The Making Up of the Anxious Student

by

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Abstract

Anxiety reigns on Canadian campuses, placing university administrators under great pressure to provide resources to support student mental health. Considering this, universities are mobilizing mental health promotional strategies as well as increasing implementation of preventative self-help strategies in the hopes of providing students with effective tools to manage their anxiety and maintain a healthy mental wellbeing. This thesis provides a critical analysis of the sorts of services and resources provided to undergraduate students. Through an application of Ian Hacking's conceptual framework in the "making up of people", in conjunction with a critique of neoliberal ideology as it pertains to post-secondary institutions and mental health services, I hope to investigate the dominant form in which Canadian post-secondary institutions frame, formulate, and propagate the concept of anxiety. Moreover, my investigation also explores the way in which undergraduate students are currently being told to view and manage their anxiety through on-campus and online resources and services.

Keywords: Anxiety; Mental Health; Student Mental Health; Mental Health Resources; Mental Health Services; Post-secondary Students; Online Mental Health Resources; Ian Hacking; Neoliberalism

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A mis queridos padres, quienes han sacrificado tanto por sus hijos y han hecho todo lo posible por nuestro bienestar, ustedes son un ejemplo a seguir. Estoy eternamente agradecida por su amor y apoyo. Los amo con todo mi corazón y espero haberlos hecho sentir orgullosos.

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Chapter 1.

Introduction

In November of 2020, the Toronto Star published an investigative series titled “Generation Distress”, exploring the alarming statistics related to the mental health of youth and young adults across Canada, specifically concerning undergraduate students.[1] According to this series, prior to 2019 the Centre for Addiction and Mental Health (CAMH) found that about 30% of university students had considered self-harm and suicide due to their “failing mental health.”[2] In fact, according to another article, the most commonly reported issues concerning mental health amongst undergraduate students include stress, anxiety, and depression, with about 83% of students reporting overwhelming anxiety.[3] In light of these startling statistics—which have only been exacerbated by the COVID-19 pandemic[4]—along with pressure from undergraduate students themselves, universities across Canada are in dire need of finding effective solutions to what some people are calling a “youth mental health crisis.”[5]

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[1] Robert Cribb, “The Kids Are in Crisis - and Covid-19 Is Making It Worse in Canada, Deteriorating Youth Mental Health Is Leaving a Generation in Distress,” *Toronto Star*, November 23, 2020, https://www.thestar.com/news/investigations/the-kids-are-in-crisis-and-covid-19-is-making-it-worse-in-canada-deteriorating/article_16b37c86-46c5-5c7b-82a5-1fcb602dc5e4.html;.

[2] Cribb, “Generation Distress”.

[3] Elnaz Moghimi et al., “Mental Health Challenges, Treatment Experiences, and Care Needs of Post-Secondary Students: A Cross-Sectional Mixed-Methods Study,” *BMC Public Health* 23, no. 1 (April 6, 2023): 655, https://doi.org/10.1186/s12889-023-15452-x.

[4] Moghimi et al., “Mental Health Challenger,” 656.

[5] Matin Moradkhan and Saba Vatanpour, “Youth Mental Health Crisis: The Pandemic Fallout,” *UNICEF Canada*, August 23, 2023, https://www.unicef.ca/en/blog/youth-mental-health-crisis-pandemic-fallout.

In an attempt to combat the mental health resource gap[6] on Canadian campuses, universities are increasingly mobilizing mental health promotion strategies to strengthen "mental health literacy" (i.e., "the knowledge and skills that enable people to access, understand and apply information for mental health") among students. In addition, schools are also increasing implementation of preventative self-help strategies in the hopes of providing students with effective tools to manage their anxiety and maintain a healthy mental wellbeing. Such strategies come in the shape of workshops, Info Sheets and a variety of mobile apps (including breathing and meditation apps such as BellyBio and Calm, and cognitive behavioural therapy based apps such as MindShift and Headspace).

Indeed, all over SFU campus and on the health and counselling website, students can find promotional posters on "Mental Health and Wellness" and "Mindfulness Meditation," a program offering session every Monday to "help relieve stress and anxiety."[7] In fact, in March of 2020 I decided to attend one of SFU's mental health seminars on "Understanding and Coping with Anxiety and Depression," designed to help students and faculty understand symptoms of anxiety and depression and "discover strategies to manage them." The seminar was run by Dr. Shona Adams, a registered psychologist working at SFU's health and counselling center. Throughout the session, Dr. Adams described a way of understanding anxiety and depression that was based on the Human Givens perspective which proposes that mental illnesses such as depression and anxiety emerge from a failure to satisfy an individual's innate needs. Such perspective uses the fight or flight response—an evolutionary biopsychological perspective—as the dominant

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[6] Véronique Drolet and Grace Sarabia, "The Mental Health Resources Gap on Canadian University Campuses" (December 2020), 3, https://www.mcgill.ca/ahcs/files/ahcs/a_guide_to_addressing_the_mental_health_resource_gap_on_canadian_universities-clean.pdf.

[7] "Mindfulness Meditation," Health & Counselling - Simon Fraser University, accessed November 18, 2023, https://www.sfu.ca/students/health/get-support/support-groups/groups/mindfulness-meditation-sfu.html.

source of knowledge through which one can begin to understand why and how symptoms of depression and anxiety arise and how one can develop coping mechanisms to relieve these symptoms. I learned from this biological understanding of anxiety that seeks to naturalize anxiety, that symptoms of anxiety are normal during threatening situations. Moreover, I learned that individuals could learn to control their anxiety "mak[ing] it work for you instead of against you."[8]

This seminar painted anxiety differently from other mental health conditions where anxiety (unlike depression for example) need not be negative and is in fact necessary for the survival of our species. Simply put, anxiety is a natural and normal reaction to perceived threat. However, if it is the case that anxiety is a normal human reaction, one that can be "controlled", why are students today having such a difficulties controlling their anxieties? Are the resources and services available to students alleviating any of the student anxiety or only adding to it? What are mental health care professionals saying about this new phenomenon taking over post-secondary institutions? These are the larger questions which point to what I call, the "making up of the anxious student."

My thesis proposes to examine this making-up of the anxious student by first reviewing the literature on anxiety itself to see how its conceptualization has evolved over time. Following this, I will provide a theoretical foundation structured around the works of Ian Hacking and scholars such as Michel Foucault and Nikolas Rose who question the impact of the current neoliberal rationality on institutions such as the

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[8] Mary Acreman, Jenn Bossio, Carole-Anne Vatcher, Freeman Woolnough, "Your Best You: Managing Your Anxiety," Queen's University, September 2014, 2, https://students.cms.ok.ubc.ca/wp-content/uploads/sites/90/2019/09/Your-best-You-Managing-Your-Anxiety.pdf. Interestingly, when I first checked this workbook, it was a PDF. It has now been modified into an online course.

hospital, the state, and higher education. My methodology will comprise of eight in-depth interviews, with the experts in the field of psychology and psychiatry, as well as content analysis of three different university mental health and counselling websites. Finally, I will discuss my results and provide a critical analysis of the concept of anxiety developed in post-secondary institutions with an eye to understanding how it is involved in the making up of the anxious student.

Chapter 2.

Review of the Literature

2.1. Pre-Existing Literature

Anxiety, as we think of it today, is conventionally discussed under the umbrella of psychology and medicine. Within the last six decades, researchers and practitioners in these fields have had a significant influence in how we come to understand our experiences with anxiety. In fact, it is almost second nature for many to think of anxiety within the realm of evolutionary psychology, a normal and universal human experience necessary for the survival of our species. However, prior to its introduction into the third edition of the *Diagnostic and Statistical Manual* (DSM)—the authoritative manual describing symptoms of mental disorders—anxiety was subject to a variety of explanatory frameworks. In this section, I will review how anxiety has undergone various transformations, from an imbalance of the four humours throughout the Middle Ages to an unconscious psychological process as popularized by Sigmund Freud in the 20th century. My goal for this section is to provide the reader with some background on the nosology of anxiety as well as to hopefully demonstrate the changing conceptualizations of anxiety which suggest that today's Western understanding of anxiety is historically, conceptually, and discursively contingent.

2.2. A Brief History of Anxiety

2.2.1. How should I live my life? Cicero, Stoicism and Epicureanism

Anxiety, as a human experience, has a long history dating back to the Hippocratic Corpus, an extensive collection of medical texts strongly attributed to the Greek philosopher, Hippocrates. While the modern concept of anxiety did not exist in

ancient times, ancient philosophers often alluded to emotional states similar to the ones we experience as anxiety today. For example, in his book, “On Disease”, Hippocrates describes a set of somatic symptoms including worries, the feeling of a pricking thorn in the viscera, nausea, fearfulness, sensitivity to touch, fear, frightening visions, and dreadful dreams.[9] Hippocrates describes these symptoms as merely somatic manifestations which can be alleviated through a balanced lifestyle. Other thinkers have alluded to various instances in which contemplation of one’s mortality may give rise to feelings of angor (anxiety or anguish) and sollicitudo (worry).

In his philosophical work, Tusculan Disputations written in 45 B.C.,[10] Cicero discusses the nature of emotions, such as grief, pain, and fear, and offers philosophical insights for the pursuit of happiness. Of special interest in his work are his insights into one’s imminent mortality and one’s concern with “futurity”, which to him are contemplations which bring about much anxiety. For Cicero, and for many other thinkers after his time, human beings universally exhibit a significant degree of anxiety concerning matters related to the future and its uncertainty. In the case of Cicero, his focus was on discussing whether our anxious ponderance of something beyond the present life indicates the possibility of an immortal soul, or some form of continuous existence beyond death. Cicero’s contemplations on the immortality of the soul[11] and his own anxiety of the seeming impermanence of the physical world reflects various

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[9] T. Haustgen, "Anxiety Disorders in the History of Medicine First Part: From Hippocrates to “Nervosism." *PSN* 8, no. 4 (November 1, 2010): 197–206, https://doi.org/10.1007/s11836-010-0147-6.

[10] Walter Englert, “Fanum and Philosophy: Cicero and the Death of Tullia,” *Ciceroniana on Line* 1, no. 1 (May 17, 2017): 41, https://doi.org/10.13135/2532-5353/2202.

[11] Sergio Starkstein, *A Conceptual and Therapeutic Analysis of Fear* (Cham: Springer International Publishing, 2018), 57. https://doi.org/10.1007/978-3-319-78349-9. Cicero himself wrote this while grieving the loss of his daughter. For Cicero, writing these works was self-therapeutic.

influential philosophical schools of his time including Stoicism, Platonism, and Epicureanism.[12]

Stoicism and Epicureanism were two philosophical schools concerned with achieving *ataraxia* or bringing about a state of "tranquility" and calmness, a freedom from mental disturbance.[13] Such pursuit was not aimed at pathologizing states of anxiety the way that modern psychology and psychiatry do, rather the teachings were meant to provide individuals with philosophical frameworks in which to understand their suffering and emotional state.[14] The concept of ataraxia is specifically attributed to Epicureanism and the teachings of Epicurus. In Epicurean philosophy, ataraxia was considered a desirable state of mind to be cultivated because it represented the absence of mental agitation and distress, achieved through the pursuit of pleasure, avoidance of unnecessary desires, and detachment from worldly concerns.[15] Similarly, Stoicism was also concerned with attainment of tranquility and inner peace. The Stoics believed that external events are beyond our control, but that we do have control over our own thoughts, attitudes, and judgment. The Stoics taught that it is our judgments and interpretations of events that give rise to negative emotions, such as anxiety or fear. Much of Stoicism encourages individuals to align their desires and expectations with

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[12] Fran O'Rourke, "Immortality of the Soul in Plato and Aquinas," *Classics Ireland* 27 (2020): 240-241, https://www.jstor.org/stable/27076613. For example, Platonism purports the soul's immortality as being part of the theory of Forms. For Plato, the soul was eternal and transcendent, existing only in the realm of pure Forms before being temporarily incarnated in the material world.

[13] Marc-Antoine Crocq, "A History of Anxiety: From Hippocrates to DSM," *Dialogues in Clinical Neuroscience* 17, no. 3 (September 2015): 320, 10.31887/DCNS.2015.17.3/macrocq.

[14] Paul McReynolds, "Changing conceptions of anxiety: a historical review and a proposed integration." *Issues in Mental Health Nursing* 7, no. 1-4 (1985): 136, https://doi-org.proxy.lib.sfu.ca/10.3109/01612848509009453. These two philosophical schools, Stoicism and Epicureanism originated during the Hellenistic era, a period of significant turmoil marked by political, social, and cultural changes.

[15] McReynolds, "Changing Conceptions," 132-133.

what is within their power. In doing so, the Stoics purported, individuals can reduce the tendency for anxiety that arise from an attachment to situations out of their control.[16]

The Hellenistic period was characterized by intense socio-political and cultural transformations which may have evoked emotional and psychological responses among the people of the time. Following the death of Alexander, the Great, "[the] 'decline of the Polis' precipitated a '*failure of nerve*' (my emphasis) in the cultural sphere" made evident by the "apparent recrudescence of superstition and the rise of apolitical *individualism* (my emphasis) and self-serving ideals of cosmopolitan nonattachment and indifference."[17] The rise of individualism (due to several factors such as the cultural blending of various traditions,[18] a decline in the traditional Greek polis, and an increase in urbanization[19]) has been cited as a possible explanation as to why philosophical frameworks such as Stoicism and Epicureanism became prominent in addressing the challenges that people faced during this tumultuous era. Such philosophical understandings may have provided people with a way of reconceptualizing their rapidly changing world as well as giving people a sense of purpose and determination.[20]

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[16] McReynolds, 137-138.

[17] Joseph M. Bryant, *Moral Codes and Social Structure in Ancient Greece: A Sociology of Greek Ethics from Homer to the Epicureans and Stoics*, SUNY Series in the Sociology of Culture (Albany, N.Y.: SUNY Press, 1996): 4, https://search-ebscohost-com.proxy.lib.sfu.ca/login.aspx?direct=true&db=nlebk&AN=5197&site=ehost-live.

[18] John Ferguson, "Hellenistic Age | History, Characteristics, Art, Philosophy, Religion, & Facts | Britannica," last updated November 17, 2023, https://www.britannica.com/event/Hellenistic-Age.

[19] Leonard R. N. Ashley, review of *Renaissance Man* by Agnes Heller and Richard E. Allen, *Bibliothèque d'Humanisme et Renaissance* 42, no. 2 (1980): 102, http://www.jstor.org/stable/20676134.

[20] Wilfred M. McClay, "Individualism and Its Discontents," *The Virginia Quarterly Review* 77, no. 3 (2001): 391–405; Paul McReynolds, 136.

2.2.2. From Christianity to Galen's Humoral Theory

The rise of Christianity in the West, according to some scholars, played a crucial role in re-shaping conceptions of the individual and their place in the world.[21] Christianity represented a progressive shift toward individuality, emphasizing personal autonomy and the power to choose between good and evil. Central to this view was the concept of sin, which posited that anxiety was rooted in guilt. The vivid descriptions of Dante's Hell in "The Divine Comedy" and St. Augustine's "The Confessions" became emblematic of this type of anxiety, which was made to be a central component of spiritual life, understood as the suffering of the soul trapped in sin, longing for redemption, and fearing eternal damnation. This idea differed from the perspectives of Epicureanism and Stoicism[22] and it called for different approaches to relieve anxiety, such as confession, penance and prayer.[23]

Despite the dominance and authority of the church during the Christian Era, the early medical idea of the four bodily humours eventually became one of the most dominant and enduring medical theories in Western medicine up until the late 18th century.[24] The humoral theory made its first appearance *On The Nature of Man,* written by Polybus[25] where Hippocrates posited that the human body was governed by four primary fluids (or humours), and that an imbalance among these humours was believed to cause various

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[21] E. R. Dodds, *Pagan and Christian in an Age of Anxiety: Some Aspects of Religious Experience from Marcus Aurelius to Constantine*, of *The Wiles Lectures* (New York: Cambridge University Press, 1990): 13; Allan V. Horwitz, *Anxiety: A Short History* (Baltimore: John Hopkins University Press, 2013), 36-37; McReynolds, 139.

[22] Although both schools of thought recognized the existence of evil, they did not see it as something existing outside the material world (i.e., heaven and hell). For them, evil was a lack of harmony in the physical world.

[23] McReynolds, 140.

[24] Glas Gerrit, "A Conceptual History of Anxiety and Depression." In *Handbook of Depression and Anxiety* (Boca Raton: CRC Press, 2003), 1, https://doi.org/10.3109/9780203911822.

[25] Hippocrates's student and son-in-law who worked on the Hippocratic Corpus.

physical and mental ailments.[26] More concretely developed after his death, the four humours were said to be composed of four different "fluids". Blood (sanguine) was said to be associated with warmth, alertness, and cheerfulness; phlegm was characteristic of a well-tempered, passive and calm individual; yellow bile (choleric) indicated aggressiveness, impulsivity, and restlessness; and finally black bile (melancholic) was characteristic of an anxious, moody, and pessimistic individual.[27] The four humours became a quintessential framework for many physicians and was highly influential in the development of melancholy in the middle ages. It is important to clarify that melancholy does not necessarily equate to anxiety as we think of it today. Many scholars have pointed out certain overlapping features of melancholy with modern day conceptualizations of anxiety, however, melancholy was a general term that encompassed many psychological conditions.[28] Within these psychological conditions were some features of anxiety as we think of it today: excessive worry and distress, irritability and a sense of impending doom, as well as physical manifestations such as heart palpitations, trembling, sweating, fatigue and changes in appetite and sleep.[29]

According to Galen, the framework of the four bodily humours encompassed three different forms of melancholia, two of which were attributed to the presence of "black bile" and the "obstruction of blood vessels in the brain"[30], and the third, which was characterized by symptoms in the upper abdomen, was not directly attributed to black bile itself. Instead,

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[26] Jacques Jouanna, "The Legacy of the Hippocratic Treatise the Nature of Man: The Theory of the Four Humours," essay, in *Greek Medicine from Hippocrates to Galen Selected Papers* (Boston: Brill, 2012), 335, https://www.jstor.org/stable/10.1163/j.ctt1w76vxr.21.

[27] Stelmack, Robert M., and Anastasios Stalikas. "Galen and the Humour Theory of Temperament," *Personality and Individual Differences* 12, no. 3 (1991): 255-256, https://doi.org/10.1016/0191-8869(91)90111-N.

[28] Gerrit, "A Conceptual History", 7.

[29] Horwitz, 40-41.

[30] Gerrit, 6.

Galen believed that “a vapor emanating from the fluid” was responsible for the symptoms, and if the vapour were to reach the brain it could result in "obscuring thought".[31] Galen recognized that anxiety and depression could manifest in various ways, but he believed that at the core of melancholia lay “despondency and anxiety” and in particular the fear of death.[32]

As mentioned earlier, Christianity and theology were major sources of influence and their dominance extended to medical understandings of emotion, including anxiety.[33] During the Middle Ages, most medical knowledge could be found in monasteries and cathedral schools. During this time the influence of Christianity was pervasive in medical terminology. This meant that for many thinkers of the time, “psychic phenomena” were considered as belonging to “the faculties of the soul”.[34] As such, physicians began to attribute moral values to humoral imbalances, for example classifying melancholics as “degenerates” and “Sanguinics” on the other hand representing men “as God intended him to be.”[35]

2.2.3. Robert Burton’s The Anatomy of Melancholy

Anxiety as a condition of the soul began to decline in popularity during the Enlightenment era. During this time, there was a significant cultural transformation in Western Europe, in the understanding of the individual driven by notions of freedom and individualism, and a rise in scientific observation to explain natural phenomena. It is during this cultural shift

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[31] Gerrit, 5-6.

[32] Gerrit, 6.

[33] Damien Boquet and Piroska Nagy, “Medieval Sciences of Emotions during the Eleventh to Thirteenth Centuries: An Intellectual History,” *Osiris* 31, no. 1 (January 2016): 25, https://doi.org/10.1086/688041.

[34] Boquet and Nagy, “Medieval Sciences,” 38.

[35] Gerrit, 7.

that Robert Burton's book *The Anatomy of Melancholy* (1621) emerged as an influential work in the field of psychiatry, exploring various psychological and emotional human conditions, including anxiety.[36] Drawing on medical knowledge, theology and history, Burton, sought to explain how during the 16th and 17th centuries, melancholy was understood mainly as a form of delirium characterized by mental distress, impaired mental faculties, and the presence of fear and sorrow.[37] While Burton was neither a physician nor an expert of the mind, his work "offered a compilation of all contemporary knowledge on the subject of melancholia."[38]

Although in his work Burton acknowledges anxiety as a universal experience and an "integral aspect" of human life, he also recognizes its potential for inducing mental disturbances.[39] Consequently, Burton split melancholy into two categories, the first being "melancholic disposition" and the second "melancholic habits". Melancholic disposition refers to a temporary condition characterized by sadness, sorrow, and despondency and is linked to specific life circumstances or external factors that have influenced one's psychological state.[40] On the other hand, melancholic habits were seen as emotional responses "without a cause" and were considered a more enduring trait of the individual's personality.[41] To clarify, Burton's *The Anatomy of Melancholy* is not to be understood as

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[36] Tracy Dennis-Tiwary, *Future Tense: Why Anxiety is Good for You (Even Though it Fells Bad)* (Hachette U.K.: Little, Brown and Company, 2022) 160-161.

[37] Michael Edwards, "Mad World: Robert Burton's The Anatomy of Melancholy," *Brain* 133, no. 11 (November 2010): 3480, https://doi.org/10.1093/brain/awq282.

[38] Gerrit, 11.

[39] Horwitz, 40.

[40] Horwitz, 40.

[41] Here we are starting to see a categorization akin to that of classification of different personality traits today. For Burton, there was a normal and expected anxiety, one that came due to external circumstances such as a loved one dying or heartbreak (grief). On the other hand, an individual that tended towards sadness, worry and/or sorrow "without a cause" garnered special attention. However, this is not to say that Burton pathologized the second type, only that it differed and may need more special attention than the first type.

a diagnostic tool. Burton was interested in the complex interplay between social, cultural, environmental, and political circumstances which made melancholic conditions possible during his time.[42] Finally, because his framework encompassed a diverse array of different perspectives, he saw the cure for melancholy as extending beyond medical remedies and involving aspects of pastoral care, work, and moral philosophy.[43]

2.2.4. The 17th Century Mystical Bedlam

The idea that socio-political, cultural and environmental conditions could have a significant impact on the mental stability of individuals can also be found in the collection of Michael MacDonald's book, *Mystical Bedlam,* where he recorded an astounding 767 accounts of individuals who sought the help of physician and reverend Richard Napier during the 17th century.[44] During Napier's time, England was undergoing important religious and political changes such as the English Civil War and the transition from religious and supernatural explanations of mental distress to emerging medical and scientific explanations.

The accounts of Napier's patients paint a picture of the anxieties of the time. For example, debt and the fear of poverty were of significant concern, particularly for men worried about their financial stability and their ability to provide for their families. Worries about witchcraft accusations within their villages contributed to patients' anxieties as well as fear of sins leading to damnation.[45] Contrary to popular belief, Napier's patients sought treatment primarily for very realistic sources of anxiety, not for "madness or

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[42] Edwards, "Mad World," 3481.

[43] Edwards, 3481. Also similar to Cicero, Burton's work was deeply personal to him and can be seen a form of self-therapy. In the beginning of his book, he claims to "write of melancholy by being busy to avoid melancholy."

[44] Horwitz, 43. Richard Napier, was a physician and clergyman.

[45] Horwitz, 43.

melancholia".[46] Therapies for this general anxiety varied often involving both medical and religious approaches such as purging, bleeding, prayer, and the use of amulets. Despite some patients showing more disordered or abnormal mental conditions, Napier was mostly interested in recording and treating patients suffering of "every-day" anxieties.[47]

2.2.5. The Demise of the Humoral Theory

Between the late 17th century and early 18th century, the works of physicians such as Thomas Sydenham, George Cheyne, and William Cullen challenged the idea of the four bodily humours and its relation to melancholia. This challenge was primarily due to advancements in the medical field and the emergence of new scientific perspectives such as psychology and psychiatry.[48] Furthermore, the 17th century marked a significant turning point in the understanding of the nervous system. Theorists such as Thomas Willis and René Descartes attempted to explain how nerve signals were transmitted through the body. Such a neurocentric view became influential for some physicians in explaining mental conditions. For example, in his work, "*The English Malady*" (1733), George Cheyne advanced a mechanistic model of the human body that focused on the nervous system, fibers, tissues, and physical organs. His goal was to establish a connection between mental conditions such as hysteria, melancholia, and hypochondria and physiological factors rather than attributing them solely to the mind, emotions, or the soul.[49] As such, these mental conditions were conceptualized as "nervous disorders". Interestingly, Cheyne attributed the prevalence of nervous disorders primarily to the wealthy and those of higher social classes. Those who were privy to an excess of wealth and luxury suffered

[46] Horwitz. 44.

[47] Horwitz, 45.

[48] Gerrit, 17.

[49] Horwitz, 50.

overindulgence resulting in bodily imbalances which to Cheyne lead to an increase in nervous afflictions. This attribution of mental health conditions to the higher echelon normalized anxiety and even "helped promote the notion of nervousness as a fashionable feature of well-bred gentlemen and ladies."[50]

Despite attributing mental disturbances to the higher classes, however, psychiatrists in the 18th century were more interested in treating states of psychosis linked to insanity. Treatment of nervous disorders was left to physicians, herbalists, faith-healers, and spiritual healers.[51] In this sense, nervous disorders fell under the umbrella of "pathological activity", which implied an "organic illness". From this perspective, the ones suffering from any of the nervous disorders had minimal to no control over their mental state.[52]

The mid and late 19th century witnessed considerable technological innovation and further scientific development. Terminology and methodology in the field of medicine was fast approaching a significant transformation. Suddenly, everything could be measured, counted, and documented. Positivism became the main pillar of knowledge production, which led to a systematic and scientific approach to the classification and understanding of different mental conditions.[53]

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[50] Horwitz, 51.

[51] Horwitz, 53.

[52] Gerrit, 15; Horwitz, 53.

[53] Horwitz, 56.

2.2.6. The 20th Century: Psychoanalysis and the Rise of Psychopharmaceutical Intervention

Despite the dominance of empirical research and scientific observation that will come to characterize research on mental illness in the 20th century, Sigmund Freud's psychoanalytical framework became, in the late 19th and early 20th centuries, one of the most notable approaches to the study of mental conditions paving the way for the development of psychology as a field separate from psychiatry and medicine in general. Freud believed that mental illness was not organic, but primarily rooted in unconscious processes. During this time, his talking cure became highly popular in treating anxiety.[54]

The mid 20th century, however, witnessed a significant change in the understanding of mental illness and anxiety with the increasing role of pharmaceuticals and tranquilizers in treating individuals reported as suffering from anxiety disorders.[55] This rise in diagnosis has been linked to the introduction of the DSM in the 1950's whose primary purpose was to create a cohesive and standardized classification system that could consolidate various diagnostic terms used by different psychiatric organizations.[56] During the period spanning the 1950s to the 1980s, a notable sequence of drugs were introduced into the market, including Miltown, Ritalin, Valium, and Xanax. These medications gained substantial popularity due to their efficient and economical approach to addressing anxiety; suddenly, all your problems could disappear with just one pill.[57] By

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[54] Ian R. Dowbiggin, "High Anxieties: The Social Construction of Anxiety Disorders," *The Canadian Journal of Psychiatry* 54, no. 7 (July 1, 2009): 430-431, https://doi-org.proxy.lib.sfu.ca/10.1177/070674370905400.

[55] Dowbiggin, "High Anxieties," 431.

[56] Roger K. Blashfield et al., "The Cycle of Classification: DSM-I Through DSM-5," *Annual Review of Clinical Psychology* 10, no. 1 (2014): 25–51, https://doi.org/10.1146/annurev-clinpsy-032813-153639.

[57] Andrea Tone, "Listening to the Past: History, Psychiatry, and Anxiety," *The Canadian Journal of Psychiatry* 50, no. 7 (June 1, 2005): 376-377, https://doi.org/10.1177/070674370505000702.

the 1980s, classification of anxiety related disorders changed from anxiety disorders grouped under the broad category of "neuroses"—a general and less specific classification that included various forms of anxiety disorders—to separate distinguishable categories, such as generalized anxiety disorder (GAD), panic disorder, social phobia, other specific phobias, and obsessive-compulsive disorder (OCD).[58] Many external factors also seemed to contribute to what many people were calling "the age of anxiety" (an expression taken from the title of W. H. Auden's 1947 poem). These factors (at least in North America) included the rise in nuclear weapons, the AIDs outbreak, global warming, global political and economic events, and mass panic around terrorist attacks[59]. By the late 20th century and now in the 21st century, pharmacotherapeutic along with psychotherapeutic (often cognitive behavioral therapy or CBT) treatments of not only anxiety but various other mental disorders have been and still are the most common ways of treating anxiety disorders in both North America and across Europe.[60]

2.3. Current Conceptualization of Anxiety

This brief look into the history of anxiety shows how anxiety has been intertwined within the discourses of religion, medicine, psychology, psychiatry and mental illness in general. However, as I have attempted to demonstrate, manifestations of anxiety have not arisen

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[58] Dowbiggin, 432; *DSM-II: Diagnostic and Statistical Manual of Mental Disorders*, Second edition (Washington, D.C.: American Psychiatric Association, 1968) 39;*Diagnostic and Statistical Manual of Mental Disorders: DSM-3*, Third edition (Washington, D.C.: American Psychiatric Association, 1980) 225-235.

[59] Dowbiggin, 431; Tone, 376.

[60] Alexandra Chapdelaine et al., "Treatment Adequacy for Social Anxiety Disorder in Primary Care Patients," *PLoS One* 13, no. 11 (November 2018): 2, https://doi.org/10.1371/journal.pone.0206357; Andreas Ströhle, Jochen Gensichen, and Katharina Domschke, "The Diagnosis and Treatment of Anxiety Disorders," *Deutsches Arzteblatt International* 155, no. 37 (September 14, 2018): 616, https://doi.org/10.3238/arztebl.2018.0611; Farhad Dalal, *CBT: The Cognitive Behavioural Tsunami: Managerialism, Politics and the Corruptions of Science* (London: Routledge, 2018), 7, https://doi.org/10.4324/9780429457814.

in a vacuum. Indeed, many thinkers have acknowledged how environmental circumstances, cultural transformations, and political changes can have a significant impact on the mental state of the population at large. That being said, in the 20th century, the dominant interpretation of anxiety and anxiety disorders in general became deeply rooted in psychological and psychiatric understandings of the "abnormal"—thoughts, behaviours, and emotions that deviate from what is considered typical, normal, or within a certain range of expected variation. Interestingly, and perhaps of special concern, is the way research today is striving more and more towards a biogenetic understanding of anxiety etiology that naturalizes anxiety and presents it as a "normal" reaction to perceived threat. This understanding could have an impact in the way that we, as individuals capable of experiencing anxiety, come to understand ourselves and the world around us.

2.3.1. Anxiety in Post-Secondary Education

Today Canadian post-secondary students are reporting high levels of mental distress at an alarming rate. The most commonly reported mental health issues among post-secondary students in Canada include anxiety disorders, depression, and stress, with up to 83% of students reporting overwhelming anxiety.[61] it is no secret then that anxiety reigns on university campuses, placing university administrators under pressure to provide resources to support student mental health.

Current research on anxiety in Canadian post-secondary education focuses mainly on the rate of reported mental illnesses and mental distress,[62] promotion of mental health

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[61] Elnaz Moghimi et al., "Mental Health Challenges, Treatment Experiences, and Care Needs of Post-Secondary Students: A Cross-Sectional Mixed-Methods Study," *BMC Public Health* 23, no. 1 (April 6, 2023): 2, https://doi.org/10.1186/s12889-023-15452-x.

[62] Robert Cribb, "The Kids Are in Crisis." In clinical terms, mental illness differs from mental distress as it relates to diagnosis and pathology. Although mental illnesses indicate mental distress, mental distress does not necessarily indicate a mental illness. Mental illness (or disorder) is ultimately a clinical diagnosis which can only be done by a physician. Mental distress,

services, the types of services and resources provided by post-secondary institutions and whether these services are sufficient in addressing student mental health demand.[63] Interestingly, research focusing on efficiency of mental health services in Canadian institutions suggest the importance of help-seeking behaviour and self-recognition of mental health symptoms.[64] These same studies advise institutions to enhance mental health literacy and to implement program initiatives geared towards identification of students suffering from mental illnesses.

Outside Canada, some scholars have begun to raise questions about the impact neoliberalism might have on the mental health of post-secondary students. Neoliberalism is at its core a "political-economic project"[65] and a mode of governance prioritizing a free-market economy driven by competition and limited government intervention.[66] However, its ideological dimension has reached beyond the economic, penetrating even the most seemingly ordinary sectors of human life, dictating human action and reshaping normativity.

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on the other hand, is a general term that describes symptoms related to mental illnesses, such as sadness and stress (which can be related to depression and anxiety disorders) but do not necessarily indicate an illness. A student may be in mental distress and exhibit symptoms of anxiety, but they are not diagnosed with an illness.

[63] Dimitris Giamos et al., "Understanding Campus Culture and Student Coping Strategies for Mental Health Issues in Five Canadian Colleges and Universities," *Canadian Journal of Higher Education* 47, no. 3 (September 2017): 121; Emma Heck et al., "A Survey of Mental Health Services at Post-Secondary Institutions in Alberta," *Canadian Journal of Psychiatry* 59, no. 5 (May 2014): 257-258.

[64] Bonnie Kirsh et al., "Experiences of University Students Living with Mental Health Problems: Interrelations between the Self, the Social, and the School," *Work* 53, no. 2 (January 1, 2016): 328; Heck et al., "A Survey," 253.

[65] David Harvey, "Neoliberalism Is a Political Project," interview by Bjarke Skærlund Risager, *Jacobin*, July 23, 2016, https://jacobin.com/2016/07/david-harvey-neoliberalism-capitalism-labor-crisis-resistance/.

[66] David Harvey, *A Brief History of Neoliberalism David Harvey* (New York: Oxford University Press, 2005), 3.

In her research on the rise of mental illness in undergraduate students, Sarah Cant applies the Bourdieusian concept of *hysteresis* as a hermeneutic tool in understanding the link between the rising number of undergraduate students in the United Kingdom with disclosed mental health conditions and the growing participation of individuals in post-secondary institutions.[67] Despite the amount of data surfacing on increased levels of reported mental illness in post-secondary institutions, Cant points out that much of this data is collected by counselling services and academic research dominated by biomedical and psychological models that fail to explain the link between socio-demographic factors and mental illness. She ultimately argues that our current neoliberal culture of meritocracy, competition, and entrepreneurship encourages individuals to market themselves through economic, social, and cultural capital. However, the ability and skill to accumulate capital is ultimately attributed to the self and thus the individual is made to take responsibility for personal successes and failures. The rise in mental health problems among undergraduate students is said to be a result of the responsibilization of academic success that takes a mental toll on individuals, especially those of low socio-economic status many of whom also lack social and cultural capital.

Berg and colleagues also look at the way in which neoliberalization in the academy "produces an ongoing sense of anxiety among academic workers."[68] They argue that anxiety among faculty and graduate students at North European universities is a direct result of shifting ideologies of the value of academic work that prioritize

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[67] Sarah Cant, "Hysteresis, Social Congestion and Debt: Towards a Sociology of Mental Health Disorders in Undergraduates," Social Theory & Health 16, no. 4 (2018): 311-325.

[68] Lawrence D. Berg, Edward H. Huijbens, and Henrik Gutzon Larsen, "Producing Anxiety in the Neoliberal University," *The Canadian Geographer* 60, no. 2 (2016): 168, https://doi.org/10.1111/cag.12261.

efficiency and competition over quality of academic work and mental well-being of their faculty and students. Even though this article focuses mainly on faculty and graduate students, the proliferation of a competitive culture focused on efficiency and accumulation of academic credentials can also be extended to undergraduate student culture.

Berg and his colleagues and Cant offer a compelling argument for the rise of mental illnesses in post-secondary institutions, however they fail to take into account the role of legitimizing systems of classification that may influence the appearance of rising mental health issues within post-secondary institutions. In their study, Wiens and his colleagues suggest that instead of an alarming increase of poor mental health among university students the increase is in diagnosis of mood and anxiety disorders which gives the appearance of an increasing rate of mental illness among undergraduate students.[69] Interestingly, this study implies a change not in student's mental state per se but rather a change in the rate of classification of mental illnesses such as depression and anxiety.

Could the rate of diagnosis noted in most studies be due to increased mental health promotion which focuses on de-stigmatization and acceptance of mental health issues thereby making it easier for students and mental health professionals alike to recognize signs and symptoms of mental illness? This is an interesting question that unfortunately is not fully addressed in the literature. Most studies take the statistical increase in the numbers of mental health diagnosis for granted and from there posit

[69] Kathryn Wiens et al., "Mental Health among Canadian Postsecondary Students: A Mental Health Crisis?," *The Canadian Journal of Psychiatry* 65, no. 1 (January 1, 2020): 32, https://doi.org/10.1177/0706743719874178.

ways in which the universities can respond to the crisis.[70] This of course has an impact on policy making in post-secondary institutions concerning mental illness and mental health as well as the sorts of services and resources provided to undergraduate students. It is imperative that these services and resources be analyzed and looked at closely as they make a significant impact on undergraduate student life. My thesis proposes to do just that. Through an application of Ian Hacking's conceptual framework in the "making up of people", in conjunction with a critique of neoliberal ideology as it pertains to post-secondary institutions and mental health services, I hope to investigate in this thesis the dominant form in which Canadian post-secondary institutions frame, formulate, and propagate the concept of anxiety. Moreover, my investigation also explores the way in which undergraduate students are currently being told to view and manage their anxiety through on-campus and online resources and services.

[70] Emma Heck et al., 258; Helen Vallianatos et al., "ACCESS Open Minds at the University of Alberta: Transforming Student Mental Health Services in a Large Canadian Post-Secondary Educational Institution," *Early Intervention in Psychiatry* 13, no. 1 (June 2019): 56.

Chapter 3.

Theoretical Framework and Methodology

3.1. Theoretical Framework

My own struggles to manage my anxiety, like those of many undergraduate students, are not unique. They take place in the larger social context of institutions like the university and their mental health services. This is why it is imperative that Canadian post-secondary mental health services and resources are analyzed as they make a significant impact on undergraduate student life.

My theoretical framework is twofold, the first aspect consists of an application of Ian Hacking's conceptual framework known as the "making up of people". This framework not only provides the foundation for the investigation of my research, but it also puts into question the classification of anxiety as it is conceptualized today. The second aspect of my theoretical framework provides a critique of neoliberalism in the context of post-secondary education as it relates to issues surrounding mental health, in particular the way that academic institutions encourage students to view and manage their anxiety. Through the use of both frameworks, I hope to build a foundation on which I am able to investigate how Canadian post-secondary institutions and their mental health services frame and deploy the concept of anxiety, thereby producing the anxious student.

3.2. Ian Hacking's Classification of Interactive Kinds: A Conceptual Tool

In his book *The Social Construction of What?,* Ian Hacking introduces the concept of "interactive kinds" as part of his framework for understanding how categories and classifications emerge in science and society.[71] Hacking makes a distinction between those entities who are self-aware and conscious of their classification (and are therefore active participants in their classification), calling them "interactive kinds," and those entities unaware of their classification (in which case such entities are unable to interact with their classification) calling them "indifferent kinds". Central to this concept, and to my theoretical framework, is the means by which classifications become legitimate and accepted in our society.

In his article, "Kinds of People: Moving Targets", Hacking offers a conceptual tool for exploring the way that classifications come to be a normative part of our lived experiences.[72] This tool is composed of five elements that together constitute the making up of people. First is the *classification* itself. More specifically, classification of people into kinds. Second are the *individuals* and *people* subjected to different classifications. Third are the *institutions* that uphold and legitimize the classification of the individuals being classified. These institutions include bureaucratic structures, organizations, administration, and, as per my research, post-secondary institutions. Fourth is *knowledge*, which is decided and disseminated by the fifth aspect, *experts*. Hacking showcases various examples in which such elements interact with one another and

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[71] Ian Hacking, *The Social Construction of What?* (London: Harvard University Press, 1999), 32. https://doi.org/10.2307/j.ctv1bzfp1z.

[72] Ian Hacking, "Kinds of People: Moving Targets: British Academy Lecture," in *Proceedings of the British Academy, Volume 151, 2006 Lectures*, ed. P. J. Marshall (British Academy, 2007), 296-298.

consequently “make up” a particular kind of person—one that is strictly contingent in their socio-historical positionality.

Of particular interest is his example on the transient mental illness of multiple personality disorder (MPD), now known as dissociative identity disorder (DID). The classification in this case is of course MPD, a label produced by people in the field of psychology and psychiatry. What is of interest to Hacking here is how mental health professionals, as experts in the field and responsible for the production and dissemination of such knowledge, categorize and diagnose this condition. For Hacking, diagnostic categories evolve and change over time, which of course directly affect the experiences of the individuals being classified. Moreover, such evolution in classification also means a change in diagnostic criteria and therefore, a change in the inclusion and exclusion of certain people into kinds. In the case of MPD, Hacking points out that prior to the 1980’s, the concept of MPD was not recognized as a distinct diagnostic category in the DSM; cases of individuals with MPD were quite rare. However, as the classification gained recognition, more cases began to be reported and diagnostic cases went up. Here we see the interplay between institutions, experts and knowledge more clearly. Mental health institutions (the clinics, hospitals and professionals) respond to policymaking, regulations, and resource allocation that are informed by expert knowledge (knowledge pertaining to the scientific and medical understanding of MPD, which of course is subject to change depending on scientific developments). Indeed, MPD started as a simple case of “split” personality, where the individual exhibited two to three different personalities, however as the condition became more prevalent, patients began reporting more and more personalities. At one point, the average number of different personalities an individual with MPD could exhibit was seventeen! Today, however, MPD is no longer recognized as a legitimate disorder. Psychiatrists have

instead reclassified the condition as dissociative identity disorder (DID) in order to reflect a change in diagnosis criteria. Although very similar symptomatology to MPD, DID emphasizes "disintegration" or "fragmentation" of the patient's sense of *identity* rather than the existence of two or more whole independent *personalities*.[73] This difference is important to those being diagnosed, as it shines a light away from the personalities themselves and instead focuses on the root problem, the patient's inability to grasp a single and cohesive sense of identity. According to Hacking, such a change was possible only through criticism and revision from the "multiple movement" itself, not a movement in the traditional political sense but rather a collective identity and experience among individuals with the condition.[74] Such a change, once again, reflects the *contingency* in classifications of mental health conditions, as well as the impact those self-aware of being classified (the interactive kinds) can have on the classification itself.

Ultimately, Hacking's framework allows us to question and explore the intricacies and complex power relations between classifications, the act of classifying, and the people subject to such classification. For Hacking, classifications are not static and objective descriptors of pre-existing phenomena but rather they actively interact with people, institutions, knowledge, and experts. This interaction leads to a feedback loop where classifications influence how people perceive themselves, institutions reinforce the legitimacy of classifications, experts contribute to their development, and knowledge

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[73] Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (Princeton University Press, 1995), 24-26. Unlike DID, MPD focuses on the existence of two or more *whole* personalities, independent of the "original". However, this emphasis on the possible existence of multiple personalities existing within one individual takes away from what psychiatrists see as the main problem, the patient's "difficulty in integrating disparate elements of memory, identity and consciousness, rather than the proliferating of personalities." Thus, although the current DSM does still mention the possible presence of multiple personality states, a change in nomenclature reflects a more wanted emphasis on the patient's lack of a single, cohesive, or continuous sense of identity.

[74] Hacking, "Rewriting the Soul," 241.

is shaped by the act of categorizing. Although this thesis does not address this "feedback loop" per se, my research does make use of Hacking's conceptual tool in order to investigate how experts—mental health professionals such as clinical psychologists, psychiatrists, psychiatric nurses, case managers, and therapists—who are responsible for producing and disseminating knowledge, in conjunction with Canadian post-secondary institutions, conceptualize anxiety in undergraduate students.

3.3. Neoliberal Rationality and Mental Health

Since its inception into the world of political economy in the 1970's, neoliberalism has not only been transforming and reshaping entire societies but has also been involved in "reformulating personhood."[75] Although its original focus was primarily involved in reconceptualizing economic practices for the purposes of "human wellbeing", neoliberal governance has gained a strong foothold in other sectors of human life, including post-secondary institutions and the mental health field.[76] It is therefore important to address the concept of neoliberalism in university settings and its relation to mental health and the field of psychology in general.

Scholars such as Michel Foucault,[77] David Harvey,[78] and Nikolas Rose[79] have suggested that we live in neoliberal times, referring to a type of rationality that prioritizes the primacy of the free market and which requires that the state "take an active role in

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[75] Jeff Sugarman, "Neoliberalism and Psychological Ethics," *Journal of Theoretical and Philosophical Psychology* 35, no. 2 (May 2015): 104.

[76] David Harvey, *A Brief History,* 3.

[77] Michel Foucault, *The Foucault Effect: Studies in Governmentality with Two Lectures by and an Interview with Michel Foucault*, ed. by Graham Burchill, Colin Gordon, and Peter Miller (Chicago: University of Chicago Press, 1991), 2, https://press.uchicago.edu/ucp/books/book/chicago/F/bo3684463.html.

[78] Harvey, *A Brief History of Neoliberalism*.

[79] Nikolas S. Rose, *Governing the Soul: The Shaping of the Private Self*, 2. ed., (London: Free Association Books, 2005), 230, http://www.gbv.de/dms/mpib-toc/637013107.pdf.

the creation of market relationships where they otherwise would not exist."[80]. For Foucault, the "art of government" or "governmental rationality" was what he referred to as "the conduct of conduct" or a "form of activity aiming to *shape*, *guide* or *affect* the conduct of some person or persons."[81] Governmentality, thus, acts as a system of thought and reasoning through which practices, strategies, and policies of governance can be enacted morphing how problems are viewed, how objectives are defined, and how governing techniques are developed and established. Engaging closely with the concept of governmentality, Nikolas Rose's works examines the way that institutions and governmental practices have influenced individual subjectivities and behaviours.[82] For Rose, the field of psychology and psychiatry (along with its psy-professions) provide the means through which human behaviour is regulated, managed and ultimately governed, shaping the conduct of the individual and the population.

Other scholars have investigated the way that the area of wellness and mental health encourages individuals to think of themselves and perform as "entrepreneurs of a business"[83] putting forward their best skills and assets. Ultimately, individuals' mental and physical wellbeing are investments which they—as autonomous, self-reliant, and productive individuals—must work on, develop, and manage in order to become their best versions of themselves. If the individual is unable to perform accordingly, however (i.e., in a productive and efficient manner, taking care of their mental and physical health, all while maintaining a work-life balance), they are alone in their failure and are

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[80] William Fay, "Neoliberalism and Radical Rights: On the Work and Theory of Law and Organising," *International Journal for the Semiotics of Law* 36, no. 2 (2023): 411.

[81] Foucault, *The Foucault Effect*, 2.

[82] Rose, *Governing the Soul*, 230; Nikolas Rose, *Inventing Our Selves: Psychology, Power, and Personhood*, (Cambridge: Cambridge University Press, 1998), https://doi.org/10.1017/CBO9780511752179.

[83] Sugarman, 104.

"expected to bear sole responsibility."[84] Such market-driven and entrepreneurial logic extends to university settings and has affected the implementation of mental health services and resources available to students.[85] An analysis of the type of aid readily available to students through their post-secondary institutions is therefore of prime concern in order to understand in what way neoliberal rationality has influenced and shaped such school resources and services.

My hope is that by combining both Hacking's conceptual framework and a critique of neoliberalism in the mental health services of Canadian post-secondary institutions, I can offer insight into the way the institution engenders ideas around anxiety and is ultimately involved in the "making up" of the anxious student. As such, at the core of this investigation lie the following research questions. First, how is anxiety conceptualized and disseminated by experts within the university, specifically as it relates to undergraduate students? Second, how does discourse on anxiety in post-secondary institutions influence the type of resources and services available to students? Finally, how does discourse on anxiety (or the way that anxiety is conceptualized by experts), as well as the type of services and resources that universities promote, both work in tandem to produce the "anxious student"?

In what follows I will outline the qualitative methodological approach used to answer the abovementioned questions along with some considerations due to the advent of the COVID-19 pandemic during my investigation.

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[84] Sugarman, 105.

[85] Katie Aubrecht, "The New Vocabulary of Resilience and the Governance of University Student Life," *Studies in Social Justice* 6, no. 1 (October 16, 2012): 80.

3.4. Methodology

Hacking's conceptual framework in the "making up of people"[86] directs our attention to the work of institutions and the expertise they rely upon. In my thesis, I investigate how the institution of the university, with its experts in mental health, participate in the making up of the "anxious student." By combining Hacking with a critique of neoliberalism, I also seek to examine how production of knowledge on anxiety and mental health places a significant degree of responsibility and accountability on the student encouraging an already anxious student to see themselves as entrepreneurs of the self, capable of managing and regulating their own conduct.

3.4.1. Data Collection

My research methodology integrates qualitative methods with a focus on in-depth interviews and website content analysis. To gain a comprehensive understanding of the forces at play, eight *experts* actively participating in this process were interviewed. These experts include two access case workers, two psychiatric nurses, and four clinical psychologists affiliated with three distinct universities: the University of British Columbia (UBC), the University of Victoria (UVic), and Simon Fraser University (SFU). Selection of these participants is primarily due to their position as mental health professionals working directly with students seeking mental health support. I also believe this diverse group of experts allows for an exploration of how anxiety is conceptualized within the institution.

I recruited participants via email, using a standardized template, and reached out to several mental health professionals from different universities using their contact

[86] Hacking, "Kinds of People," 298-299.

information listed on the websites of their respective university. In the initial emails, I outlined the purpose of the study, assuring participants that the interviews would take approximately 45 minutes to an hour maximum and would be recorded and transcribed for analysis. Upon their agreement to participate, I provided them with a consent form that emphasized the ethical considerations of my study as well as the measures in place to maintain their anonymity (such as using random pseudonyms not related to the participant). Several participants requested that I share the interview questions prior to the interview, to which I had no problem with and willingly shared the interview questions in advance. I did, however, mention that the structure of the interview was flexible and might lead to additional questions or points of interest during the conversation.[87]

My list of interview questions consisted of general questions asking participants about their job title and description of their role and responsibilities. I asked participants to describe anxiety and mental illness and how the two concepts are related to one another, if anxiety to them is viewed as a mental illness or not necessarily so. These questions usually prompted more questions that were not part of my list but seemed to come up naturally in conversation such as questions around student wellbeing and mindfulness and what these terms mean in relation to student anxiety and mental health and mental illness.[88] I also included questions on resources and services available to students and their opinions of them. These questions were meant to investigate the way that conceptualizations of anxiety are reflected in the resources and services available to

[87] Selection of participants was unfortunately cut short due to certain unforeseen circumstances. Upon my explanation of the study to one of the potential participants, they requested to meet with myself, my supervisor (Dr. Dany Lacombe) and their supervisor to ask for further details of the study. Although my study had been approved by the Ethics Review Board and I guaranteed complete confidentiality of participants the request for an interview with this prospective interviewee was denied on account that my data would not protect the identity of my subjects.

[88] Many participants preferred to use the term “mental health” as opposed to “mental illness”. For example, how anxiety affects one’s mental health, which does not necessarily signal a mental illness.

undergraduate students. I have provided the full list of my interview questions in the appendix section.

3.4.2. Website Content Analysis and COVID-19 Considerations

Significant advancements in technology have made it easy and convenient for people to access assistance through online platforms, and mental health resources are no different. Although access to mental health resources via the internet was already on the rise prior to my research, the advent of the COVID-19 pandemic and the consequent lockdown forced most in-person mental health services to transition to an online format, including post-secondary institutions.[89] Universities across Canada have revamped their mental health and counselling websites to include an array of digital mental health support, most in the form of self-help and self-management strategies.[90] Thus, considering the amount of information and resources now available in digital spaces I decided to integrate a comprehensive review and analysis of the health and counseling websites of UBC, UVic, and SFU into this study. These websites serve as official platforms for disseminating knowledge related to mental health services, thereby offering a unique window into the strategies and practices that universities deploy and encourage as a response to the rise in reported anxiety amongst university students.

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[89] Resources such as one-on-one counselling, group counselling, and psychiatric consultations whether on- or off-campus were done remotely, through telephone calls or videoconference platforms.

[90] Devon J. Hensel, “Digital Interventions to Improve College and University Student Mental Health,” *Journal of Adolescent Health* 71, no. 2 (August 1, 2022): 141–42, https://doi.org/10.1016/j.jadohealth.2022.05.017.

3.4.3. Data Analysis Using NVivo

To ensure a comprehensive analysis of the data gathered through expert interviews and website content, I used NVivo, a qualitative data analysis software which assists in organizing, coding, and analyzing qualitative data. Data from interviews and website content were transcribed and systematically organized within the NVivo software. The raw data was then coded to identify recurring themes and relevant patterns. Finally, I conducted a thematic analysis to identify key themes and sub-themes, which will be discussed in depth in the following chapter.

Chapter 4.

Findings: Defining Anxiety

In this chapter, I will begin by unpacking the definition of anxiety gathered from both my interviews with experts (i.e., mental health professionals) and my review of health and counselling websites from three post-secondary institutions— SFU, UBC and UVic. I hope to demonstrate the way in which a specific description of anxiety, particularly what it means to be an anxious student in university, not only works to pathologize and individualize students' experiences with anxiety, but also to normalize these experiences.

One of the surprising findings of my research is that anxiety nowadays comes with benefits. Without questioning that anxiety can be a terribly debilitating state for a university student, experts have come to think about a "healthy" anxiety, suggesting that a certain amount of it is useful to us and even necessary for our survival. By *de facto* naturalizing anxiety, experts imply that it exists on a continuum between healthy and unhealthy anxiety. This idea that anxiety exists on a spectrum of mental health helps experts describe and measure students' experiences with anxiety as either normal (even beneficial) or a mental illness. Furthermore, the implication of a spectrum not only serves to normalize healthy anxiety, but it also invites students to continuously surveil their own thoughts, behaviours, and emotions to ensure their anxiety does not become unhealthy.

4.1. Anxiety in General: A Simple "Fight or Flight" Response

When prompted to define and discuss what anxiety meant, most participants took a few seconds to formulate their thoughts before listing off a set of physiological reactions including a racing heartbeat, rapid breathing, racing thoughts, sweaty palms, and so on. For most of the participants, anxiety was easiest to describe in terms of one's biological "fight or flight" response, stating anxiety to be a "system-wide explosion that affects your body… your thinking… your emotions and your behaviour." Another participant echoed similarly, stating that "anxiety is marked by physiological symptoms… Like muscle tension, increase in heart rate, breathing changes are almost always noted, and digestive discomfort." However, although participants' discussion of anxiety was initially focused on the physiological changes one experiences in that state, for most participants, anxiety also became a discussion of the context under which these physiological reactions associated with anxiety tend to arise. Indeed, for many participants, anxiety is a normal natural reaction to unforeseen circumstances in one's environment. Many gave the example of a situation in which one may encounter a physical threat such as a wild animal—a situation that triggers a natural "fight or flight" response. Participants recognized that in the case of a university setting, it was a given that students would feel a level of stress during their undergraduate experience. For example, one participant stated, "a lot of student anxiety is focused primarily on writing exams, or I guess now it's like online learning." Another participant mentioned that the student "could be dealing with an exam and that's a stressful experience… there's also a threat attached to it of getting a bad grade and the implications of that." Moreover, it seems that participants are well aware of the stressful *environment* that is post-secondary education indicating that various socio-political and economic conditions negatively affect students. Still, participants do not seem to question this environment, and student struggle is often portrayed as something to be expected, as a

matter-of-fact by-product of higher education. This acceptance normalizes the relationship between student anxiety and the university context, and in the process shifts most, if not all, responsibility onto the student.

As mentioned, for participants the “fight or flight” response was a popular way of describing anxiety. This response is specifically attributed to evolutionary approaches to psycho-physiological human experiences. Such an approach suggests that anxiety is an adaptation that has evolved over time to help us avoid danger and increase our chances of survival. This view of anxiety was also prominent in the information provided by webpages. Although many of the webpages seem to skip in-depth descriptions of anxiety—perhaps assuming students already know what anxiety is—those that do provide a brief definition often rely on evolutionary ideas of human psychology. For example, anxiety info sheets provided by the Centre for Clinical Intervention (or CCI, a website commonly found in the self-help resources section of university health and counselling websites) asserts that anxiety serves as an “evolutionary purpose to perceived danger”. The CCI info sheets go on to explain that “the experience of anxiety is very similar to the experience of fear, the main difference is that anxiety occurs in the absence of real danger” meaning that an individual’s life is not actually in any *physical* danger, but the person may *believe* they are. Anxiety in this instance is described as one’s reaction to perceived *potential* danger, and not an actual “objective” or “physical” threat in and of itself. Thus, anxiety can arise whenever, wherever and for whatever reason.

The information in websites along with participants’ description of anxiety paint an isolated picture of anxiety making students’ experiences highly individualized. Indeed, experts (i.e., participants) and website information provided by universities maintain that anxiety is a very normal and natural human reaction. “What causes the experience of anxiety is that the person believes that they are in danger. Therefore, in the case of anxiety

there may not be any actual danger—the person just thinks there is.[91] "But while the claim that students are not in any "real" physical danger in universities—there is no lion waiting to jump at them in the classroom— seems obvious, it does leave unexamined the deeper structural conditions affecting the current generation of students. There might be many other reasons—environmental, economic and political— why students are stressed out or anxious at this time. By emphasizing mainly that anxiety is a natural and inevitable human response, experts end up detaching anxiety from the larger context in which it manifests itself and inadvertently normalize difficult and stressful conditions under which students study—large student debts, fear of future employment, fear of environmental disaster, and so forth, on top of their academic stressors. Additionally, this detachment shifts responsibility of fearful experiences onto the individual, specifically.

In the next section, I will discuss the concept of mental health and show how students' ability to cope with anxiety (or how students choose to handle anxious experiences) functions as an indicator of their overall mental health.

4.2. Anxiety and the Mental Health Spectrum

Although anxiety itself was not always explicitly described as existing on a "continuum", all participants and most websites discussed anxiety as pertaining to one's overall mental health. Moreover, as participants stressed, mental health today is always discussed as existing on a continuum of health. "Mental illness is when your mental health on a *continuum* (my emphasis) has become problematic in that it is interfering with [your] ability to function". Although it is unclear from this participant whether what has become

[91] Centre for Clinical Intervention, "What is Anxiety?," Government of Western Australia, 1, https://www.cci.health.wa.gov.au/~/media/CCI/Mental-Health-Professionals/Anxiety/Anxiety---Information-Sheets/Anxiety-Information-Sheet---01---What-is-Anxiety.pdf (accessed July 1, 2023).

problematic is one's anxiety itself, we can assume from this statement that any mental state which seems to hinder the student's ability to *function* can be deemed problematic and therefore has the potential to be diagnosed as a mental illness. Indeed, another participant clearly echoes the link between anxiety and mental illness by stating, "I think that anxiety can be more or less distressing, and it isn't until an experience really debilitates quite seriously—or like, in an ongoing, prolonged period—that I would consider it a mental illness." For participants, one's inability to handle anxiety, especially on a regular basis, indicates a disruption of one's mental wellbeing.

Interestingly, within the spectrum of mental health, anxiety can serve as a "productive" mechanism, in which case anxiety is deemed "unproblematic" and one's mental wellbeing "normal" or "healthy". A news blog on "Mental Health Myths and Facts" found through the UVic website explains how "anxiety can help us prepare for future obstacles," moreover, "experiencing fear is advantageous when we must escape or confront an immediate hazard."[92] But for anxiety to be beneficial, the student would need to shift their perspective and view their anxious experience as something other than a burden—and therefore not necessarily a bad thing—as something that can spur them into academic productivity. Then perhaps this type of anxiety would not have to be an enemy but could instead be harnessed and used to the student's advantage.

The concept of mental health plays an important role in how experts conceptualize student's anxiety. My participants explain how anxiety can be problematic insofar as it negatively affects students' overall mental health. Anxiety is often described as something that although brings about negative psycho-physiological feelings—increased heart rate,

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[92] Reina Stewart and Cassandra Turner, "Mental Health Myths and Fact*," University of Victoria, The Online Academic Community,* October 8th, 2019, https://onlineacademiccommunity.uvic.ca/riskybehaviourlab/mental-health-myths-facts/

shortness of breath, muscle tension, sweating, ruminating thoughts, and so on—it is ultimately something that the student can learn to control and cope with, if they so choose.

In the next section I will first introduce the idea of "helpful/unhelpful coping" as described by participants. This idea was often used by participants to illustrate what it means to "properly" cope with one's anxiety. Indeed, this is what mental health professionals refer to when they mention that students can choose to learn to control their anxiety. Following this, I will discuss how student's ability or inability to cope with their anxiety is said to impact their overall function. According to participants, if the student is unable to develop helpful coping habits to deal with their anxiety, then they run the risk of developing a debilitating anxiety that can potentially impair their everyday functioning—bringing the student closer to a state of mental illness.

4.3. Helpful/Unhelpful Coping and Student Function

Through their discussion of coping with anxiety, participants and webpage information described students' method of coping—or how students choose to handle their anxiety—as either helpful or unhelpful. They described the idea of helpful/unhelpful coping as the students' ability or inability to *use* their anxiety to their advantage. One of the participants, for example, mentions how new undergraduate students will most likely "feel anxious" as they enter a new environment with new sets of expectations and academic material they have never encountered before. In this case, "a certain level of stress *is required* (my emphasis)" for the student to grasp the new material and perform adequately.[93] Such stress (or anxiety) can be deemed beneficial so long as the student manages it using

[93] It is also worth mentioning that stress and anxiety were often used interchangeably amongst participants. However, this was not always the case with information disseminated in online spaces.

helpful strategies that allow for acceptable academic performance. Another participant also alluded to the necessity of anxiety stating, “everybody has anxiety, and we *need* it. It serves an incredible purpose in our lives. So, we don't want to *train* away people's anxiety.” In other words, student anxiety, a natural response to the university context, must be mobilized to produce a positive outcome.

Along the same lines, information provided by websites assert that in the right context *and* if dealt with “properly”, student anxiety—about keeping up with new material in a competitive environment for example—can elicit “beneficial” outcomes.

> Everyday stress actually makes us stronger. Like exercise works our muscles and prepares them for greater physical exertion, managing everyday stress by using healthy coping strategies helps us become emotionally and psychologically stronger. It makes us more resilient to life’s challenges.[94]

In the Emotional Wellness page found in SFU’s Health and Counselling website students are encouraged to download the Mindshift app that helps students recognize their anxiety and shift their perspective in order to “develop effective ways of thinking”. Furthermore, many workshops offered to students through the Health and Counselling website are designed to encourage students to not only recognize what anxiety is and when it may arise, but to also help students “build resilience” through “shifting perspective and practicing self-compassion.” Indeed, anxiety does not have to be an overall negative experience, it may begin as an uncomfortable reaction, but it need not develop into unhelpful coping habits. Depending on how students choose to approach their anxiety, they may actually be able to *thrive* with it rather than succumb to it.

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[94] “Every Day Stress,” *Residence Life blog, UBC*, accessed November 17th, 2023, https://vancouver.housing.ubc.ca/everyday-stress/.

While anxiety is said to have its benefits (depending on how the student "chooses" to deal with their anxiety), participants also indicated unhelpful approaches to anxiety which although may provide short-term relief can become detrimental to the student. One of these unhelpful approaches (and really the only unhelpful strategy brought up by participants and found in webpages) is that of "avoidance behaviours": avoiding signs of anxiety (i.e., ignoring or downplaying symptoms of anxiety and waiting until they subside) and/or avoiding triggers or situations that can cause the student to become anxious.[95] As explained by one of my participants "the natural reaction to whatever is causing me anxiety is to avoid. But you know, you get some short-term relief out of it, but it actually can make things worse in the long term."[96] Although in the context of an objective danger (an encounter with a wild animal for example), avoiding such danger may save one's life, in a university setting, avoiding completing assignments or procrastinating is an unfavorable reaction and is therefore deemed unhelpful to the student.

Moreover, unhelpful coping strategies, such as the ones mentioned above, indicate to the participants a psychological state which hampers students' ability to function in everyday life, and which can ultimately lead to a mental illness. One of my participants mentioned, "I think that anxiety can become a problem when you try to manage it in a way that maybe [works] in the short term, it's helpful, but longer term actually makes things worse", implying that seemingly "helpful" strategies such as avoidance may

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[95] Marco Istasy, Rana Elias, Maria Raheb, and Zack Cernovsky, "Substance Abuse and Stress Levels in Canadian University Students," *Archives of Psychiatry and Behavioral* Sciences, 2, no. 2 (2019): 5. Avoidance manifests in a multitude of different habits such as procrastination, avoiding uncomfortable situations, and downplaying one's mental state. However, more serious coping habits include the use of alcohol and non-prescription drugs to relieve stress. Although, surprisingly (to me) substance use was not found anywhere in my data collection, it is an unhelpful coping strategy prevalent in within this population and one universities are also struggling to curtail.

[96] The statement that avoidance in the long-term is not a sustainable management strategy for anxiety, of course, alludes to the type of self-management strategies deemed appropriate for students that I will touch on in chapter 6.

in the long-run become an unhelpful way of coping. Another participant stated that "depending on how we react to the anxiety, how we *choose* to manage the anxiety, that could lead to mental illness or an anxiety disorder." Meanwhile, information found in the anxiety disorder section of the Canadian Mental Health Association (CMHA) echoes both participants stating that "anxiety disorders may be more likely to occur when we have certain ways of looking at things or learn *unhelpful* coping strategies from others."

For participants and webpage information, it is imperative that the anxious student makes the right choice. This begins by wanting to learn the right strategies to cope with the overwhelming emotion that is anxiety. In claiming that there are different ways to cope with anxiety (helpful and unhelpful ways), experts essentially task the anxious student with taking near full responsibility of their own mental health condition, despite any and all factors that may trigger anxiety.

4.4. Normalization of Anxiety: A Natural and Inevitable Experience

Thus far, I have described the way anxiety is defined according to mental health practitioners and website information (or the experts). Indeed, one common theme that emerged (as already stated) is that of naturalizing anxiety—anxiety as a natural, accepted, and inevitable part of the human experience, inherent in our system of processing danger. This process of naturalizing is important in shaping our collective understanding and perception of anxiety. However, in the making up of the anxious student, naturalizing anxiety is but a small (although integral) part in the bigger process of normalization.

A pivotal component in the making up of the anxious student is the process of normalization, a process which requires that knowledge on the subject of anxiety be circulated within the student body. Ultimately, this dissemination of knowledge to the

subjects being labelled (and even those not yet labelled) will have an impact in shaping their self-understanding as anxious students.

In this next section I will describe the role that psychoeducation and mental health promotion play in the process of normalization. I will then delve into the concept of the spectrum that serves to define anxiety's seemingly fluctuating "nature" (patterns which are not yet considered a disorder or illness but for which it could have the potential to become detrimental to the student) as a normal part of the student experience. The idea of the spectrum not only serves a role in normalizing anxiety, but it can also serve as a self-measurement tool letting students know if they have a proper handle on their anxiety or if they are tittering on the edge of illness. Finally, the spectrum as a self-measurement tool invites students to continuously surveil their own thoughts, behaviors, emotions, and actions. This constant self-surveillance, I argue, promotes maintenance and proper self-management of one's anxiety so as not to fall into the realm of illness.

4.5. Psychoeducation and Mental Health Promotion

Interviewees and webpage information, along with other campus-wide promotion strategies, make an effort to provide a clearcut definition of anxiety through a concept known as "psychoeducation". Psychoeducation merges together components of cognitive behavioural therapy, group therapy, and education.[97] It is the process by which individuals can increase their mental health "literacy" or knowledge on various mental illnesses. It also seeks to provide strategies and skills that individuals can utilize on an everyday basis.[98]

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[97] Sujit Sarkhel, O. P. Singh, and Manu Arora, "Clinical Practice Guidelines for Psychoeducation in Psychiatric Disorders General Principles of Psychoeducation," *Indian Journal of Psychiatry* 62, no. Suppl 2 (January 2020): 319–23, https://doi.org/10.4103/psychiatry.IndianJPsychiatry_780_19.

[98] Sarkhel, Singh, and Arora, "Clinical Practice Guidelines," 320.

The goal of psychoeducation is to help individuals understand their condition, develop coping strategies, and improve their overall functioning and quality of life.

A central focus of webpage information is to destigmatize mental illness in general while promoting mental wellbeing through psychoeducation. In 2021, the CMHA provided examples of how universities across Canada could increase mental health awareness. One of these examples was through the use of “mental health symposiums, forums and dialogues on mental well-being and mental health issues across campus” which would “decrease stigma and fear while increasing openness to taking action.” Student services at UBC is also making an effort to “open up conversation” around mental health stating that often “many students won’t seek help because there is still a stigma around mental illness… That’s why it’s important to talk openly and honestly about mental health.” In an effort to destigmatize mental illness, mental health promotion strategies ultimately seek to normalize and reinforce particular discussions around anxiety. This is to say, the type of information the student finds online helps to open up conversation around mental illness and mental health. It also reassures the student that they are not alone, and that anxiety is not all that abnormal, especially in such a competitive environment such as post-secondary.

Anxiety websites recommended to students are designed to destigmatize anxiety. For example, the CCI Info Sheet on Anxiety reassures the student:

> “Anxiety can affect any kind of person at any stage of their life, whether they are an introvert or an extrovert, socially active or shy, youthful or elderly, male or female, wealthy or poor…whatever your distinction, you can become anxious… [meaning] that any person you know is also fair game.”[99]

[99] Centre for Clinical Intervention, "What is Anxiety?" 1-2.

Such professional reassurance encourages the student to view their anxiety as something they should not be ashamed of as it is something that "everyone experiences at some point during [one's] undergraduate degree."[100]

Furthermore, as a student of SFU, if you are in search for some self-help resources,[101] the SFU website provides a link to HealthLink BC that takes you to a page where you can find further information on plenty of mental disorders and mental health in general, including anxiety. According to HealthLink BC, "mild to moderate anxiety can help you focus your attention, energy, and motivation." Some interviewees echoed similarly mentioning that a "certain level of stress is necessary" and that we need to "learn a relationship with anxiety; that sometimes anxiety can be okay and can serve a purpose. It doesn't always have to elicit fear." Understandably, if we are to assume that anxiety is and will be an expected part of the student experience, then the student must come to recognize it in order to choose the proper coping strategies.

4.6. The Spectrum as an Invitation to Self-Surveillance

Now that the student has been educated on issues of anxiety such as what it feels like, its conception as a natural human experience, its inevitability and so on, the student has as their task to not let anxiety "get the best of [them]" as one of my participants stated. For this task, the student has a great tool at their disposal, that of the spectrum. The concept of a spectrum—or as some participants refer to, a "continuum"—is incredibly important, not only in its role in normalizing anxiety, but also in its role in educating the

[100] Participant 7.

[101] I myself was recommended to this section of the website while on the waitlist for a practitioner.

student on what “proper” management of anxiety looks like in order to “better” one’s overall mental wellbeing.

A current issue within the psy-community (and a tension which was also present in my interviews) is their efforts to remain independent of the medical community. For example, illness and disorder are often concepts that many clinicians and people in the psy-professions have continually tried distancing themselves from. However, psychopathological terminology remains omnipresent on campus. In their concern with trying to distance themselves from terminology that seems to align more closely with medicine, mental health professionals (and promotional strategies alike) offer instead the idea of a spectrum. Within this spectrum, concepts such as mental illness or disorder are of last resort. As one of my participants stated, “mental illness is different from anxiety. Anxiety is not mental illness. And anxiety disorder would be classified as a mental illness, but I think, most of the experience that most students experience is not mental illness.”[102] Minimizing the idea that anxiety is a mental illness or disorder, another participant stated, “I think when you get trapped in that kind of management[103], you know that’s when we start to talk about disorder, or a mental illness. But… it has to impair *functioning*. If the person is still functioning, then I don’t think—we wouldn’t call it a disorder.” The spectrum thus attempts to present an alternative to the more categorical medical terminology of anxiety (i.e., disorder and illness), a shift that provides the

[102] This quote echoes most participants on the idea of disorder and mental illness. Other participants stated that when the student “[is] not actually performing—where they're not able to have connection in a relationship or where they're not being successful at all academically, in those situations absolutely (diagnosis may be necessary). And that's why I think we need to save the resources. We need the resources; psychiatry and medication when people have severe illness, but that isn't the majority.”

[103] Here the participant was referring to an unhelpful management of anxiety, an avoidance strategy, where the student is constantly avoiding doing things that induce anxious feelings and it slowly turns into a vicious cycle, “[for example] the more I avoid the more anxious I get. And then the more I want to avoid and the more anxious I get.”

student with a more dynamic or fluid way to measure their own mental state. Moreover, because illness and disorder reside at the most undesirable end of the spectrum, students are encouraged to keep an eye on their mental state (and therefore their anxiety) so as to remain on the healthy side of the spectrum. The spectrum, thus, deploys an understanding of anxiety, where anxiety moves on an axis with healthy and unhealthy anxiety at each end. With the spectrum in mind, students can begin to evaluate how their coping strategies (helpful/unhelpful) lead to healthy or unhealthy anxiety.

The spectrum gives rise to a particular kind of atmosphere, one that affects the way students are encouraged to understand themselves as anxious students. By offering students the idea that anxiety can affect anyone and everyone at any point in time and that it need not be pathological for it to merit continuous attention the student is invited to a constant surveillance of their thoughts, emotions, and behaviors. Although most students will not be diagnosed with any type of anxiety disorder, the atmosphere on campus is one of *potential* mental diagnosis. The making up of the anxious student thus necessitates that the student, with all their newfound knowledge applies such psy-knowledge to their understanding of themselves and remains cautious of their potential to become mentally ill. The student must use this information to their advantage by first accepting and embracing[104] the "fact" that anxiety is an inevitable human experience—especially in an environment that fosters a high level of academic performance and ruthless competition—and then finding "proper" ways to cope with this inevitability.

[104] Interestingly, a big component of a therapy rising in popularity called Acceptance and Commitment Therapy (ACT) assumes that individual's suffering arises from attempting to control or avoid unwanted thoughts, emotions, and experiences, and therefore instead of fighting their situation the individual could benefit from accepting them instead.

4.6.1. The Making Up of the Anxious Student

In sum, this chapter demonstrates an in-depth exploration of anxiety as conceptualized in the context of post-secondary education, emphasizing the role of experts and website content, psychoeducation, and the normalization of anxiety. Anxiety is conceptualized as a natural and inevitable human experience that can be used to the student's advantage. Such normalization is reinforced through mental health promotional strategies and psychoeducational information which students are encouraged to integrate into their day to day lives. The idea that anxiety can be harnessed for academic productivity points to a neoliberal rationality emphasizing personal agency and the belief that individuals can turn potentially negative experiences into positive outcomes. In addition, by framing anxiety as existing on a spectrum and pressuring students to maintain constant surveillance of their mental health, students are encouraged to take control of their emotions and behaviours, fostering a sense of self-responsibility and self-determination. Indeed, such an expectation that students should continuously keep a watchful eye on their own thoughts and behaviours reflects the neoliberal ethos of self-discipline and self-optimization.

Chapter 5.

Findings: Managing Your Anxiety

In this chapter, I will be discussing how the transformation of therapeutic models found in the universities of British Columbia play a crucial role in shaping the counseling services available to students. I will also discuss certain limiting factors that affect the composition of these models and how understanding such limitations is essential to comprehending the current landscape of mental health resources on campuses. Through my investigation with participants, it becomes evident that mental health practitioners are confronted with numerous challenges which ultimately compel them to adapt their therapeutic models and promote self-help resources as a means of addressing these limitations.

One specially damning limitation that students must grapple with is the long wait times for counselling on campus. In response to the challenges associated with long wait times for professional assessment and counseling, universities are increasingly encouraging the use of self-assessment tools and online resources to mitigate students' mental health. Although these tools come with the caution that they should not substitute professional assessment, they play a significant role in shaping students' understanding of themselves as anxious students.

In addition, these self-assessment tools also provide recommendations for students, mostly in the form of self-help strategies. A myriad of self-help and self-management tools for students can also be found in all three of the universities' mental health and counselling websites. In the final section of this chapter, I will select a sample of the various mobile applications and online self-help resources the universities make

available to students and show how these resources play an important role in the making up of the anxious student.

5.1. Transformation of Therapeutic Models in B.C. Universities

It is important for my research to investigate the way that limiting factors, such as long wait times for students seeking counselling, can have an impact on the type of counselling (or therapeutic model clinicians prefer using) students can expect from professionals as well as how these limiting factors influence other types of mental health services offered to students. As we will see, the ongoing reformulation of therapeutic models relies heavily on self-help tools (such as workshops, mobile applications, audio and video recordings and so forth) and promotes constant self-surveillance and management of the self.

As one of my participants commented, “demand is high; resources are limited”, it is no secret that post-secondary students usually experience long wait times for on campus counselling services. Even prior to the COVID-19 pandemic, Canadian universities have seen an increase in demand for mental health services, in particular one-on-one counselling. And while many universities are experiencing budget cuts due to decreased student enrollment, among other reasons, demand for mental health services remains steadily high.[105] The fact that students will usually experience long wait times and universities have limited mental health resources available is very well known amongst mental health practitioners. For example, one of my participants stated, “I don't think we're doing enough. I think the fact that we've got to wait list… speaks to our falling

[105] American Psychological Association, "The Crunch in College Counseling," *Monitor on Psychology*, September 2020, https://www.apa.org/monitor/2020/09/crunch-college-counseling.

short of what would be really helpful… We just don't have the resources to meet the needs of all the students in a timely fashion." Another participant mentions how universities keep growing but resources "keep maxing out"[106].

Limited resources are not the only factor influencing the nature of mental health resources. Participants also mentioned the rate at which students discontinue therapy sessions prematurely as a key factor influencing the current transformation of therapy on campus. One participant, when asked to estimate around how many of the students he treats are recurring clients stated, "I think in terms of recurring, it is actually a very small number. I would say it's maybe 5%."[107] Another participant stated, "looking at our stats here, I would say students on average were doing two to three sessions, a term." Recognizing that "students are busy" and might not "have the time to commit to the work" of counselling, this participant added that their office is "also looking at one session at a time" to give students everything they could in that initial session to help them cope.

Finally, some participants alluded to the nature of academia as a possible factor affecting students' attendance rates. For example, one participant stated, "health services are only eligible to you while you're a registered student taking classes. So, for some people that's only… maybe three, four years of their life so it would be shorter terms of work."[108] Another participant explained how due to the short-term length of semesters, students may be in dire need of help during the most stressful times of the

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[106] Mind you this statement was recorded during the early months of the COVID-19 pandemic and so the participant was referring to the mental health resources available before the first lockdown of 2020.

[107] The participant also mentions that this number is arbitrary and that to him it seems as though a very low number of the students he receives ever actually come back for more than one or two sessions.

[108] Participant 2.

semester, but then during the holidays for example, students may not feel as though counselling is needed anymore. In addition, a combination of both long wait times and fluctuating patterns of anxiety —due to the changing academic intensity experienced in a student's undergraduate life—complicates an already complex issue even more.

As it is the case, semesters are usually only four months long, and during that time the student will go through very stress-inducing situations such as adjusting from high school to post-secondary, rigorous studying, deadlines and exams. Getting to see a clinical psychologist when needed is not easy. Let's take the example of a student who feels overwhelmed at the beginning of a semester and seek counselling then. First, the student will most likely have to wait an average of four weeks[109] to get any sort of a mental health assessment before consulting. To be clear, this preliminary assessment, which can be done by a clinical psychologist, a psychiatric nurse, or an access case manager[110], does not include a therapy session. For some background information, the purpose of a preliminary therapy assessment, also known as an intake assessment or initial evaluation, is to gather important information about the client and their presenting concerns, as well as to establish a baseline for treatment planning. Following this assessment, the student may be appointed a psychologist from the University—or, if that is not possible, the student may be encouraged to make an appointment with other off-campus partner companies such as Morneau Shepell. However, due to high demand, their first therapy session may not be until later in the semester, or perhaps into the next semester (even partner companies such as Morneau Shepell experience long wait

[109] Beth Dennis, "Mental Health Support Wait Times are a Crisis on Campus," *The Queen's University Journal*, November 11, 2021. https://www.queensjournal.ca/story/2021-11-11/opinions/mental-health-support-wait-times-are-a-crisis-on-campus/.

[110] From participant 1, 3 and 4.

times).[111] Once the student is finally given the chance to attend their first counseling session, their condition is likely to have passed. In fact, according to participants, it is unlikely that the student will continue counseling long-term. This might seem surprising, but when one experiences anxiety time is of the essence. -Time limitations for the first counselling appointment, as well as financial limitations preventing students from seeking private psychologists, have presented university mental health professionals with the task of adapting and reformulating the construction of their therapeutic models. Indeed, in speaking with participants, the concept of a "brief model" was presented as the most ideal way to tackle such limitations (including financial limitations such as lack of funding for mental health resources).

5.2. A Brief Model of Care

At SFU, students are informed that "once it's determined counselling is the right option for you, you can expect registered clinical counsellors and registered psychologists to work within a *brief* (my emphasis) model of care to promote positive growth, well-being, and mental health."[112] This approach amounts to "giv[ing] students what they need in a very brief way and then if they need more put[ting] them up the next step."[113] While some participants expressed the need for more funding to accommodate the growing number of students demanding counselling services, most participants agreed that therapeutic approaches should change to reflect the limitations seen in university mental health and

[111] Of course, a student does not have to seek mental health help from the university. There are plenty of other clinics that could be recommended through a general practitioner outside of campus. However, these services can cost anywhere between 50 and 300 dollars (or more) per therapy session. Students may not have this luxury and therefore, university mental health services are incredibly important to them.

[112] Quentin Beck, "Here's What to Know about Counselling," *SFU Our Learning Community*, June 19th, 2023, https://olc.sfu.ca/olc/olc/index.php/blog/heres-what-know-about-counselling.

[113] Participant 5.

counselling services. Thus, according to my participants, a brief model of care, also known as a “stepped care model”, which is currently being implemented in university health and counselling services across Canada, is the way to go.

Although participants provided some description of the Stepped Care model, I decided to investigate further on what it entailed for students and Canadian campuses. In 2019, the Centre for Innovation in Campus Mental Health, in partnership with post-secondaries across Ontario and the Canadian Mental Health Association, developed a project that seeks to enhance post-secondaries’ ability to support student mental health and their wellbeing. This project provides a guide for developing and implementing a Stepped Care model due to increasing student demand for mental health support across Canada. The model also claims to be more “client-centric” and acknowledges students’ individual differences in levels of care. Furthermore, according to this guide, the level of care a student may receive is dependent on their individual needs and therefore the level of care can be “stepped up” or “stepped down”. Basically, what this means is that in the very first meeting with a health care professional, the professional will assess the types of needs the student is looking for and will recommend what resources are available to them at that point in time. According to the Guide, because one-on-one counselling can be time consuming and expensive, and because not every student’s needs can be resolved through psychotherapy, campuses must begin to implement more “sustainable” models of care. For example, depending on the level of treatment a student needs they may be provided with “less intensive treatments [that] include self-help approaches or peer support” (i.e., a “stepped-down” level of care). Whereas more intensive treatment may include individual therapy or psychiatric consultations (i.e., “stepped-up” level of care). Such intensive treatment may also potentially involve

medical prescription depending on the level of severity. The use of medication, however, is left as a last-resort option.

Returning to what my participants had to say on the subject of a stepped care model, it seemed that even those participants who did not mention the Stepped Care model voiced approval for implementation of changes reflecting such model. One of my participants for example mentioned that a couple years ago, SFU itself began to move "towards briefer forms of therapy, brief therapies." This in turn allowed mental health services "to double [their] individual caseloads." Since then, they "have continued to always work at trying to provide ever *briefer* forms of therapy still trying to be helpful and effective but doing brief therapy" (my emphasis). For many participants, due to the limited one-on-one sessions and long wait times, brief and packaged therapies that could fit everyone seemed to be the best option for offering students "tips, tricks, and skills" for managing anxiety, as one of my participants put it.

It is clear that mental health professionals are tasked with tackling a complex issue unique to the undergraduate student experience. On the one hand, there is an increased number of reported anxiety amongst undergraduate students and thus a high demand for mental health resources. On the other hand, however, students seem to express a low level of commitment to long-term counseling due to a multitude of personal and/or practical reasons. In such cases, clinicians only get one maybe two sessions with a student; traditional long-term counseling becomes unpractical for the student and the clinician. A brief model of care is thus presented as a favourable solution capable of tackling these limitations. However, this model can also be seen as a cost-effective "one-size fits all" model characteristic of neoliberal ideology. Indeed, under neoliberalism counseling and therapy become instruments of self-governance, encouraging individuals to adopt self-disciplinary practices to enhance their mental

wellbeing. So, while it may be that the stepped care model is currently the best approach to dealing with these limitations it can also be seen as a by-product of a larger system that prioritizes cost-effective measures and maximizes efficiency at the expense of more holistic ways to attend to students and their mental needs.

5.3. "Time to check in on your mental health" – Self-Assessment (Diagnostic) Tools

Whether it is to counteract the slow-moving waitlist for counselling (and/or to see a physician[114]), or to increase access to psychoeducational information (or both), online access to self-diagnostic tools is becoming increasingly encouraged to university students. In this section I will describe two popular online self-diagnostic tools that are representative of most tools offered through UBC, UVic, and SFU's health and counselling websites that I examined during my investigation: The Bounceback self-assessment quiz[115] and the Here to Help Screening Self-Test.[116]

5.3.1. The BounceBack Quiz and The Here to Help Screening Test

The Bounceback quiz is a tool meant to assist students identify their current degree of resilience and provide insights into how they may enhance their ability to "bounce back" from stressful situations. During the quiz the student is asked to rate their responses to a variety of circumstances on a scale of 1 to 5 in a series of questions throughout the test. A variety of subjects are covered in the questions, such as one's capacity to control stress, adjust to change, and keep an optimistic viewpoint. The

[114] I mention physicians since other than psychiatrists, general practitioners can also prescribe certain mental health medications.

[115] A free program from the CMHA.

[116] A project of the BC Partners for Mental Health and Substance Use Information.

student is then given a score at the end of the quiz that represents their level of resilience. Additionally, they also receive tailored feedback that highlights their advantages and places for development. Similarly, the Here to Help screening test is a self-diagnostic tool created to assist people in determining whether they are exhibiting signs of common mental health illnesses. The self-screening consists of a series of inquiries into one's attitudes, feelings, and actions over the previous two weeks. The questions are intended to assist in identifying symptoms that are frequently linked to various mental health conditions. These conditions can range from feeling more stressed than usual (which is not necessarily a disorder) to more debilitating mental states such as depression, anxiety, eating disorders, and substance abuse disorders. After completing the screening, the student is given a score that indicates how likely they are to develop each disorder. This does not imply that the student has a disorder. The scores only demonstrate how likely it is that the student will develop a mental health disorder (such as depression, anxiety disorders, eating disorders and substance abuse disorder) if they continue feeling the way they currently do.[117] Additionally, they also get personalized feedback that offers explanations for their current mental state and suggestions for the way forward.[118] Finally, both tools mention that online screening

[117] For example, when I did a sample self-assessment (answering in the way I assume an anxious student may be likely to answer), my results indicated that I have "symptoms of depression" which also indicate "some risk to self-harm". The screening also found that I have some "symptoms consistent with one or more anxiety disorders, or that milder symptoms are negatively impacting [my] daily life." Finally, the test concluded that "a full evaluation by a mental health professional is recommended."

[118] Such feedback gives students an indication of whether they are experiencing symptoms of depression, anxiety disorders, eating disorders, and/or other mental illness. Feedback also includes psychoeducational components, for example, the section on wellbeing (which includes anxiety) informs students on what proper wellbeing looks like and factors that could hinder their mental wellbeing. The section on anxiety indicates how likely the individual is to have symptoms consistent with various anxiety disorders. The assessment also informs students about their level of function in various important areas of their life such as work life, home and social activities. Finally, the feedback gives students different resources they can access, most of which include self-help tools and "tip sheets". Interestingly, it also encourages students to "check-in" again in a few weeks: "feel free to come back in a week or two and screen yourself again."

should not be used in place of a professional evaluation by a mental health specialist because it is not a diagnostic tool.

Despite the common cautionary statement present in most tests—that it should not be used for diagnosis and instead should be thought of as a tool for psychoeducating the student—the tests ultimately invite the student to understand themselves within the realm of psychology, mental health, and disorder. Language and discourse, as Foucault discusses in various of his works[119], have the power to shape and influence social behaviour. Indeed, labels are never innocent. Power dynamics are inherent in classification systems and language use. Consequently, such self-assessment tests will inevitably have an impact in the way that the student comes to understand their lived experience as a student under immense amount of pressure. Although my investigation lacks the direct experiences of undergraduate students themselves, these self-tests highlight an ever-present atmosphere on campuses—one of self-surveillance through a psychologically dominated lens. Self-surveillance in this context not only propagates a particular understanding of the self as an anxious student but it also champions self-management practices. A professional diagnosis is not needed for treatment.

Of course, a self-assessment into one's wellbeing is only the initial step into the self-management of anxiety. Likely unable to receive affordable traditional counselling on campus when they need it, students can easily fall in line with neoliberal ideology of self-reliance and self-responsibility as they learn that it is up to them to practice and maintain anxiety-management skills. The rest of this chapter will focus on

[119] Michel Foucault, *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, trans. Colin Gordon (New York: Vintage Books, 1980), 69-70.

the various self-management tools and practices encouraged to students throughout universities' online spaces.

5.4. Online Self-Help Resources

Throughout my investigation I found that the most popular form of disseminating self-management skills come in the form of self-help strategies through online spaces. Even when mental health professionals provide students with resources that can help them outside of counselling these resources are often found online. Moreover, the advent of COVID-19 also necessitated that most resources adapt to online spaces. For example, many of the workshops provided by SFU Health and Counselling often used to take place in lecture halls or smaller rooms throughout all three of SFU's campuses. However, today most workshops are found online, through the health and counselling website. Although workshops are a popular tool encouraged to students, other resources include self-led courses, information sheets, worksheets, audio and video recordings and apps dedicated to cultivating behaviors that can foster one's mental health. In what follows, I will be discussing different themes that emerged during my investigation into these different resources. Although I will not be going into full detail on every resource I found, there are a few that I believe aptly exemplify self-disciplinary themes found throughout all self-help student resources.

5.4.1. Relax and Take a Breather! Relaxation, Breathing and Meditation Apps

If a student decides to browse the SFU website for some resources to help them cope with their anxiety, they can find several in the main page of the website. Clicking on "Finding Resources" will bring the student to a page with several different options, the

very first one being “self-guided resources”.[120] Some of the many self-guided resources include audio and video recordings—usually facilitated by clinical counsellors or practicum students—as well as app recommendations specific to breathing techniques and relaxation. Two very popular mobile apps recommended by SFU’s health and counselling website under their self-guided resources are Headspace and Calm. Both are geared towards cultivating mindfulness and promoting relaxation and better sleep. I will be discussing how they work in the following paragraph, however, I found that these two apps are so close in similarity that explaining both in depth would be redundant, therefore I will be focusing mostly on Headspace as it better encompasses a lot of what the other self-help apps have to offer.

Once the student installs the Headspace app on their mobile device, they will be asked to set up an account where they can specify their goals, interests, and current state of mind. According to Headspace, this helps personalize the experience and recommendations within the app. The app offers students various guided mindfulness and meditation sessions led by instructors and meditation teachers. Interestingly, Headspace includes an educational element to it that is not shown in the app Calm (although this element is present in the Mindshift CBT app developed by Anxiety Canada, which I will be delving into later in this section). Headspace provides a series of introductory meditation sessions that guide the student through the basics of mindfulness and meditation. In addition, it also features articles related to mindfulness and wellbeing. The educational sessions cover fundamental techniques, such as focusing on the breath and cultivating awareness. Other features from this app and the Calm app include breathing exercises, which involve following visual cues or audio

[120] Other resources include on and off campus options, resources specific to indigenous students, black students, international students, students with disabilities, students identifying with the LGBTQ community and resources on substance abuse.

prompts to guide the breath in specific patterns; sleep stories, which cover a range of genres and topics intended to create a calm and relaxing environment for sleep; and calming music tracks and nature sounds. Finally, this app also lets students track their meditation progress by providing streaks, milestones, and reminders to help users establish a consistent meditation practice (although for an undergraduate student, this may also start feeling like homework rather than a relaxed break from school).

5.4.2. Cognitive Behavioural Therapy at your Fingertips

It is no secret that cognitive behavioural therapy (CBT) is one of the most popular forms of psychotherapies practiced in North America, the UK and various parts of Europe.[121] Although originally intended for practice between a therapist and their client, CBT today has transcended traditional confines, finding popularity in unexpected domains such as mobile apps. In fact, most of the apps recommended by university websites involve some form of CBT.

One app developed by Anxiety BC and the BC Mental Health and Addiction Services is MindShift CBT. This portable anxiety management tool can be accessed through a mobile device and is designed to help individuals manage their anxiety and stress using “scientifically *proven* (my emphasis) and clinically recommended solutions” based on the principles of CBT. Like Headspace and Calm the student will first need to set up an account where they will be asked to provide information on their anxiety symptoms and their goals. The student is then taken through a series of questions to

[121] Stanley Rachman, “The Evolution of Behaviour Therapy and Cognitive Behaviour Therapy,” *Behaviour Research and Therapy* 64 (2015): 2, https://doi.org/10.1016/j.brat.2014.10.006.

assess their symptoms, identify triggers, and track their progress over time[122]. The app will then provide the student with “personalized recommendations” to help relieve their anxiety. The student may be recommended the following strategies, activities, or tools: a thought journal where the student can record their anxious thoughts and use “cognitive restructuring techniques”[123] to challenge their negative thoughts; coping cards containing positive statements and reminders for the student to manage their anxiety in the face of stressful situations; guided relaxation sessions much like those offered by Headspace and Calm; and goal setting where students can set up specific anxiety management related goals and keep track of their progress over time. Finally, like the other apps, Mindshift also offers reminders and notifications to encourage the student to check in on their mental wellbeing, practice coping strategies, and complete activities.

5.4.3. It’s not as bad as it seems! Shifting Perspective

A concept rising in popularity amongst mental health resources and self-help apps is that of resilience. The idea of resilience in the field of psychology refers to an individual’s ability to adapt successfully in the face of adversity.[124] The SFU health and counselling website offers students various workshops and online training designed specifically to help students “build resilience” in an academic context. One of these online training programs includes an eight-part YouTube series titled “8 Ways to Build Resilience”

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[122] In this section the student can also learn about the different types of anxiety and the common signs and symptoms related to that anxiety type as well as different tips on how to better manage their anxiety (the student is psychoeducated on what anxiety is, how to recognize it, and what helpful coping strategies they can use to better manage their anxiety).

[123] Cognitive restructuring techniques focus on “unhelpful” and self-defeating thoughts that may arise in anticipation of or following “situations that provoke anxiety” and encourage the individual to question and challenge these thoughts. For example, if I become anxious due to an upcoming exam and I begin having unhelpful and self-defeating thoughts, this technique recommends that I take time to think about these unhelpful thoughts and consider other ways to look at the triggering situation to help reduce my anxiety.

[124] "Resilience," *American Psychological Association*, https://www.apa.org/topics/resilience (accessed June 21, 2022).

designed to educate students on how shifting perspective of their stressful circumstances can help them build resilience. In addition, SFU also offers an online resilience training called “Bouncing Forward” which the student can access through Canvas. This online training promotes resilience-building skills that students can implement in their day-to-day life. Moreover, students learn to see their stress as beneficial to their success through self-guided activities, videos, readings, and self-reflection questions.

Meanwhile, over on the UBC website, under the “Understanding Stress and the Stress Response” page, the students can scroll down to the “Build Resiliency” section for tips and tricks on how to maintain a routine that will help them manage the negative symptoms of anxiety while fostering the beneficial side of anxiety.[125] In addition, UBC’s Thrive campaign dedicates a whole month to a “series of events focused on helping everyone at UBC explore their path to mental health” including mental health literacy promotion (i.e., psychoeducation), stress eating education, arts and crafts, yoga and mindfulness classes, and self-care kit workshops.[126] According to the UBC Thrive campaign, mental health literacy is paramount to building students’ resilience on campus. Moreover, amongst their “interactive resources” section, the student can find a riveting TED talk called “How to make stress your friend” led by health psychologist, Dr. Kelly McGonigal, where she introduces research suggesting how “stress may only be bad for you if you believe that to be the case.” Her advice is simple: “When you change your mind about stress, you can change your body’s response to stress.”

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[125] This routine consists of taking “care of the basics” (i.e., getting a full night sleep, remembering to eat adequately, and staying active), making sure the student “takes time to unwind” and staying connected with friends and family and/or getting involved in their community.

[126] “UBC Thrive,” *UBC Human Resources*, https://hr.ubc.ca/health-and-wellbeing/mental-health/ubc-thrive (accessed November 3, 2022).

5.4.4. Packaged Therapies, CBT and Resilience Building

It is clear that universities are scrambling to accommodate to resource constraint and increased demand for mental health services on campus. As a response, schools are quickly adopting cost-effective solutions such as implementing a “brief model” of care (or stepped-care model) and outsourcing to digital spaces. Although the brief model of care comes across as a source-efficient strategy providing students with mental health care options based on their individual needs it is too early to tell if such a model is effective in addressing students’ heightened levels of anxiety. In addition, although not all participants mentioned the stepped-care model, some suggested a type of one-on-one counselling that tries to deal with students’ needs in a single or a few sessions. Such packaged therapies or a “one-size-fits-all” model have not only the potential to ignore the nuances of individual student needs, but they also speak to the transformation of therapeutic models in the context of neoliberalism in higher education. By minimizing the need for traditional psychotherapy in a post-secondary environment and increasingly implementing more and more resources and services into online spaces, students’ problems with their anxiety and/or other mental health issues are left to the students’ sole responsibility.

It is also not surprising to see the supremacy of CBT within the institution as it is currently one of the most popular types of psychotherapies in North America. Unlike traditional psychotherapy, where it is required that a practitioner (whether a therapist or clinical psychologist) be present and conduct their session one-on-one with their client, the CBT model has transformed into a type of Do It Yourself (DIY) model that does not require the presence of a therapist, or any mental health practitioner. Designed as a

"structured, time-limited, and goal-oriented"[127] model requiring no professional assistance, CBT is the perfect psychotherapeutic intervention for an institution seeking rapid and cost-effective measures. In addition, with its "evidence-based" and "backed up by science" seal of approval, CBT becomes an unquestionable force within the institution. If students learn (through mental health literacy) that they are in fact mentally unwell, students do not only become their own mental health assessor, but they also become their own therapists with certified (or "evidence-based") tools and techniques to manage negative thought patterns and maladaptive behaviours.

Finally, it seems as though anxiety in post-secondary is an inescapable fact of life. The student will come across many difficulties along their undergraduate degree, but this is just the nature of higher education. In fact, it is so much so the nature of university that resilience-building is not just advised but, as we have seen, highly encouraged for a successful academic journey. Found across campuses, in workshops, training programs, events, and online resources, resilience-building is aimed at shifting students' perspectives on anxiety and stress, promoting the idea that anxiety can be a positive force in their lives (as the saying goes, "if life gives you lemons, make lemonade" right?). Indeed, resilience-building is at the heart of positive-psychology, a more recent branch of psychology which champions positive emotions, character strengths (such as courage, kindness, and creativity), optimism in the face of adversity, and human flourishing.[128] And although building resilience could be seen as a positive and harmless strategy to difficult challenges, such vocabulary of "thriving" or "persevering" in the context of

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[127] "Cognitive Behavioural Therapy CBT," *CAMH*, https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/cognitive-behavioural-therapy#:~:text=CBT%20is%20a%20structured%2C%20time,reactions%20that%20cause%20them%20difficulty (accessed November 3, 2022).

[128] Martin E. P. Seligman, "Building Resilience," *Harvard Business Review*, April 2011, https://hbr.org/2011/04/building-resilience.

neoliberal ideology downplays critical examination of structural barriers. It portrays a story of hyper-individualism and ultimate self-determination where “helplessness and powerlessness…are not matters of social [in]justice, but of individual responsibility and capacities.”[129]

[129] Aubrecht, “The New Vocabulary," 68.

Chapter 6.

Concluding Remarks

Throughout this investigation I have attempted to answer the following questions. First, how is the concept of anxiety both conceptualized and promulgated in post-secondary institutions? Second, how does current discourse on anxiety within the university shape and determine the types of resources and services available to students? And finally, how does the current discourse on anxiety in tandem with the types of services and resources offered to undergraduate students work to produce the “anxious student”?

My research has helped me uncover how the definitions of anxiety used by the university mental health experts I interviewed, and those offered through university websites are not only descriptive but also normative. These definitions suggest that anxiety is a natural evolutionary reaction to perceived threat, one that if successfully harnessed can be used to one’s advantage. For experts, then, it comes as no surprise that students will experience such an emotion in a highly demanding and competitive environment. It is a normal emotion in the context of the university, especially for first-year students coming from high school, and psychoeducational information aims to relay just that. Students are educated on the types of experiences considered normal (anxiety as a normal and expected experience in undergraduate school) and those experiences considered “unhealthy” for normal student function (leaning towards “disorder”). Ultimately, the information on anxiety that mental health experts and university websites disseminate is one that normalizes anxiety. Through this information, students learn that anxiety is an expected aspect of the university student experience, one that they must become accustomed to and that they should learn to manage.

Let us not forget, however, that for a student trying to complete their undergraduate degree, everyday life involves a significant number of academic stressors on top of other non-academic stressors which differ from student to student (e.g., a student's socioeconomic status, family life, and personal stability). Despite these stressors, however, the student is still expected to "function normally". Indeed, this idea of functioning normally helps determine the mental health status of students. If the anxious student is performing well academically, it signifies to experts that they are still functioning within a normal range. In that case, they are not perceived to be suffering from "mental illness". However, if the anxious student's performance falls below acceptable levels, then anxiety has gotten the best of them, impairing their overall function. In that case, they could very well be perceived and be classified as "mentally ill".

How then to manage this fine line, between healthy anxiety—where the student's mental health status lies anywhere in the normal side of the spectrum—and illness? For university mental health professionals, this has been an issue that, coupled with high demand, limited resources, long wait-times, and students' attrition rate has led them to adopt a brief model of care. Unlike traditional one-on-one psychotherapy, this brief model of care claims to provide varying degrees of care based on students' needs—such as self-help approaches and peer support—with the hopes of incorporating less intensive treatments while increasing caseloads. In addition, universities are also rapidly increasing the use of digital platforms to promote mental health literacy among students. Self-assessment tools such as the Bounceback self-assessment quiz and the Here to Help Screening Self-Test are designed to educate students on psychological conditions as well as providing students with basic psychology and medical information which they can use to assess their current mental wellbeing. These self-assessment tools help the

student stay on track of their mental health by encouraging self-surveillance of thoughts, feelings, behavioural patterns, and triggers. In other words, the student is being taught how to understand themselves and the world around them through a psychological and medical framework, one that tends to point the finger at the individual's psyche as the main source of the problem, responsibilizing them and holding them accountable for their mental health. Finally, both experts and post-secondary institutions are insistent on the use of self-help tools. Apps such as Mindshift CBT, Headspace and Calm are promoted as "evidence-based" and cost-effective tools that the student can use to "develop more effective ways of thinking" and ultimately "take charge of their anxiety."[130]

My investigation has helped me uncover that first and foremost the student is seen as a self-reliant and autonomous subject of academia capable of self-regulating and managing their anxiety in ways that will not only benefit their mental wellbeing but also their academic performance. However, the student is also seen as an anxious subject, an individual who will *inevitably* go through highly stressful and anxiety-inducing situations, as that is the nature of higher education. For experts, student's overall mental health exists on a spectrum, one where the student has the *potential* of falling victim to "unhealthy" anxiety, becoming "dysfunctional" and risk being diagnosed with a mental disorder. On the other hand, the student also has the ability to choose to listen to expert advice and begin using "evidence-based" self-help strategies in order to stay on the healthy side of the spectrum. Within the context of the university, the spectrum functions as a neoliberal tactic of self-surveillance and self-discipline, expecting students to learn to know themselves so completely—their emotional and behavioral patterns, their triggers and desires and expectations of themselves as students—that they need not

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[130] "New MindShiftTM CBT App Gives Canadians Free Anxiety Relief," *Anxiety Canada*, April 22, 2019, https://www.anxietycanada.com/articles/new-mindshift-cbt-app-gives-canadians-free-anxiety-relief/.

rely on professional intervention. Additionally, even though mental health promotion strategies seek to destigmatize discourse around mental illness, the idea of mental illness acts as a cautionary tale, warning students of the dangers of what could happen if they do not start forging self-help practices early on in their academic career. Finally, the student must learn to remain alert—or as experts put it, "mindful"—of their environment as to become tolerant of—or "resilient" to—the inevitable hardships that are to come during their undergraduate experience, using their anxiety to their advantage as opposed to succumbing to it. To echo Nikolas Rose, students have been encouraged to "become intensely subjective beings", where their "techniques for managing [their] emotions have been reshaped" and their sense of self "has been revolutionized."[131]

6.1. Limitations and Future Considerations

I hope that my investigation has shed light on the way post-secondary institutions and the agents of power involved conceptualize anxiety in post-secondary institutions and consequently "make up" the anxious student. Indeed, it has been interesting to see the way experts envision how the student ought to be. Even though there is much evidence that points to students' awareness of the mental health crisis that permeates Canadian universities, my research is not able to provide an in-depth analysis of students' lived experience with anxiety and therefore I am unable to contribute to what Hacking called "the looping effect" (how those classified by experts interact with the classification to reinforce or resist it). I do, however, believe that my research raises questions for future considerations. It is evident, that students are immersed in the discourse of psychology, psychiatry, and even medicine, and use such discourse to make sense of themselves and the world around them. But while students are influenced by powerful psychology

[131] Rose, *Governing the Soul,* 3.

discourses, they are neither passive nor docile and therefore, they will inevitably interact with their classification and ponder what it means to be an individual in post-secondary, how anxiety and mental health in general fit into their life, and whether they decide to reject, accept, or remain neutral in their classification.

We are also seeing the rapid incorporation of Artificial Intelligence (AI) in everyday life, and such incorporation should not be taken lightly. How might this new technology be used in the field of psychology? What will this mean for student resources and services in the near future, and how will students begin interacting with such rapidly available and affordable tools in a time of inflation? Could we soon see the complete withdrawal of all in-person and/or one-on-one counselling? Could AI technology soon replace the human expert? Or do we still have a long way to go before AI revolutionizes the field of psychology and psychiatry, and in particular psychotherapy?

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Appendix.

Interview Questions

General questions:

1. What is your job title and what are your responsibilities and requirements?
2. How long have you worked at Simon Fraser University?
3. Is this your only the place of work?

More specific questions

1. How do you define mental illness?
2. How do you define anxiety?
3. How does wellbeing and mindfulness fit into mental health?
4. Do you separate anxiety from mental illnesses? Or is anxiety a mental illness according to you?

Services and resources:

1. What are the mental health resources and services available to students that you are aware of?
2. Are there specific ones that deal with student's anxiety?
3. Are you aware of how these services define anxiety? If so, how are they defining anxiety?
4. Do you agree with their definition of anxiety?
5. When a student comes in, do you refer them to other services or resources?
6. What are the most helpful services for anxiety available to students in your opinion?
7. Do you think or know if the services you know of are designed for long term or short-term help?
8. Do you think this institution is doing enough for student mental health? If yes, how so? If not, why? Could the institution improve?
9. What factors, according to you, either limit or encourages the implementation of certain services and resources?

Questions that were not planned but came about naturally in various conversations with participants:

1. What are the implications of using the different terms (mental illness versus mental health)?[132]
2. What are the most common reason students come in for?

[132] This participant was adamant about separating the two terms.

3. What is psychoeducation and what is the role of it in providing student mental health?
4. One of my other participants mentioned the concept of “brief therapy” so I decided to add these questions in my interviews:
5. I have recently heard of some universities applying a “brief model” approach to student counselling, have you heard of this and do you know what it is? Why has it come about?
6. When a student comes in to see you, do you see them as a patient or a student or both? And what would be the difference?
7. Usually are your clients recurrent or have they already sought any other mental health or resources before coming in to see you?
8. According to you when does medication become a viable option for the student or an option at all?
9. In terms of the types of therapies that are out there, what type of therapy are you most comfortable practicing with, with the students?
10. Do you see that there has been a progress in terms of mental health services and counselling services within SFU from when you started?
11. When did you notice wellness and well-being programs begin to appear in the services available to students?
12. What exactly do you see in these workshops (the participant mentioned online drop-in workshops that students could attend)? What is provided to them (students)?
13. When a student in distress comes in, what are the services you would refer them to?
14. Have you noticed a tendency to self-diagnose amongst the students who come to see you? And do you find having to correct the thinking of self-diagnosis?