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## “I’m running my depression:” Self-management of depression in neoliberal Australia

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### ABSTRACT

The current study examines how the neoliberal imperative to self-manage has been taken up by patients, focusing specifically on Indian-Australians and Anglo-Australians living with depression in Australia. We use Nikolas Rose’s work on governmentality and neoliberalism to theorise our study and begin by explicating the links between self-management, neoliberalism and the Australian mental health system. Using qualitative methods, comprising 58 in-depth interviews, conducted between May 2012 and May 2013, we argue that participants practices of self-management included reduced use of healthcare services, self-medication and self-labour. Such practices occurred over time, informed by unsatisfactory interactions with the health system, participants confidence in their own agency, and capacity to craft therapeutic strategies. We argue that as patients absorbed and enacted neoliberal norms, a disconnect was created between the policy rhetoric of self-management, its operationalisation in the health system and patient understandings and practices of self-management. Such a disconnect, in turn, fosters conditions for risky health practices and poor health outcomes.

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### 1. Introduction

‘Self-management’ is now ubiquitous in government policies and strategies, health promotion campaigns and patient intervention programs across most of the Western world, including Australia, UK, Canada and the US (Department of Health, 2010; Health Council of Canada, 2012; National Prevention Council, 2011). The term refers to medical, behavioural, role and emotional management, the end result of which is better management of the self and of one’s disease rather than cure (Lorig and Holman, 2003). Widely used in conjunction with chronic disease programs, self-management involves teaching patients skills such as problem-solving, decision-making, how to find and utilize resources, partner with health providers and to take action appropriate to their circumstances. The imagined result is a health-literate, empowered patient, one who can reorient her life and monitor her own health to bring about positive change (Lorig and Holman, 2003).

Faced with an ageing population and rising chronic disease

burden, the promise of an empowered patient participating in shared decision-making and self-managing her disease has proved appealing to governments across the world. However, as Trish Greenhalgh (2009) argues, the evidence-base for the efficacy of self-management is thin and most conventional self-management programs have been proven unsuccessful. Contributing factors include the failure to consider cultural norms and health literacy levels, lack of attention to the need for family and social support, a fragmented approach to the provision of health and social care, and lack of engagement between patients and staff (Greenhalgh, 2009).

Yet governments’ enthusiasm for patients to be self-managing remains unabated, a fact several scholars attribute to the close alignment between self-management practices and neoliberal principles (Clarke, 2005; Crawshaw, 2012; Fullagar and Gattuso, 2002; Teghtsoonian, 2009). Neoliberal principles often assign responsibility for social risks such as illness, unemployment and poverty to individuals and families as a problem of ‘self-care’ (Lemke, 2001). Self-management in practice often means a stronger reliance on individual self-sufficiency and pro-market forces, matched by a concomitant drop in government funding for social and care services (Clarke, 2005; Sawyer, 2008; Webb, 2006).

Although the literature on neoliberal discourses, self-management and patient healthcare is vast, little has been written on how neoliberal discourses have been taken up by patients

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living with mental illness and what implications this has for their health. Studies have examined the neoliberal/self-management/mental health trifecta through the lens of policy formulation (e.g. Teghtsoonian, 2009), health systems implementation (e.g. Henderson et al., 2011), the added administrative burden on frontline services (e.g. Sawyer, 2008), self-help literature (e.g. Philip, 2009) and the pharmaceuticalization of mental distress (e.g. Moncrieff, 2008). Two points emerge from this scholarship; first, self-management in a neoliberal context involves labour by patients, is individually-oriented, combines positive and negative dimensions and transpires within particular socio-cultural, economic and political localities (Corbin and Strauss, 1988; Fullagar, 2009; Fullagar and O'Brien, 2014; Moncrieff, 2008). Second, the design and implementation of neoliberal policies, despite their claims otherwise, may in fact have a deleterious effects on patient's health and overall quality of life (Sawyer, 2008; Teghtsoonian, 2009). What is missing from this literature is an analysis of the process of self-management. How does one become a neoliberal patient? How do practices of self-management change over time? What do these changes reveal about individual agency?

Addressing these questions, the aim of this paper is to describe practices of self-management among Indian-Australians and Anglo-Australians living with depression in Melbourne, Australia. A key finding from our research is that participant's practices of self-management – reduced use of healthcare services, self-medication and self-care – transpired incrementally over time, informed by unsatisfactory interactions with the health system, the accumulation of confidence in their own agency, and constitution of their own therapeutic strategies. Neoliberal ideas around self-autonomy and self-regulation influenced this process. We begin with a brief description of the Australian mental health system to contextualise our study, before drawing on Nikolas Rose's work (1996a; 1992) on governmentality and neoliberalism to frame our argument.

### 1.1. The mental health system in Australia

Estimated to affect about 45% of the adult population (7.3 million people) at some stage of their life, mental illnesses are responsible for 12.9% of the burden of disease in Australia (Australian Institute of Health and Welfare (AIHW), 2013). Annual costs associated with mental illnesses are as high as \$20 billion, including lost productivity and labour force participation (Australian Bureau of Statistics, 2009). Tackling the deleterious effects of mental illness is a national health priority (AIHW, 2015) and since the early 1990's, successive Australian governments have given increased policy attention and funding to mental health (AIHW, 2014). Recovery, prevention and early detection of mental illness, and timely access to appropriate services are core outcomes for most policies and strategies (Department of Health, 2008). These outcomes are to be realised through inter-agency collaboration (e.g. across health, housing, employment and justice services) (Department of Health, 2009) and through patient-centred services that support self-management and individual preferences (Department of Health and Ageing, 2009).

Despite government efforts, the rates of mental illness have remained stubbornly high, around 65% of individuals with mentally illness do not seek treatment, several disadvantaged groups (e.g. immigrants, Indigenous Australians) receive inappropriate and inadequate treatment, and among those that do avail of the services, continuity of care and satisfaction with care received is lower compared to consumers of other health services (Griffiths et al., 2015). Reflecting these shortcomings, the latest report card from the National Mental Health Commission included an open letter to the Prime Minister from the Commission Chair:

Our current system is not designed with the needs of people and families at its core. These needs are wider than health services – they are about supporting recovery and leading a contributing life (Fels as cited in *A Contributing Life*, 2013, p. 6).

The problem, according to Chairman Allan Fels, is a system that is complex, fragmented, characterised by overlapping responsibilities between service networks and providers and insufficient coordination among these actors (National Mental Health Commission, 2013). Lack of government accountability and monitoring of the delivery of mental healthcare have been identified as the main issues and experts recommend, “that new investment is directed to reorganising and reforming, rather than perpetuating a dysfunctional system” (Griffiths et al., 2015, p. 174).

### 1.2. Neoliberalism and mental healthcare

According to Nikolas Rose (1996a,b) such dysfunctional systems reflect current conditions of practice in neoliberal societies. Specific to mental health, Rose argues that the closure of state psychiatric hospitals in the 1990s signalled a shift from 'big government' to community, families and individuals. As the delivery of mental healthcare moved from the hospital to the community, so did the baton of responsibility. Individuals and families took on more of the care work while the state receded to 'govern at a distance' (Rose and Miller, 1992). This is not to suggest the complete disappearance of the state and state-sanctioned coercion of the mentally ill, particularly those deemed incapable of self-management (e.g. through mandatory treatment in the community or involuntary hospitalization and treatment). Rather, for those seen as capable of self-managing, through a suite of programs and activities – 'governmental technologies' – the state forwent coercion or direct control of the individual in favour of creating an alliance between itself and its citizens (Rose and Miller, 1992). The language of partnership, community-collaboration and individual agency came to replace the hard imprimatur of state intervention (Teghtsoonian, 2009). What resulted, according to Rose (1996b), was community psychiatry characterised by three distinct features: neoliberal norms of personal responsibility, choice, and empowerment; greater involvement with other agencies in the delivery of mental healthcare; and a culture of accountability and blame.

Expanding on Rose's three precepts, first, the neoliberal imperative for patients to self-regulate has meant that patients with mental illness are often tasked with the responsibility of constant self-improvement through self-surveying and self-managing their health and wellbeing. Patients thus feel they should manage alone, whether through the use of medication or self-transformative practices (e.g. exercising or meditation) (Gattuso et al., 2005; Outram et al., 2004). Such practices are highly problematic because locating depression as an individual problem requiring individual solutions negates the contribution of wider socio-structural factors such as poverty, class, work inequities and violence in the experiences of depression and also obscures the actions of the state in these areas from any analysis (Gattuso et al., 2005; Peacock et al., 2014a; Teghtsoonian, 2009). Little attention can then be paid to factors such as the structure of the health system, the strategies of risk mitigation by service deliverers, the administrative burden on frontline workers and what effect this has on the delivery of care.

Second, focusing attention on the individual means mental health professionals and other human service providers (e.g. housing, employment) become tutors in self-care, tasked with developing the autonomous, self-regulating patient, capable of coping with adversity. There is increased inter-agency collaboration

as new rationalities and techniques of care are brought to bear on patient-provider relationships (Sawyer, 2008). However, these new rationalities are about mitigating professional and service risk in case of an untoward event and the techniques of care focus less on a healing therapeutic relationship and more on administration, documentation and communication (Sawyer, 2008). The result is a 'paper-trail' detailing why patients, based on their risk status, do or do not receive timely and appropriate mental healthcare (Sawyer, 2008).

Finally, if and when patients are unable to self-regulate their illness, they face censure and strain, the broad consequences of which include:

The greatest burdens falling on those most unable to shoulder them. When failure results, this can only be understood as a reflection of individual merit or effort – to seek to explain it any other way is further evidence of one's own moral and practical deficits (Peacock et al., 2014a, p. 179).

There is now a burgeoning literature documenting how neoliberal discourses are being taken up by people, shape individual experience and mitigate what protections and resources might be available (Crawshaw, 2012; Peacock et al., 2014b; Peacock et al., 2014a; Seear, 2009; Weiner, 2011). Peacock et al.'s work (2014a), focusing on women in Salford, UK, revealed that participants had internalised neoliberal discourses to the extent that they felt they had right to state welfare, were completely responsible for themselves, and that to claim otherwise was painful and damaging. Similarly, Crawshaw's (2012) work with unemployed UK men found that ultimate responsibility for managing and monitoring health rested with the individual. However, Crawshaw's participants also resisted the imperative to self-manage, instead arguing for more situated and realistic understanding of health relevant to their own lived experiences. Both studies demonstrate that the link between neoliberalism and the obligation to self-manage health resonated among men and women. However, participants in these studies were relatively healthy and presumably white (participants ethnic background and health status were not discussed), thus it is difficult to know whether those who have a mental illness and are from different cultural backgrounds perceive these responsibilities differently. Weiner's (2011) US ethnography of members of a bipolar disorder support group, demonstrates that there are key differences in how self-management is practiced by people with mental illness. Her work showed that to be an expert and responsible enough to self-manage, patients must inherently distrust themselves and cast their behaviour as uncertain and unreliable, questioning whether their behaviour was a consequence of their disorder or themselves. However, these three studies focus on self-management postscript, i.e., how one manages. Building on this work, this paper focuses on the prelude to self-management, i.e., how one comes to self-manage, how one sustains managing and what implications this has for individual agency.

## 2. Methods

Data were collected as part of a larger qualitative study comparing depression and health-seeking between first and second generation Indian-Australian immigrants to Australia (hereafter Indian-Australians) and White-Australians, i.e., those of Anglo-Saxon and Celtic heritage who had been born and raised in Australia (hereafter Anglo-Australians). Rationale for selecting these two groups are that Indians are the fastest growing immigrant community in Australia, while Anglo-Australians represent the majority population in Australia (Department of Immigration and Citizenship, 2013).

Comprehensive descriptions of the study methods have already been published (Brijnath et al., 2015). Briefly, 28 Indian-Australians and 30 Anglo-Australians diagnosed with depression were interviewed between May 2012 and May 2013. Participants were recruited from the community via e-classifieds, community advertisements, and direct presentations to community groups (e.g. women's groups, sporting clubs). Inclusion criteria were being a member of either the Indian- or Anglo-Australian community, proficient in English, 18 years of age or over, as an adult have received a diagnosis of depression by a qualified health professional, be currently under medical treatment and have used or be using one or more complementary or alternative medicines (CAM) for their depression. There was purposive sampling on the basis of gender, age, income and experiences with biomedical and CAM products. To disentangle the health-seeking pathways of depression from the health-seeking pathways of other complex and often co-occurring health conditions, those who were substance dependent, disabled, pregnant, had a history of severe head injury or neurological diseases were excluded. Recruitment continued until data saturation was reached.

Following written informed consent, interviews were conducted in English by the first and second authors. Interviews were 45–60 min, audio recorded and, reflecting the average hourly wage, participants received a \$40 gift voucher for their time (Australian Bureau of Statistics, 2013). Participants were asked about how they managed their depression, informal and formal sources of support, their feelings about the care received and barriers to seeking healthcare. Interview questions were based on the culture, migration and mental health-seeking literature, then verified through community consultations and finally refined inductively during fieldwork.

After transcription and data cleaning, interviews were de-identified and participants assigned pseudonyms. Thematic analysis, including data familiarisation, line-by-line coding and collation of codes into thematic clusters was completed (Braun and Clarke, 2006; Ryan and Bernard, 2003). The first author led the analysis and codes were cross-checked by an independent colleague; interpretive differences were resolved by consensus. Two additional rounds of reviewing codes and themes were completed to make further refinements before data were imported into NVivo for further analysis (QSR International 2012, Melbourne). The study was approved by the Monash University Human Research Ethics Committee.

## 3. Results

All together there were 58 participants. The oldest participant was 84 years of age and the youngest 19 years of age (mean age = 39.9 years; SD = 15.8 years). There were marginally more women in both groups (Anglo-Australian women = 20/30 (66%), Indian-Australian women = 15/28 (53.6%)). High rates of unemployment and casual work (46.6%), low weekly household income (24.6% earned < AUD 300 per week, which is below the poverty line) and low weekly household expenditure (<AUD 660 = 58.6%) were common to both groups. Most Anglo-Australian's had lived in Australia their entire lives, whilst the average length of time Indian-Australians had lived in Australia was 9.9 years. The majority of Anglo-Australians were Christian (33.3%) and Indian-Australians were Hindu (66.7%). Anglo-Australians only spoke English at home, whereas Indian-Australians spoke English (67.9%), Hindi (50%), Punjabi (21.4%), Tamil (10.7%) and Malayalam (3.6%).

When asked to recall what words came to mind on hearing the word 'depression,' responses included 'sadness,' 'stress,' 'losing interest' and 'decision making is terrible.' Though participants identified social causes for their depression (e.g. workplace

bullying, violence at home, abuse, poverty), depression was problematized as a lack of self-control:

I think it's all about controlling mind. Like if you have a control of mind I think you can make wonders. It's all [a] mind game. You don't have control over mind and that's why mind is playing with you (*Vinod, male (m), 29 years (yrs), Indian-Australian*).

A feeling that I was out of control, that I wasn't able to keep all the balls where they should have been in the air (*Maria, female (f), 54yrs, Anglo-Australian*).

Because participants strongly associated depression with not having control over their thoughts and emotions, they valued regaining control over themselves and their illness. Being 'in control' or 'under control' meant being self-reliant, mastering depression and having fortitude:

I've sort of taken control of my life now. I'm not letting the depression run me. I'm sort of running my depression (*Susan, f, 45yrs, Anglo-Australian*).

If you have to get out from the struggle, you have to do it yourself ... you help yourself. The people are there, but that's only for the temporary sort of support (*Anand, m, 55yrs, Indian-Australian*).

To obtain and maintain control over their depression, participants did seek help from health services. However, their encounters with the health system were often unrewarding and health providers reinforced that the responsibility for help-seeking and self-managing rested entirely on them. Consequently, many participants sought to withdraw from using healthcare services and to self-manage their depression through self-medication and transformative self-practices that involved self-labour to monitor and maintain mood. These pathways are illuminated below.

### 3.1. Encountering the system

All participants initially sought help from health professionals – general practitioners (GPs), psychologists, psychiatrists and social workers – for their depression. These experiences were often unsatisfactory, governed by particular rationalities and techniques of care that restricted access to affordable mental healthcare and placed the onus of help-seeking entirely on the individual. Participants said they faced difficulty managing the costs of care – “My joke is that I have put both my therapists' children through private schools,” struggled to find a good GP and/or mental health provider – “you really have to shop around and you might have to go to 10 before you find a good one,” and felt frustrated by the non-responsiveness of the system – “Why are they waiting me to ring them?”

Costs associated with accessing care were particularly salient even though most participants, through holding Australian citizenship or permanent residency visas, were entitled to up to 10 state-funded counselling sessions per year with mental health professionals. (Exceptions included seven Indian-Australians on student and work-visas that were covered by their private health insurance to consult GP, psychologists and psychiatrists). However, participants said that 10 state-funded sessions were insufficient and that there were costs associated with using these so-called 'free' services such as paying fees upfront and then being rebated by the government or paying gap-fees. Those who could not afford these costs and sought fully rebated services often had to wait longer for treatment.

The psychiatrist I see now cost \$230 dollars per session. You know you get \$170 or something back on Medicare but you know you have to pay it first (*Jade, f, 34yrs, Anglo-Australian*).

I could sort of feel myself slipping back to where I was last year. I called a psychologist and got the appointment. “It's going to be for the next day,” [said the receptionist]. So I said, “Sweet, okay.” “It's going to be \$108,” “Okay, don't you bulk bill?” “No, [for that] you have to go on a waiting list and that's a couple of months down the track [and] you will be able to see someone” (*Andrew, m, 34yrs, Anglo-Australian*).

\$80 per session, I mean that I can really only afford this [one] session a month ... I have stopped seeing them because I'd be out of funding (*Greg, m, 67yrs, Anglo-Australian*).

Compounding the costs of care, participants expressed frustration with the non-responsiveness of the system. Many reported encountering a strong expectation by health providers that they would be self-managing in their help-seeking. One Indian-Australian participant recounted his experience of obtaining a referral from his GP:

I'm not familiarized with the medical system in Australia ... I went to a GP and she said like, “Fine, I can give you a referral. You go and find a doctor [psychologist/psychiatrist] who's got the most recent availability” (*Dhruv, m, 26yrs, Indian-Australian*).

Responsibility for finding or changing providers and attending services rested on participants, irrespective of their capacity and motivation. But some participants said that when they experienced bouts of severe depression, they felt suicidal and socially disengaged, time points when they were least motivated and capable of navigating the health system. Yet at these crisis points the process of seeking help required greater efforts on their part and less face-to-face contact with services. During times of crisis, when they required immediate help, participants described being referred to under-resourced helplines and being given pamphlets and brochures, none of which were found to be helpful.

What needs to be done to get better I have no idea. I'm totally, totally lost. Just giving me a number of Blueline or Lifeworks or Lifeline doesn't help. When do I call them? You know when I'm depressed I don't know until I hit rock bottom, I don't know I'm depressed (*Amir, m, 35yrs, Indian-Australian*).

I tried to call Lifeline a few times but their line! ... It's ridiculous ... when you're in this crisis and you need someone to talk to and you're on hold for like half an hour (*Olivia, f, 19yrs, Anglo-Australian*).

### 3.2. Becoming a neoliberal patient

For those who managed to obtain continuous care from a health provider, the experience was often disappointing. The efficacy of psychiatrists and psychologists were often evaluated unfavourably and there were low expectations about the capacity of these professionals to help. Participants also feared that too much reliance on health professionals was a sign of failure to manage the self. The neoliberal imperative for individuals to be self-regulating and self-managing was expressed:

My psychiatrist, I just, I do not know, I have tried, I have tried to not go and have not been very successful ... I rely on her a lot which I do not think is healthy ... I just do not think it is healthy

to have such a reliance on someone (*Melissa, f, 29yrs, Anglo-Australian*).

I do not give any credit to counsellors and to the psychologists. I give credit to myself, to my own [self], looking at the situations and have the experience in life that ultimately [it] is you. You have to move forward, nobody else can do anything for you. That's my perspective (*Saurav, m, 34yrs, Indian-Australian*).

These neoliberal ideas of personal responsibility were internalised by participants based in part on their experiences with the health system and in part on being trained to self-manage by various health professionals. *Rose (1996b)* describes the role of the health professional as a tutor in self-management, whose job it is to inculcate in patients a kind of bureaucratic self-management that includes making and keeping appointments, abiding by drug regimens and self-managing in daily life. Many study participants recounted being schooled to consult a GP for a referral, then book an appointment with a psychiatrist, then go for counselling and also experiment with different medications. Participants saw this process as a 'hassle' and were often unwilling to seek care from health services:

If I have been waiting there for two hours, [I am] expecting to see a doctor with whom I can chat for almost like 10–15 minutes and explain my problem. But like after one or two minutes, you're out of the room. It's just so quick. And that really doesn't make me feel that I'm treated well, just feels like they're just doing their job and it's just part of their job, but not someone who really want to take care of you (*Gauri, f, 25yrs, Indian-Australian*).

These experiences of care discouraged many from continuing to seek help from health services and as participants reduced their interactions with the health system, they increased their practices of self-medication as a way to contain their depressive symptoms.

### 3.3. Managing through self-medication

Participants reported that for health providers, prescriptions appeared to be an easier option, helped create self-managing patients and reduced service demand. Only one participant reported any difficulty obtaining a prescription; others said it was relatively straightforward. In some cases, such as Adam's, prescriptions were recommended over counselling. Adam explained that after five weeks of therapy, his psychiatrist said:

"You obviously function" and he's like, "You know I see people that can barely sit down." He said the same thing [as the GP], he said, "Look if it [antidepressants] works, it works but you'll have side effects. You just have to balance it up and you know it's up to you" (*Adam, m, 33yrs, Anglo-Australian*).

Several participants sought to balance the pros and cons of consuming antidepressant medication. For some, antidepressants did help improve mood: "Brain space springing up," "even keel" and "reduces the pain" were common descriptions of the positive effects of antidepressants that had to be balanced against negative side-effects such as dry mouth, sexual dysfunction, lethargy, tiredness, feeling dizzy and jittery. Participants recognised that medicines, specifically antidepressants were not 'silver bullets' or 'magic,' often caused severe side-effects, and required experimentation until an appropriate drug and dosage was found. Nevertheless, taking antidepressants was perceived as 'easier' as participants

only had to consult two practitioners (the GP for a script and a pharmacist to fill the script), could purchase medicines at reduced cost on the government funded Pharmaceutical Benefits Scheme and avoid the effort of finding a mental health professional, care costs and the emotional work of therapy.

Part of balancing the effects of antidepressant use included self-medication. Self-medication involved adjusting drug dosages, combining antidepressants with alcohol and other drugs, and concurrently using antidepressant and complementary and alternative medicines (CAM). In some instances, participants even went so far as to either buy medicines online or bring in medicines from overseas (discussed elsewhere see *Brijnath et al., 2015*). Combining antidepressant consumption with alcohol and other drugs was a practice restricted to the Anglo-Australian group and driven by a need to manage insomnia and an inability to relax, two common depressive symptoms.

I would drink just to sleep. I wouldn't drink for the fun of it. It's just a case of if I don't drink, I will just lie awake and I will be awake for 72 hours. It was a no brainer (*Michael, m, 27yrs, Anglo-Australian*).

Wine, is that self-medicating? Because if it is then I do that a lot, a lot and I know it's bad but sometimes ... I'll go home at night and all I want to do is have a drink of wine because I know it'll help me relax (*Jennifer, f, 31yrs, Anglo-Australian*).

Both Indian-Australians and Anglo-Australians adjusted their prescription dosages and used CAM to manage their depressive symptoms, viewing it as part of their self-management strategies. When she felt 'down,' Julie said, "I'd add on like five [Lexapro® 10 mg tablets]," while Karen said, "I run out of the Effexor® and instead of taking two I just took it down to one". Participants reduced their dosages with the intent of discontinuing medication. Being 'drug-free' was interpreted as a sign of being cured from depression, particularly among Indian-Australian participants (see also *Brijnath, 2015*). Amir (*m, 35yrs, Indian-Australian*) said:

It was July or something like that, I started reducing my dosage. September–October I stopped it completely. November–December it hit me really hard. Just couldn't concentrate on anything, felt really bad, I just can't explain, it was so bad. And then when I went back to the doctor in Jan (sic) I was made aware that it's because that I stopped the medication and they wanted to try getting me back on. And after me starting it, I started feeling much better ... and I don't have that much of head pain, I don't feel so yucky. But still, it's kind of dying inside.

*Rose (2003)* argues that the consumption of pills, especially ones that alter the self neuro-chemically, are less about pathologising deviance and more about modulating unruly or uncontrollable aspects of the self. But many participants in this study perceived just taking antidepressants as problematic because it was 'the easy way out':

Other people assume that I'm on it [antidepressants] because I'm lazy because I don't want to put in that effort to go see a psychologist and empty my emotional bucket all the time (*Natalie, f, 31yrs, Anglo-Australian*).

For participants, an 'authentic' experience of self-management (possibly recovery) required self-labour in order to build self-confidence. Unlike antidepressants, taking CAM was seen as part of a suite of activities designed to build this confidence, better manage depression and transform the self into a more productive

person.

With some of the herbal or the Ayurvedic remedies, it's not just a matter of swallowing that. Along with that you've to control or monitor a change of diet, the physical exercise, yoga and breathing and meditation (*Sumant, m, 31yrs, Indian-Australian*).

### 3.4. Transformation and self-labour

Alongside taking CAM, participants undertook a set of transformative lifestyle practices including exercise, healthy eating, keeping mood journals, meditation and prayer. Participants used the word 'toolkit' to describe these activities; Rose, using Foucault, views such activities as 'technologies of the self,' i.e., practices that allow individuals to work on themselves by regulating their bodies, their thoughts and their conduct to secure normality, contentment and success (*Rose, 1996a*). For instance, Clifford, a young Indian-Australian man, who had experienced several depressive episodes in the past five years, said that in order to feel 'fine' he meditated every morning and went to the gym every evening. To maintain his state of 'finess' he also took various proteins, multivitamins and nitric oxide to improve his gym workout; zinc and magnesium to help him recover from his workout; and hydroxytryptophan (a dietary supplement for depression) to help him sleep and dream more vividly at night. Clifford purchased the products from an online US pharmacy (discussed elsewhere see *Brijnath et al., 2015*). Undertaking these transformative lifestyle practices to manage his depression was labour intensive, unlike antidepressants, the so-called 'easy' option. Building and sustaining this toolkit was also cheaper and more convenient than seeing a health professional:

It is more of a money issue, say for like long therapy ... go to the doctor first and get referred to a psychologist and then possibly stay with the psychologist for another six times. So that strikes me, it is not really convenient. You know, I could just go to some of my friends and family every weekend and talk. So yeah, cheaper therapy (*Clifford, m, 29yrs, Indian-Australian*).

Most participants, like Clifford, managed their depression by developing their own therapeutic strategies. *Rose (1996c)* views this kind of transformative self-labour as part of the demand neoliberal governments put on their citizens to be autonomous and active in order to maximise their quality of life. *Dia (f, 59 years, Indian-Australian)* said, "I think it's me, I should be working on [my] depression." For *Dia* this transformative labour also included further studies in childcare, yoga, exercising, walking, shopping, going out with friends and visiting a holistic doctor to obtain numerous CAM pills (when she could afford it). Such transformative labour did help and many reported an improvement in mood. But such labour required constant effort and was often prompted by a sense of obligation and exchange, for example, the need to honour commitments ("not let down the team"), maintain relationships ("If my dad would tell me, 'Do you want to go for a dirt bike ride?' I say, 'Yeah we'll go'") and use services that were paid for ("We paid for these kick boxing classes, you have to go").

In taking on various practices of self-transformation, participants exercised agency and took responsibility if their depressive symptoms did not abate. There was silence on the responsibilities of the state in providing succour. Instead participants blamed themselves for not putting in enough effort to get the desired results:

He [psychologist] left the practice and I dropped the ball from there (*Nikhil, m, 25yrs, Indian-Australian*).

My fault. Sometimes I get a little bit slack with my medication ... I was a little bit overwhelmed when I came back to the house at the start of the year getting kids ready for school, schoolbooks, covering them, uniforms, just getting into that routine again (*Karen, f, 45yrs, Anglo-Australian*).

The analogy of unsuccessfully juggling different aspects of life is evident from these quotes and speaks to the complexities of managing illness, managing the self and managing everyday life. While most participants were able to undertake all these tasks concurrently, there were two who found the labour involved in self-management overwhelming:

I'm trying to get my depression and everything under control with medication therapy. I can't add eating healthily and exercising regularly to that right now. If I add that it's too much pressure and I break (*Olivia, f, 19yrs, Anglo-Australian*).

I always have that kind of little hope, which always says that if I follow everything properly, I'll be out of this someday or a bit later. But, I never put an effort to actually follow that (*Gauri, f, 25 years, Indian-Australian*).

## 4. Discussion and conclusions

In this article, we explicated how people with depression came to self-manage their illness within a neoliberal setting, focusing on how one comes to self-manage and how one sustains managing.

Using *Rose's (1996a, 1996b, 2003; 1992)* work on governmentality and neoliberalism, we have shown that there is a significant (and dangerous) dissonance between the rhetoric of self-management versus the practices associated with it. The rhetoric of self-management advocates patient problem-solving, decision-making, finding and utilizing resources, partnering with health providers and taking action appropriate to circumstances in order to create an empowered self-managing patient (*Lorig and Holman, 2003*). On the one hand, participants in this study actively problem solved, made their own decisions, found and utilised resources. They valued being in control, being resilient and having the strength to withstand hardship. Finding a responsive health provider, seeking treatment, opting to take medication and pursuing a suite of self-management activities (e.g. exercise, yoga, further education) to craft their own therapeutic toolkits are examples of participant's self-managing their illness.

On the other hand, to be successfully self-managing also meant disengagement from health services, self-medication and self-labour. Participants in this study neither talked about their right to state services nor about familial, social nor work reforms; despite conditions of inequity, they perceived that change needed to occur only within them for their depression to improve. To that extent, Indian- and Anglo-Australian participants appeared to have become neoliberal patients, releasing the government from its responsibilities and allowing it to govern at a distance. They had absorbed, enacted and responded to the current rationalities and techniques of care within community psychiatry by emphasising personal responsibility, self-directing their help-seeking and treatments and blaming themselves when they failed to achieve their desired outcome. This is an important finding because we anticipated that there would be cultural nuances in how the two communities conceptualised depression and self-management in relation to factors such as family norms, gender, and meanings of mental illness. While there have been differences in terms of health-seeking, medication (including self-medication), and

recovery (for more see Brijnath, 2015; Brijnath et al., 2015), we could not find any discernible differences in both groups' understandings and practices of self-management. This is a troubling finding, also made in other studies (Gattuso et al., 2005; Outram et al., 2004); troubling because when depression is seen as an individual problem requiring self-labour and self-transformation, socio-structural factors such as poverty, class, and work inequities are ignored and the state is absolved from acting in these areas (Gattuso et al., 2005; Peacock et al., 2014a; Teghtsoonian, 2009).

Becoming neoliberal patients began with the imperative to self-manage; reinforced to study participants through their dealings with the health system and with health providers. The language of inter-agency collaboration was replaced by the realities of patient's self-directed help-seeking where rather than agencies working together to support patients, the latter were tasked with obtaining a GP referral, locating timely and appropriate mental health services and incurring costs. These systemic barriers were reinforced by health providers' instructions to participants to find a suitable therapist, make and keep appointments, follow drug regimens and self-manage in daily life. Such practices are about mitigating risk (Sawyer, 2008) where the health provider's job is not to treat, but rather tutor patients to self-manage (Rose, 1996b).

However when therapeutic responsibility passes from provider to patient, so does the burden of care and patients undertook a tremendous amount of solitary labour to manage themselves, a finding that also resounds with previous research (Corbin and Strauss, 1988; Seear, 2009; Townsend et al., 2006). Such labour required individual discipline, financial resources, time, experimentation and endurance. These elements may be viewed as positive components of agency but the practices they begot were highly problematic. Depressive symptoms, particularly insomnia and an unsettled mind, were disruptive and to manage these symptoms Anglo-Australian participants self-medicated with alcohol and drugs (illicit and prescription medications). Both Indian- and Anglo-Australian participants also modified their diets, did exercises and consumed CAM products. These efforts transpired in addition to the activities of everyday life and were less about pathologising deviance and more about modulating uncontrollable aspects of the self in order to improve and/or maintain function and productivity (Fullagar and O'Brien, 2013; Rose, 2003).

Only two participants found the burden of self-management overwhelming, making tactical decisions about which aspects of their health to prioritise over others (e.g. depression over healthy weight). To that extent our findings match Crawshaw's (2012) work with unemployed UK men who also resisted discourses to be healthy, categorising such ideas as unrealistic, instead arguing for more situated understanding of health relevant to their own lived experiences. But overwhelmingly our findings demonstrate the pervasiveness of the neoliberal directive that the ultimate responsibility for managing and monitoring health rested with the individual. Many studies have made this argument (Greenhalgh, 2009; Townsend et al., 2006) but few have examined how patients take up and apply these discourses in their own lives. Peacock et al.'s (2014a); Crawshaw's (2012) and Weiner's (2011) are notable exceptions and our study builds upon this research by showing that the neoliberal directive to self-manage, while differing in practice, holds sway across cultures (Indian- and Anglo-Australians), gender, age and health status (our participants were depressed; Weiner's experienced bipolar disorder and in the UK studies they were presumably healthy).

Our study is limited by its focus on participants with one condition (depression) in a single location (Melbourne). Additional work should include perspectives of key service providers (health professionals and policy-makers) and patients with other mental illness (e.g. schizophrenia) to respectively understand how

neoliberalism affects professional performance and illness severity modulates patient understandings of disease and responsibility. Attention must also be paid to the specificities of neoliberal practices through prisms of locality and policy (Ong, 2007); for example, how neoliberal rationalities transpire in rural and remote Australia will be different to how it plays out in urban Melbourne. Similarly, policy perspectives should examine how neoliberal ideologies are embedded and function within the system's architecture – in the Australian setting, practices of self-management are driven by a fragmented and complex system that does not prioritise the patient (Griffiths et al., 2015); in other settings, it may be austerity measures or health provider scarcity. Finally, we are cognisant that there is an implicit assumption in our argument that a fuller engagement with mental health services will be of benefit to people with depression. However, the psychiatric survivor movement argues otherwise (Chamberlin, 1979; McLean, 2003; Rissmiller and Rissmiller, 2006) and so future research should interrogate whether more 'optimal' delivery of mental health services actually benefits patients and families living with mental illness.

In summary, there is a disconnect between the policy rhetoric of self-management, how it is operationalised within the mental health system and what patient's ultimately articulate as their understandings and practices of self-management. Such a disconnect creates conditions for risky health practices and poor health outcomes. Few would consider self-medicating with alcohol and other drugs, adjusting prescription dosages without the input of a qualified health professional or reducing interactions with health services as optimal practices for people grappling with depression. Instead such practices highlight that the operationalisation of self-management within a neoliberal context without giving sufficient acknowledgement to the importance of a therapeutic relationship, a reciprocal bond, a feeling of being cared for, may ultimately do more harm than good to human health.

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