicidal Thoughts")

While Aurora posts that she "has had a plan since [she] was 12 years old," in no way does her

post indicate that she is in distress or needs to call 911; nevertheless, the campaign responds with

a form response that directs her to emergency services. Not only does the response equate the

poster's critical comment with crisis and the hospital, which identifies any disclosure of mental

health (not framed in a happy success story) as a need to be hospitalized, the actual critical

comment in the post is ignored. The poster asks to talk about funding for psychiatric research

and services. Aurora poses a valid and valuable criticism to a discussion on how to improve

mental health services. Not only does ensuing discussion not occur, but Bell directs Aurora to

seek help at the Canadian Association for Mental Health for an anxiety disorder. Not only is this

absurd, but Bell's response points to deeply troubling issues that attend allowing a corporate

entity to control a social discussion on mental health and mental health policy. This campaign

suppresses, through social media, the sort of critical commentary and engagement that is

necessary to improve mental health services, by unconsciously associating psychiatric disorder

with crisis, hospitals, and emergency 911 services.

By associating mental health with a hospital, Bell Let's Talk fails to address what an adequate mental health care response should look like, by effectively cutting off discourse on how to reform our system. Michelle da Silva writes about her experience of seeking mental health services during a depressive episode. She relays her frustration about Bell Let's Talk day, which reduces mental health to a singular day and overly simplistic treatment messages, such as suggesting hospitalization. As she states, "Eventually, [she] started therapy. It was expensive, but because I had a job and some savings, I was able to afford it. I also have health benefits, but it covers psychiatry not psychotherapy. Psychiatry tends to be more expensive, so $500 of insurance only gets you around two or three sessions. Plus, do you know how long the waitlist is to see a psychiatrist in Canada?" ("Much More"). Da Silva points out that adequate mental health care services are not accessible (long waits) or affordable for people who need them. Notably, 911 emergency services are not equipped or designed to treat ongoing mental health issues. As da Silva writes, psychiatrists have long wait lists and suggesting calling 911 or seeking hospitalization is not a reasonable response to someone who needs regular counselling and medication.

Tools and Techniques of Biopolitical Organizations

Biopower is a theory conceptualized by Foucault as a power that "is able to access the body because it functions through norms rather than laws, because it is internalized by subjects rather than exercised from above through acts or threats of violence and because it is dispersed through society rather than located in a single individual or government body" (Taylor, 43). Lives are controlled in a biopower system through both individual and group means. While at one level lives are controlled through prisons, schools, and psychiatric hospitals that target individual bodies that deviate from normative value systems, on another level the state is

78

interested in "monitoring and organizing the forces within it" by regulating "birthrate, longevity, public health, housing and migration" (140).

The regulation and control of the subject is highly apparent in the toolkit that Bell corporation provides as a propaganda tool. This toolkit establishes normative healthy lifestyles that individuals should aspire to. In the toolkit on Bell's website (this tool kit is also linked to clients in Bell's responses in social media forums), people are given very specific and simple outlines for how to have conversations about mental health in both private spaces and the workplace. This toolkit consists of "a conversation guide, helpful tips for the workplace as well as shareable images for [the client] to use to show your support" ("Tool Kit"). The images are mostly Bell Let's Talk logos that people can print, photograph, and share on social media with their own self-care recommendations. These images operate as publicity tools for the corporation. The conversation guide is a PDF that people can print and use to host mental health workshops with friends, the public, or in the workplace. The workplace-specific PDF links the user to various other business and governmental organizations that focus on workplace mental health. Overall, the toolkit[23] supports the view that individuals should talk, search, and share with others in their individual search for good health.

The toolkit represents a de-centralized power approach to government. Subjects must personally search for private, business, or government organizations—and there are many—to service their individual desire for good mental health. Moreover, the conversation guide shows how normative value systems in discourse are both prescribed and re-inscribed into other subjects from the campaign. The toolkit is a perfect example of Foucault's notions of biopower. The toolkit functions to control the body through language by setting out a normative discourse

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[23] Figures 1.2 and 1.3

79

for subjects to use to speak about mental illness. The toolkit is also dispersed throughout society because various subjects are encouraged to share the images and speak in very specific ways (both privately and through work) using the presentation materials contained in the PDF files. Bell, the corporation, is engaging in the decentralized governance of bodies with this toolkit. Through normative, healthist rhetoric, Bell shapes its clients just as citizens are shaped through control, regulation, and self-governance.

Conclusion

What I have begun to document in this chapter is the highly problematic healthist assumptions underlying the rhetorically persuasive techniques that a corporate entity identifies with in order to connect with its client base through technology and social media. The corporation persuasively argues that clients *take control* of their own health by *independently* managing themselves using self-care techniques. This healthist agenda is framed as working in and through technological communicative means. Bell is, after all, a communications company. By framing the Bell Let's Talk Day as both a charitable cause and a health-promoting lifestyle campaign, the corporation promotes the illusion that we can, as individuals, improve our collective mental health by simply trying harder to be healthy. The corporation promotes the idea that our collective goal should be normative mental states for all, as we post, call, and tweet our way to wellness. But, as Price states, this too is an illusion. There is no *normal* brain state that we should all aspire to. Due to the sheer volume of persuasive media messages, subjects are called forth to act in the campaign, and it is through their acts that subjects are shaped through a process of interpellation. The campaign calls forth and sculpts the appropriate subjectivity by technologically shaping performance through media. On various levels, the campaign operates to limit and control the ways in which proper subject performance should be enacted through

technological responses. The discussion of how biography and the Faces of Mental Illness operate as an epideictic genre, by socially valuing heroes who overcome mental illness and additionally establishing "real" mental illness as physically disabling, establishes who exactly may respond to the campaign. People who experience mental illness are not hailed to respond to the campaign. People with mental health issues who make disclosures are dismissed and relegated to the margins. This chapter began by relaying two stories of women who lost their livelihood by disclosing illness. McLean was fired from her position with a Bell subsidiary company for disclosing that she required two weeks off to adjust to her antidepressant medication. Ho, also a former Bell employee, was emotionally traumatized due to workplace stress and was unable to access health benefits for counselling, as she was a contract employee. These women experienced poverty and distress as a result of speaking up about their illness. People with mental illness are dismissed, silenced, and further stigmatized. The commercials further establish, through a neo-Aristotelian rhetorical discussion, that the audience called forth is a caretaker, a caring human being, or an upper-middle-class client interested in being charitable and promoting a healthy lifestyle. Bell is successfully connecting with its target client base using the illusion that *we can* or *we are* becoming (mentally) healthier through this campaign.

The corporation becomes more powerful and more profitable by expanding its customer base as well as by funding education, government, and private mental health organizations through the campaign. This campaign obscures the fact that a corporation is influencing the funding of mental health services, which is highly problematic because corporate interests are not always humanistic interests. This campaign also obscures the fact that mental health services should be legislated and developed by the government. This campaign also obscures speech that

81

addresses the political and racial injustice behind mental illness. On Tumblr, an account entitled "Lets Actually Talk," posted on January 23, 2017, shows a picture of a middle-aged woman of colour named Gloria, who writes:

> It's hard to talk about mental illness, especially if you are a black woman whose ancestors have suffered in silence for centuries because we were told we had to be strong and not complain. It's difficult for the black community to end the stigma when the people speaking about this illness looks nothing like us. Mental illness does not see race, sex, or economic status; yet, those who are marginalized are the ones whose voices and needs are not prioritized in such campaigns and dialogue. Making me feel like my depression isn't important doesn't help me heal. I am not invisible. My name is Gloria and my depression is political. ("Let's Actually Talk")[24]

This Tumblr account is an example of how individuals are voicing experiences that cause us to pay critical attention to the intersectionality of race, disability, and political issues. The Bell Let's Talk campaign, as demonstrated in my reading of Simon's biography, reduces race to a euphemism. Gloria's narrative is a counter-strategy to the depoliticization and erasure of racialized experiences of mental health. Narratives like Gloria's are important to note because the Bell Let's Talk campaign obscures the fact that our government is not properly addressing the real and concrete social conditions and concerns affecting the well-being of Canadians.

Healthist rhetoric depoliticizes issues that sorely need addressing as public concerns. On the Bell website, the company publishes a thank you from the Nunatsiavut Government for reducing suicide rates for the young people of Nain. The accolades Bell receives and the feel-good response of the public obscure the fact that aboriginal peoples in Canada are severely

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[24] Figure 1.4

underfunded, ignored, and the government does not provide adequate social and living conditions, which is a contributing factor with regards to youth suicide. Many communities do not even have access to clean water. This is not a mental health issue, but related to how this campaign depoliticizes, through healthist rhetoric, very real social issues. Bell is becoming a new leader in the collective search for health, paradoxically, by profiting off the ill health of citizens. And this identification online with customers occurs by convincing us that technological communication equals good health. Proper subjectivity is called forth by encouraging the sharing, tagging, and posting of appropriate posts that promote a healthist ideology. Any questions that critique the sort of discussion necessary to enact genuine social change are framed as a crisis, with individuals directed to go to the hospital or to call 911. This response effectively cuts off any more critical discourse.

Bell persuasively frames technological communication as an act that supports good mental health. Yet instead of helping people with mental illness, Bell Let's Talk Day perpetuates problematic disability stereotypes. This campaign shapes subjectivity in harmful ways that ignore the lived experiences of those with psychiatric disabilities. A caregiver audience is addressed instead of people with disabilities and the campaign attempts to co-opt psychiatric patient discourse, which erases the possibility of engaging in radical "talk" of a more critical nature. The highly celebratory and supposedly healthy use of technology in the campaign obscures the fact that a corporate entity is both rhetorically defining and calling forth a proper performance of healthy subjectivity which operates to silence critical discourse. The corporate campaign calls forth the act, which is the call to text or tweet in the interest of health, and this hails or ingrains in the subject the performance of self-control, self-care, and self-regulation. By talking, texting, posting or engaging in self-care, the subject comes to believe that they are taking

control of their subjectivity through these small communicative acts. Not only does healthist

rhetoric in the campaign create the illusion that it is impossible for an individual to be personally

responsible for their mental health, healthist rhetoric obscures the fact that a major corporation is

hailing subjectivity. This subjectivity, as read through a disability studies lens, this chapter

argues, is highly problematic because mental illness is not a biological flaw or defect, but a

rhetorical entity that changes according to social and cultural ideological constructions.

Chapter 3

Government Rhetoric

On March 3, 2016, the Canadian Institute of Health Research sent out a press release

entitled the "Government of Canada supports new eHealth research projects to empower patients

and enable better health care." This initiative provides 13.8 million dollars in funding directed to

programs for e-health projects aimed at youth mental health. The release states that, "in recent

years, the field of eHealth has moved beyond basic electronic medical record databases. Today,

eHealth innovations use sophisticated technology to create greater efficiency within the health

care system, improved patient experience, and better coordination across various levels of care.

Canada has the talent, the intelligence, and the passion to become a world leader in the field of

eHealth" ("Empower Patients"). E-health, persuasively touted by the government as "more

efficient," "better coordinated," and "improved," is rhetorically presented in the government news

release as a "sophisticated" technological response designed by our most intelligent citizens.

By all outward appearances, government funding directed toward "youth mental health"

services is, by all assessments, *a good thing.* The Government of Canada strives to convince

citizens to believe that funding directed towards e-health is *a good thing* for all stakeholders

involved. In fact, the government implemented a large public health campaign to persuade

Canadians that e-health is a cheaper, progressive, and more effective way to treat mental illness.

To "become a world leader in the field of e-health," the Government of Canada established and

funded Canada Health Infoway, an "independent" not-for-profit corporation, to convince

Canadians that e-health is the "more sophisticated" way to treat mental health. Canada Health

Infoway launched a public health campaign called "Better Health Together" that persuades

Canadians to use e-health services. Better Health Together runs the Digital Health Week annual

campaign. This campaign's goal is to inform Canadians about the benefits of using digital health technology. Given that many corporate health organizations have a vested interest in the success of e-health technologies, not surprisingly, Better Health Together (funded by Canada Health Infoway, which is funded by the Government of Canada) partners with these private health corporations. Government e-health is, coincidentally, supporting multiple large corporations by awarding lucrative e-health technology contracts. On May 11th, 2017, Canada Health Infoway revealed that the government had selected Telus, a major telecommunications company, to provide all e-prescribing services for Canadians. According to a Telus CEO, the government contract enables Telus to develop what he calls "Telus Health":

> As a longstanding technology provider enabling improved health outcomes for Canadians, we are proud to be working with Infoway to develop and operate PrescribeIT. PrescribeIT will be built on our open, interoperable and vendor agnostic TELUS Health Exchange platform, which is already enabling collaboration and efficiency in the primary care ecosystem ... We look forward to advancing this service in support of driving better health outcomes for Canadians and helping to bring PrescribeIT to patients as soon as possible ("Infoway Selects Telus").

Telus appears similarly vested in convincing Canadians that electronic health is a *good thing*. This contract, which effectively gives a major telecommunications company control over the electronic health information of private citizens, is presented, by the Better Health Infoway team, as an "open," "collaborative," and more "efficient" health care delivery system. Terminology such as "primary care ecosystem" is used to suggest to citizens that somehow Telus will deliver healthcare in a more organic manner through the corporation's technological system. The

government's e-health strategy campaign, run through Canada Health Infoway, is, by its very nature rhetorical, though ostensibly medical or scientific.

The government's e-health strategy largely links technological use to better mental health. Additionally, a considerable amount of government funding supports mental e-health applications. Patients are encouraged to *share their stories* about how e-mental health is *a good thing*. To disrupt this highly celebratory sharing framework, rhetorical analysis shows how mental health is (re)written, and (re)presented through the government's E-Health Strategy campaign. Aristotle's three modes of persuasion, *logos*, *pathos*, and *ethos,* act as a sentimental guide to the analysis in these sections. This analysis uses a combined rhetorical methodology of classical analysis alongside a more contemporary Burkean reading to examine the rhetoric of the Canadian government's electronic mental health strategy as motivated discourse. Burke's theory of terministic screens and his notion of rhetoric as motivated discourse inform this reading.

Terministic Screens

Burke's theory of terministic screens is a useful theoretical framework because of the way he theorizes langue as reflecting a certain reality (which, by default, deflects other realities). According to Burke, we see the world through a lens, or screen composed of selective symbols that compose our reality. He writes, in *Language and Symbolic Action*: "Even if any given terminology is a reflection of reality, by its very nature as a terminology it must be a selection of reality; and to this extent must function also as a deflection of reality" (45). In other words, Burke notes that language creates a screen which creates, for the audience, a very specific mode of viewing a particular issue. Through these screens, specific issues are reflected and others are, by default, deflected. Everything in life is mediated through signs/discourse/speech that reflects a certain world view. Examining these screens is particularly helpful to suss out the motivations,

87

or world view of the speaker in a speech, for example, in the political arena. Terministic screens are a particularly helpful way to look at government material as propaganda. Examining terms used in government material is useful because these terms reveal how the speaker wants the audience to view a particular issue. Terministic screens are particularly helpful to ascertain the nature of persuasion ingrained in the presentation of an issue.

The study is grounded in a health rhetoric project that seeks to read medical texts as persuasive. Rhetorician of science, S. Michael Halloran, notes that scholars must analyze scientific writing to document how health research is rhetorical. I read, following Judy Segal, government medical e-health texts as "rhetoric, as motivated discourse with persuasive force" (Segal, 2). The first section, *logos*, unpacks the linguistic terms of commodification through Burke's notion of terministic screens (analogies of e-health as shopping, e-health as technological rebirth, and patients as doctors) demonstrating how the logic of technology and progress advances healthist ideology, resulting in problematic disability stereotypes. The second section, *pathos,* examines patient stories of mental illness from an emotive standpoint. Burke's notion of terministic screens shows how emotional appeals promote problematic disability stereotypes. These problematic stereotypes deflect attention away from the social issues that citizens with psychiatric illness experience. The section entitled *ethos* considers the ethical implications of the government's propaganda material in the campaign, material that masks the government-speaker as the source of the message. Ethical considerations guide this section, which reads propaganda material as motivated discourse that attempts to provoke, through Burke's concept of dramatism, an *act.* This chapter concludes by bringing together the three sections to examine the "how" of governance in a reading that builds on theories of healthism and biopower.

A disability studies perspective is employed to complicate the highly celebratory framework of the Canadian government's e-mental health strategy. This analysis strives to consider the (troubling) implications of e-health policy for people with psychiatric disabilities. The three sections below, in concert, address the ways in which the rhetoric of the campaign advances health policies that could be problematic for those with disabilities. By troubling the celebratory rhetoric of the campaign, this analysis troubles the *acts* called forth by the discourse.

Logos

Logos is the Aristotelian concept that a rhetorical argument must appeal to the reason and logic of an audience in order to gain acceptance. According to Aristotle, "persuasion is effected through the speech itself when we have proved a truth or an apparent truth by means of the persuasive arguments suitable to the case in question" (Aristotle 1356a 2,3). For the argument to gain acceptance, rhetors must appeal to the audience based on seemingly rational, logical, and true arguments. This section demonstrates how the Canadian government advances their technological health care campaign, based on the logos of capitalism and progress, in order to appeal to the rational side of citizens' consciousness. Through Burke's notion of terministic screens, the rhetorical appeals linking health and commodification on the Canada Health Infoway website are dismantled. By showing how the government texts disseminate analogies (through linguistic techniques such as metaphor, simile, and metonymy) that rely on capitalist logic and assumptions of technological progress, this section disrupts the outwardly logical appeals of these analogies. According to Segal, "in the United States and Canada, problems in health care are typically framed in public discourse as, in the first instance, economic problems: We cannot afford all the health care we need" (119). In Segal's opinion, the values and linguistic

89

tropes used in the health care debate influence and affect health policy by limiting the ways in which it is possible to frame the health care debate.

This section, "Logos," uses an approach based on Segal's metaphor analysis and further argues that the government's mental health strategy is limited by the language of analogy (definable lexical clusters widened in scope to include comparisons such as simile, metonymy, and metaphor) that the campaign employs. This section isolates three terministic screens found in the government's e-mental health campaign on their Canada Health Infoway website and blog posts. The first analogy links consumerism and mental health by employing a shopping simile. The campaign material posits that accessing e-mental health is like shopping at the grocery store. This metaphorical analogy constructs the patient as a consumer and the government as a business. The second terministic screen uses the language of birth to conceptually reimagine the patient as being reborn as a "better" and more empowered citizen through e-health. The campaign further argues that *good* mental health is the byproduct of this technological rebirth. Through technology, the new mentally ill patient is reborn into a healthier version of himself or herself and disability is overcome. The third analogy shows how patients use technology as medicine to present themselves as doctors who self-treat. Here, patients as doctors are responsible for their own health. These three linguistic markers work according to Burke's notion of terministic screens, insofar as consumerism is enacted as a screen to constrain the very conditions through which we examine and view government healthcare. The language of commodification constrains the ways in which mental health is discussed in the government's e-health strategy, and these terms further enforce disabling disability myths and stereotypes. The rhetorical possibilities of this campaign work to further stigmatize and limit, treating mental health as a problematic disability by rhetorically framing the mental health e-strategy as

supporting a corporate rebirth of new, more empowered, expert patients. These terministic

screens restrict the possibility of having an open, critical discussion concerning government

treatment of mental health by relying on common disabling tropes regarding people with

psychiatric disabilities.

By situating analogies where health is an individual consumerist enterprise that clients

must master by overcoming psychiatric disabilities on their own accord, this section further

argues that the government's campaign rests on healthist ideology. In these analogies, health is

framed as an independent enterprise specifically with the agenda of removing from government

the responsibility for caring for the health and wellness of citizens. The problematic

depoliticization of the decentralized governmental approach to electronic mental health, which is

engrained in the neo-liberal Canada Health Infoway strategy, means that private enterprises and

citizens themselves are solely responsible for creating their own good mental health and wellness

by accessing technological tools and treatments available on the market. In plain language, in

the age of e-health, it is the consumers' responsibility to access/purchase health services and

technologies. The campaign rhetorically reinforces that *good* patients are *good* consumers. The

healthist assumptions engrained within the terministic screens enacted through the government's

e-health strategy strip the government of the responsibility to reform its current approach, which

has many holes, of providing mental health services. Following Emily Martin, who has called

for individuals to "wake up sleeping metaphors" in medicine, and using a framework based on

the Aristotelian sensibility of *logos*, this section concludes that analogies employed in this e-

health strategy are grounded in problematic assumptions such as "overcoming" disability. The

three terministic screens "woken up" (to use Martin's terminology) in this section show how

rhetoric masks government responsibility in a system that turns citizens into clients.

Genre

This analysis examines how the mentally ill patient is rhetorically structured online through the notion that terministic screens are erected to constrain the very conditions surrounding how the government frames healthcare. This chapter adheres to Segal's well-established rhetorical principle that "the nature of discursive encounters is conditioned by speakers' constructions of their audiences" (17). Additionally, Miller and Kelly argue that genre is shaped through repetitive encounters that firmly establish norms of behaviour for both rhetor and audience. To this effect, Segal, Miller, and Kelly argue that there is a link between genre and how the rhetor's message can affect audience through established conventions. Linguistic markers establish norms and values that shape the ways in which the audience perceives, speaks, and (re)enacts embodiments of psychiatric disability. Moreover, the ways in which analogies infuse illness with norms and values can be extremely harmful. In *Illness as Metaphor,* Susan Sontag writes about the dangers of speaking about disease using metaphor, arguing that doing so further silences and stigmatizes people with diseases.

This section isolates three screens through which a set of comparative symbols is put in place, as a way for the audience to perceive the state of e-health medicine in Canada. These screens use a language of commodification to mask alternate ways of viewing e-healthcare. The screens frame e-healthcare as scientific and non-rhetorical. However, not only is rhetoric an element embedded within medicine itself, but rhetorical presentations of medicine influence how a culture responds to presentations of disease. Professor of sociology Paul Starr notes that, "our conceptions of disease and responses to it unquestionably show the imprint of our particular culture" (1). The discourse surrounding health and wellness in our society speaks to the particular values of our historical epoch. While these analogies made in terministic screens are

92

often taken as fact, as arhetorical, these screens are in fact highly persuasive representations that reveal how disease is presented. Additionally, these presentations affect health policy by limiting the ways in which we describe and view disease in healthcare policy. As Laurence Kirmayer writes, "when values are explicit, they may be openly debated but rhetoric uses metaphor [or analogies] to smuggle values into discourse that proclaims itself rational, even-handed and value-free" (57). The Canadian government legitimates health policy by, to use Kirmayer's terminology, "smuggl[ing] values into [mental health] discourse" regarded as scientific, "rational, even-handed and value-free."

Grocery Store

A blog post written by Dennis Giokas, the Chief Technology Officer for Canada Health Infoway, erects a terministic screen, where accessing e-health is depicted as being like grocery shopping. The article argues for a more rigid approach to health care diagnosis, so that online technologies can better adept and serve "customers" depending on their diagnosis. The Canadian government relies on the logos of capitalism to argue that technological advances in health should be structured, logically, like a business model, in order to guarantee this venture's success in the Canadian healthcare system. To show how the logos of the Government's metaphorical appeal is disrupted, Burke's idea that language both *reflects* and *deflects* is used in this section. In Burke's theory of how rhetoric operates as a terministic screen, symbols are the tools we use to understand and explain the world. Language is not a neutral tool used to describe reality; instead, the symbols used to explain existence are steeped in rhetorical strategies. Language used by the rhetor reveals their motives and intentions; furthermore, the language used shapes the perception of the audience. In *Language as Symbolic Action,* Burke writes that "even if any given terminology is a reflection of reality, by its very nature as a terminology it must be a

selection of reality; and to this extent it must function also as a deflection of reality" (45). In this definition by Burke, all language is rhetorical and strategic insofar as the symbols used to describe an environment are strategic "selections" aimed at "deflecting" attention from one mode of seeing the world towards another. To illustrate how the government selects a certain symbol system in order to deflect our attention away from another value system (or, in Kirmayer's words, "smuggles values into discourse"), it is noteworthy how the following blog post—which outlines an extended analogy of e-health as a grocery store—operates according to Burke's theory of terministic screens. The analogy outlined in the blog post below establishes how various terms, according to Burke's concept of language as symbol system, work to *select* and *deflect* reality in the metaphor. This process of selecting and deflecting underlies his definition of terministic screens, which are sets of terms and symbols, or screens, through which we perceive the world. Terministic screens mask a certain reality to present another. The blog post on the Government of Canada's Digital Health Week website, entitled Canada Health Infoway, masks critical issues through the grocery store analogy. It is problematic that government strategists argue that merging patient records online in a way that allows the electronic systems to easily speak to one another can solve the issue of accessibility in healthcare. For people with psychiatric disabilities, interoperability of records means that diagnostic labels, medications, hospital visits, and medical reports would be easily accessible online to all health care providers.

The link between rhetoric and psychiatry is well established in the health rhetoric field. In *Patient tales: Case Histories and the Uses of Narrative in Psychiatry,* Carol Berkenkotter offers the first book-length study of the case history in psychiatry. Berkenkotter shows how the genre of the case history changes over time to mirror developments, attitudes, and shifts in psychiatric clinical practice. Berkenkotter documents the ways in which the case history was

increasingly codified from the asylum era to Freud, who incorporated narrative devices into the genre. Berkenkotter concludes her study by showing how patient-reported speech becomes (re)contextualized into a standardized APA form in the medical model of the DSMs. Following Berkenkotter, I speculate that the government's desire to incorporate interoperability of health records would further standardize, limit, and silence patient-reported speech into a genre of medical short form. Further study of electronic patient records would be useful in this area in light of the government's new mandate to move records online, since the implications of interoperability for people with psychiatric disabilities are various and discussions of how privacy should be a key feature of online psychiatric records is noticeably absent from the government's message. Instead, the shopping simile redirects any discussion away from privacy or the implications of what the interoperability of records could mean for patients. The government rhetorically frames the issue of online patient records as metaphor of grocery shopping. This quote describes the Canadian government as a retail grocery store that must cater to the electronic medical needs of citizens, just as a grocery store must stock shelves and offer food for sale:

> For [the] issue of [digital health systems], we need to think like a grocery store and how
> it caters to the needs of the consumer. The primary role of a grocery store is to sell food.
> It puts food products on the shelves and in bins, refrigerators and freezers. As
> consumers we go into the store (physical or virtual) with our list and fill our cart with the
> things we want to eat. There is one thing a grocery store does very well — it curates and
> makes available food products to its consumers which form the basis for their food
> consumption and recipe needs. The food products come in standardized forms and with

95

standardized labels that can be brought together in many ways to satisfy different

consumer needs. ("Think Grocery Store")

By referring to patients as "consumers" who purchase items for consumption—or "things we

want to eat"—this blog post frames citizen healthcare through a business model analogy. Just as

the "primary role of a grocery store is to sell food," the blog post argues that the Canadian

government's "primary role" should be to "make available products" in the health care system.

In this case, the "product" that the government is trying to make available (or rhetorically *sell* to

the consumer) is an online, technological amalgamation of all citizen's health records. By using

terms such as "consumer" instead of "citizen," the language of capitalism evokes symbols of a

very specific ideological framework within the discussion. Terms like "consumer," "product,"

"consumption," and "needs" cast healthcare within a capitalistic framework. The grocery store

simile, in Burke's words, "selects" a very specific worldview and "deflects" our attention away

from any opposing viewpoint through selective terminology. The ethical implications of making

psychiatric patients records available online for all health care providers to access fails to enter

the discussion as a concern in an analogy that assumes a business model. The government's

mandate is reflected in this blog post, as it appears that there is a split audience for this post: one,

the audience appears to be other government workers who share and tweet this blog post online

(more on this practice later in the "Ethos" section of this chapter); and two, the audience is,

clearly, Canadian citizens who access e-health (mainly middle to upper-class citizens with

reliable, high-speed, in-home internet access). If the government's main mandate is, as the blog

post asserts, to "sell food," or sell health care products to "consumers," then ethical implications

and the needs of all citizens do not factor into the discussion, as this screen effectively frames the

aims of business (aims that are profitable) as those to be achieved. By turning the citizen into a

consumer, this screen *deflects* our attention away from issues within the social sphere, such as considerations of ethics and disability, by *selecting* symbols of profit and business as the driving forces behind capitalism. By using these terms, the terministic screen rhetorically presents healthcare as a business and citizens as consumers.

The above quotation is, moreover, highly problematic from a disability studies perspective. Disability scholars note that paradigms that move away from the standardized medical model are necessary to conceptualize and honour the various and unique ways in which human beings vary from a normative value system. The need to categorize, label, treat, and cure disability speaks more to how, culturally, we[25] are terrified of accepting disability as a normative state. Stuart Murray critiques the use of diagnostic labels and the language of the *Diagnostic and Statistical Manual of Mental Disorders*. He writes that an autism diagnosis constitutes "a marker of identity for a non-disabled majority" (163). The idea that one person could be labeled autistic insinuates in the very act of diagnosis itself that there is in fact a larger population without any identifiable markers of difference (which is a fallacy). Instead of embracing the fact that populations consist of many differences and variances, the diagnostic system reflects a dream that we can mark any one person as different from the general population. The exclusionary nature of Western cultural identity leads to people being diagnosed as a marker with which to differentiate those who are *normal* from those who are non-normative. A "standardized" ideal of what constitutes normative disability is highly problematic and, inevitably, results in further stigmatization. The idea that disability can be standardized and made normative (and thus coded into technological form) works against the ideals engrained in disability studies, which aims to disrupt the notion that a normative value system is even possible. Normative value systems

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[25] The pronoun "we" in this sentence refers to the cultural majority that fears disability and subscribes to a normative, ableist value system

stigmatize, excluding anyone who deviates from the norm. The idea that online mental health

can be standardized into a codified language is highly problematic because it further excludes

Canadian indigenous identities. Jeanne L. Connors and Anne M. Donnellan note that how

disability is experienced in Navajo society differs from Western, biomedical modes of diagnosis

and treatment. The government's logical appeal to "standardize" clinical reporting into a single

streamlined technological apparatus ignores culturally specific experiences of disability. The

quotation above speaks to the need to "standardize" electronic records by alluding to grocery

stores, stating "the food products come in standardized forms and with standardized labels that

can be brought together in many ways to satisfy different consumer needs" ("Think Grocery

Store"). The government's grocery store allusion argues for even more standardization, so that

online reports can effectively and electronically speak to each other. The following analogy

likens the standardization of medical records and clinical visits to shopping for prepared meals at

the grocery store:

> One food type in grocery stores is the prepared meal — I just heat and serve or use it
>
> "out of the box." This is akin to the exchange model of interoperability where I want
>
> systems to connect "plug and play" but using the data I pre-package in anticipation of a
>
> use case's need. Just like the prepared meal, exchange-based interoperability requires
>
> a well-defined specification that has to be defined in advance often by consensus, then
>
> curated, adopted and tested ... grocers do not know in advance when these
>
> ingredients will be needed or how much will be needed. So what do they do? They stock
>
> the shelves with the basic ingredients. ("Think Grocery Store")

Logically, this screen taps into one of the most basic purchases each Canadian family makes—

buying food at the grocery store. While this terministic screen ignores families facing food

insecurity, who must rely on food banks for sustenance, the government targets a wide range of

lower to upper class Canadians in this analogy. Most Canadians would not argue with the logic

of how a grocery store should be structured, or with the logic that a "prepared meal" is an

effortless way to feed a family, or that "basic ingredients" should be stocked at the local grocery

store. This kitschy, folksy terministic screen appeals to the most basic of Canadian activities.

The issues engrained within the grocery store simile, however, occur when the linguistic

markers, in Kirmayer's words, "smuggle the values" of access and standardization into analogies

in ways that normalize and rationalize issues that should be subject to mass scrutiny by the

Canadian public. The following excerpt is a rationalization of why the Canadian government

should further standardize clinical information to fit a data platform that can integrate each

Canadian citizen's medical information using the terministic screen of the grocery store.

According to the blog post, this standardization is termed "an access model" ("Think Grocery

Store"). This "access model" is meant to model a grocery store, where all the "shelves are

stocked" with patient information, so that the system can easily organize information, such as

diagnoses and treatments, in the online technological system. The blog post further

conceptualizes, through the grocery store analogy, how shopping speaks to ease of access:

> An access model is one where the system(s) that need information get just what they
>
> need, when they need it, from the original source system or an intermediary. One of the
>
> best ways to implement this approach is via a data platform of patient-centric personal
>
> health information. Data platforms are ideally suited to support a data access paradigm.
>
> They are a modern way of bringing producers and consumers together for new value
>
> creation. In this case the core ingredient for value creation is personal health information.
>
> Health oriented data platforms are emerging as products and should be considered as

enablers for this new approach to our systemic interoperability challenges … For an

access paradigm to work we need the "grocery store shelves stocked." We must curate

and make available clinical information, just like the grocery store does with food. When

it comes to interoperability in health care the most important thing, in my opinion, is the

clinical content. We need standardized clinical information (e.g., detailed clinical models)

that we all agree on, that experts (e.g., clinicians) curate. Therefore, solutions which are

the original source of data need to either make it accessible directly or need to write it

into the data platform for authorized access when needed. ("Think Grocery Store")

The above screen employs a troubling use of the term "access." In the Canadian consciousness,

"accessibility" most often refers to the ability of those with disabilities to make use of

adjustments in terms of approaches, technologies, or aids to navigate their environment. In this

terministic screen, the discourse of "accessibility" is co-opted to mean the ease with which the

government health care system shares information internally. While the analogy attempts to

appeal to the logos that shopping for groceries should be as easy as accessing health care

electronically, the notion of ease of "access" ignores how standardizing diagnosis electronically

limits how people are diagnosed with psychiatric illnesses. What is "smuggled into the

discourse" as rational (though, indeed, it is arguably irrational) is the argument in the above that

"we need standardized clinical information (e.g. detailed clinical models) that we all agree on,

that experts (e.g. clinicians) curate." In this quotation, the pronoun "we" in fact refers to the

government. While it may be in the government's interest to further standardize medical

diagnostic labels into an easily accessible online format, it is most certainly not in the best

interest of Canadians to have disabilities further normalized, standardized, categorized, and controlled.[26]

Standardization helps streamline the process through which pharmacies can dispense medicines, as all patient records and physician notes are online. In terms of what pharmacies need to have "in stock" in their grocery store with regards to medications, it can all be ordered easily (and cheaply) when medication information is electronically available. Moreover, this information itself is profitable consumer data. In Canada, Shoppers Drug Mart is a drug store owned by Loblaws, which is a literal grocery store. The grocery store/pharmacy corporate interest in streamlining pharmaceutical records for ease of access (and cost savings) should not be minimized. Loblaws[27] has a monopoly over the grocery and drug store sector, as the corporation made, for example, 45.394 billion in 2015 ("Annual Report"). By contrast, Bell Canada grossed approximately half the amount that Loblaws made in the same year, at $21.51 billion. Loblaws is a major corporation in the food and drug industry, linking grocery stores directly to health care products like pharmaceuticals in terms of what needs to be "in stock" for customers.

Through the increased standardization of bodily processes, diagnosed and documented

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[26] Figures 1.5 and 1.6, entitled "How does it work?" and "Standards Tools," show screen shots taken from the Canada Health Infoway website, which demonstrate how the government campaign rhetorically structures technological standardization as a logical, simple process. By using cartoon spread sheets (pictured in Figures and Tables), arrows, and describing the process as being led by a "terminology expert," the tables manage to hide the complex implications that standardizing clinical terminology will have for people with psychiatric disabilities.

[27] The Loblaw Company states the following on their website:

> Loblaw Companies Limited is Canada's food and pharmacy leader, the nation's largest retailer, and the majority unit holder of Choice Properties Real Estate Investment Trust. Loblaw provides Canadians with grocery, pharmacy, health and beauty, apparel, general merchandise, banking, and wireless mobile products and services. With more than 2,400 corporate, franchised and Associate-owned locations, Loblaw, its franchisees, and Associate-owners employ almost 200,000 full and part-time employees, making it one of Canada's largest private sector employers (Loblaw).

into codifiable technological form to be manipulated, studied, monitored, and treated (via increased monitoring and biochemical alterations), the government is exercising its biopolitical muscle. Standardizing diagnosis into a centralized, online technological system that is controlled and monitored by the government is a tool of biopolitical control and not in the best interest of citizens—especially those with psychiatric disabilities. It is, in fact, documented in the literature that increased standardization in clinical practice does not benefit citizen health, as the government attempts to argue through the terministic screen of the grocery store.

A significant body of work documents how patient-reported speech becomes limited, rewritten, and taken out of its original context in clinical settings in order to suit a standardized form acceptable for medical reports and treatment (Berkenkotter, 2008; Kelly, 2014; Buttny and Williams, 2000). Medical standardization has been shown to not only limit the expression of patient-reported speech by reframing the discourse into a medically standardized form, but studies further show that psychiatrists rewrite patient speech using their own medical terminology that is often not faithful to the original narrative. Patty Kelly's 2014 study on patient-reported speech in clinical settings shows how the very nature of psychiatric discourse and treatment give rise to an exemplary speaker who speaks in acceptable medical terms. Disability scholars further argue that standardized labels are harmful. The top-down hierarchal model of medicine fails to account for the unique and various ways in which people experience psychiatric (and other) disabilities, limiting how it is possible to speak about illnesses. By evoking a logical grocery store analogy through a terministic screen, the government smuggles the message into the discourse that "we" the "consumers" require more control, more standardization, and more normative value systems in our health care system. Moreover, the government smuggles into the discourse the notion that it, the government, needs more control

and more access to the personal health information of "consumers." In the labeling and sorting of grocery stores, products are categorically coded for ordering/stocking in a supply and demand model that tracks sales and purchasing information. By labeling and sorting customers' medication, ordering, and purchasing practices online, the government e-health system can operate like a grocery store (to literally serve grocery stores) by tracking customer behaviour online to manage the health supply chain product delivery system.

Furthermore, this screen sets up the health care system as a "product," where citizens are both "consumers" of the system and elements of the system itself. In this terministic screen, the machine does not need to adapt to the disabled body. In fact, the disabled body needs to adapt to the machine itself. Bodies must conform to the standardized nature of technology, become more easily codable, more easily read. In North American contemporary discourse surrounding medicine, a terministic screen that situates the body as a machine is a common linguistic analogy. Segal observes that, "a dominant metaphor of biomedicine is the body as machine" (121). "Biomedicine," the western, scientific, approach to disease tends to view the body as a machine that can be fixed via technological intervention. Critic Ivan Illich considers "the economic causes and effects of the notion that the body is the possession of a consumer who is able to purchase 'repairs' for it" (Illich qtd. in Segal 122). As consumers, people can obtain technological fixes for illness by submitting to the government's system.[28] In this biomedical terministic screen that sets up the body as a technological machine, the idea that disability may be "overcome" by technological use underlies the discourse in an unsubtle manner. In this

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[28] A technological fix is the idea that technology holds the solution to most problems. However, many scientists warn of the technological fix. David Suzuki states that "we often look to technological fixes without acknowledging our ignorance about how the world works, and then we end up trying to correct the unexpected problems that result" ("Technological fixes can have serious consequences").

screen, the government creates an endless client base for its "product" insofar as the body may forever be improved, fixed, and altered technologically in the quest for bodies to conform to the normative value systems prized in this linguistic construction. Being healthy means being electronically connected in a manner that centralizes all patient records online, so we can easily "access" information. Being healthy means creating a never-ending market of technological apparatuses for the consumer to endlessly seek out to improve their health through technological means.

Similarly noting the capitalist assumptions upon which the current government health care system rests, Nikolas Rose notes:

> ...medicine [has] been reshaped by its intense capitalization. Basic and applied biological research—whether conducted in biotech companies or in universities—has become bound up with the generation of intellectual property, and illness and health have become major fields for corporate activity and the generation of shareholder value. In these processes human vitality has been opened up, at the molecular level, for technological innovation, economic exploitation, and for highly competitive forms of bioeconomics.
>
> (11)

In this capitalistic, technology-driven space of healthcare, Rose defines "bioeconomics" as the new age of medicine, which seeks to improve, sell, and manipulate the body at the molecular level through new healthist endeavors. According to Rose, it is no longer sufficient for medicine to peer into the body through the clinical gaze, as that gaze has now been supplanted by the "molecular gaze" (12). This gaze is now understood "at the molecular level, in terms of the functional properties of coding sequences of nucleotide bases and their variants, the molecular mechanisms that regulate expression and transcription, the link between the functional properties

of proteins and their molecular topography" (12). In Rose's view, "bioeconomics" is the new

age of medicine in which corporate and government interests combine to sell, manipulate, and

create new products and new clients based on the idea that bodies can be changed at the

molecular level in the eternal quest for perfection. In this healthcare market, a terministic screen

between the body as a machine that improves through technological advances drives the very

idea that we can improve our bodies to suit our environment. The screen enacted to situate

health as a grocery store commodification marks the government's desire to fully digitize,

categorize, control, code, buy, and sell the very elemental molecular elements of life itself.

Birth

An element of the "molecular gaze," as conceptualized by Rose, is a value smuggled into

the second terministic screen considered in this section: the birth screen. The Digital Health

week campaign uses linguistic markers of being reborn to demonstrate how care, delivered

through technology, will give birth to better health services for consumers. Steeped in the

discourse, the language of birth and rebirth promotes the myth that, through technology, clients

will be reborn. A page of the Canada Health Infoway website designed for clinicians instructs

primary care health workers to "support patient adoption of consumer digital technologies" and

"deliver results to the patient…by [using] consumer digital health technology" ("Leading

Practices"). The argument is that through digital health, a new, empowered, and productive

citizen emerges. A report on the website proclaims, "technology has permeated every aspect of

our world and improved our ability to lead more productive, informed, and healthier lives"

("Report on Digital Health"). The patient's life is described as being revolutionized by

technology. With technology, the patient is reborn into a more "productive," better "informed,"

and "healthier" consumer. Likewise, first care responders are also hailed through the ideology

that technological apparatus is the mode through which consumers are reborn as improved and more informed subjects. The report further extrapolates that the health care delivery system will "evolve" into a more "innovative" ("Report on Digital Health") system. In fact, Digital Health Week is promoted as a campaign through which Canadians should imagine, according to the government's campaign, "how their lives will change" ("Digital Health Week Launches") when they are able to go online to access their health care information via one portal delivery system.

Specifically, the Digital Health Week campaign frames this technological rebirth of more progressive, empowered patients as a birth that occurs through talk, through telling stories. The problematic assumptions of talk were touched on in the previous chapter on the Bell Let's Talk campaign. Embedded within the concept of talking about your illness are problematic ableist assumptions that all citizens can talk about their illness. Using this model, the campaign assumes that patients are ready, willing, and able to speak about their illness. Some people, such as someone with a dissociative disorder, may be unable to form a cohesive narrative in the genre expected by a clinician. This privileging of speech speaks to the "name and shame" nature of our society, which demands confessions from those with psychiatric disabilities so that we can categorize, diagnose, treat, and protect ourselves from people outside normative value systems— who therefore pose a threat. The socially protective requirement—the requirement that demands people with psychiatric illnesses talk about their diagnosis so that we enact population control measures—speaks more to public values of control and surveillance than the actual nature of psychiatric disability itself. To *deflect* attention away from the practice of demanding confession from citizens whose experiences remain outside the norm, the Canada Health Infoway rhetorically situates "talk" as a required confessional element of a healthy community. This talk gives birth to a new, more empowered patient. This talk gives birth to a communal body of

citizens, government, and businesses working together for everyone's better health. Talk, or sharing one's story, is constructed through a set of terministic screens as a logical, necessary step towards better health. By situating talk as the logos in "even better health," the government argues that citizens becoming consumers in response to its biopolitical strategy will give birth to new, healthier, improved subjects. In this birth terministic screen, the government masks biopolitical strategies of control by rhetorically arguing that the act of speaking into this system as a subject leads to better health. The following blog post on the Canada Health Infoway website erects a terministic screen through birth analogy. The Vice President of Communications for the government's digital health campaign, Shelagh Maloney, posted this blog on September 17, 2014. She writes that stories are the elements that give birth to the technological body of Digital Health Week. The screen employs metonymy to paint a picture of patient speech giving birth to the body of the campaign. This construction shows how the terministic screen rhetorically constructs patients as being reborn as new, technologically empowered consumers of digital health. The blog tells the story of how digital health started in Canada:

> Story tellers were the key to our campaign – "real" Canadians sharing their stories
> about how digital health has positively impacted their lives. …these stories resonated
> with Canadians and are great testaments to the difference that digital health is making in
> the lives of millions of Canadians today. If patients and their stories were the heart of our
> campaign, our partners were its arms and legs. Every single provincial and territorial
> government in Canada, and Health Canada at the federal level, supported the
> campaign. In addition, over a dozen highly respected national organizations served as
> campaign Supporting Organizations…They renewed their commitment to help spread

107

the word that digital health is improving the health of Canadians and improving the

patient experience…I wonder if we need to change the campaign name to "Even Better

Health Together! ("Better Health Together")

In this screen, talk is the logos through which healthy embodiment occurs. The blog post uses

metonymy to rhetorically argue that talk is the apparatus through which the government gains a

literal embodiment. Through talk, citizens' stories "form the heart" of the governmental body,

and various businesses and government "partners were its arms and legs." The body, composed

of separate body parts representing various citizens and stakeholders in the public health

campaign, is born out of patient speech, which gives rise to a new, healthier, and improved

citizen. The message to "spread the word" and tell stories that "resonate" with the "difference"

digital health is making to "improve" the health of Canadians valorizes talk. The simultaneous

standardization and valourization of talk is problematic for people with disabilities. In our

environment, talking publicly about psychiatric illness results in stigmatization and other

negative consequences. When people with psychiatric disabilities are diagnosed with

stigmatizing diagnoses, talking about illness (and documenting a diagnosis in a permanent

electronic health record where privacy cannot be guaranteed) can have very real negative

consequences. Diagnosis and treatment of psychiatric disability is not always an empowering

experience; moreover, it is problematic to represent speech about illness as giving rise to a whole

body—with arms and legs—free from disability. The idea behind the metonymy is that by

talking one can eliminate disability, thus becoming physically whole through speech. If the

patient is reborn physically through speech, as the terministic screens suggest, they will be

healthier as a whole citizen, and given even "better health" through the process of telling their

story.

This new, empowered patient whose embodiment is formed through storytelling is rhetorically presented as being technologically reborn through digital health. In the campaign, good mental health is rhetorically presented as being a direct result of using the government's e-health strategy. The Canadian government's Digital Health Week campaign rhetorically argues that using the government's e-health system will result in good mental health for users. Using the government's technological system is represented as a logical, progressive, and rational next step in evolutionary medicine; furthermore, as medicine evolves, the following commercial argues, so does the patient, from an unhappy, disconnected patient to a more "empowered" citizen. A video entitled, "Connecting Patients for Better Health," posted on Infoway's YouTube channel in 2016, flashes words across a white screen with upbeat, happy music in the background. The message states, "those with access to digital health services report positive benefits including feeling more…[a three second pause before the following words appear one by one in large letters on the screen]: empowered; confident; informed." When the last message scrolls off the screen, the following words appear on the bottom of the screen with two pictures, each of a middle-aged couple staring at a laptop together, smiling, with cups of coffee: "best of all, research shows empowered, engaged Canadians have better health outcomes." The last message scrolls off the screen and the following message appears: "how is digital health working for you?" Lastly, the message "Join the Conversation. Better Health Together. Canada Health Infoway" appears with the Better Health Together and Canada Health Infoway logos attached ("Connecting Patients"). By telling consumers to "join the conversation" the government of Canada's e-health strategy rhetorically situates talking as the practice through which better health occurs. Problematically, in this campaign, "talking" in the conversation about digital health means that citizens sign up for the e-health campaign, supporting government and businesses'

109

control of citizens' health information. By signing up, citizens are reborn into more "empowered, confident, and informed" "consumers" whose buying power gives them a feeling of authority. In purchasing government digital health services, consumers are "making digital health work" for them. It is through using technology available on the market that citizens become happier and mentally healthier. In this commercial, which features a man and a woman happily smiling at a laptop, technology is the symbol of progress, the symbol standing in for the logos of technological innovation. By reflecting symbols of progress and technological innovation in the symbol of the laptop, the commercial deflects attention away from the more complex implications of digital health. Digitized heath systems give the government increased control over the bodies of subjects; digitized health systems standardize and limit how people with psychiatric disabilities can explain their experiences; digitized health systems can further stigmatize people with psychiatric disabilities when their diagnosis is feared—such as those with schizophrenia or personality disorders; and moreover, digitized health systems deflect attention away from those with disabilities who cannot talk, who are unable to formulate their experiences in standardized technological short form. What the terministic screen in this commercial *deflects* attention away from is that talking about certain disabilities will result in more information being used to stigmatize and control. The technological rebirth rhetorically argued in this campaign to be a more progressive, new age in health care involves, in fact, increased governmental control marketed as innovation. What attention is further deflected away from via this terministic screen is who benefits. As Telus has the contract to provide these services to consumers through TelusHealth, the corporation has a strong interest in consumers' adaptive behaviours with regards to the government's e-health services.

The following blog post exemplifies how the government's digital health campaign promotes the idea technology creates a new, more empowered patient:

> The digitization of health information has been an enabler of innovation. Whether you are a researcher studying a new treatment, a policy-maker looking for better funding models or an entrepreneur developing a new app, your work is enabled by the availability of digital information, which was considered an innovative concept not that long ago … Innovation can improve the patient care experience and enhance patient safety and transitions in care, particularly as patients move between multiple care providers.
>
> ("Innovation of Health Care")

In this argument, the government sets up a linguistic terministic screen to *reflect* innovation as a logical element of healthcare. The terministic screen of innovation masks, however, the very real implications of these developments. The post tells us that innovation is designed to help "researchers, policy makers, and entrepreneurs." "Innovation" refers to the governmental desire to market healthcare to private enterprises and decentralize the delivery of healthcare services from a central government source to multiple private tech companies. These technological apparatuses, the post explains, will help with the "monitoring" and "management" of the bodily processes of citizens. In this biopolitical health care system, health is a market open to private enterprises in which bodies can be monitored, citizens can be managed, and private information is available in technological form to both government and private enterprises. While some of these technological moves may be viewed as being "good" for citizens, there is certainly nothing arhetorical about this healthcare campaign.

Making health records accessible online to private and government stakeholders has enormous implications for people with psychiatric disabilities, who may have been mistreated,

misdiagnosed, or who are misunderstood in the normative health care regime. In this system, stigmatizing records could follow a patient for their whole life and affect further treatment. There is also the unspoken assumption in this post that patients require "monitoring" and controlling when between health care providers, which may not be the case. Often, first responders are not equipped to adequately deal with psychiatric illnesses in the health care system, and many patients may require multiple visits with various clinicians before finding someone who can help—though they may never find that help in the traditional health care model. It would be incredibly difficult, if not impossible, to find a psychiatric professional willing to overturn a mental (mis)diagnosis made by another physician, so usually patients are permanently "stuck" with a misdiagnosis on their records.

Taken in its entirety, the birth screen deployed in this governmental campaign infantilizes patients as sad, disconnected children who must be reborn as happier and more empowered consumers through technology. This delivery of a new, empowered patient through technological rebirth masks the question of what kind of patient needed to be reborn, and further raises the question, what kind of patient needs to be changed? In examining what is *reflected* in the terministic screens of the campaign, this analysis also attempts to answer what is *deflected* by the terministic screens. The psychiatric patient is most often the patient who does not easily conform to the medical model. Mentally ill patients are historically framed as simultaneously the most difficult and the most childlike. The idea behind making health care more technologically accessible for mentally ill patients appears, outwardly, to aid care. If a patient is struggling, increased surveillance and control will help a childlike or difficult patient to cope with their illness. However, a technological rebirth terministic screen obscures, or is based upon, the notion that mentally ill patients access health care irresponsibly; furthermore, the surveillance

112

system argues that information needs to be visible to prevent mentally ill people from "abusing" the system. The post discussed above speaks about how technology can monitor and surveil patients as they move between health care providers. Intertwined with this idea is the notion that so called "doctor shopping" by mentally ill people leads to drug-seeking behaviour and abuse of the medical system. This notion that it is innovative to monitor patient visits to multiple doctors suggests a bias against people with psychiatric disabilities. Through technology, patient behaviour can be monitored, tracked, and made known to all treating physicians. Patients would not be able to choose who they want to see and which information they wish to disclose. What the technological innovation terministic screen masks is the gaps that exist today in the very system itself. There are gaps in the system; the system is unable to fully care for mental illness. Simply integrating a system electronically does not fix the system. Technology simply gives the system itself more control, not the patient. In this new system, a patient can be electronically labeled with a stigmatizing psychiatric disability for all future treating clinicians to see. Now, a patient is labeled in one hospital and that information is not shared across practices, so another clinician can still treat the patient properly. Disabled patients are often misdiagnosed as "doctor shopping" or having "drug seeking behaviour" simply because they are not being treated properly by clinicians or their underlying conditions are not being treated. Making stigmatizing labels and judgments available online for clinicians to access may have harmful consequences. The highly celebratory rhetoric of online information access masks very real ethical implications concerning how psychiatric disabilities will be treated in this system. The rhetoric in the government campaign uses technological rebirth terministic screens to argue that this new system represents progress in the search for new, better, collective social health. However, the rhetoric obscures the fact that not only does this new health system decentralize health services

113

from government to private enterprises, but it also fails to address gaps within the system, such as those related to mental health treatment.

Patients as Doctors

The third and final terministic screen explored in this section is how patients can self-treat through technology, which gives rise to the patient linguistically being cast into the role of being their own health care provider. By framing the patient as doctors, or "experts" on their own care, the government persuasively argues that good health is an individual responsibility; as such, healthcare becomes a personal responsibility and the onus on the government to provide healthcare is diminished. Nikolas Rose notes that the decentralization of health from governmental regulations to independent bodies puts the responsibility for good health on private individuals who are "consumers of medical services and products ranging from pharmaceuticals to reproductive technologies to genetic tests" (4). This shift from citizen to consumer opens up an entire market of healthcare, where individual bodies are subject to various technological tools that monitor, treat, and collect data. The government campaign rhetorically presents patients as experts as an enticement to utilize various technological apparatuses designed to treat, monitor, and privatize healthcare by design. The rhetorical argument behind the analogies made in the Digital Health Week terministic screens is based on healthist assumptions that situate healthcare as a private rather than a public concern. By depoliticizing healthcare, moving it from a government responsibility to the responsibility of individuals, health care costs are reduced (for the government) and become individuals' burdens to bear. After first establishing how this government campaign casts patients as health experts in order to advance the healthist ideology that individuals must be responsible for their own health through terministic screens, this section

114

concludes with a discussion of the implications that technological monitoring will have for people with psychiatric disabilities as viewed from a disability studies perspective.

In this neo-liberal government's digital health campaign, online tweets persuasively argue that through technological consumerism citizens can master their own mental health. This analysis unpacks tweets on the Canada Health Infoway Digital Health Week website to show how patients are framed in terministic screens as doctors who are responsible for their own health. The logical effect of this argument is that if patients are their own treating clinicians, then health becomes a private concern and not a public (government) responsibility. By depoliticizing health and making patients pay for and treat themselves through health technologies, the government offloads the responsibility to provide and treat healthcare concerns; moreover, when bodies voluntarily submit to technologies that regulate, monitor, and collect information, decentralized bodies such as insurance companies and other private enterprises become responsible for controlling the behaviour of subjects instead of a centralized government. Through the screen of patients as doctors—an ideology of healthism—subjects are convinced that submitting to self-treatment and self-technological regulation is in their best interest and will, in fact, increase their mental well-being.

This particular screen is erected through a practice known as "astroturfing." A play on words that is in contrast to grassroots movements, Aimeé Morrison notes that astroturfing is the practice of falsely obscuring or masking the source (or sponsor) of a message. The speaker appears, on the surface, to be promoting a message (or service) as a disinterested party, when in fact this speaker has been paid or is somehow benefitting from relaying the message (Discussion, August 21, 2017). Government employees tweet and share posts from other employees using their private Twitter accounts. These employees fail to disclose their position within the

government. In some cases, corporation heads post as private citizens and fail to disclose that their business has government contracts. This practice of assuming a false or misleading online persona, Morrison notes, is known as "sockpuppeting" (Discussion, August 21, 2017). The blog is generated as a form of media that can be shared by sockpuppets through astroturfing—to "generate a buzz," so to speak.

A thread on the Canada Health Infoway blog states that, "Digital health can help empower patients" ("Digital Health Week"). The tweets made in response to a thread using the hashtag #thinkdigitalhealth speak to the screen made in the Digital Health Week campaign that, through technology, patients become doctors who can manage and treat their own health. Through technology, the tweets argue, patients become empowered, they can advocate for themselves, and they can inform themselves about their own diseases; in this system, the patients bear the responsibility to treat their disease, not the government. The idea in the government campaign that patients are experts concerning their own care is highly celebratory rhetoric. One tweet in twitter chat featured on the Infoway website using the hashtag "hcsmca", written to Andrew Levy, Senior Program Consultant at Ontario Ministry of Health and Long-Term Care from Infoway, proclaims that "digital health can help provide patients with more information and empower them" ("Infoway"). Michelle Mula, Executive Director of Clinical Informatics, likewise posts that "Citizen health portals are making a difference" ("Think Digital Health"). Justin Noble, responsible for consumer health and innovation at Infoway, tweets to Shelagh Maloney, Vice President of Canada Health Infoway, that "people powered health is the future" ("A Look Back"). The idea that healthcare should be "people powered," as in managed and purchased by private people and not governmental organizations, is a popular notion disseminated by the campaign. In fact, the campaign rhetorically constructs technological self-

116

care as an act that creates mental wellness. A tweet by Canada Health Infoway argues, "those with #digitalhealth are more engaged and more empowered. And they have better health outcomes" ("A Look Back"). The argument is that if a citizen uses e-health, they will be "more engaged," "more empowered" and have "better health" overall. Justin Noble likewise posts that "patients feel more empowered by self-managing their care" - Gary, engaged patient" ("A Look Back").[29] This post, professing that, "patients are empowered by self-care" is re-tweeted and re-posted by multiple stakeholders on the forum.

Not only are patients "empowered" by self-care, they are also responsible for their ultimate well-being. GenXys Health Care Systems posts that "an informed patient is empowered to drive their own care and destiny" ("A Look Back"). In being required to "drive their own care and destiny," the tweets culminate in the notion that individual people are responsible for their own health—it is their "destiny." Not only is the patient's "destiny" to self-manage their care, but they can become their own physicians by simply using the health technologies available to them. A tweet by the Mental Health Commission of Canada, a government organization, questions, "did you know? E-Mental health services can be as effective as face-to-face therapy" ("A Look Back").[30] By proclaiming that e-mental health services are "just as effective as face-to-face therapy," and further arguing that the very act of accessing e-health leads to better mental health, the government's campaign effectively places the onus for healthcare onto the patient. In doing so, the government is absolved of any responsibility to provide mental health services, since these services can be outsourced to private enterprises then accessed by the consumer. In this system, the campaign argues, the very act of accessing e-mental health makes one healthier.

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[29] Frank is not the real name of this patient. Names have been changed to preserve anonymity.
[30] This tweet sparked many of the questions guiding this dissertation.

117

A tweet posted by Karen Parker, Director of Shared Services Canada (a government agency) states that, "E-mental health can empower self-care" ("A Look Back"). Not only does e-mental health empower patients to be their own health caregiver, the campaign rhetorically argues, but it is logically argued to be even more fitting for someone with a psychiatric disability to access care online.

Andy Hind, an independent consultant in the healthcare technology and IT sector, writes that, "digital health technology provides ease of access & anonymity appealing to mental health patients #ThinkDigitalHealth" ("A Look Back"). This argument is a doubled-edged sword. People with disabilities do in fact need "ease of access" and "anonymity" when seeking treatment. However, on the other side, the argument engrained in this tweet is that people with psychiatric disabilities desire to be or should be treated anonymously, in secret, at home with a simple Internet connection instead of in a public system. The self-serving logic of this argument is problematic. People with psychiatric disabilities should not be forced to treat themselves privately because the health care system is not adequately funded. What is being touted in this campaign as logical, technological progress—patients evolving to be their own caregivers through technological innovation—in fact creates a terministic screen that obscures issues related to funding (or the lack thereof) in healthcare delivery.

The terministic screen that frames patients as masters of their own care dominates many aspects of the Digital Health Week campaign. Another tweet on the Canada Health Infoway website features an article from a UK publication, *The Guardian,* entitled "Patients Take Care of Themselves." In this tweet, the article linked to discusses the idea that, through technology, patients can become like doctors in charge of their own care. A physician, Dr. Simon Bourne, is quoted as stating that, "we have proved that if you put the right tool in patients' hands, they

118

really can become experts in their condition and transform the way they use healthcare facilities"

("Patients Take Care of Themselves"). The article reflects the idea that not only can patients take

care of themselves, but also that the onus for maintaining good health should be put on

individual measures taken in private, not in public. The idea of social prescribing is introduced

as a solution for both physical illness and mental health. Social prescribing, also known as

community referral, is the practice of allowing health care professionals to refer patients out of

the medical system to local, non-clinical services. Social prescribing "aims to support

individuals to take greater control of their own health" ("The Kings Fund").

While there are certainly benefits to social prescribing, as a vulnerable segment of the

population can be reached and treated non-medically, a rhetorical examination of how social

prescribing is presented—as an individual pursuit—reveals that there are problematic, healthist

elements to the practice. According to Digital Health Week, social prescribing should be

embraced, and technology is the vehicle through which socially prescribed events occur:

> Social prescribing can also be boosted by technology. In the Creggan estate in Derry,
>
> one of the poorest areas of Northern Ireland, a 12-week pilot program is being rolled
>
> out by social prescribing software company Elemental. Through using its software, 56
>
> pre-diabetic participants had the choice of more than 40 different activities relating to
>
> diet, motivation and mental health. All participants lost weight – some as much as 4
>
> stone – by engaging with the program…Work is underway to help clinicians choose
>
> and recommend reputable apps, starting with mental health, diabetes and
>
> COPD. ("Patients Take Care of Themselves")

In this passage, social prescribing, an approach where primary care would be relegated to various

other communal services, is recommended. While it is indisputable that a strong social

community can help people cope with the mal-effects of illness, here, in this passage, social prescribing is recommended in the "poorest areas of Northern Ireland." This is extremely problematic, because social prescribing should not be a solution to government responses to poverty, nor should social prescribing be a solution to primary care. In this passage, social prescribing as "boosted by technology" is presented as a logical response to poverty, mental illness, and various other illnesses. Private citizens are tasked with individually treating their illnesses through social prescribing applications. The passage implements a terministic screen showing how health, through technology, is achieved by giving proof that "all participants lost weight…by engaging with the program." However, simply losing weight by using a program does not necessarily prove that the program was successful. A person's weight fails to correlate to their overall well-being; weight loss is not a measure of health, necessarily, nor is it a measure of the success of social prescribing. In linking social prescribing with the success of weight loss, the passage reflects a terministic screen where people who partake in individual health measures by treating their own health are represented as healthier, thinner, and more motivated individuals than those who access primary care. This is problematic because technological apps that facilitate social prescribing are created, monitored, and sold by private health corporations—and this data is worth a lot of money.

Social prescribing marks a new era of biopolitical power in which bodies are subject to powers of surveillance as subjects of biomedical research and consumers of their products. Emily Martin writes that we must "wake up the sleeping metaphors" in science to discern what types of discourse are being promoted as logical and value-free. What is being promoted as logical here—social prescribing—is in fact discourse that, in Kirmayer's terminology, "smuggles" the healthist ideology into analogies that promote patients as agents of their own

120

health. The idea that patients are experts on their own care and, furthermore, should be responsible for managing their own health through private technological inventions, hides the fact that government wishes to decentralize health into the private, corporate sphere. In a system where individual health is electronically tracked as a personal responsibility, insurance companies could remove health coverage if the individual fails to use the electronic system as outlined by private enterprises. While this is speculative, this outcome could have very harmful effects on people with disabilities who may not be able to consistently take their medication as required or even take part in the social prescribing described above. In this social prescribing model, someone with agoraphobia, mania, psychosis, or depressive illness may be unable to attend social gatherings, make social connections, or reach milestones as outlined by the application. The very idea that one could overcome their illness simply by using a social application completely ignores the real lived experience of many people with psychiatric illnesses who struggle specifically with social interaction. Again, this model is a double-edged sword, like the anonymous online treatment system proposed on the government's Twitter feed. While people with disabilities could experience positive outcomes from social prescribing and online communal meet-ups, there are drawbacks to the system that should be considered.

Pathos

This rhetorical analysis now shifts perspective from the logos of technology as read through terministic screens to a look at how pathos operates in the Digital Health Week's mental health stories section, featured on the campaign website. According to Aristotle, pathos is the aspect of a rhetorical argument that draws out a sympathetic emotional response from the audience. In *Poetics*, pathos is also described as a literary component of a tragic plot, necessary to purge the audience of pity and fear. Pathos is an important aspect of a rhetorical appeal

121

because a speaker's success lies in their ability to connect emotionally with their audience. Just as an audience must connect emotionally with the protagonist of a tragedy, a rhetorical appeal must evoke an emotional response from the audience in order to persuade. This section analyzes four stories of mental illness featured on the government's digital health strategy Canada Health Infoway website to assess how pathos is used by the campaign as a strategy of appeal. Terministic screens reflect a very specific emotional appeal in the campaign; this emotional appeal is set up to deflect the audience from acknowledging that there are issues concerning how the government fails to address and treat mental illness and the underlying factors that contribute to mental illness. In fact, there is a marked absence of mental illness in the stories. These mental health stories are troubling depictions of psychiatric illness insofar as the stories reinforce disabling and stigmatizing disability stereotypes such as overcoming, addressing caregiver audiences, self-care, disability as a tragic object of pity, and treating disability as a medical emergency.

On the Digital Health Week website, there are fifty-six pages of patient and health care provider videotaped stories. These stories feature Canadians speaking about how digital health has affected their lives. On each of these fifty-six webpages, up to seventeen videotaped stories are present. The stories section is a large component of the Digital Health Week campaign website. However, while the campaign argues that accessing e-health will lead to better mental health, there is a marked absence of mental health stories in this section. Only four patient stories are found on the Digital Health Week website by searching "mental health." These four stories are the only direct mental health narratives on the website, and they fail to address the

direct lived experience of having a mental illness. A woman given the pseudonym Susan

narrates the first story of mental illness.[31]

Under the heading "Canadian's Stories," Canadians tell videotaped stories about how

digital health benefits them personally in relation to their mental health. In the first story, a

middle-aged woman with glasses and short blonde hair speaks, sitting on a chair against a white

background, with soft music playing in the background. For anonymity reasons, I will call her

Susan, but the government site does give her another name. She is featured speaking in a video

entitled "Connecting with an online community":

> Digital health has made a positive impact on my life by providing me with a lifeline
>
> after the death of my son, being able to reach out and talk to other mothers who also lost
>
> their children and teenagers and getting that support and it was really really important and
>
> really really crucial. It helped manage my mental health. When you are going through
>
> something as profound as grief, as losing a child you don't always know if your reactions
>
> are normal, and you have concerns about your other children. You know, how do you
>
> help them, depending on their age and stage. If they are young, how do you explain it?
>
> It's also really important to remember for all of us that when you are going through a
>
> tragedy in your life there is self-care and there is a lot of digital health and e-health stuff
>
> to help you whether it's to remind you to take medication or to get some exercise and just
>
> stay on track at a time when you need some reminders that you need to take care of
>
> yourself as well. I see digital health as so empowering for patients and caregivers alike.
>
> I see it as an opportunity for a partnership in improved communication, so I think we are
>
> going to see better care sooner and more streamlined care in people feeling empowered as

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[31] Names have been anonymized in this analysis to protect identities; however, the Digital Health Week
campaign does not anonymize the citizens speaking about their experience online in video form.

partners in their care instead of simply the patient [a white screen with the words "Better Health Together" flashes for 3 seconds] ("Canadian Stories").

Susan's story is heartbreaking. Certainly, online connections with other parents who have experienced the loss of a child would absolutely be helpful for Susan or any other parent experiencing grief over the loss of a child. Susan's story is an emotional appeal that touches upon the fears of any viewer who has a child. Even viewers without children could not help but feel extreme sympathy and empathy as an emotional response to Susan's grief over the tragic loss of her child. What Susan does not have, however, is a mental illness. Susan describes normal reactions of grief during a tragedy, and the government's campaign commercial problematically links having a psychiatric illness with grief and tragedy. Susan's story is the first story to appear in the "Mental Health" story section, and Susan does not have a mental illness; instead, Susan's story is used in the campaign to elicit an emotional appeal on the audience by playing on the audience's worst fear—losing a child. By associating the experience of being mentally ill with the experience of grief, loss, death, and tragedy, the campaign further stigmatizes mental illness as an abnormal, non-normative experience that must be rectified and fixed so that "normal life" can resume. But mental illness is not necessarily tragic. Mental illness is not necessarily an experience of grief or loss. Susan's depiction stigmatizes people with mental illness as objects of pity and fear, which is highly problematic from a disability studies perspective.

Furthermore, this campaign story promotes healthist ideological principles insofar as self-care techniques are advocated for as a response to her mental distress. The rhetor tells the audience to "reach out and talk" about their mental well-being, "get some exercise," "take care of yourself," and "just stay on track" to self-manage mental illness. Susan's responsibility to self-

124

manage her (non-)illness includes taking her medication when reminded by her digital health and e-health applications. While it is unclear in this narrative why Susan would need to be reminded to take her medication, the idea that mentally ill consumers need to be reminded to take their medication and "get some exercise" is paternalistic. The idea that Susan should use an online reminder system infantilizes people with mental illness as somehow not capable of caring for themselves. The government campaign plays upon the stereotype of people with disabilities as "eternal children," to legitimate technologically monitoring disabled citizens.

Technological Surveillance as Self-Care

The self-care techniques presented by the campaign as an "empowering opportunity" for patients puts them in a dichotomous conundrum. The patient is rhetorically positioned as more powerful for taking individual responsibility for their own health; however, this action turns the patient into a consumer of digital health technologies that, inevitably, gives more power and control to government and private enterprises via patients submitting their bodies to the tools and techniques of digital surveillance. The rhetorical construction of the campaign creates a terministic screen of symbols aimed at deflecting attention away from issues of surveillance, ethical implications, and government control. When Susan, a white, middle-aged, middle class woman, explains to the audience, using emotional appeals, that digital health both helps her manage her mental illness as well as creating better emotional health, simply through the act of using the technology, the signs of "better mental health" mask the wider ethical implications of the digital health campaign's health policies. Susan's story promotes the healthist ideology that, if one simply talks or *joins the conversation* about mental health, mental health can be *cured*. The idea that mental health can be overcome simply by talking is a fallacy supported by ableist assumptions that talk is possible, preferred, and suitable considering our cultural climate. In fact,

125

the demand that people talk about their mental illness, as discussed previously, operates as a socially exclusionary ideology; the idea behind demanding talk as a self-care technique here, in Susan's story, works to exclude those in society whose mental state is judged to be a threat to a normative value system. Susan is a relatively low threat and voluntarily submits to technological surveillance. The Digital Health Week campaign is aimed at citizens who will voluntarily submit to self-surveillance. Healthist principles such as self-care and social prescribing are designed to encourage citizens to self-control and self-govern, for citizens who self-govern absolve the government of the responsibility to provide concrete and accessible health care services. In Susan's story, the rhetoric is deflecting attention away from the government's responsibility to provide sufficient healthcare services.

Alienation and Isolation

Terministic screens are further used in the government's e-health strategy campaign to depict mental illness as pain, loss, alienation, and isolation, as depicted in the next story analyzed: Gloria's. Gloria is the pseudonym chosen for the woman in this story. Her story is found written in the video section of the mental health stories chosen to persuade Canadians to use e-mental health services. Gloria's story does not have a video component. She wrote a story about how digital health has helped her. Her narrative is entitled, "Gaining Support through an Online Community":

> On July 15th, 2012 I lost my partner of 23 years to bladder cancer on what was to be our wedding day. The following day my mom, the other closest person in my life was hospitalized and I lost her less than two months later. With few family members or friends to support me emotionally, I looked for a way to deal with my grief. Searching the internet I found the Virtual Hospice Society which I credit with saving my sanity and

126

possibly my life. I instantly found strangers who were also dealing with pain and loss

and were so ready to welcome me and most importantly, understood the raw emotions

and fear that I was feeling. Through the tears and sorrow I formed friendships and soon

found myself welcoming newcomers and offering them the same support that was given

to me. The love, the unique bond, the understanding never ceases to amaze me and the

friendships that I have found bring me strength when I feel like I can't go on. We are

united as one in a way that others may not understand. We share the laughter, the tears,

the good days and the bad and know that at any time all we have to do reach for our

keyboards and someone will be there who will virtually hold us close and wipe away the

tears. What a blessing this site has been. ("Gaining Support")

The compulsion to depict mental illness as a state of alienation and isolation is clearly

represented in the stories section of the campaign, and Gloria's narrative is certainly a good

example. Gloria enters the symbolic order of language by appealing to audiences via emotion.

She is a survivor of sorts, a woman who was saved by the internet from a mental illness that

almost took her life. Technological logos is literally the lifesaving element in this story. This

analysis does not wish to diminish the very real emotional supports that Gloria finds online.

These supports do exist and do benefit people with mental illness; however, the government's e-

mental health strategy is co-opting the discourse of grassroots online communities by turning

mental health into a medicalized, regulated market for healthcare. Problematically, the

government's campaign rhetorically solicits users by depicting mental illness as an isolated,

alienated state that can only be rectified by using the government's technological system.

Gloria's narrative speaks to grief; Gloria's narrative speaks to loss; and Gloria's narrative speaks

to being a caregiver. Gloria's story, like Susan's story above, is heartbreaking. Gloria

experiences the loss of her loved ones and presumably cared for her partner during their fight with cancer. Gloria's story facilitates a purging of pity and fear in the audience, to use neo-Aristotelian terminology. Gloria lost her loved ones, leaving her alone and in a state of grief. This tragic story, problematically, depicts mental illness as an isolated, alienated state of grief and loss. This story is featured in the mental illness section, but rhetorically addresses a caregiver audience that has experienced pain and loss.

Without the Internet, Gloria is alienated and left alone with, as she tells us, "few friends to support her emotionally." Her experience of mental illness is depicted as incredibly tragic. Mental illness, in this story, is depicted through signs such as cancer, grief, tears, pain, and the threat of suicide. Death is the sign most often associated with mental illness in this story. Gloria's story tells us, very distinctly, that she "credit[s] [online use] with saving [her] sanity and possibly [her] life." While being mentally ill is positioned as tragic and painful, the campaign rhetorically situates technology as allowing individuals to overcome the pain of mental illness. Joseph Shapiro notes that depictions of disabled people as objects of pity are extremely disabling. In his words, "these images are internalized by disabled and non-disabled people alike and build social stereotypes, create artificial limitations, and contribute to the discrimination and minority status held by most disabled people" (30). Gloria's story operates in a similar manner. Gloria's story depicts psychological disability as a state of isolation, sadness, and loss, where life is not even worth living. This is highly problematic because Gloria's story perpetuates the myth that being psychologically disabled does not even constitute a life worth living in our society. In fact, it is only because Gloria "overcomes" her psychological disability by "picking up a keyboard" and joining the government's e-health strategy that her story is a success. The rhetoric in the campaign co-opts the discourse of community and online blogs in order to market

128

online community as government e-health. Gloria's narrative is acceptable for a mass Canadian

audience because she is able to "overcome" her mental illness. It is highly problematic to depict

disability as something to be overcome. This sends the message to people with disabilities that

their lives are not worth living. The rhetoric in the government's campaign sets up a terministic

screen against mental illness as a negative state, which further establishes and perpetuates

harmful disability stereotypes that scholars like Shapiro work to dismantle.

While Gloria's story also speaks to the tendency in the government's campaign to

rhetorically address a caregiver audience instead of people with mental illness, perhaps the

problems engrained in this strategy can best be unpacked using another example. The following

story rhetorically appeals to audiences' emotions by depicting disability via a terministic screen

as a frightening, isolated, and painful state. This story speaks to the various harmful ways in

which disability is depicted by the government's e-health strategy campaign. Disability is

reflected in the campaign in a way that perpetuates harmful, stigmatizing stereotypes. The

emotional address isn't even directed toward those with psychiatric disabilities. Instead, the

focus of this story is a mother with a child who has been diagnosed with autism. I will refer to

the mother with the pseudonym Eve, and her child the pseudonym Ashley. This story is entitled

"Support for Parents." Eve's narrative is featured in the mental health stories section on the

Canadian government's Better Health Together e-health campaign website.

> In 2007 my daughter was diagnosed with autism. Every day is a challenge for her and
>
> also for me as her parent and primary caregiver. Health information technology has had
>
> a huge impact on us. For autism caregivers, today's digital health platforms can offer the
>
> personalized tools, resources, and support they need to live healthier lives and, in turn,
>
> better care for those who depend on them. The caregiver's own mental and physical

well-being is often neglected, but these individuals need their strength to provide loved

ones with the support they need — which is where new digital health technologies come

in. Facebook and online autism support and information groups are great for meeting

other parents with similar challenges and answering questions about autism. Digital

games and apps help my daughter with areas she needs extra help in (social skills etc.).

Telehealth is great for answering questions instead of sitting in the doctor office waiting

room with long waiting times. Booking clinic times online is a handy health IT advance

as well. ("Stories")

At first glance, it is unclear why the government campaign would feature a story from a mother

with a child diagnosed with autism in the mental health narratives section. Upon closer analysis,

this section reads four problematic strategies in this rhetorical presentation that will be discussed:

one, the campaign presents autism as leading to mental illness; two, the campaign uses an

autistic child to play on the audience's sympathy; three, the campaign address a caretaker

audience and not people with mental illness; and four, the campaign presents the benefits of e-

health (none of which are directed towards mental illness) as healthier when they appear, in fact,

to be tools and technologies provided through private enterprise.

The campaign sets up a terministic screen in which autism is depicted as leading to or

causing mental illness and distress. The campaign intends to elicit an emotional response from

the audience by depicting autism as a disability or a hindrance. The mother writes that "every

day is a challenge for her, and also for me as her parent and primary caregiver." Presenting

autism as a "challenge" that creates obstacles every day is highly problematic because this sets

up a false dichotomy between those with autism and those without autism; if having autism is

rhetorically presented as a "challenge," this statement establishes not having autism as a

130

preferable state of being. By establishing normative value systems, and reinforcing through negative terminology that autism is not desirable, this campaign reinforces negative stereotypes of disability as a lack, or as something that is pitiable. This issue is further compounded insofar as Eve writes that "every day is a challenge" because she must parent Ashley. The audience's emotions in reaction to this story are intended to be directed toward Eve. Since Ashley is Autistic, Eve's mental state is depicted, in the story, as understandable; therefore, Eve is not at fault for her symptoms and deserves the audience's sympathy.

The government's campaign elicits audience sympathy for Eve, a mother whose mental health is poor because of her daughter Ashley's disability. Problematically, the disability is represented through terministic screens that represent disability (in this case, autism) as both a child-like and a silent state. Moreover, this voice perpetuates the stereotype that people with disabilities are eternally children or objects of pity. The stereotype of the poster child for disability has advanced in western society dangerously, from figures like, as Shapiro notes, Tim and Tammy, who were used to solicit donations for the Easter Seals, to poster children used by Autism Speaks. Jennifer Stevenson, Bev Harper, and Morton Ann Gernsbacher "hypothesize that support organizations, which are created and run by parents, [are] very likely to infantilize autism to bolster the representation of autism as a childhood disability" ("Infantilizing Autism"). These scholars found that fear-mongering images perpetuated the myth that autism is a children's disease by predominantly featuring images of children rather than adults in campaigns. Moreover, patronizing and belittling language contributes to the infantilization of autistic individuals. Through a terministic screen that depicts a struggling mother who is burdened with a silent, autistic child, the government campaign employs language that represents autism as a childhood disease. The screen presents a child with "challenges" who "needs extra help." In

131

aiming the rhetorical address at caregivers of autistic children, adults with autism are completely ignored by the government's e-health strategy. Instead, caregivers are given a voice in this movement instead of people with autism, which is problematic. Addresses to people with disabilities are notably absent from the campaign.

The government's rhetorical addressing of caregiver audience and not those with mental illness or other disabilities is a problematic element of this campaign. As an additional layer, Ashley's autism is depicted as specifically causing Eve's poor mental health. We, the audience, are called upon to feel sympathy for Eve, who is burdened with Ashley's care. The story forwards the notion that disabilities cause mental distress—a failure to function according to a normative value system will result in a degradation of the mind. The story engages with the idea that psychiatric illness causes physical disablement by representing autism as a silent, infantilized state in order to justify, and sell, technological health aids.

Terministic screens rhetorically depict technology as a vehicle for overcoming disability. The pathos in Eve's story shifts from a tragic narrative—her struggle to raise Ashley—to a feel-good narrative when "digital health technologies come in" to the story. Through strategic language, the government campaign's discourse reveals the motivation behind the advertisement. Digital social media and online health groups are, as Eve's story tells the audience, "great for meeting other parents" to combat the isolation experienced due to disability. Moreover, "digital games and apps" are, ironically, touted as helping children learn social skills. Doubtful speculation regarding whether a digital application can help a child to learn social skills aside, additional online tools such as "telehealth" are mentioned offering caregivers assistance. The government's health system, "telehealth," and "online booking" technological services are, Eve states, technological solutions that help caregivers manage their children's disabilities. These

132

solutions are described as "handy," time-saving tools that offer "extra help" to both caregivers

and disabled children. In fact, Eve's narrative tells the audience that, "for autism caregivers,

today's digital health platforms can offer the personalized tools, resources, and support they need

to live healthier lives and, in turn, better care for those who depend on them".

Disability scholars do not view disability as a deficit rooted in the medical model, and

this field of study is highly critical of the idea that technological fixes can help individuals to

cure or overcome a deficit. Sarah Gibbons melds critiques of the technological fix in the realm

of environmentalism with criticism of medical cures for autism in her work, *Disablement,*

Diversity, Deviation: Disability in an Age of Environmental Risk. In this ethical, engaged, and

balanced contribution to the field of disability rhetoric, Gibbons introduces the concept "critical

ecologies of embodiment" that reformulates articulations of disability to resist stigmatizing

metaphors. This critical project involves articulating bodies that represent elements that are

deemed unnatural or contrary to nature. For example, in a section on the concept of cure as

rebirth, Gibbons "consider how similarities between eco-critical critiques of techno-fix solutions

and disability studies critiques of 'cureist' thinking can be cultivated to resist a return to the

medical model for explanatory authority" (281). This type of project resists the urge to celebrate

technology as a cure for disability, instead suggesting a more nuanced mode of analysis where

metaphors are, in Gibbons' terminology, "generated" instead of perpetuated as "dominant"

stigmatizing stereotypes.[32] The government e-health campaign rhetorically addresses a caregiver

audience to argue that people with autism require technological apps and aids to help them

develop "social skills." The government campaign story reinforces the dominant stigmatizing

metaphor that technological cures are necessary for people with autism. This metaphor

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[32] Figure 1.7

reinforces negative stereotypes of autistic people as being unable to communicate and self-function without intervention and parenting. Regarding the idea that technological aids can help people with autism, Gibbons explains that, "in the context of autism, the idea that an individual may need help with tasks, such as communicating through augmentative and alternative communication, affects perceptions of intelligence" (226). Following this, Gibbons notes specifically how autistic individuals who communicate through typing are viewed as less intelligent and less able to function in society than those who communicate vocally. Her critique is not focused on the use of technological tools, but the idea that people think that autistic people who use these tools are less intelligent or less capable. In other words, the critique is not of autistic people using technology, but of the imposition of "social skills" training using technology. I borrow Gibbons' argument to argue that medical cures through technology, in the government's campaign, assume a lack in terms of ability to function, and, by extension, presumes a lack of intelligence, as the child cannot function without technological interventions.[33] In their essay "Autism and Rhetoric," Paul Heilker, and Melanie Yergeau address the importance of reading representations of autism as rhetorical:

> ...whatever else it may be, autism is a profoundly rhetorical phenomenon. And we all … would be significantly empowered to understand and respond to it as such. In the continuing absence of stable scientific or medical knowledge about Autism, we need to shine a bright and insistent light on how brazenly rhetorical any utterance, especially any highly visible utterance, about Autism really is (486).

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[33] Disability scholars dispute the use of the term "high-functioning," arguing that the term's use perpetuates the myth that people with disabilities lack intelligence; moreover, the term "high-functioning" is a judgmental term that prevents acceptance of neurodiversity.

The government e-health campaign, read rhetorically, is a "highly visible utterance: that

perpetuates, in Gibbons' words, "dominant" metaphors. These metaphors are harmful

representations of autism, as these images perpetuate stigmatizing stereotypes, such as the eternal

child, overcoming disability through technological repair, and disability as an object of pity and a

state of pain. By outlining these dominant metaphors in this highly visible government

campaign, an ethical approach, as advanced by Gibbons, is applied, which does not view

disability as a defect that requires technological or medical fixes. This particular way of seeing

"point[s] toward the generative possibilities of other ways of knowing that have been discounted

as defective forms of communication" (33). This way of seeing requires moving away from the

medical model and the dominant metaphors used in the government's e-health campaign. The

reliance on technology to fix autism, or the treatment of disability as a painful condition to stir up

an audience's sympathy, re-establishes stigmatizing rhetorical linguistic constructions. This has

very problematic consequences for the ways in which disability is treated and viewed in the

Canadian social and medical environment.

The Medical Model

Notably absent from the following story by Dr. Sing is any emotional appeal. By

removing sympathy for the subject of a real mental health treatment, this story medicalizes

mental health, positioning it as something that *belongs* in a medicalized environment; moreover,

this story argues, using business logic or the logos of technology, that the medical model can

thrive online. Disability theorists are highly critical of the medical model, which privileges

normative value systems of wholeness; disability, by contrast, is medically constructed as a

deficit needing a cure. In a curative medical system, treatment is aimed at making the individual

whole again or functional, in an attempt to overcome disability. In a medical model of disability,

135

a large amount of government funding can be directed towards curative-based disability research

and technologies instead of being directed towards social programs that will deal with underlying

issues. The digital "sociality" of e-health is different from the "social model." The digital

"sociality" of the government e-health is designed to encourage private citizens to bear the cost

of healthcare, which should arguably be the government's responsibility (the government has a

responsibility to fund social and medical programs for taxpayers).

By ascribing to the medical model, the government rhetorically argues that curative-

based approaches arise from adopting a business approach to healthcare. A psychiatrist referred

to by the pseudonym Dr. Sing wrote the following story. Dr. Sing's story, entitled "Access to

Care through Telepsychiatry" offers a highly celebratory depiction of online psychiatric services:

> Public investments in digital health have quite literally made my career as an e-Health
>
> leader. When I started my medical training, something as simple as video chatting was
>
> choppy and more of a gimmick than an effective communication tool. I entered
>
> residency in a field that remained largely unchanged for more than 50 years. I saw
>
> patients in clinics and hospitals built decades ago. My professional life was tied to the
>
> city that I lived in. There were few opportunities to reach people in distant communities
>
> unless I was willing to deal with a grueling travel schedule. Everything changed when
>
> our government made public investments in videoconferencing technology in clinics and
>
> hospitals throughout the province. Telehealth became available in nearly every small
>
> town and city. Suddenly the world was opened to me. I decided to build a career on this.
>
> I became the medical director of telepsychiatry services at _____ Hospitals. I became an
>
> advocate for using digital solutions to address pressing concerns such as equal access
>
> to health care services no matter where you live. I am a psychiatrist, but I do not have a

couch in my office. Instead I have computers, a tablet, and a smartphone. These tools

and public investments in digital health allow me to build a career that will look nothing

like those of the people who have gone before me. It's an exciting time for the medical

community and patients in this country. (Telepsychiatry, Better Health Together)

Dr. Sing's story presents an argument that "public investment in digital health" is a logical,

progressive, and accessible response to mental health. The ideology underlying this argument is

that the medical model can easily be transferred online into technological services; moreover,

these progressive "digital solutions" to healthcare create a business that helps not only the

careers of doctors but patients as well. Dr. Sing's career is, in fact, the subject matter of this

story. The narrative employs the terminology of medicine as a business to argue that a cost-

effective treatment model within a curative value system should drive healthcare. Dr. Sing

becomes an "e-health leader" instead of a physician in this story. The success story in this

narrative is specifically that of career progression as tied to technological progress. Dr. Sing tells

the audience that as "video chatting" progressed from "choppy" video to an "effective

communication tool," his career progressed to him becoming a "medical director" who uses

"computers, a tablet, and a smartphone." At no point does Dr. Sing address the benefits to the

patient in this narrative. His career trajectory, a career that he notes both frees him from being

tied to one place and simultaneously provides "equal access" to patients, is the feel-good success

story in the narrative.

If pathos is present in this story, it is in the happy feel-good story of success. This story

is highly celebratory and attempts to argue through a success narrative that "digital solutions"

offer responsible, progressive, technological solutions with regards to mental health care

services. In arguing that the medical treatment model can simply be delivered online by using

business terminology denoting cost-effectiveness, easy delivery, and the "opportunity for growth," the terministic screens in this story subscribe to a medical model of care; moreover, that medical model of care opens up healthcare as a business. Essentially, the story suggests "public investments in digital health" by citing telehealth as another (arguably successful) digital solution to healthcare. And this "public investment" is one that directs public money to a corporatized e-health technology sector that detaches health care from place. By detaching the notion of treatment (via the medical model) from place, the government avoids the responsibility for improving underlying social issues tied to geographic locality. For example, if the government provides e-mental health (or private enterprise offers e-mental health), the responsibility for the government to create adequate mental health services for northern populations is removed. However, while the rhetorical screen enacts the linguistic value system of a business that provides psychiatric services online as an adequate response to psychiatric disabilities, this theory is untested.

In the medical model, treatment may be adequately provided online for patients; however, in the social model of disability, this theory obscures and hides issues such as inadequate housing creating mental health issues, along with other issues such poverty, hunger, situational abuse, stigmatizing issues within the environment, and myriad other social issues that "digital solutions" and ongoing "public investments in digital health" cannot rectify. Moreover, while Dr. Sing argues that his career opens up room for growth and "opportunity," the story obscures the fact that people in poverty do not have access to "a computer, a tablet, or a smartphone" to obtain his services. The "public investments in digital health" services a middle-to-upper-class population that can afford these technological devices. Very poor rural areas still do not have high-speed Internet or the monthly income to afford expensive data through tablet or

138

smart phone plans. A 2016 report by a telecom research firm found that Canadian cellular services are among the costliest in the world (Hansen, CBC). People experiencing psychiatric disabilities often live in poverty, as social factors—in the social disability model—can certainly exasperate or cause mental illness, and for those affected by poverty costly cellular services would not be easily accessible. By subscribing to the medical model, a model of business, treatments, and cures, this narrative sets up a screen of success and progress to obscure the investment of substantial amounts of public money into an increasingly privatized health sector that only services elite Canadians.

Moreover, the campaign persuasively argues that (government) technology is the answer to all mental health problems. Mental illness is not addressed in the stories section of the campaign, which silences and ostracizes people with a psychiatric disability. Stories are told by upper middle class citizens whose mental illness is "not their fault," so to speak. The types of citizens who can access telepsychiatry are upper middle class. This connection requires high-speed internet ($100 per month), it requires one live in a well-serviced high-speed area (so, not the country or northern Ontario where many aboriginal citizens live), it requires a home computer for privacy ($1000) and a private home space. There is a relatively high personal cost associated with obtaining telepsychiatry. The costs may be reduced on the government's end, but the costs are passed onto the citizens, and this makes telepsychiatry inaccessible for many.

Notably absent from these stories are people with actual mental illness. All the stories in the mental health section involve people without a mental illness. Embedded within this idea is the notion that society rejects people with disabilities, and society is unable to feel sympathy for people they abhor. For the government campaign to elicit an audience's sympathy, the campaign offers stories from people whose poor mental state did not arise through any *fault* of their own.

This notion, the notion behind the campaign's refusal to directly tell a story from someone who is mentally ill, reinforces the idea that people with mental illness cannot speak to Canadians. This notion represents the removal of rhetorical agency from people with a psychiatric illness. Through emotional appeals, the stories convince the audience that disability is an experience to be feared, rejected, and reviled. Terministic screens employ terms that situate disability as a painful, isolated, and tragic experience. Dolmage states that the myth that disability is an isolated experience is used to "justif[y] the 'warehousing' of people with disabilities in institutions, segregated classrooms, sheltered workshops, and so on" (43). In the government's campaign, disability is presented as an isolated experience, as justification for the increased prevalence of online tools and techniques developed for mental health care. Online communities, health apps, and technological tools are available, the government argues, to end the isolation that mental disability creates. By stirring audience's sympathies through stories of the isolation, pain, and alienation associated with mental illness, the government campaign erects a terministic screen using health as a business model, or technology as progress, to obscure the government's responsibility to provide an adequate social environment within which citizens can thrive. The stories campaign problematically stigmatizes the sector of society that the campaign purports to treat; moreover, stigmatizing depictions of mental illness are perpetuated by the campaign to legitimate turning healthcare into a business model and patients into consumers.

Ethos

A neo-Aristotelian notion of ethos guides this final short analytical section. Aristotle states that, "persuasion is achieved by the speaker's personal character when the speech is so spoken as to make us think him credible. We believe good men more fully and more readily than others" (Book 1, Chapter 2, 1356a). According to Aristotle, the personal character of the speaker

affects the rhetorical weight of their message. This section shifts the reading of ethics slightly, from Aristotle's ideas quoted above to a neo-Aristotelian sensibility regarding terminology ethics. In this sensibility, government speech is read alongside Burkian notions of rhetoric as motivated discourse. This section argues that the government campaign obscures the speaker in advertisements to unethically co-opt patient discourse. By obscuring the speaker in campaign advertisements, the wider effect calls ethical implications into question. In this section, the "how" of the government's e-health campaign is unpacked by examining the discursive rhetoric of mental illness as PR specifically by focusing on Twitter advertisements as well as advertisements linked on Twitter. This section reads the campaign as propaganda that increases government control by subjecting bodies to increased technological surveillance, as informed by Foucauldian notions of biopolitics and governmentality, along with healthist theories from Nikolas Rose and Petr Skrabanek. The government material uses technology to encourage citizens to practice self-control, self-medication, and self-governance.

Skrabanek writes about the dangers of embracing healthism. Skrabanek observes that, "all totalitarian ideologies use the rhetoric of freedom and happiness, with false promises of a happy future for all" (11). He further notes that what he terms "the utopian nature of the health promotion movement" that uses "a rhetoric of freedom and happiness" has been historically used by totalitarian regimes. He argues that healthism was evoked in Nazi Germany and Communist Russia. Skrabanek writes that, "once the majority has been persuaded that 'the health of the nation' is a laudatory end, without understanding the means by which this end is to be achieved, healthism and lifestylism get universal support. The perversion of language obscures the power motive behind the seemingly altruistic pursuit of health for all" (12). Skrabanek links political considerations with health policy when he identifies that the first stage of healthism involves the

141

government beginning to use propaganda to establish normative healthy lifestyles that

individuals should aspire to. His argument points out the importance of carefully weighing

government motives against the messages represented in propaganda material. According to

Skrabanek, "the pursuit of health is a symptom of unhealth. When this pursuit is no longer a

personal yearning but part of state ideology, healthism for short, it becomes a symptom of

political sickness" (15).[34] This section argues that Skrabanek's definition of healthism as an

[ethical] "political sickness" exists in our free-market liberal democracy because government

"uses various forms of coercion to establish norms of a 'healthy lifestyle for us.'" Moreover, the

intent of the government goes beyond merely arguing that citizens should be healthier, to co-

opting discourse and unethically masking the speaker in various propaganda materials in order to

convince citizens to improve their health through technological means. These technological

means, moreover, give the government and private enterprises like insurance companies

increased powers of surveillance and control over the bodies of citizens. Because a psychiatric

disability cannot be seen, the call for speech, or the call for patients to speak online, calls

subjects to voluntarily enter the unconscious assumptions underlying the social field of

knowledge where they become subjects in a field of power contestations. They are called forth

to enter the field of knowledge, as subjects, where they can be manipulated through action.

     To motivate the act with a purpose, the tweets promote the idea that better health will be

the outcome of electronic participation in the campaign. It is important not to forget the sheer

scale of the government's e-health social media platform. The campaign engages people through

social media with the idea that collectively we are working for better mental health. The Vice

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[34] Petr Skrabanek links public health to the rise of immigration and population control and healthism as a justification for racism, segregation, and eugenic control since "healthy means pure…while unhealthy equals foreign, polluted" (15). According to Skrabanek, "The first compulsory mass medical screening was, in fact, carried out by immigration authorities" at Ellis Island in New York (169-70).

President of Digital Health Week posted a message on the Canada Health Infoway Website,

thanking employees who posted and tweeted online during the campaign, writing that they

"generated over 4,800 tweets that garnered over 23.8 million impressions! Several themes

emerged from these conversations. The two that resonated most with me are 1) the importance of

including patients in the design of digital health solutions and 2) the ability of digital health to

transform the delivery of care" ("A Look Back"). It is also important to note that the number of

tweets generated has financial value as well. Digital Health Week is lucrative. In order to sell a

product, the corporation must generate consumers of this product and additionally make the

product desirable (by generating an online customer "buzz"). According to Julian Cheek, the

search for good health has risen to "sacred status" (974) in society. Moreover, as people are

driven to seek good health, they are driven to seek out various technologies, services, treatments

or surgeries that are otherwise unnecessary if it were not for the desire to, as the Digital Health

Week campaign motto asserts, attain "better health." In this impossible search for wellness, neo-

liberal capitalist ideology raises "better health" to "sacred status" in order to open up markets for

healthcare technologies and services. The VP of Communications for Digital Health Week

responds to a tweet from what appears to be a private citizen,[35] but is in fact a sockpuppet, noting

that, "being engaged as a patient means asking a lot of questions. #thinkdigitalhealth" ("A Look

Back"). Participation in this campaign, under the guise of seeking better health, motivates the act

of going online and "asking questions," entering your information online, or purchasing health

apps. These acts are the acts of a consumer. Seeking "better health" is thus a consumer act.

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[35] The tweet containing the question, that has since been erased, was generated by a Health Care IT professional.

143

The notion of government as business leads to the decisive point in this analysis, which is the rhetorical conditions of symbolicity in the Twitter campaign establish and restrain the types of actions possible for the consumer. More specifically, the ways in which the campaign frames the conversation as scientific, through numbers, graphs, and study-driven conversation, limits the ways in which patients can respond. In Burke's view, "words create orientations and attitudes, shaping individuals' view of reality and thus generating different motives" (Foss, 197). Acts are never completely free from the symbol system in which the subject is immersed. The government campaign, by rhetorically framing e-mental health as a number-driven, statistic-driven, scientific symbol system, limits actions and responses that may contrast with its framework. Narratives that break conventional codes and responses that might defy logic or would not be considered scientifically or medically credible are dismissed in this system. For example, the tweets generated repeatedly cite statistics and graphs, making health measurable. Canada Health Infoway posts on Twitter that "Cdns report long wait times. Learn how #digitalhealth can help improve access to care #thinkdigitalhealth" ("Wait Times"). Health issues like wait times are measurable; however, emotional health is less quantifiable and measurable. Focusing on "long wait times" fails to consider the social issues underlying why wait times are long. Simply stating that e-health can help with long wait times (presumably due to patients accessing care online instead of in person) fails to address that there are serious issues leading to crowded emergency rooms. These issues include inadequate senior housing and poverty, and simply focusing on wait times cannot solve them.

In her study of the rhetoric of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), Patricia Kelly shows how the DSMs standardize a common language that constitutes psychiatric knowledge. While the DSM meta-discourse outwardly appear arhetorical, Kelly

notes that the arhetoricity of the texts is their rhetorical position. The DSMs use scientific jargon as rhetoric. In a 2002 study, Berkenkotter and Ravotas show how patient speech is completely retranscribed in clinical practice. The study shows how psychiatrists rewrite patient-reported speech using diagnostic language. While scientific language outwardly appears arhetorical, there is a rhetoricity to scientific meta-language. In the government's e-health campaign, the repeated citing of statistics rhetorically constrains the sorts of discourse that can occur; statistics constrain the sorts of acts called forth in response.

The increased reliance on statistics and numbers constrains the conversation to a business model of healthcare. The tweets generated by the Digital Health Week team all contain a statistic of some kind. A Manager of Health Policy is quoted on the Digital Health Week website as tweeting, "annual tracking surveys what Cdns think about digital health; 96% think we should take full advantage of DH tools" ("A Look Back"). The statistic creates a conditional response of its own making; if '96%' of people agree to digital health, the logical thought progression would be for the government to implement digital health. Problematically, the tweet fails to link a study proving that 96% of people agree to digital health in Canada (which seems to be a high number). Users must take, at face value, that 96% agree. Likewise, the VP of Communications for Canada Health Infoway writes, "Patients in eCBT have better outcomes and fewer drop-out rates than conventional therapy" ("A Look Back"). This is a strong statement. The VP of Canada Health Infoway asserts that digital psychiatric health is in fact "better" than conventional therapy. Again, a study is not linked, so users are unable to comment further or examine any possible bias/funding source of the study. Government funds the majority of studies, or private corporations do, which is problematic when the findings of those studies are further used to promote a government or corporate strategy. Similarly, the Mental Health

Commission of Canada tweets that "over 90% of #youth use the Internet. Research shows #eMentalhealth is a promising way to reach them" ("A Look Back"). Again, the tweet fails to cite a study; however, the tweet erroneously associates the statistic that 90% of youth use the Internet with the conclusion that their mental health issues can be treated successfully online. While this may be the case, the MHCC fails to link a study to support its claims. While I have provided three examples of statistical reliance in the Twitter platform, there is no shortage of statistical claims from the Digital Health Week campaign that are offered without a contextual study linked to the tweet. The Digital Health Week website generates a stream of statistics-driven tweets aimed at debunking digital health myths.[36] The campaign urges Twitter users to "join us each week as we bust common #digitalhealth myths and get to the facts" ("Myth of the Week"). In one myth-busting post, the campaign cites the statistic that Canadian health records are now "93.8% digitized" ("Digital Health Myth") to "bust the myth" that Canada is not progressive in terms of digital health. The idea that Canada is not progressive in technology— indeed, the Twitter post tells the user this is a common myth—is a speculative assertion. However, by citing statistics, presumably statistics measuring the percentage of patient records that have been digitized, the tweet rhetorically turns health into a number-driven measure of progress. Statistics contain the conversation and response that can occur in this system. Statistics turn healthcare into a business, where costs and numbers dictate the measure of success. Patients become consumers, whose participation is judged within a system that measures length of time, profits, costs, and margins. However, good health care, especially good psychiatric health care, takes time, and sometimes the success of good mental health care cannot be measured by statistics because sometimes health is not measurable in graphs, numbers, and

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[36] Figure 1.9

profit margins. Numbers and statistics may serve bureaucrats, but statistics fail to measure qualitative data in the human sciences.

E-health, touted by the Government as a more progressive, improved, and more efficient mode of health care, is presented by the e-health campaign as a more sophisticated design, invented and used by our most savvy citizens. However, e-health is not necessarily helping the everyday lives of citizens, and especially not the lives of those with disabilities. Rhetorically, e-health is presented as the final frontier in health care delivery—a frontier that citizens can master by taking up an online or technologically monitored presence—and in mastering this frontier, the government argues, citizens will be mentally healthier and more advanced. This rhetorical analysis, however, troubles many of the assertions made in the campaign. Better Health Together appears designed to coordinate better business together between government, consumers, and corporate stakeholders. In the "Logos" section, it is noted that the terministic screens erected in the Better Health Together campaign reflect a logic of technology and progress that advances healthist ideology and, simultaneously, problematically, promotes harmful disability stereotypes. In the "Pathos" section, patient stories were explored through Burke's concept of terministic screens to show how emotionality was used rhetorically to further advance harmful and inaccurate disability tropes. In the "Ethos" section, the analysis is concluded by arguing that the means by which the government disseminates propaganda materials in the Better Health Together campaign is an ethical concern for Canadian citizens. By reading government health campaign material as propaganda, this chapter aims to disrupt the *act* that the material calls forth from citizens, by pointing to how government power works rhetorically in this material because this act is provoked to further increase the surveillance, control, and monitoring of consumer behaviour. Taken as a whole, this analysis concludes that

the government health campaign is highly rhetorical. Furthermore, these rhetorical arguments

have harmful or problematic implications for citizens—especially citizens with psychiatric

disabilities. Perhaps Skrabanek encapsulates the idea I am attempting to convey in this

conclusion best when he writes, in *Death of Humane Medicine: And the Rise of Coercive*

Healthism, that, "while bureaucrats fiddle with health statistics, the world burns" (99).

Chapter 4

Institutional Rhetoric

This is a tale of two students, two stories, two schools, and two responses.

Chase Christopher Graham was an International Baccalaureate student who was looking forward, by all reports, to studying computer science at the University of Waterloo in Waterloo, Ontario, Canada. Chase won several awards at his High School graduation and graduated with top honours. He started his first-year program Fall of 2016. His father describes him as a "bright, energetic and soft-spoken young man" ("Students"). Chase was a "math whiz" ("Students") and online accounts from other students at the University of Waterloo, expressing awe at Chase's mathematical abilities and kind nature. On March 20, 2017, 19-year-old Chase Christopher Graham passed away at The University of Waterloo Student Residences, just 7 months after starting first-year university. Graham's death was the second student suicide in that same residence at the University of Waterloo that year.

Jack Windeler was an 18-year-old first year student at Queen's University in Kingston, Ontario, Canada. Jack attended Ridley College in St. Catharines, a private boarding school where teachers described him as "intellectual and thoughtful" ("Remembering"). He was an avid rower, loved the water. Jack was an extremely popular boy who was "a thoughtful and kind individual who lived courageously" ("Remembering"). His mother describes him as "a quiet family man with a dry sense of humour" ("Remembering"). While he was diagnosed with Attention Deficit Disorder and treated with a low dose of Ritalin, Jack did not have a history of any mental illness. Jack's parents would text and call him regularly to see how he was faring in first year university. They received positive reports from him about his school progress during the first year. Jack signed a lease agreement on a house for his second year and there were no

signs anything was amiss. In March 2010, a police officer informed Jack's parent's that their son

had passed away at his residence room at Queen's University. After Jack's death, three more

students took their own lives at Queen's University in the next year ("Queen's University

Suicides").

This comparative study looks at the rhetoric of mental health in an institutional setting by

using the body, talk, and performance as key thinking devices. Using these three key rhetorical

concepts, this chapter compares, contrasts, and points towards best practice strategies for mental

health policy in an institutional setting. These concepts, also referred to as moves (as in

theoretical moves or rhetorical moves[37]) or principles interchangeably guide the following

analysis. This chapter is based upon the excellent work done in this area by Jay Dolmage and

Margaret Price along with critiques of sexual assault on campus by Jennifer Doyle and Sarah

Ahmed. This study is guided by concepts extracted from the previous two chapters applied

through a methodological case study analysis. This chapter concludes that institutional rhetoric

surrounding mental health is based upon what Crawford would call "healthist" assumptions;

moreover, read through Michel Foucault's theory of governmentality and biopolitics, this study

suggests that mental health policy born from these healthist institutions is biopolitical in nature.

Talk

In the media coverage of these two students, the articles make notable mention that

neither boy had a history of mental illness, nor displayed any signs of major depressive disorder

or had reported suicidal thoughts. The focus on reported speech in this event, or the construction

of the lack of speech as a problematic entity, firmly locates the intense cultural desire to diagnose

mental illness as a secret fault within the individual—a secret that must be spoken. The

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[37] I would like to thank Dr. Sarah Gibbons for contributing the terminology 'moves' for this chapter.

rhetorical assumption underlying the focus on the student's failure to speak is the idea that they were mentally ill and kept their illness, their truth, a secret. It is through public confession that a subject becomes a subject. Confession is called forth as an obligation to society—something that sets us free, as we are free when we speak the truth of ourselves. Not confessing, in Western society, is framed as a sin—secretive and dishonest.

At first, the University of Waterloo suppressed talk of mental health (and experienced a large backlash from students, professors, and staff). In the words of Jay Dolmage, the normative demand in academia is that "disability must disappear" (Academic Ableism, 59). When staff and students responded to the University's silence surrounding student suicides via media, rallies, and petitions, the institutional response carefully controlled avenues of campus speech by implementing its own 'talk' blog. On this blog, the institution locates the failure of speech, the failure to talk about the secret thoughts inside, as the primary locale upon which to 'fight' youth suicide at the University of Waterloo.

The silence from the University has a strong financial element. Certain students are desired—Dolmage notes that the top tier American universities recruit using 'super zips' which are zip codes in high income areas—and certain (disabled) students are not. Chase passed away in March, which is the specific time of year that Universities are recruiting students for the upcoming year. Moreover, the top high school students are choosing which schools to attend, and the University of Waterloo did not want to deter these top students from choosing the University of Waterloo with negative press. Enrolment rates affect university funding— specifically which students enroll. According to Alex Usher, president of Higher Education Strategy Associates, a Toronto-based consulting firm, "half of university operating revenues come from tuition fees, which depend completely on enrolment levels" (University Affairs).

Students pay for half of all operating costs of the university. This latter point means that students themselves pay for more than half of counselling services at the respective universities. Moreover, operating revenues increase when tuition fees come from international students, whose fees are much higher. While in 2017 a domestic student pays $7,549 in math, an international student pays $30,511 for the same math degree (Future Students, UW). Negative press for the University of Waterloo would affect which students chose to attend Waterloo. Chase passed away around the time of year first-year application and acceptance occurs, and this directly affects the response from the university administration, who attempted to silence the fact students were taking their own lives in residence. The university desires to attract high-paying international students, and they believed press around the issue would deter international students. The University of Waterloo has a vested interest in protecting their rankings to attract top students. In 2018, The University of Waterloo was rated seventh in Canada and 240th in the world rankings by the Times Higher Education World University Rankings ("Rankings"). MacLean's rated the University of Waterloo 2nd in Canada, and most innovative university for the 25th consecutive year ("University Rankings"). The reputation of the University is used to attract high paying international students who pay top dollar for their education. The negative press following Chase's death was a financial threat for the university as this press directly affects which students choose to attend the university.

Following the large-scale negative backlash and protest to the Universities silence, the University of Waterloo responded by forming a committee on May 24, 2017, well-over two months after Chase's death. President Feridun Hamdullahpur named the task force "The President's Advisory Committee on Student Mental Health". At the time of writing, the results

are not available from the "President's Advisory Committee on Student Mental Health" (PAC-SMH) who is tasked with the following:

> The PAC-SMH is tasked with ensuring the collection of a broad set of information on student mental health considering both the UW student body and the larger societal context. It will review the data and information collected and advise on the status of the progress of mental health initiatives across the university. It will examine root causes of student stress, anxiety and depression, and how to mitigate them proactively instead of reactively. ("Presidents Task Force")

The committee is tasked with investigating the student body. The task force will collect information on "student mental health" and examine root causes of "student stress, anxiety and depression" and how to "mitigate proactively" with students. At no point is task force directed to turn a critical eye towards the university itself or examine root cause analysis within the institution.

At Queens University, something very different happened. A large grant from the Windeler Family established jack.org, a student volunteer led charity that trains student speakers to go into schools, speaking to institutions about their mental health. The jack.org response is tailored toward 'talking' and treating student mental illness earlier so that students can get the psychiatric help they need while in university. Both responses, while they (at first) outwardly contrast in approach, reflect how institutional rhetorical responses to mental health locate a diagnosis of mental illness within the individual.

The Body

Deeply intertwined within the requirement that students confess their illness is the institutional treatment of student bodies in the literal sense. When students fail to perform well

153

academically (due to mental illness), they are encouraged to take a voluntary leave of absence for a period of one year. When this leave is taken voluntarily, students are given options when they return. In Engineering, for example, a leave of one year is granted in the case of illness. If the student fails to return, the student is automatically removed from the program but can choose to reapply. Should they desire to return to the Engineering program specifically, and their application for return is successful, students face two options: they can choose to repeat their courses (essentially starting from first year status) or continue where they left off in their degree ("Request to Complete"). These are voluntarily withdrawal policies for students in good standing. In a required to withdraw circumstance, in which the student is being forced to leave, the student will be removed out of their program. If the student petitions, they could be placed into a general degree program for one final term—in this term, they would be required to complete requirements for a general degree. Often, student's performing poorly academically have mental illness or circumstances that would constitute a disability, but these students are either unable to access assistance on campus, or they may be unaware of available supports. By forcing out students who appear to be struggling without assessing how to keep these students in the program by providing supports, the university effectively culls the student body population (of mentally ill students) through their withdrawal policy.

Many students rely on student loans for support, which they lose when they withdraw. These students could be left in debt (having to repay student loans) and living in poverty when their loans are discontinued. The financial implications of this should not be minimized. If a student is unable (or too ill to arrange the paperwork) to make minimum payments on their student loans during their leave of absence (Ontario student loans, for example, become repayable after 6 months after leaving school) they will be ineligible to receive further student

loans, which would effectively prevent these students from returning to their programs.

Furthermore, after struggling university students are pushed out of their programs, the university

fails to follow up or assist these students—there are no statistics for how many of these students

return to their studies after one year. There are no systems in place to further monitor students

who are struggling who have been forced to take a leave from the program. Moreover, these

students could be given additional supports to stay in a funded program instead of encouraging

sickness leaves. It is worrisome that struggling students are pushed off campus and cut off

student funding (which could be their only means of support) without any follow up from the

institution or mental health supports.

Students in this position constitute a fairly large segment of the student body. Dolmage

gives the statistic that "a 2015 study at the University of California Berkeley found that 47% of

graduate students suffer from depression" (Academic Ableism, 23). The National Alliance on

Mental Health reports that 64% of students who leave college cite mental illness as their reason

for withdrawal. Of that group, 50% did not access mental health supports on campus ("Survey").

Students who are mentally ill *are often* the students who are flagged for academic probation due

to their symptoms and *these are* students who are either required to voluntarily or involuntarily

take a leave of absence from university. The statistics reflect a large number of students who

have mental illness issues. Many of these students leave school. An unknown number do not

return, and do not graduate. These students are often left in debt without a degree. Institutional

withdrawal policies are part of a systemic exclusionary process that prevents students with

disabilities from obtaining degrees in higher education.

For students who are seriously mentally ill or speaking of suicide, the campus policy

refers off-campus for support. The University of Waterloo approach to seriously mentally ill

155

students is to get them off campus immediately, directing all students to call 911 in event of a mental health crisis. When students have serious mental illness, they are locked in cells under bright hospital lights for 24-hour emergency observation if they are deemed a risk to themselves or others. This cold, laboratory-like method of psychiatric intervention is detached, clinical, and isolating. Should a student report a suicidal ideation to a health care worker (who has a duty to report), they will be involuntary hospitalized for observation in a psychiatric facility. This is what is known as being 'formed'. It is outside the scope of this argument to debate whether or not 'forming' is necessary, because indeed in some cases forming is necessary. Understandably, the university does not want to assume liability; the point, however, is being raised here to highlight that the practice of sending students to the hospital (to be 'formed') is an issue primarily of space. The university may not want the liability, nor the student, if they are seriously mentally ill.

In the Canadian media, news reports frame mentally ill student bodies as financial liabilities. The reports focus on the financial aspect of student mental health by arguing that disability services are a large scale financial drain on the university community; furthermore, the media frames these 'seriously mentally ill' students as having no place on the university campus. Recent 2017 Canadian media coverage of campus suicides describe the "suicide crisis" as being a financial problem and a burden. Media coverage in 2012, following the suicides at Queen's University was extensive. Maclean's, a major Canadian publication, published multiple reports outlining the "crisis". One article, entitled, *the mental health crisis on campus: Canadian students feel hopeless, depressed, even suicidal* writes that "a quarter of university-age Canadians will experience a mental health problem, most often stress, anxiety or depression". Margaret Wente, the *Globe and Mail's* conservative editorial writer contributed a Eugenics

156

based opinion piece entitled "University's not meant to be easy" where she locates the problem of student suicides and mental health as "we've bred the independence and determination out of them" (Globe and Mail). Wente describes mentally ill students as being of inferior stock, with poor breeding. The media coverage in 2012 was extensive, and in 2017 the same media explosion occurred where media coverage of student suicides paints the 'problem' of student mental health as both a failure of the individual body to thrive, and moreover this poorly bred body is framed as being a financial burden on both the government and institution.

On February 12th, 2017, The Toronto Star headline reads, "University of Guelph Struggling to Meet Mental Health Needs." The tagline explains that "in the wake of the fourth suicide at U of G since September, university officials say they need help to meet the growing demand for mental health services" ("University of Guelph Struggling"). The media headlines pose the University itself as the burdened victim who requires 'help' as it 'struggles' to meet unfair 'demands' placed upon the institution by students experiencing mental illness. 'We're not a treatment Facility' another Toronto Star headline reports, proceeding to lay out the 'burden' of mental health in an article that justifies referring students off campus for mental health supports. In another article, the Toronto Star reports that the government of Ontario announced, on May 3, 2017, that funding for student mental health services increased by a "substantial" 6 million dollars, bringing the total government funding of mental health services in colleges and universities to 15 million. However, the 15 million dollars for mental health services is allocated between 45 different college and universities annually, leaving (if distributed equally, which it is not) 333, 333.00 dollars to each institution for university counselling and mental health services ("Province Announces").

This said, at many schools, students pay for almost half of all mental health services on campus. At the University of Waterloo, for example, in 2015, out of the total "2.2-million-dollar budget for counselling services, $1.1 million [came] from student ancillary fees, and $1.3 million from the university" ("Students"). It is unknown how much of the remaining $130, 000 in funding from the university came from the government, which would be taxpayer funded by student's parents. If we take the 2017 government average of $333, 333.00 deducted from the total budget of $130, 0000 in 2015 (assumed to be stable for 2017), the University of Waterloo would be responsible for 966, 667 dollars to fund counselling services, which means that students pay more than the university for counselling services on campus. $966 667 is by no means a monetary crisis or burden on the university considering the overall operating budget of the university. In fact, in 2015 the University of Waterloo published a revenue of $936 240 000, expenses of $906 730 000, and a budgetary surplus of $29 510 000 ("Financial Statements"). An institution with an almost 30-million-dollar annual surplus is not in a monetary crisis, and a service where students are funding more than half of the operating budget is far from being a financial burden on the university. My rudimentary calculations suggest that it is a myth that there is a funding crisis for mental health services on campus.

The Canadian Minister of Advanced Education and Skills Development, Deb Matthews, is quoted as stating that "despite the cash injection, campus services will not be able to meet everyone's mental health needs" ("We're Not"). The Government representative releases the following statement:

> for some students, on-campus resources such as counselling and/or peer support may be the best and most helpful provision of care. For students with more complex mental health needs, the institution can serve as a point of referral or information in helping that

158

student access the appropriate community supports and get the help that they

need. ("We're Not")   In

this comment, the Minister delineates between acceptable disabilities and non-acceptable

disabilities within the institution. A University of Waterloo student, Alicia Raimundo, is quoted

in the article, stating that when she pursued mental health services on campus they referred her

off-campus: "They gave me a number and a pamphlet and said good luck" ("We're Not").

Raimundo states that "Schools are their own communities, especially ones that have huge

populations of students that move to that city or town for that school. When you refer somebody

out . . . it's basically like referring somebody to another town" ("We're Not"). In the Canadian

media, student mental health is framed as a crisis on campus that causes an enormous financial

drain on government resources where only students able to perform socially acceptable

disabilities are accommodated. The disabled body is framed as a financial drain. As a financial

drain, the body is moved off campus into the community for treatment.

Performance

Concepts of the body and talk also include theories of performance regarding the rhetoric

of mental disability. Jennifer Doyle poetically outlines her experience of making a harassment

complaint to her institution in her book, *Campus Sex, Campus Security*. In the text, institutional

administrative process itself is constructed as a form of harassment. While Doyle deals with

sexual harassment politics and security in the text, many conclusions and observations she

describes are relevant to a discussion on campus mental health. Doyle writes that on campus,

"boundaries are being violated; walls need to be shored up. A pervasive sense of vulnerability

yields a constant state of crisis—the building of one set of walls for another" (11). I believe this

statement from Doyle relates to what is occurring on campus in mental health. While campaigns

159

and initiatives may outwardly appear to be erected in the interests of safety, security, and

communal inclusiveness (and indeed these campaigns discussed here may have aspects of these

elements) there are elements to the rhetorical construction of mental illness and suicide that

sustain walls that indeed exclude students. The rhetoric of mental health on campus is, to use

Doyle's terminology, 'a set of walls' erected to distinctly standardize *acceptable* performance of

mental illness as opposed to *unacceptable* behavior.

In this section, talk is read through the element of prized interlocution, which is taken up,

framed, and articulated in an institutional rhetorical setting. Our first principle in talk is the

practice of standardizing the rhetoric of mental health by upholding a hero, or in Joseph

Shapiro's terminology, a 'super-crip' narrative. Hero narratives promote problematic and

damaging disability stereotypes. In this section, institutional disability 'heroes' are discussed in

a comparative analysis that applies the theoretical moves taken from the previous two chapters in

an attempt to discern the rhetorical response to people with psychiatric disabilities in an

institutional setting. Through critique, this exploration on 'talk' further points towards ways in

which disability can be valued without defaulting to heroism or stigmatizing charitable

organizations in higher education.

Following Jack Windeler's suicide, Jack.org implemented a student speaker program to

go into schools and speak about mental health. The Jack Talks Campaign is a large component

of the campaign, which strives to recruit and train student speakers to participate in the charitable

program. Jack Talks is like Ted Talks, the organization that publishes inspirational and moving

speeches so popular on social media today. The idea is that student speakers with a history or

experience of mental health 'struggles' are trained to speak to large audiences about their

experiences. Student speakers were implemented by the charity as a strategy to prevent students

160

from taking their own lives; Jack paradoxically did not *speak*, and so these speakers are, in a sense, speaking for him in his absence. Both the jack.org summit and the Jack Talks speaker program trains students to become prized interlocutors in an institutional setting. The summit is designed, the website states, to "[build] and [support] student leadership in mental health…we bring student leaders together to learn from each other and build the skills needed to elevate their impact back at home" ("Summit"). The Jack Talks speaker program is specifically designed to train 'student leaders' recruited at the summit who wish to have 'further impact' as 'mental health leader[s]'. The website explains that the role of a Jack Talks speaker is to "fight stigma and spread the message that we all have mental health" ("Summit"). The program is aimed at training students to speak a very specific message:

> [jack.org uses] contact-based education and peer-to-peer outreach to teach students across Canada that we all have mental health and we all need to care for it. Using a professionally developed curriculum, young speakers will help audiences to understand mental health and how to look out for each other and ourselves. They will also inspire audiences to keep the conversation going with concrete steps to create lasting change in their community. ("What are Jack Talks?")

Jack.org notes that the curriculum is 'professionally developed' to articulate a very specific 'inspirational 'message aimed at 'keeping the conversation going' in the audience. This section looks at what types of speakers are chosen as well as the process by which their speeches are crafted, what messages they are speaking, and how the organization guides this talk from the students into acceptable avenues by regulating and training their performance. A video linked to the jack.org website features an attractive red-haired girl in her 20s speaking against an office background happily about her experience as a Jack Talks speaker:

161

My name is Cynthia[38]. I'm a student at the University of ___. And I'm a Jack Talks speaker. I decided to get involved with jack.org for a couple reasons. One, I'm a student leader. I love to be involved. I love to take initiative in fields that I'm really passionate about and mental health is something I'm super passionate about because I have lived with mental illness for most of my life. After applying to be a Jack Talks speaker, I was accepted, and I was super excited, and I came to Toronto with 10 to 12 other students. There was a whole group of us (a picture of happy, smiling teenagers flashes on the screen). And we got trained the whole entire weekend which was such a cool experience. Leading up to the training weekend we were told to write out a rough story, a rough speech that we would present, and I wasn't alone when I came into the weekend with 5 pages of story to present to everyone. Throughout the weekend we learned how to make that much more concise, how to get to the point with what we were saying, and create a speech that not only would people want to listen to and learn from but would also be really healing and awesome for us to present. I remember after one talk a student came up to me and we started chatting and we realized we had very similar stories. While we were talking I told her all about jack.org. I told her about the summit, I gave her more details about how I got involved. She went home and looked it all up applied for the summit, and told her friends in Calgary about the summit who also applied and got accepted as delegates and it was mind-blowing to me how far our message really got. When you go out and tell hundreds of people your story you have to own up to it. You can't pretend that its fake. You can't pretend it didn't happen. It's part of your story and it's part of who you are. ("Summit")

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[38] All names in this chapter have been changed to protect anonymity.

By pointing to Cynthia's narrative, I am not calling into question the value of people with psychiatric disabilities speaking publicly about their lived experience. Nor am I intending (and I would like to make this point very clear) to diminish the necessity of people with psychiatric disabilities leading mental health movements. I believe many of the messages that Cynthia and her peers speak of are incredibly important. What I am intending to critique here is the process by which Cynthia's story is shaped into a palatable, 'more concise', positive speech so that she can disseminate a message 'people would want to listen to and learn from'. The process by which Cynthia's message changes from the beginning of her story from her own individual narrative that takes shape in 5 pages, which is then edited, trained, and shaped into a more concise narrative that 'people would want to hear' is troubling. This speech exemplifies what Andrea Nicki calls the "good" disabled person. Nicki argues the "good" disabled person is called upon to enact a "cultural demand of cheerfulness" (Nicki quoted in Price, 13). This cheerfulness, when enacted, erases the very conditions of the disability itself. Cynthia is incredibly cheerful, happy, and positive. The problematics of publicly parading happy, smiling university students into institutions to speak about mental illness is that representationally, the rhetorics of a happy smiling student speaking in positive terminology erases the very condition of the disability itself. The speaker's happiness and ability to overcome disability enough to be a public speaker turns good health into an individual pursuit. Rhetorically, students are called upon to overcome their illness enough to publicly speak about mental illness in happy and cheerful terms. The use of prized interlocutors masks the institutional responsibility to provide mental health services in a university setting because the message is crafted and designed to place the burden of good mental health onto the individual.

163

Monitoring the speech and performance of 'good disabled students' is further problematic because the focus turns from the institutional responsibility to provide mental health services to a process that examines thoughts, speech, and behaviour of the students themselves. Moreover, student speech and performance are shaped by healthist discourse that dictates the responsibility of *good* mental health as an individual pursuit. In an E-brochure, the organization explains that Jack Talks are designed to perform the following functions within the institution:

> These presentations are based on our professionally-developed curriculum and focus on equating the importance of mental health to that of physical health. Speakers will help audiences to understand their own mental health, how to identify a crisis, how to seek help, and how to support a friend who may be struggling. They will also inspire audi-ences to keep the conversation going in their school community by offering concrete steps to create lasting change. The average Jack Talk is about fifty minutes long and is delivered by two post-secondary aged speakers. All speakers have been extensively trained and are regularly evaluated to ensure that they deliver Jack Talks in a safe and en gaging way. Mental health resources are also discussed in each Jack Talk and school sup-ports are encouraged to be in attendance. ("Transform")

Notably, the very first sentence states that Jack Talks speakers are trained to disseminate a "professionally-developed curriculum," and this curriculum is based entirely on the individual student's role of speaking, identifying, helping, or acting in their own community (with the speech or act focused on themselves or other students). The "peer-to-peer," "youth-led" speakers are highly trained in a "how-to," step-by-step curriculum: "how to" understand their *own* mental health; "how to identify a crisis"; "how to seek help"; and "how to support a friend." The organization shapes the narratives of speakers in very particular ways, clearly outlining how

to feel, how to act, and how to speak about mental illness. The organization mandates that the "extensively trained" speakers "offer concrete steps," and these speakers are, the organization states, heavily monitored to ensure that their speeches match the goals, training, and message of the organization. Moreover, the speakers are monitored and "regularly evaluated" to ensure they "are engaging" and "inspiring audiences" when they speak. The organization thus monitors the speakers to ensure that they are adhering to the "cultural demand of cheerfulness" that, Nicki states, the "good disabled" person is called upon to meet in both speech and action.

Speakers are trained and recruited in a highly stylized and formulaic fashion. In one video posted on YouTube by Jack.org, a young, white, attractive, physically healthy, blonde-haired female describes the process of being accepted as a Jack Talks speaker:[39]

> ...once I was accepted to be a Jack Talks speaker, there was a two-month training program over the course of a summer. We got to watch a video every week where we would go through different elements of the talk and we got tips on how to become better public speakers. ("Jack Talks")

Another young, white, physically healthy, attractive, brown-haired 20-year-old male appears on the screen and states, "after completing the training we had to present our story and pass a final exam." The blonde female appears on the screen and explains, regarding the exam, that, "it covers what mental health is, some basic facts about mental illness, how mental health and physical health are similar, how they are different." A different, young, white, attractive, brown-haired male with a beard appears on screen to speak about the exam: "there's also a lot of things

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[39] I requested information on Jack Talks speakers in an email to jack.org on September 22, 2017. The organization sent a link to this Youtube video as well as an E-brochure entitled *Transform How Your Student's Think About Mental Health.* I requested a video of a Jack Talks speech, and the organization responded that I could book a speaker for the cost of $1000.00, and noted that bursaries are available to cover partial or whole costs should I require financial assistance.

to learn about helping your community and helping your school that you can take away and do right after the talk." The blonde-haired female's voice speaks over a silent video of the previous speaker giving a public presentation in a blue Jack Talks shirt: "ultimately, the talks promote better understanding of everyone, whether you have a mental illness or not. The idea is that everyone has mental health and so we all have to be looking out for each other." The image shifts from the boy speaking to the girl speaking on a large stage. A large screen in the background shows the message, "we ALL have mental health!" The young male with a beard appears on-screen to speak and states that, "jack.org is for students by students, so it really makes it easier to take away what's being said and apply it to your life right after. The first boy who spoke appears on screen again, stating with a smile that "my name is Lee and I'm a Jack Talks speaker." He further encourages others to "go to jack.org to submit a request" to apply to be a speaker. Like Cynthia's narrative, these students promote a healthist message that suggests mental health can be overcome by speaking about it publicly and helping your community. The message that "we all have mental health" is the conclusion of both Cynthia's talk and the students' speech quoted above. Considering that each Jack Talks speaker goes through the same process—two months of training along with an exam—the narratives are trained, streamlined, and standardized by the organization so that the message of each talk is similar (if not the same), that "we all have mental health" struggles.

In the Jack Talks campaign, students are called to stand up and "own" the symptoms of their illness publicly, in a performance that demands good health. Students are the primary focus of this campaign, which focuses on "individual behavior, attitudes, and emotions as the relevant symptoms needing attention" in the student mental health care debate. By outlining the various elements required of the story, and requiring that people "own up to" their mental illness, the

166

practice fails to question what the normal mind is, by requiring that students tell their story as an inspirational figure in formulaic form. To truly end stigma, stories must call into question what we mean by a normal mind. Publicly demanding that speakers enact a "proper," cheerful, or happy performance of mental illness does not fight stigma. Mental illness is stigmatized negatively in society. Placing young university students speaking about their mental illness online is an ethically questionable practice. People who are disabled mentally are denied rhetorical agency: their arguments do not hold weight and they are dismissed as unreliable. In Prendergast's language, "to be disabled mentally is to be disabled rhetorically" (Prendergast quoted in Price, 26). University students could face future ramifications for speaking about their mental illness online. These speakers could be stigmatized for speaking about stigma. Limiting, shaping, and regulating acceptable forms of "talk" is problematic. Some types of "talk"—and it may not be happy or cheerful or institutionally supportive—raise critical issues that truly require our collective social attention.

A disability studies perspective can shift the focus from requiring that individuals perform in very specific ways towards more fruitful perspectives that consider environmental and systemic injustices as contributors to inequity. Price speaks to this very issue:

> Although [disability studies] is concerned with individual experience, it is first and foremost a social and political perspective. As such, it shifts the "problem" of disability away from individuals and toward institutions and attitudes. Strongly indebted to postmodern ways of knowing, [disability studies] generally understands the institution as a system that produces human oppression (as well as privilege). (5)

Price's statement that disability studies is a "social and political perspective" that "understands the institution as a system that produces human oppression" is key to understanding why the

established practice of making students publicly own their illness is a problematic enterprise.

These narratives promote problematic healthist assumptions (among others) that individuals are responsible for their own good health, which obscures the universities role in disabling environments.

The institutional environment, while possibly participating to a lesser extent than maybe government or corporate environments, engages in disabling practices. Price is right when she eloquently states that, "academic discourse operates not just to omit, but to abhor mental disability—to reject it, to stifle and expel it. For thousands of years academe has been understood as a bastion of reason, the place in which one's rational mind is one's instrument" (8). Mental disability is regarded as the antithesis to academic reason because to be mentally disabled, in our society, is regarded as having a fractured or disordered mind. Collectively embracing a rhetoric where non-normative minds are respected and valued would end stigmatizing notions of mental illness as irrational or as being due to a defective brain. To achieve this, we must value all forms of talk—or no talk at all—and refuse to shape discourse into a rhetoric that ascribes to normative principles that create and sustain stigmatizing narratives of mental illness as a defect, a lack, or a liability.

The Silencing of Talk: Student Protest

In contrast to the student speakers organized through jack.org as a response to Jack's suicide, and indeed the organization should be commended for responding to student mental illness, UW's climate has been, until recently, one that, in Price's terminology, "rejects, stifles, and expels" mentally ill students. On Reddit, user Cole135G posts the following message in a thread entitled, "I'm the brother of the student who committed suicide yesterday morning":

168

It doesn't feel real to type that title. None of this feels real yet. He was, as many of you are, a brilliant mind. To those who will say that UW doesn't isolate their students, I'd like to tell you that you're kidding yourself. My brother is the second person to die like this in this year alone at his residence. Waterloo hasn't called my family. We have no support from the school in this. I don't want to see the look on my father's face when he begs me not to leave him. I don't know who any of you are, and none of you know who I am, but please fucking know that you can go home whenever you want. It's just school. It's just a fucking grade. You're worth more than a fucking job or a degree. Chase was in the co-op program and the idea of moving back and forth every 6 months must have scared the living hell out of him. The fact that my brother was reduced to a number and was mistreated by the entire structure of the Waterloo campus is sickening. I read through the article published on uwimprint.com and the only words I could say were "fuck you". They say they offer their deepest sympathies when they never even gave us the courtesy of a phone call. My brother is dead because of the school and system that has become accepted. My brother is gone and I'll never be able to tell him I love him ever again. I'm 16 years old and will soon be deciding on where I'd like to go for school. I'm so hurt, I'm in so much pain. I need help. I need to know that you guys will be okay. I need you to know that you have a family and a home. School is not everything. Do me a favour and go home as soon as possible and hug your parents. They don't deserve this and neither do you. If you're ever homesick and feel so lonely you can't bear it then just fucking transfer schools to be closer to your family. Just please let my family be an example of the cowardice and the borderline criminality of the system we're all a part of. If you're attending the University of Waterloo next year or have an open invitation, please

decline it or seriously consider another alternative. Save a life and be there for your

roommate, your friend, and your family. ("I'm the Brother")

It is important to recognize the impact of this post on the ensuing response from both students,

faculty, and the media following Chase's suicide. This post, an honest depiction of university

life, resonated with students and professors at the University of Waterloo. The subreddit

responses, lengthy and detailed, also shared similar narratives of university life along with the

barriers to accessing mental health treatment on campus. What is important to note here is that

Chase's brother is not a prized interlocutor, nor does he subscribe to using a cheerful narrative of

overcoming to deal with the issue at hand. This narrative firmly places the responsibility on the

university to provide an adequate structure that does not "reduce [students] to a number" or

"scare the living hell" out of students by placing them in unstable living situations and financial

precariousness in a constant job-search program (the co-op program at UW).

Both the silent response and the prized interlocutors also put the responsibility for good

mental health on the speaker or individual, which absolves the institution of the responsibility to

provide services. Healthist messages, with a focus on individual acts and beliefs, obscure the

institutional responsibility to protect and provide for students. The individual student bears the

responsibility for their own good mental health through either suffering in silence or "speaking

out" and overcoming mental illness. This section ascertains that both institutional responses

outlined here—silence and prized speakers—rhetorically frame good mental health, through

healthist ideology, as an individual student responsibility. While the Jack Talks campaign might

be a better response than silence, these highly trained speakers disseminate an inspirational

message and not a critique; these prized interlocutors inevitably end up masking an institutional

responsibility to provide adequate mental health services on campus. Appropriate responses to

mental health in the university setting should be addressed, as Chase's brother's Reddit post points towards. His story places the blame on institutional structures that create student mental illness and not on students themselves.

The Shaping of Talk

One way to better understand this disjunction between students and administration is to draw a contrast between the UW President's message and an article from the UW student newspaper *The Imprint*. *The Imprint* ran the following article after the first student suicide at the *UW Place* residence during the 2016-2017 school year:

The body of a University of Waterloo student was found in UW Place's Beck Hall on Jan. 12 around 3:30 p.m. Police, paramedics, and the fire department, as well as a hazardous material team, answered a 911 call in response to concerns of "chemical exposure," according to police. Students from Beck Hall were evacuated for several hours as the officers worked. While details surrounding the death and the chemical exposure still remain scarce, police have confirmed that the deceased was an 18-year-old female. Information about the cause of death and the chemical vapour remain unclear, to the frustration of many UW students. Users on the university's subreddit expressed confusion surrounding the evacuation and events surrounding the death. Waterloo Region Police Services Executive Officer Mike Haffner explained that given the circumstances surrounding the case, few details would be publicized. "We wouldn't be reporting on the name of the individual, obviously out of respect for her and the family, and especially involving the circumstances … with certain situations and call types that we would respond to, our information with all media is pretty minimal," Haffner told Imprint. Carleen Carroll, UW associate vice-president of communications,

171

released a statement on behalf of the university. "We are deeply saddened by the death of

one of our students and express our heartfelt condolences to the student's family and

friends," Carroll said. "We are respecting the family's wish for privacy and will not be

commenting further. ("Student's Body Found")

This event is minimized by the lack of disclosure.[40] The UW *Imprint* article fails to mention the

cause of death as suicide. The student's name is withheld. The student is referred to as a body,

which works to dehumanize her in the narrative. The death is described in details that emphasize

the role of "police, paramedics, the fire department, and the hazardous material team" in the

evacuation of the building instead of the death itself. While "frustration" on the part of UW

students at the lack of information is noted, the UW Associate Vice-President of

Communications responds that information will not be released, citing "the family's wish for

privacy." The discourse used to control the flow of information released to the public silences

the issue of student mental health on campus by relying on stereotypical notions of mental

disability as a crisis and a tragedy.

A major component of this analysis is to emphasize how, rhetorically, corporate,

government (and here, institutional) mental health discourse frames disability as an isolating or

tragic state. This move is enacted to either silence and reject disability (expel the body or voice)

or to use the trope of tragedy to elicit sympathy and donations. The University of Waterloo

attempts to limit discourse surrounding the suicides by rhetorically framing mental illness as

something that is so abhorrent, so dangerous, and so unthinkable that silence and mystery must

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[40] As UW's student-run paper, *Imprint,* is authored by student writers and not university administration, the student newspaper is not considered an official UW source. Student writers at *Imprint* may assume a critical eye towards the institution in articles. However, *Imprint* is an important source to consider in the context of this chapter because the text speaks to the ways in which mental disability is constructed and viewed on campus culturally. In this instance, whether knowingly or inadvertently, or simply due to university policy and lack of information, the campus paper participates in institutional erasure.

shroud the event. By refusing to address mental disability on campus, the institution advances

the myth that disability is and should be an isolating experience because disability is abnormal.

By controlling the message and silencing the event, the university upholds the image that UW

students are both intellectually and emotionally healthy, while avoiding the responsibility of

recognizing that students may require services that require additional staff, funding, and possible

changes to both the architecture and social environment in the residence buildings.

Following Chase's suicide, UW's *Imprint* released the following article:

Waterloo Region Police were called to the UW Place residence at 6:24 a.m. on March

20 when a body was found on the ground. After investigating the scene, police

determined the deceased took their own life, according to Waterloo Region Police

Services Executive Officer Mike Haffner. While the victim will not be identified, Haffner

confirmed the 19-year-old male was a University of Waterloo student. At the time of

reporting, the deceased's next of kin had not been notified. "Right now, through some of

the people we have been able to speak to, we have determined that it is a University of

Waterloo student," Haffner told Imprint. "It's one of those situations where any death in

our region is tragic," Haffner said ... At the time, police evacuated the building, though

Haffner noted Monday's incident posed no threat to public safety … UW Director, Media

Relations and Issues Management Matthew Grant released the following statement on

behalf of the University of Waterloo late Monday afternoon: "Today the university

community is deeply saddened by the loss of one of our students. This tragedy leaves our

campus community in mourning and we offer our deepest sympathies to the student's

family and friends," Grant said. "We encourage anyone who needs support at this time to

take advantage of the university's counselling services and peer support programs or to

173

contact the post-secondary student helpline, Good2Talk. This matter is currently being

investigated by the Waterloo Regional Police Service. ("Another Student Death")

This article attempts to address mounting frustration in the university community following the

second student death at UW place; however, the primary speaker in this article is a police officer,

Haffner, and not an official university administrator. The suicide is framed as not being a "threat

to public safety" and is "being investigated as a police matter." In this article, there is relative

silence from UW following the death of the first student, and their response mirrors the canned

public relations release made following the death of the 18-year-old female student. The

university is framed as the victim of a tragedy, as they are "deeply saddened." The University of

Waterloo attempts to silence the mounting frustration voiced in both this article and on the

university subreddit by embedding terminology of tragedy into the discourse. While UW's

statement claims that it is in "mourning" in response to the "tragedy," Chase's family voiced

extreme frustration and doubt at the sincerity of the heavily controlled message. His brother

writes on Reddit that, "Waterloo hasn't called my family. We have no support from the school

in this" ("I'm the Brother"). He further voices disgust at the sincerity of the school's message

when he read the *Imprint* article, stating, "they never even gave us the courtesy of a phone call"

("I'm the Brother").

The President of UW, Feridun Hamdullahpur, responded with the following message

following the statements from Chase's family and the wider university community by again

framing Chase's suicide in discourse of loss and mourning:

Our university community is deeply saddened by the loss of one of our students. This

tragedy leaves our campus in mourning, and we offer our deepest sympathies to the

student's family and friends. We know this is a very difficult time and we take to heart

174

the concerns we've heard from our campus community. We thank those who have

shared their views with us, including through a petition on the subject of mental health

supports on campus. While the university has significantly increased its focus on

student mental health services over the past few years, we know more can be done to

increase the awareness and effectiveness of these services so that those who need help

can get it. We encourage anyone who needs support with a mental health issue to seek

help, whether it be counselling, support groups or the post-secondary student helpline,

Good2Talk, which is available 24/7. ("Waterloo Saddened")

In this vague and non-committal statement, the university response reflects what critic Sara

Ahmed speaks to when she writes that institutions are "against students." She explains what she

means by this in the following:

what do I mean by "against students"? By using this expression, I am trying to describe a

series of speech acts, which consistently position students, or at least specific kinds of

students, as a threat to education, to free speech, to civilization: we might even say, to life

itself. ("Against Students")

The president's message positions students—at least it positions mentally disabled students, or

suicidal students—as a threat to the university itself. There is a definite divide in this statement

between the university as a threatened body and the individual student who passed away as a

threat to the system. The focus is on the university itself, a body "in mourning" during this

"difficult time." The university is further placed in a position of hardship as it is "facing mental

health challenges." The protagonist in this statement, the university, speaks as if it is being *acted*

upon and *placed within* a difficult, tragic situation caused by the student's actions; instead of

focusing on the role of the university, the university is framed as the victim in this narrative,

175

being "put out" by the actions of a single student. The sentiment and discourse in this statement

reflects what Ahmed refers to as being "against students" insofar as students are regarded as

threats to the overall good health on campus.

In contrast to UW's attempt to control the message regarding campus mental health,

online and media responses commenced a massive backlash that questioned both the university's

sincerity and its actions. In the UW campus magazine, *Imprint,* Chase's mother and father were

interviewed about UW's statement. In the interview, Chase's mother responds (when questioned

about what supports UW had provided) that, "the university itself has really done very little to

nothing. I actually did not hear from the university at all. I was never contacted by the

university" ("Straight from the Source"). Chase's father also expressed the same sentiment that

"Support? Nothing. We haven't't heard from them until I was up there to pick up Chase's stuff

on Friday (March 24). They offered their condolences and stuff. I was appalled by the fact that

there was no notice of anything, not even flowers where he fell. Or notices on the elevators or

doors. Nothing" ("Straight from the Source"*)*. The university failed to make a public statement

perhaps due to the fear of negative press. As a result, the university hides behind the family in

their refusal to address student mental health directly.

The president of the university does not address the death directly, and instead makes the

following statement: "When tragedies like this happen, the University's main concern first and

foremost is the student's family," then Hamdullahpur continues, "We do not take lightly our

obligation to ensure that they have been informed and do our upmost to respect their wishes. The

University always reaches out to the families to offer any support they need. This is a very sad

duty, but must be done" ("University of Waterloo President"). While UW's president's remarks

focus on the "sad duty" that must be performed to notify the family following a suicide,

attempting to cement the conversation around notions of politeness, social convention, and tragedy, other sources question the sincerity and even truthfulness of these statements. In Jennifer Doyle's study of campus sexual assault, she writes of the Chancellor, who is "anxious about the university's legal exposure" (17). In this response from the President of the University of Waterloo, this same anxious fear about the university's legal exposure is present. There appears to be an underlying notion that if the university speaks about the suicide, then the university may be legally culpable.

Additionally, it is easy to cynically worry that the university wished to silence the deaths so as not to adversely affect the reputation of the institution, as Chase passed away during the time when high school students are choosing which university to attend. There is an underlying anxiety in the university's terse messages, which speaks to the culture on campus that strongly delineates the behaviour of (supposedly) normal university students (the happy smiling ones that are so desirous) versus those with psychiatric conditions (undesirable). There is a fear that if the institution acknowledges that students are mentally ill, the very existence of these students will threaten the ableist history that the institution itself is built upon.[41]

Chase's family, in fact, publicly challenge the statement from UW, claiming that no one from the University informed them, nor were they spoken to following their son's suicide. Chase's mother states:

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[41] In *Academic Ableism*, Dolmage expertly outlines the ableist history of the academy, one that is fraught with irony. He notes, for example, through a reading of David Rothman's *The Discovery of the Asylum,* that the histories of academic institutions and mental institutions are deeply intertwined—and yet we view them as opposite: "The college or University is in fact exactly the same as the almshouse or asylum, organizationally and even architecturally" (176). In fact, Dolmage powerfully argues, the history of the academy is deeply intertwined with and based upon eugenic ideological principles and policies. If "mad" students are accepted as part of the institution, the eugenicist and ableist notions upon which the institution is built are questioned, threatening the university at its very core. As such, discussion of students with psychiatric disabilities is hushed, silenced, and ignored by the institution to maintain this imaginary divide between the academic institution and the mental institution.

177

...there was no inquiry as to what my wishes are. If my wishes had been followed I would

have been certain that there was immediate counselling available in Chase's building. I

want door to door check-ins with the kids. I would want the entire faculty and students to

know that my son committed suicide on campus. We're very open about this. And for

them to send a statement out, to me it almost felt like they were excusing their lack of

communication with us out of respect for our privacy, when in fact we are not interested

in that. I'm interested in making sure students get the help they need and that this is not

swept under the rug, because I feel this is an issue that needs to be addressed. We are

very disappointed by the university, that the letter from the president said that they were

sorry that their level of communication with me did not meet my expectations. Which I

found ridiculous. ("Straight from the Source")

Chase's mother's discourse speaks to concrete steps the institution could have taken to address

student mental health on campus. Her statements reflect the wider sentiments on campus at the

time, as students as well as professors began organizing and posting alternate strategies for

dealing with student suicide. The attempt to suppress the message resulted in a large-scale media

backlash against the university. After Chase's brother's message was posted, and this interview

was published in *Imprint*, other people responded in kind. These students posted online to

Reddit forums criticizing the response as well as criticizing campus mental health services.

Professor Aimée Morrison responds to the issue, writing,

we need something more than 'campus wellness days' and a 1-in-5 that only has happy

people in the video. We need more than working groups and statements of support. We

need concrete counselling supports diffused across campus, and in the residences. We

need training for staff in spotting and supporting students in crisis. We need faculty

training in how to design curriculum and pedagogy that is less structurally likely to push

people over the edge. We need programs that work to ensure that all students are

supported toward graduation, rather than celebrating toughness by measuring drop out

rates. We need universities that don't, structurally, haze students with sink-or-swim

social, institutional, or academic models. (*Hook and Eye*)

Morrison's post, in stark contrast to the university's silence over the suicides, promotes concrete

social and institutional change at the structural level to change mental health culture *for students*

instead of *against students.* As a reaction against university silence, staff and student protestors

further organized a vigil, an online petition garnered 15 000 signatures, and a "600 page petition

urging a reassessment of UWaterloo's mental health resources and policies was presented to

Chris Read, Associate Provost Students at the vigil" ("Community Urges").

Online, students responded with a plethora of comments on Chase's brother's Reddit

post, various additional subreddits, and the petition, with personal narratives and suggestions to

improve the approach to mental health on campus. A talkback of sorts was occurring. This talk,

however, was not speech that painted institutional silence in a positive light. Online criticism of

the mental health services at the institution appeared on Reddit, petitions and the media, as

professors, parents, and students (both past and present) wrote in the margins, so to speak, in a

highly critical manner, of institutional barriers to psychological well-being. The online backlash,

for the institution, was severe. On one Reddit post, a user named machinepower posted,

following Chase's suicide, the following comment that places the blame squarely on the cold and

detached institutional environment:

 I personally actually blame UW Residences the most. The DON system works, but not

that well when barely anyone ever shows up to their events, and residents can't form

179

meaningful connections with their dons or other residents/roommates. Ive lived in UWP.

Chase probably felt mega-isolated in there. Since that was Chase's defacto HOME for

the majority of his time at school, huge neglect on mental wellness probably arises from

there, as his UWP residence definitely does not feel like a HOME. ("Student Suicide")

I do believe that it is important to include students and people with mental illness in the

conversation about mental health services, and this is the type of critical conversation is

necessary to enact change on an institutional level. The entities of "isolation" and feeling

"alien," in this post, are attached the institutional environment, which is a change from the usual

stereotypical depiction of "isolation and alienation" as associated with mental illness in an

individual's (faulty) brain. Another UW student poster responds with a subreddit about the long

waits at counselling services, commenting that "my last counselling appt was a 7 week wait"

("Another Student Death"). This comment points to the inadequately staffed and serviced UW

counselling office and the necessity for increased funding and increased services offered to the

student body. A post by Anonymous on the petition entitled, "Urge the University of Waterloo

to Change Approach to Mental Health," that was started by a student after Chase suicided,

reached 14 967 supporters. Online comments responded to the current state of mental health

services at UW. A poster named anonymous wrote the following message:

Had a serious issue with depression and suicidal ideation. I sought help from UW

Counselling Services after being urged by my friends to do so. After being told "well this

isn't my problem, but I'll direct you to someone" multiple times and being given an

appointment, I was then blown off 3 times by the same person. After which, I didn't show

up feeling worthless that even someone whose job is to be there, isn't. I spiraled and

was a mess for several months before I once again tried to get on the road to recovery.

It's like they couldn't care less what happens, so long as you die out of sight and away

from campus. Then there's those I know who fall into the same situation and I cannot

even recommend them to seek Health Services. They will indeed see you briefly, but you

may not get a follow up, in fact they may just forget all about you. ("Change Approach")

The sentiment from the poster above, voicing the concern that institutional staff and services do

not really care about students, is common. A person with their name not displayed wrote: "I was

a UW student who once felt the same. My faculty advisor helped me by listening to my rants and

supporting my decision to switch programs before I took a dive off a building. At the time I did

not even know where to look for a counsellor, and felt a professor who was teaching his students

would understand them more" ("Change Approach"). Another poster echoed the previous poster

and wrote, simply, "I feel the same way Chase did" ("Change Approach"). One poster named

immentaluw writes on a Reddit thread, speaking about his counsellor at UW, "she makes [me]

not want to go to [my] counselling appointment. She made me want to shoot myself" (Another

Student Death, Reddit). A poster named WhitePotion responds to this poster by saying, "I had a

similar experience…the social worker seemed hurried and I had vibes (aka maybe it was my

anxiety talking) they wanted to send me to drug solutions or group counselling because one on

one was in high demand" ("Another Student Death"). The responses outlined demonstrate that it

is not only the stigma preventing students from accessing help, it is institutional responses to

these types of requests for help that constitute a major barrier, and listening and honoring the

types of talk that occur in the margins is integral to responding to student mental health in the

institutional environment.

The Demand for Talk: Confession in an Institutional Environment

In the Jack.org campaign, a very different scenario was (and is) occurring. Instead of suppressing talk from students, this campaign recruits and trains students to speak on a large scale. In this organization, students are encouraged to "get loud" and join together in a unified message. The Jack Summit is one event the organization uses to recruit student speakers: "Jack Summit is the largest gathering in Canada for young leaders working to end the silence around mental health" ("National Summit"), where they are encouraged to "become louder than ever before" ("National Summit") in the "fight" against stigma. Jack.org has a vision of "no more silence" ("Financial Statements"). The entire raison d'être of the Jack campaign is to give students the platform to talk, to confess, to encourage others to share their stories. This critique is not targeting individuals who speak through this campaign, who (surely) experience positive benefits through this organization's initiative. This analysis critiques the process by which this talk is called forth, demanded, and reconstituted in an institutional setting, as a fight against mental illness and not the institution itself. By framing the "fight" against mental illness, negatively stigmatizing depictions of psychiatric disability are reified and reinforced in the rhetoric, which serves to perpetuate and uphold disabling mental disability stereotypes.

Talk is further used as a strategy in mental health campaigns to promote values of self-control, leadership, and a more compliant (and socially productive) subjectivity. In the campaign, *good* health is linked to the ability to have *good* speech. One speaker's biography reads, "after taking some time to feel more stable and healthy, Joe applied to be a Talks speaker so that he could use his story to help others. He'd never really had public speaking training before, and was excited to learn how to craft a powerful message" ("Paying it Forward"). Here, the biography relies upon healthist assumptions that Joe has a personal responsibility to overcome his illness and be "more stable and healthy"; as well, the measure of ultimate health

and success is his ability to "use his story to help others" by publicly confessing his mental illness. Good health is also linked to having good speech in the "Testimonials" section of the Jack.org website, where one student is quoted as saying the following about the summit: "I really liked the public speaking workshop skills. It was so applicable to mental health but also gave general skills. I walked away feeling like I could use this in day to day life" ("Testimonials"). By providing students with public speaking workshops, the summit promotes the idea that public speaking—or, more specifically, public confessing—is a healthy activity that one can and should use in one's day-to-day life. If one cannot be entirely healthy (absent of mental illness), the next best thing is to recover well enough to publicly confess one's "truth," thereby achieving health through the act of confession— "owning up" to one's illness. In this way, talk is an act of self-policing, where students publicly disclose the type of "threat" or liability they may pose to the overall health of the institution. Institutions cater to mental illnesses such as depression or anxiety; however, individuals with more serious mental illness, once disclosed, can be referred to off-campus supports. Encouraging students with what would be considered a serious psychiatric condition to publicly disclose their diagnosis could result in harmful consequences for the student, if the university deems that they are not equipped to accommodate this student.

The institutional demand that students talk about their illness publicly is not only a large component of the jack.org campaign, but this practice began to be implemented as well throughout UW following online criticism. Acceptable "talk" is that which originates from smiling, happy, attractive and youthful students in the Jack campaign, who positively and cheerfully speak about their mental illness in front of large crowds. Jack.org requests that students/customers "share stories" and talk—confess—in very specific ways. At UW, this "talk" is called forth from students in the form of a "secret." As a response to the flood of online

183

criticism, UW's president started an online mental health awareness blog on the university website, with a "type your secret" feature. It is here, on this blog, that discourse becomes reframed and rechanneled from critical talk *against* the university to a request that students *talk* against the *stigma* of mental illness. Students are further encouraged to publicly reveal a mental health diagnosis through confessional *talk* on the blog, which publishes biographical stories from students with mental health struggles. By demanding speech against mental illness, speech that goes against the institution is diverted and co-opted through online technological social mediums. The blog from UW's EngSoc's Mental Health Awareness team is intended to "further fight the stigma of mental health on campus" ("Message from the President"). This blog invites students to submit stories about personal mental illness. Stories are attached to the student's picture and the department they are in is also stated. As well, a feature named "Post Secret" invites students to submit a "secret":

> In addition to running this blog, the mental health awareness directors also run Post Secret every term. This is a service where people can submit short anonymous secrets, confessions, or just about anything they want to get off their chest. We write them out and stick them up on a wall for everyone to see. You can submit a secret here: https://goo.gl/ATnDFX. ("Message from the President")

At the time of writing, no secrets are posted to the wall. This in itself is very revealing. But the idea that "secrets" are held within the student body and the ensuing call from the university for students to "speak up" and give voice to their secrets is the process by which speech becomes reified as depicting the "true" nature of the student body, and perhaps most students get effectively silenced.

184

The Body

It would be impossible to further consider the rhetoric of mental health in an institutional setting without considering how this rhetoric shapes the body through discourse. In *Disability Rhetoric,* Dolmage notes that, "we should recognize rhetoric as the circulation of discourse through the body" (5). Rhetoric shapes our perceptions of the world, bodies—ours and others— and, moreover, rhetoric shapes and legitimates our perception of which bodies belong where. Essentially, rhetorical imaginings cannot be separated from conceptions of the body in the literal and figurative senses. Discourse flows through representations of the (psychiatrically disabled) body in institutional health campaigns.

The performative embodiment called forth by the jack.org charity advances an image of health and physical wellness as representative of a healthy mind. On the Jack Talks website, student speakers are pictured with short biographies. These biographies are similarly composed with a picture of a face. The face of the student always appears to be young, attractive, and smiling. The first biography in the "Speakers" section shows a tall, white, smiling, blonde-haired boy standing in a field of flowers. He is thin, athletically fit, and wears jeans and a flannel shirt. His whole body is pictured, which is not standard, as most often only the face of the student is pictured, detached from the body. This student is given the pseudonym John:

> From _____, John moved to …… where he is pursuing his Honours Bachelor of
> Science in Psychology with a minor in Gender Studies. John loves to open positive
> dialogues about mental health and allowing people to interact with this topic in fun and
> creative ways! Talking about mental health, stigma, positive psychology and gender are
> what makes John' world go around. In his down time, John likes to vent his feelings to

his plants, make small talk with his hamsters, or sing to his fish. He's always striking up a

conversation with something or someone, and today is no different! ("Speakers")

John's face overcodes mental illness with a rhetoric of happiness. If the dialogues are "positive,"

"fun," and "creative" (which is unrealistic), then mental health discussion is allowable; however,

any discussion that includes critique could be judged "not positive" and "not fun." By couching

terminology of acceptable mental health discourse in terms that are only positive, these

biographies police how people with mental illness can critique or enact psychiatric disability.

John is standing in a field of flowers, smiling happily at the viewer. His body is upheld as

representative of psychiatric disability because when he has "down time," he "vents his feelings

to his plants, makes small talk with his hamsters, or sings to his fish." John is not taking his

smiling, happy body to a student protest. John will "vent to his plant" if he feels upset.

Another speaker, given the pseudonym Bernard, is a smiling, white, brown-haired boy

with his only his face and upper body pictured, as he is paddling a canoe (seated). His body, like

John's body, is thin, and he appears physically strong. He is wearing a black tank top. It is a

summer day, and the lake is framed by mountains and trees.

> Bernard is an aspiring engineer currently studying Chemical Engineering…with the
>
> dream of having a career involving sustainability and engaging the public. He became a
>
> speaker for us because he felt that there was not enough discussion about mental health
>
> and he strongly believes the best way to see the changes you want in the world is to get
>
> involved. He feels most at home exploring the outdoors, working in his wood shop and
>
> cooking up delicious meals for his friends and family. ("Speakers")

Like John above, Bernard's biography rhetorically overcodes mental illness with happy, positive

discourse that is linked to having a physically able and healthy body. Bernard, as an outdoor

enthusiast, is physically able to "explore the outdoors" by hiking and canoeing. His well-rounded interests (cooking, working in his wood shop, athletics) is linked to his ability to "become a speaker for us all" in the discussion of mental illness. What is erased is any discussion of either John's or Bernard's personal experience with mental illness. Instead, their happy, athletic bodies are chosen specifically for their ability to perform both physical feats and their ability to speak a very specific narrative about mental illness—a happy, positive narrative, where students themselves take care of any mental illness symptoms by talking to their plants or hiking in the mountains.

A speaker whom I will give the pseudonym David, is shown with his face framed in an oversized picture. He is smiling widely while sitting in a gondola in Venice. In a smaller picture under the biographical story, David is shown running, mid-stride, wearing a race number pinned to his tank top. He is white, athletic, blonde-haired, and thin. The race picture also reveals that David is quite tall. The biography describes his role as a Jack Talks speaker:

> David grew up in the small town.… He is currently pursuing a Bachelor of Science in Medical Sciences at University, where he Leads the Jack.org Chapter. One of his biggest goals with Jack.org is to defeat the invisibility of mental health and mental illness while normalizing the conversation for everyone. If you can't find him in his room surrounded by textbooks, chances are he's out running the streets and trails, sporting his shortest-possible running shorts while training for his next marathon. ("Speakers")

Like Bernard and John, David is an able-bodied, athletic, young, thin, and motivated speaker. His biography overcodes our notions of mental illness by replacing discussion of mental health with a happy, attractive, fit, and smiling young adult. David's face and biography attempt,

indeed, to "defeat the invisibility of mental health and mental illness" by insinuating that a mentally ill person can be normal if he or she has a happy, healthy, fit, and athletic body.

Similarly, a healthy body is linked to a healthy mind through sponsored athletic events that promote the idea that a fit body is one equipped with a fit mind. The Bank of America (Merrill Lynch) sponsors "Jack's Ride," a 25, 50, 100, or 120 km bike race where "all registration fees and every rider-raised dollar goes directly to providing the tools and resources young leaders need to transform how we think about mental health" (Jack's ride, jack.org). This ride is not tailored for people with mental health struggles. This ride is marketed towards mental health *leaders*, healthy enough to bike to raise money for people *who are* mentally ill. People with mental illness are the charitable cause. These *young leaders* with able bodies and sound minds are the people being given the responsibility (as the rhetorical message is being addressed to them) for diagnosing people they see as being mentally ill, as well as being given the ability to "set the narrative," so to speak, by "transforming" how people think about mental health. The rhetoric addresses a caregiver audience, young leaders audience in this case, and not people with psychiatric disability. In order to reach a wider audience, the message is steeped in healthist, easily palatable discourse that erases real conditions of disability. While institutional responses may be not as overtly healthist as, say, corporate or government campaigns, these messages underlie the rhetoric that frames people with psychiatric disabilities as a physically weak population group in need of charity—not accommodations, charity—from those who are mentally and physically stronger.

In Jack.org, student bodies are part of the overall pyramid scheme of the organization. This is problematic when the organization is targeting young people to speak about their illness, as they may not realize the full implications of doing so. We should promote ending stigma, but

188

living in a world with stigma is a reality, and people should feel safe to come forward, but should not be pushed into doing so. People coming out, so to speak, should not do so due to an institutional demand or as the main component of an institutional approach to mental health on campus. All of these young students are online speaking publicly about being mentally ill. On the one hand, there are benefits to this practice, but on the other, the privacy of children (or young adults) is being very publicly breached. Dolmage remarks on the environment required for an ethical disability body politic to occur:

> ...we need to allow for an environment in which students can claim difference without fear of discrimination and in which this claiming doesn't simply result in the student assuming all of the risk. Disability also can't be seen as something frozen in time and frozen in othered bodies – it has to be embraced as an always-everywhere, as a material but always changing reality. (Academic Ableism, 43)

Problematically, the campus environment is not changing as a result of these campaign initiatives; instead, Jack student speakers are "assuming all the risk" in this "fight against stigma." People with mental disabilities *are* othered in our present-day environment. When a group is stigmatized and othered, a rhetoric that promotes the idea that we "all have mental illness" harmfully erases concrete experience. In reflecting on how we can adapt the institutional environment to make it an inclusive space, discourse should shift from shaping and molding student voices or performances to an interrogation of how to adapt fluidity into spaces, in order to make these spaces more inclusive and accessible. Public disclosure from a student does not amount to liberation from stigma. Public disclosure can operate to further segment mentally ill students, by taking them out of an educational setting and situating their bodies within the context of a charitable space.

When fit, healthy, happy bodies are held up as speakers who attest to the positive, happy, beneficial aspects of the mental health charity—Jack.org—people will assume that *good things* are happening in terms of campus mental health and that there is *no problem.* Thus, by erasing any negative discourse or critical commentary directed at the institution, the charity prevents real change from occurring, as it appears that *good things* are happening for campus mental health.

Speculatively, *good things* are not happening on campus for student mental health, but the affect called forth from students engages with what Nicki would call a cultural demand of cheerfulness. The performance of disability through jack.org calls forth a very specific affect from students. Mental disability is framed in positive terms as a success story by featuring happy Jack Talks student leaders. While jack.org may be the better response as compared to silence and stigmatizing depictions of tragedy and crisis, the rhetorical message on the jack.org website resorts to problematic healthist assumptions that put the responsibility for mental health onto the individual and not the institution itself, and students are embodiments of this performative ontology.

By erasing disability, and positing overcoming as a positive experience, jack.org upholds an impossible ideal for those students who are unable to leave their rooms, socialize with others, or make public speeches. One chapter leader writes on the jack.org website that, "starting my Chapter has been such a rewarding experience! Given the framework from Jack.org, my team has created a positive shift in mental health awareness in my school community by slashing stigma and changing minds!" ("Find a Chapter"). Here, the discourse of mental health moves from a discussion of how we can understand and treat mental illness to a conversation of "reward," "positivity," "change" and an active fight, in the verb "slashing." The message is that overcoming disability will be a rewarding, positive experience where people move from being

190

victims of mental illness to warriors who fight the disease. This message is built into the

jack.org organizational initiatives and mission statement. On the website, in the "About

jack.org" section, the organization states that, "we encourage and enable young people to

become leaders in the mental health conversation. Our leaders identify barriers to positive mental

health in their communities and work year-round to break those barriers down through

conversation, camaraderie, creativity and tireless community building" ("About"). By

"encouraging" people to "become leaders" in the mental health conversation by actively seeking

out "camaraderie, creativity, and tireless community building," the bodies capable of "tireless"

activity are privileged. By asking students to "become leaders" in "the fight for mental

wellness," the organization reaffirms the long history of higher educational institutions

privileging active, able-bodied leaders believed to be society's "best and brightest."

The project to change the narrative of mental illness from a negative to a positive

message, while based on good intentions, is a component of a campaign that I have mixed

feelings about criticizing, as students do experience positive outcomes thanks to these initiatives.

There are elements, however, in the jack.org message that speak to problematic performative

embodiments of representational disability politics. Representations of disability take shape as

overcoming narratives, or what Shapiro calls "super-crip" figures. Overcoming is a problematic

stereotype that upholds normativity as a goal. The representations of disability on jack.org

rhetorically argue that if we are (psychiatrically) disabled, then we will be able to overcome it by

fighting; the measure of wellness in this campaign is the student's ability to "fight" stigma.

The campaign calls upon speakers to overcome mental illness in a very public manner.

Jack.org is, the website states, "the only national network of young leaders transforming the way

we think about mental health" ("Jack"). That "transformation" in thoughts, attitudes, and beliefs

is driven by a (large) group of students trained by jack.org to speak in front of a large group of students, to spread the message that "we all have mental health." In a page entitled, "what are Jack Talks?" the website writes that, "Jack Talks bring young speakers into schools to fight stigma and spread the message that we all have mental health" ("Jack Talks"). This is a problematic spectacle for myriad reasons. The idea that a student can "fight" psychiatric conditions sufficiently to be able to speak in front of a large crowd about their illness is highly problematic and ableist. The people speaking for those with mental illness enact a very specific performativity. Moreover, the organization disseminates a healthist message that divides those who are mentally healthy against those who are not. In the speaker biographies, students are described in positive terms. One student is described as having "an upbeat and energetic charisma that inspires students" ("Speakers"). In order to qualify as a Jack Talks speaker, students with mental illness must perform a very specific outgoing, upbeat, and happy personality to engage others and "inspire" them with their story.

Sarah Gibbons draws a parallel between Jack Talks and Ted Talks, the short, usually emotionally moving videos that circulate on YouTube and the Internet more generally.[42] Gibbons notes that message is "that we all have mental health," as opposed to everyone having mental struggles (personal communication, August 17, 2017). The speakers, in their very performance, enact "good" mental health, and, by default, those who are unable to enact this public performance are deemed to have "poor" mental health. By only giving a platform to those who are able to "overcome" disability to a point where they are "well-enough" to "fight stigma," the organization is erasing attention that arguably should focused on how to change systemic inequality and barriers.

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[42] Ted is an acronym for technology, entertainment, and design. They are, in the company's own words, "short, powerful talks" ("Ted"). The tagline "ideas worth spreading" defines the organization ("Ted").

192

The Business of Mental Healthcare

The rhetoric of mental health is deeply intertwined with the big business of mental healthcare campaigns. Institutional campaigns rhetorically frame a proper performance of mental illness with terms that would describe someone who is a successful business manager or exemplary employee: terms that promote leadership, the ability to recruit others, happiness, and a big smiling face are all used. People chosen to represent jack.org enact a performance of success. Dolmage notes that, "a hallmark of neoliberalism" is "the redefinition of intellectual values that highlight the need of the individual student (or worker) to become a more flexible (and thus fungible or disposable) producer and consumer" (81). The rhetoric of mental health circulates through student body representations in mental health campaigns in order to situate a (mentally) healthy student as a productive producer and consumer. Students are encouraged to both actively consume and participate in mental health campaigns, as well as to produce or participate in business and recruiting ventures concerning mental illness campaigns as a symbol of health. In this way, institutional mental health campaigns rhetorically reflect neoliberal value systems as "hallmark" features of intellectual systems: education as a business.

On the other hand, UW has yet to respond to the issue of how to theorize/treat/respond to student mental illness with a widespread publicity campaign. At present, President Feridun Hamdullahpur has assembled a task force, called "The President's Advisory Committee on Student Mental Health," to deliberate on how to address student mental health on campus (report still pending as of fall 2017). So the quick approach to addressing mental health at Queen's University is to be commended; yet, it is important to be mindful that the success and quick implementation of jack.org is largely financially generated through charitable donations. Longmore observes that corporate charitable givers are depicted as having the highest traits of

"neighbourliness, generosity, and altruism" (16) as they donate to those who are "afflicted" (15) and "less fortunate" (15). Charitable giving becomes a spectacle run by big business, which holds up "super-crip" figures like Tammy and Timmy, who were admirable for their spirit in the face of adversity. According to Longmore, under the guise of charity, altruism, and respectability, corporations, "reinforced the legitimacy of the existing system of status and power" (48) by upholding standards of normative ideology.

Institutional responses to student mental health are tied to business interests. Jack.org is sponsored by the Bank of Montreal, Bell Canada, The Bank of America, and numerous other major charitable and financial foundations.[43] The messages disseminated through the Bell Let's Talk campaign are directly tied to the organizational initiatives of jack.org, as Bell is one sponsor of the charity. The Jack charity is like Bell in that, in just its second year, it is extremely profitable. The charity's annual assets are listed as $1,176,032 in 2016, and $993,902 in 2015 (Financial Statements, jack.org). The annual revenue is listed as $1,522,153 in 2016 and $1,357,445 in 2015.

The main financial expense of the charity is its annual summit, where students are recruited using spectacular draws such as a bouncy ball pit, dance parties, free gifts, or "swag" ("Summit") to attend workshops and listen to speakers. These workshops encourage corporatized charitable enthusiasm. One testimonial on the website describes the summit as "an amazing experience, from start to finish. Through the creative & engaging workshops to the constant flow of empowering & inspiring speakers, there was never a dull moment" ("Testimonials").[44] This spectacular event, one with "never a dull moment," and "constantly

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[43] Figure 1.7
[44] Testimonials are not attributed to any particular student speakers.

engaging" speakers, builds a corporatized charitable initiative upon the building block idea that

mental health should be a source of "inspiration." Another testimonial states, "it was such an

amazing and enlightening experience … thank you for helping me find my voice and for giving

me the opportunity to give others the chance to learn and speak up about mental health!"

("Testimonial"). This summit, aimed at "giving voice" to students with an "amazing" and

"enlightening" experience promotes the message that mental disability initiatives are only

valuable if they are empowering and inspiring experiences. Mental health strategies may not

(nor should they) always be inspirational or empowering, and nor should mental health need to

be posited in palatable terms in order to deserve charitable funding.

In the Jack campaign, students are the source of jack.org's free labour and the free

promotional work performed for the large organization. And this is a large initiative. The

organization has spread, "all across Canada: 117 Jack Chapters, 53 trained Jack Talk speakers

delivering 150 Talks this year, a national Jack Summit bringing 200 of our student leaders from

every province and territory together and youth led Jack Regional Summits popping up across

the country" ("About"). Jack trains, uses, and disseminates its organizational workforce through

the rhetoric of empowering students. Consider the following description on the jack.org website:

> Jack.org student leaders have a laser focus on drawing in individuals and communities
>
> that have traditionally been very difficult to reach. The inclusiveness of our outreach will
>
> help build a Canada that is more educated and more compassionate. A Canada that
>
> knows when to ask for help, and that has resources to offer. A Canada with a reduced
>
> youth suicide rate and a more fearless conversation. And ultimately a Canada that is
>
> more powerful in the fight for mental wellness. Jack.org student leaders have a laser
>
> focus on drawing in individuals and communities that have traditionally been very

195

difficult to reach. The inclusiveness of our outreach will help build a Canada that is more

educated and more compassionate. A Canada that knows when to ask for help, and that

has resources to offer. A Canada with a reduced youth suicide rate and a more fearless

conversation. And ultimately a Canada that is more powerful in the fight for mental

wellness. ("Leaders")

Students are described as being "laser focused," "fearless," "more powerful" and ready to "fight"

for mental wellness, armed with "education and resources" to help create a "more educated and

more compassionate" Canada. The disjuncture between the corporate, success-driven language

used to describe the student workforce and the "inclusive" and "compassionate" terminology

surrounding Canada, paradoxically described also as "more powerful in the fight for mental

wellness," is stark.   What is clearly privileged in the construction of the student speakers is the

terminology of power, strength, growth, and progress. This discourse serves to reinforce the

legitimating power structure of status and power, and does not serve in any way to challenge

normative ideology or promote alternate ways of being.

The spectacle of charity is inextricably tied to a celebration of mental health care

products. The rhetorical shift from patient to consumer is present in the institutional setting,

where students are encouraged to purchase or produce items for a market. For example, the

jack.org website features two students who produce clothing with mental health labels. On the

jack.org website, a video of these two university students who attended the summit is featured, as

they started a company together called "Wear Your Label," with the motto, "Its ok not to be ok"

("Wear Your Label").[45] The video opens with a blue screen, which white letters scroll across,

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[45] This section does not read the creation of this company in a critical light. The two students who
started this company appear to be driven by altruistic intentions. Nor does this dissertation wish to
insinuate that people should not profit off their business enterprises. It would be impossible to get outside

that read as follows: "jack.org. Annual Report 2015." A second screen appears, split into two

images (half blue, half featuring a tall man holding a microphone), that reads "jack.org/ summit:

Wear your label started at the summit. Now they're here…" A tall blonde-haired boy, about 20

years of age, appears on-screen, smiling. His head and neck are featured against a cityscape:

"'Karen and I came up with this idea to put mental health labels on clothes. And it was this idea

over a dinner conversation and she 'I love it, but what do you mean?' and I said 'What can we do

that feels so amazing for young people to feel support, to feel validated, to feel that they belong

somewhere, and how can we convey that through fashion?'" ("Wear Your Label"). A happy,

brown-haired girl is featured on-screen against a cityscape as well, and she states:

> Wear your label is a social enterprise, so we use positive reinforced messages and
>
> positive designs to create conversations about mental health and also to give back to
>
> various mental health initiatives. So, we partner with lots of mental health organizations
>
> to create cool pieces and give back 10% of our profits to our case. Tyler and I were at the
>
> Jack summit at 2014. We both were facilitators and that's how we got involved with
>
> jack.org. ("Wear Your Label")

Tyler is then again featured on screen and explains, "we got to experience a conference that was

unlike anything else. I mean, in-between your sessions when you're talking about some very

serious things you had loud music and dance and an environment that made you feel really,

really warm and respected" ("Wear Your Label"). Students in blue t-shirts that state the word

"Jack" on the front are featured at a dance party on the screen as Tyler is speaking. Students are

smiling and dancing under strobe lights and making silly faces at the camera as they move their

bodies to the music. Karen is featured again on screen, stating:

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of our capitalistic system. The criticism, here, is of the organization's wider initiative, which turns people
with mental illness into consumers. This business is merely used for illustrative effect.

We actually pitched wear your label for the first time ever to jack.org delegates and other

facilitators just throwing around this idea and saying "hey, what do you think if we

started a clothing line and put mental health labels on clothes?" We were picked up with

a lot of press in the US and we made a lot of growth this year.[46] [a USA today article

flashes on screen about the company] To see so many people rally behind a cause that

we're so passionate about, more than anything, has been a dream. ("Wear Your Label")

Karen's voice is featured over scenes of Karen making clothing and talking to people in

meetings on-screen. Tyler's upper body is then featured again, and he states:

Yeah, we had business mentors, and we have had people within different sectors who

believed that we can make revenue and eventually make profit but jack.org believed that

we can make a difference [Tyler smiles.] And that's a very different thing. A very, very

unique thing to feel as young people really trying to make an impact in the world of

mental health. ("Wear Your Label")

A blue screen comes on and white letters scroll across, offering the message: "jack.org.

Together we are starting conversations that change lives. Thanks for your support this year"

("Wear Your Label").

On the website, a black t-shirt called "Aching," featured for sale for $39.00 Canadian, is

worn by an attractive young woman with long, flowing brown hair. The t-shirt repeats this

slogan three times in large white print: "I hope you can see how very hard I am trying to erase

this aching" ("Wear Your Label"). Another red t-shirt (shown on a white background), entitled

"Mind vs. Heart," is for sale for $39.00 Canadian, with the slogan "Do not let your mind whisper

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[46] The articles shown in the video are entitled, "Here's a Clothing Line for Anyone that Needs a Mental
Health Boost" (Buzzfeed) and "Sad but Rad: fashion brand aims to get people talking about mental
health" ("Today Style").

fear into your heart. It will try. It will try" ("Wear Your Label"). The message that "your mind"

will try to "whisper fear" into "your heart" reinforces the idea that mental illness is scary,

abnormal, and threatening. The messages on these t-shirts are stigmatizing insofar as negative

mental illness stereotypes are perpetuated. Instead of celebrating non-normative ways of being,

a mind that is mentally ill is represented as something that "will try" to attack a person using

"fear." The t-shirt message that an individual must "try very hard" to "erase" the "aching"

caused by mental illness represents mental illness as something that one must "get rid of," so to

speak, as well as "try very hard" to individually deal with. Representing mental illness as a

heavy, personal burden is extremely problematic and troubling, especially for a company that

purports to wish to end stigma.

The trend to merge disability activism with a business mentality brings monetary interests

into conflict with ethical considerations concerning disability representation. Whether

unconscious or overt, the business mentality affects how disability is rhetorically constructed,

and this trend is deeply embedded in the academic model. Dolmage notes, in *Academic Ableism*,

that both academic administrators and CEOs are steeped in a business mentality:

> ...more recently, we would suggest that academics have what Donna Strickland calls a
>
> "managerial unconscious" – one that syncs up with the demand for white collar workers.
>
> So, whether unconsciously implanted in the minds of academic administrators, or overt in
>
> the words and deeds of the CEO administrators imported into academia, this business
>
> model has specifically dangerous ways to respond to and to construct disability. (58)

In the example above, the business mentality or "managerial unconscious" in Strickland's words,

manifests as a (performative) representation of disability as a barrier to a productive "white

collar" workforce. A "white collar worker" is called upon to produce, perform, and enact a

199

cheery, happy worker that reflects "well" upon the company. Jack.org praises those who can

"overcome" disability enough to be a producer instead of a "drain" on the system. Mentally ill

students participating in jack.org transform from the "patient" role into producers for the charity

(one who recruits new speakers, solicits donations, or starts a new business venture). The

rhetorical embodiment states that people (bodies) are only valuable insofar as they can continue

to contribute to the marketization of the mental health campaign.

Conclusion: Talk and Performance in the [Mentally Ill] Student Body

Two institutional approaches to mental health were taken up and explored in this

analysis. One institution silenced mental illness; the other institution moved mental illness "talk"

to a charity that demands students get "loud" and confess mental disability in a very specific

performative ideology. While these two approaches diverge, at the core of each approach are

healthist ideological principles that serve to protect the institution by framing mental illness as a

disease. When mental health is framed as a biological fault in the individual, *good* mental health

is framed as something that an individual student must work hard to obtain by overcoming

biological deficiencies.

In these campaigns, mental illness is framed as a non-rhetorical medical disease.

Through jack.org, organizations like Wear Your Label, and messages to "own your illness,"

diagnose your friends and family ("Resources"), and the call to "share your story" loudly

rhetorically construct mental illness as something that is individually meant to be diagnosed,

owned, and spoken of.

Returning to the media response to Jack and Chase's suicides, it is worthwhile to

(re)examine a *Toronto Star* article quoted in the introduction to this chapter, entitled, "'We're not

a treatment facility': The struggle for campuses to provide students mental health care." The

article states that, "campuses struggle to keep up" with the "demand for mental health services" ("We're Not"). The article outlines the financial costs of providing adequate mental healthcare for students by framing disabled students as a financial drain, something that creates a "struggle" for the campus economy. I bring this article back into the discussion to make the key point that by rhetorically medicalizing mental illness as a biological disease, institutions can then further proceed to argue, using this point of medicalization, that they are not operationalized enough to handle seriously mentally ill students, and this therefore justifies moving these students into other spaces—such as the wider community and hospitals in particular. Moving students off-campus when they are mentally ill rhetorically constructs mental illness as a frightening, abhorrent disability.

Price comments, "perhaps because of the popular conception that unsound minds have no place in the classroom, academic and especially pedagogical research seem almost obsessed with the diagnosis of sound and unsound minds" (33). To remain on campus, students must be sound enough of mind to articulate their disability through speech, as leaders in mental health, and be socially outgoing enough to attend parties at the summit and recruit other students. If these (otherwise) unsound minds can perform a very specific subjectivity, those students are accepted. However, those whose talk does not conform to positive, rational, or happy normative narratives fail to thrive within an institutional setting. As such, speech is a confessional demand the institution calls forth to assess what type of (supposed) dangers these students pose to the normative, ableist, and imperialist value systems that the institutional system is both built upon and perpetuates.

Conclusion

Mental health care campaigns in corporate, government, and institutional settings demand citizens with mental illness stand up to "talk," "get loud," and publicly "own" their individual stories of mental illness. Not only is this privileging of speech ableist, as the demand for "talk" assumes that people with mental illness have the ability to speak (using very specific, socially acceptable, terminology), it is also problematic because the demand for talk ignores the fact that it is quite possibly dangerous, detrimental, and stigmatizing to publicly claim a mental illness diagnosis in our contemporary Canadian environment. The first chapter relayed the story of two Bell employees who were fired after requesting a mental health leave. Talking about mental illness is deeply intertwined with Foucault's theory of the confession. Foucault observes that confession is "one of the West's most highly valued techniques for producing truth. We have singularly become a confessing society" (History of Sexuality, 59). The confessor is required to disclose a truth, and it is in this spoken truth (the revealing of a supposed "secret") that the speaker enters into the field of power as the subject of the confession. When citizens "talk" or "confess" their mental illness on social media through, for example, the Bell Let's Talk Day campaign, they become consumers led by a major corporate telecommunications company. By "talking," consumers are raising Bell's profile whilst simultaneously (and problematically) treating mentally ill people as charity cases within a spectacle of the campaign.

The corporate strategy of "talk" is designed to further promote the company and raise its corporate public profile. Instead of helping people with mental illness, Bell Let's Talk Day, in fact, perpetuates problematic disability stereotypes; the campaign further shapes subjectivity in harmful ways that ignore the real lived experiences of those with psychiatric disabilities; the material additionally speaks to a caregiver audience and not people with real disabilities; and

lastly, the campaign co-opts psychiatric patient discourse and erases the possibility for radical "talk" of a more critical variety that is arguably so necessary for initiating positive change in mental healthcare services.

In the Better Health Together campaign, as in the Bell Let's Talk campaign, "talk" turns patients into consumers of healthcare technology. In the government e-health campaign, "talking" about mental illness means entering this information into a permanent online health record that both clinicians and corporations like TelusHealth can access. This "talk" allows clinicians to assess, treat, diagnose, track, and label discourse. By tracking "talk" online, the e-health system sets up a dichotomy between the speech that doctors would view as rational and the types of speech doctors that may judge as being irrational. Patient speech that deviates from the medical model could further be used to diagnose patients with symptomatic mental illness.

Through the e-health system, patient speech could be further limited into a standardized, medicalized genre. This process of standardization gives authority to short-form diagnostic labels and could result in potentially removing what Prendergast terms "rhetoricity" from people with mental illness. Rhetoricity involves giving patients the authority and credibility to speak for themselves—the ability to act as their own rhetors with rhetorical agency. Yet this rhetoricity is repeatedly shaped into acceptable and non-acceptable speech and performance. In the Jack campaign, "talking" means overcoming disability enough to give hour-long, "inspiring" presentations in front of large audiences.

The "talk" called forth in these three campaigns re-inscribes four common disabling stereotypes of mental illness: one, mental illness is presented as an alienated and isolated state in the campaign commercials; two, hero or super-crip narratives in the biographies uphold a discourse of overcoming; three, a caretaker audience is targeted, and not those with disabilities;

and four, the rhetoric of "self-care" operates to turn citizens into consumers who independently seek to improve their own mental health in a healthcare market. These four problematic tropes of "talk" are discussed in all three chapters of this dissertation. These tropes have very negative rhetorical effects for people with psychiatric disabilities whose talk may not conform to the standard. For the standardization of "talk" operates as a socially exclusionary principle. Those who talk in very specific ways through these campaigns are (re)tweeted, shared, and "celebrated," but any other "talk" that deviates from these acceptable standards is discouraged in corporate and government social media forums. While the rhetoric is highly celebratory that "talk" is ending stigma and increasing positive associations with mental health, this dissertation's analysis finds that in fact the "talk" from these helper campaigns excludes those with psychiatric illness from conveying their experiences in unique, individual terms; moreover, this "talk" is healthist in nature, and healthcare is depoliticized through the rhetoric of self-care, which serves corporate, government, and institutional interests instead of those of people with psychiatric disabilities.

Questions of embodiment and performance arise in the discussion of what types of talk are called forth from subjects because the notion of discourse cannot be separated from considerations of the body. I borrow from Dolmage here, who suggests that "rhetoric is the circulation of discourse through the body" (Disability Rhetoric, 5). While this concept can be revolutionary if we represent, re-imagine, and challenge normative ways of being, the campaigns analyzed in this dissertation fail to embody difference in ways that challenge dominant modes of representation. The bodies in all three campaigns—mostly white, happy, attractive, smiling, able-bodied and athletic citizens—embody a rhetoric of overcoming. Being mentally healthy means being able-bodied and happy. The conditions through which people with mental illness

204

gain rhetoricity—or are allowed to speak in these campaigns—erase the very real symptomatic conditions of their disabilities. These "faces" must embody a rhetoric of overcoming.

In the Jack campaign, student speakers are young, attractive, happy, and smiling. Students who are unable to conform to this performance are unable to participate as speakers. The organization imposes tests and regulations to ensure that these standards are maintained. More widely, campus-wide sickness leave policy encourages students who are mentally ill to withdraw or take a leave from their program. Essentially, the embodiment within the campaigns rhetorically enacts a disembodiment when it comes to the actively mentally ill subject. In the Bell Let's Talk campaign, the commercials rhetorically depict people experiencing mental distress as being physically weak or immobile. The campaigns assume what Foucault terms the "clinical gaze" in order to denote the detachment of the subject from the body when it enters into the medical field of knowledge. The mentally ill subject becomes a label, a diagnosis, if he or she cannot overcome by enacting the very specific performativity called forth by the campaigns.

By critically taking up the question of the rhetoric of mental health, this dissertation aimed to disrupt the acts called forth in mental healthcare campaigns by calling attention to the myriad problematic ways in which mental health is medicalized, stigmatized, shaped, framed, and stereotyped by the very campaigns purporting to facilitate better mental health care. More specifically, the chapters worked in tandem to outline the rhetorical modes of affect called forth by the campaigns. It is not the aim of this dissertation to dispute that these organizations might have very real beneficial effects on the lives of people with psychiatric disabilities. Instead, this dissertation aimed to complicate the highly celebratory framework in the rhetoric of mental illness in healthcare campaigns, and further question possible gaps or problematic areas in these campaigns. By outlining the rhetoric, students and teachers with an interest in disability studies

can begin to question and refuse to participate in or perpetuate disabling myths enacted in the talk, bodies, and performance of health care campaigns. My hope is that by troubling the celebratory rhetoric of these campaigns, this analysis will further encourage readers to recognize disabling tropes in other arenas.

While all three campaigns try to turn the conversation about mental health into a positive message, it is problematic that the onus is on the individual to overcome his or her illness enough to join the "fight" against stigma and self-disclose. The onus should be on the university to provide systemic supports so that people can live with their disability on campus. Institutional mental health campaigns must eschew the overcoming narratives and instead focus on how we can adapt the environment instead of the people.

This study applied a disability studies perspective that, first and foremost, views mental illness as a rhetorical entity that changes according to social and cultural ideological contexts. To answer the question, "what is the rhetoric of mental health?" in a Canadian context, campaigns purporting to "help" people with mental illness were rhetorically examined in order to assess what types of experiences people with psychiatric disability may face when accessing help in an institutional setting. This dissertation finds that the rhetorical messages in these campaigns are tailored and addressed to a "healthy" audience and not people with mental disabilities. To the "healthy" consumer audience, negative depictions of disability serves to (re)inscribe problematic stereotypes that inevitably perpetuate stigma. Mental disability is framed firmly within the context of the medical model, and people with active mental disorders are regarded as sick. To establish proper performativity of mental illness, these campaigns generically portray "proper" affect of mental illness in order to promote acceptable ways of enacting mental disability in our society—inevitably, this is either as a charitable cause, or tragic figure, or hero

206

who is able to "overcome." By standardizing speech and performance, these campaigns co-opt speech in ways that prevent the critical discourse, so necessary for enacting real change, from coming to light. In both corporate and government "helper" campaigns, the rhetoric fails to address or consider the lived experience of people with real psychiatric illness.

The wider goal of this dissertation is to argue that a disability studies perspective is an integral component to the field of the rhetoric of health and medicine. In medicine, mental disability is constructed a biological flaw, a deficit, and this notion contributes to incredibly stigmatizing and negative stereotypes of people with psychiatric conditions. By considering the harmful stereotypes that persist in mental illness campaigns, I argue that social and cultural ideological constructions of health must shift and change to embrace non-normative ways of being. The first step to take in this direction is to recognize that mental illness is a rhetorical concept. The second step is to acknowledge that these rhetorical constructions are harmful, and in recognizing this, we can eschew harmful policies and beliefs born from these representations.

Figures

Fig 1.1 Bell Let's Talk Crisis Link first page titled "Get Help" (from the webpage
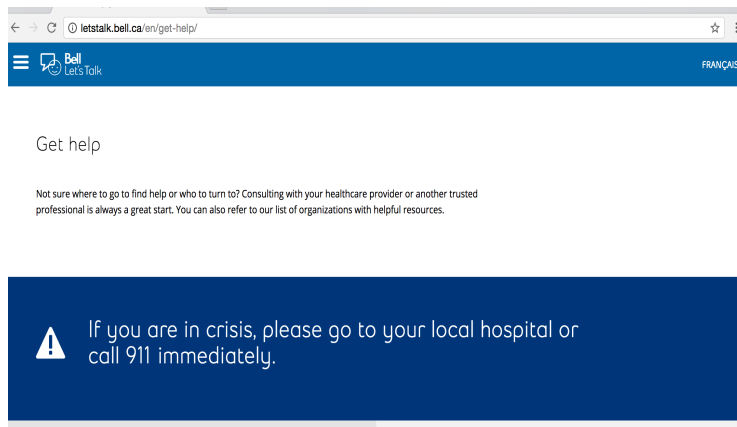
http://letstalk.bell.ca/en/get-help)

Fig. 1.2 and 1.3 The "Bell Let's Talk Toolkit" with link to a pdf conversation guide and a pdf
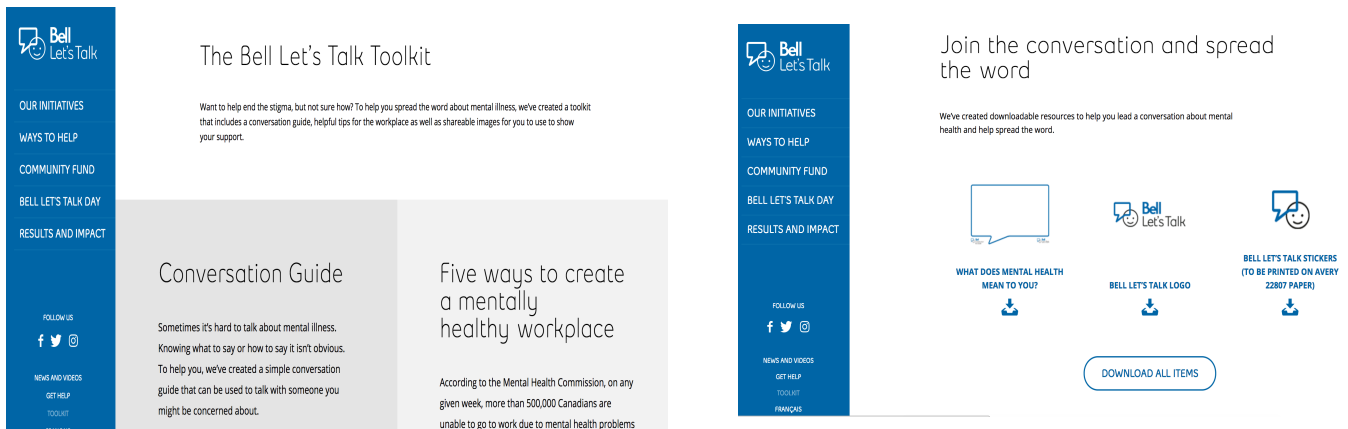
work place flyer

Fig. 1.4 Poster of woman holding her phone from "Let's Actually Talk" on Tumblr.

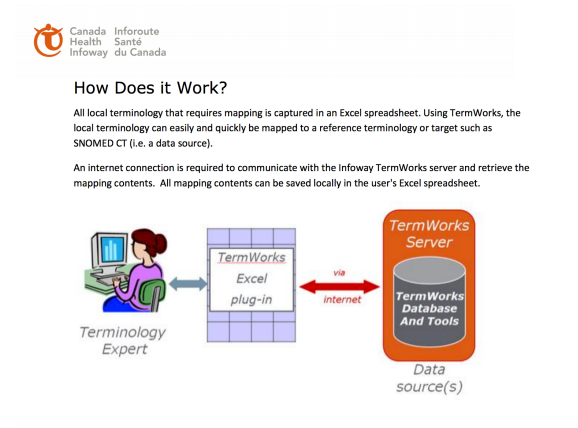Fig. 1.5 "How does it work?" from Canada Health Infoway

Fig. 1.6 Standards Tools webpage from Canada Health Infoway stresses the importance of

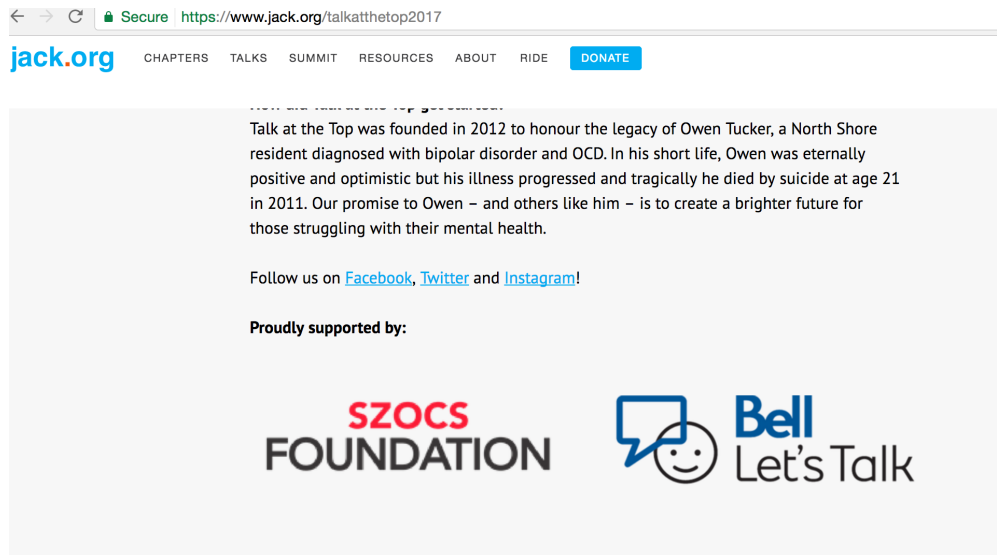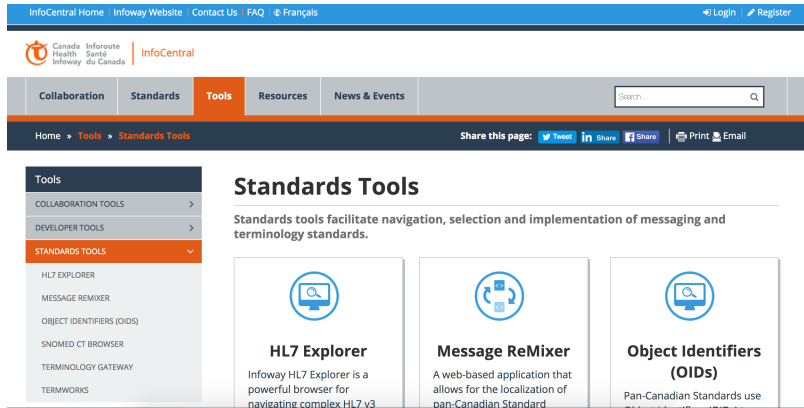navigation and the selecting of messaging and standards for terminology.

Fig. 1.7

Sponsors

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