

Research Article

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How Bell Canada Capitalises on the Millennial: Affective Labour, Intersectional Identity, and Mental Health

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Abstract: Since 2010, the large telecommunications company, Bell Canada, has invited Canadians to “break the stigma” around mental illness through a campaign called #BellLetsTalk. The campaign claims to donate millions to mental health initiatives, aiming to also “start a conversation” about mental health online. In large part, the Bell Let’s Talk campaign depends on the position of the millennial as a social media user with a real stake in conversations revolving around mental health. I highlight how the term “mental health” is often correlated to normative affect and behaviour, pointing to the importance of an intersectional understanding of mental health. Colonialism is also at play here, as the Bell campaign donates to Indigenous communities, but fails to address how psychiatric intervention is often a colonial process in itself. Through a feminist and critical disability studies lens, I critique Bell for its seemingly apolitical ad campaign, arguing that it bolsters normative narratives around psychological distress and its place in neoliberal corporations and colonial Canada.

Keywords: Bell Let’s Talk, millennials, mental health crisis, corporate social responsibility

Introduction

In 2010, the large telecommunications company Bell Canada began what would become an annual campaign to spread awareness of mental health. On one day in late January each year, the company invites Canadians to spread the hashtag “#BellLetsTalk” on social media networks, and donates 5 cents per hashtag posted on Twitter, Facebook, Instagram, and Snapchat, as well as an additional 5 cents for every text and phone conversation made on a Bell plan. The company boasts that the campaign has “set all-new records with unprecedented participation in Canada’s national conversation about mental health, the largest of its kind in the world” (“Bell Let’s Talk Day is one for the records...”). While the conversation around mental health has indeed been record-breaking in popularity, its success is partly because of its focus on youth and social media. Given the rising moral panic around young people, social media use, and mental health, Bell profits from the figure of the “millennial” and the work of young people interacting online. Using a feminist and critical disability studies framework, I will argue that the campaign reinforces normative narratives around mental health and affective labour in order to bolster Bell’s profit-motivated corporate agenda. Because this agenda is in line with definitions of Corporate Social Responsibility (CSR), neoliberal conceptions of mental health, and colonial processes, Bell’s claim to “reduce stigma” may instead reinforce normative understandings of affect.

The advertising around Bell Let’s Talk includes very particular bodies: the subjects of these videos, pictures, and descriptions are primarily white and middle class. On the Bell Let’s Talk website, for example,

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the section called “National Spokesperson” includes a short biography and picture of Clara Hughes, former Olympic medalist, and current spokesperson for the Bell Let’s Talk campaign. Also included is a long list of “Experts,” “Ambassadors,” and “Faces of Mental Illness”; these names include medical professionals, local celebrities, and five individuals with mental illness diagnoses. While most biographies begin with a short description of an individual’s professional or personal accomplishments, the “Faces of Mental Illness” section instead begins with a diagnosis. In each biography, ethnicity is not mentioned unless this individual is not white. For instance, there is one Ojibway medical doctor in the “Experts” section (“Dr. Chris Mushquash”), and one person from a “Haitian background”¹ in the “Faces of Mental Illness” section (“Kharoll-Ann Souffrant”). These two markers of identity seem to trump either the accomplishments or the diagnoses. While it is difficult to find discussions of race or gender on the Bell Let’s Talk website, these rare moments of identification highlight how inextricable race, gender, and other forms of difference are from wider discussions of mental health. Rather than explore the connections between intersectional identity and mental health diagnoses, large corporations like Bell instead cling to neoliberal definitions of selfhood as individual. By erasing claims to different identities, Bell can claim that mental health is everyone’s responsibility and that their campaign is for all Canadians. By instead focussing on intersectional identity, I will show how Bell profits from the work of particular young people online.

Corporate Social Responsibility, Corporate Charity, and Neoliberalism

While large companies may claim otherwise, corporate charitable campaigns are in line with corporate agendas and can be very profitable. Corporate charitable donations are helpful to capitalist enterprise. Archie Carroll argues that CSR is especially profitable for large corporations; they continue to engage in charity work in order to profit themselves. Donating revenue to charities can be especially profitable because of the ways these donations can impact brand appreciation. Bell has accomplished a successful campaign, if only by looking to the amount of celebrity approval its campaign has garnered. Canadian and American celebrities, such as comedian Mary Walsh, athlete Clara Hughes, and singers/performers Fifth Harmony, have shown their support. Political voices have also entered the conversation, including Prime Minister Justin Trudeau’s interview with Clara Hughes about mental health in the 2017 Bell Let’s Talk campaign. Celebrities help the image of Bell during its campaign, and Bell’s charity helps the image of these same celebrities. The interest of Prime Minister Justin Trudeau shows how the Liberal party can also doubly profit from this campaign, as they support a large Canadian corporation and a campaign that mirrors their own interests in addressing mental health in Canada. The Canadian government can, therefore, continue divesting in public health, while simultaneously centring mental health in its political platform.

As the welfare state continues to shrink, we should be critical of CSR from the private sector as a replacement for public funding. The more charitable donations a corporate body gives in the name of CSR, the less responsibility is put on the state to create and maintain spaces of social care and community. For example, Susan Braedley outlines how the privatisation of Ontarian health care has lead to more Canadians in jail or in forensic psychiatric facilities:

This situation is one more addition to the growing evidence that Ontario’s public health care and social services terrain has become increasingly fragmented, with a number of concerning effects. One of these effects is that those with unmet needs for health care and/or social services are increasingly considered to be public safety and security concerns. The result is to criminalize instead of care. This change shifts public funding from the “pink ghettos” of long-term residential care, health care, and social services to the masculinized worlds of policing, jails, probation/payroll systems and forensic psychiatric medicine. (71)

¹ Unlike the medical doctor’s Ojibway identity, we can read the “Haitian background” as a marker of difference that the acted as a barrier to this person’s medical diagnosis. This description, therefore, seems to imply that a white Canada is better for mental distress than Haitian community.

This shift from community care to individualised crisis using the justice system or the psychiatric system is exemplified in part of the Bell Let's Talk campaign. The Bell Let's Talk main website begins with the words "if you are in crisis, please go to your local hospital or call 911 immediately" ("Bell Let's Talk,"). These words point to "crisis" as the jurisdiction of the hospital or the justice system. In both cases, it assumes that these places are safe for anyone who happens to be in crisis, but these places are not necessarily welcoming to all bodies, especially those with real mental health concerns.

It is not a stretch to call the Bell Let's Talk campaign an advertising campaign. While Bell has constructed the campaign to be mainly about selling "anti-stigma," it is equally selling its own brand and services. Bell is a multi-billion dollar company that controls a large portion of the Canadian telecommunications industry. Although it no longer holds a monopoly over these services, it continues to profit from internet and cell phone use. By encouraging its customers to call and text more on Bell Let's Talk Day, it is directly profiting from these calls and texts. Bell is similarly profiting from internet connectivity on this day, reminding the country that these technologies are important for social communication. If "anti-stigma" is only possible through "talking," it is not a direct person-to-person talking, but a digitally mediated talking that depends on this major corporation's services. This might be one reason why the representation in the campaign is predominantly white and middle class; although people of colour and poor people also have psychological disabilities in large numbers, the white middle-class has more of a potential to be profitable for the company itself. Although the website gives an overview of how much the campaign has raised so far, upon further investigation, it also reveals that Bell has already set aside an amount of money for these donations. The process of "raising" funds is, therefore, a marketing construct in place to encourage Bell customers to continue actively using Bell products.

The "Stigma" around Mental Health

The information given on the Bell Let's Talk website gives an insight into the campaign's goals, its contributors, its supporters, and its donation recipients. The website lays out four pillars of focus: "Anti-Stigma, Care & Access, Workplace Health, and Research" ("Our Initiatives"). The pillars highlight Anti-Stigma as its first and main goal; the Bell Let's Talk campaign is therefore mostly focussed on "mental illness" and "overcoming the stigma attached to it" ("Our Initiatives"). On the main site, Bell gives "5 simple ways to end stigma and start a conversation" ("Bell Let's Talk"), further highlighting how the main focus of the campaign is not necessarily the funds donated—although the site is littered with reminders of how much the campaign has raised so far—but instead the "stigma" around "mental illness." The very first way that Bell says Canadians can reduce stigma is to recognise that "Language Matters," followed by "Educate Yourself," "Be Kind," "Listen and Ask," and finally "Talk About It" ("Bell Let's Talk"). In the "Language Matters" section, Bell reminds visitors of their website that "Your Words Matter" when it comes to mental health. They advocate that instead of saying "schizo," you instead say "person with schizophrenia," and instead of "crazy," you instead say "person with a mental illness" ("Bell Let's Talk"). While these are easy changes that do result in different ways of seeing those with mental distress, they highlight another kind of "stigma," one revolving around naming "mental illness."

Disability activists and care advocates have been "championing person-first language" (Jensen et al. 146) since 1988, arguing for exactly the kind of language that Bell describes in this section. However, some people in the disability community also contest this language, arguing that some diagnoses are not so straightforward. Many Autistic people, for example, prefer using Autism as a title, rather than a modifier for their personhood (Brown). Similarly, Bonnie Burstow argues that psychiatric survivors should refuse labels like "mental illness," even if they still feel mental distress, because of how much wider culture disregards the violent impacts of the medical community on those with psychiatric disabilities. In his most recent book, *Brilliant Imperfection*, Eli Clare writes of the violence of the medical system, especially for those with a schizophrenia diagnosis, and how those who are given such a name often face the realities of involuntary incarceration. George Reaume also discusses the difficulty of describing mental health, saying, "no term in the history of madness is neutral, not *mental illness*, *madness*, or any other term" (182).

People-first language is therefore complicated by the very real impacts of psychiatric diagnoses. In *Bipolar Expeditions*, Emily Martin argues that diagnoses like “bipolar disorder” are in part brought forth by the act of naming. Similar to Judith Butler’s conception of gender performativity, where gender begins with the act of naming (“it’s a girl!” begins the process of girling for Butler,) Martin argues that the psychiatric doctor has the power to begin the process of defining and performing mental illness through diagnosis. This process is continued when others repeat the diagnosis, calling the diagnosed “mentally ill” over and over again. For Martin, because mental illness is connected to irrationality, a personal rejection of diagnosis can be framed as itself proof of this diagnosis: “indeed, studies in psychiatry explicitly regard ‘poor insight,’ defined as disagreeing with the psychiatric diagnosis one is given, as diagnostic of mental illness” (130). This circular logic of diagnosis makes it difficult for the diagnosed to challenge their diagnosed irrationality. Therefore, to reframe someone deemed “schizo” as “a person with schizophrenia” may not change the stigma around such a diagnosis, instead merely reiterating the power of the medical system.

Mental Health and Physical Health

Many parts of the Bell Let’s Talk campaign compare mental health to physical health. In multiple campaign videos, celebrities ask whether the same stigma exists for physical health or receiving medical care for physical health. One example of this is the 2015 campaign video featuring comedian Howie Mandel. Mandel asks whether the same stigma exists around going to the dentist when something is wrong with our teeth, saying “if we take care of our mental health like we take care of our dental health, we’ll be okay” (“Bell Let’s Talk 2015- Howie Mandel Testimonial”). More recently, the 2017 campaign videos have featured university athletes from across Canada who talk about how they need to take care of their bodies and their minds. These young, fit people seem to represent the healthiest bodies in the country, and yet, in many moments, they admit that they too have experienced mental health issues. The message of these videos seems to imply that any body, no matter how physically healthy, can still be mentally “ill,” while also claiming that doctors should have just as much to say about mental illness as physical illness.

Philip Rosenbaum and Heather Liebert caution against using allusions to health in attempts to alleviate stigma, saying: “in the case of mental health, the close connection of health to medicine potentially leads to the medicalization of psychological experience” (Rosenbaum and Liebert 185). Rosenbaum and Liebert highlight how “mental” can mean everything about consciousness, including “a person’s thoughts, feelings, affects, emotions, beliefs, expectations, hopes, dreams, judgments, and ideas of who and how they became that way (history)” and how “health” both connects it to medicalised conceptions of health and creates a binary between healthy and unhealthy (Rosenbaum and Liebert 181, 184). Connecting “mental health” with the medicalised “cures” places the power back in the hands of the experts, i.e. the medical system, rather than recognising the many ways that mental health depends on community and interdependence. In their view, physical health is not comparable to mental health because the descriptor “mental” is highly dependent on behavioural and affective difference. Mental capacities, unlike “objective” examinations of the body,² are dependent on moral norms, dictated by a wider structure of normative bodies. Those who are singled out in society for their difference are, therefore, more at risk of experiencing mentally unhealthy crises, simply because they are already perceived as mentally unhealthy. By categorising mental health as under the jurisdiction of the medical industry, Bell ignores the many ways that “mental” capacity depends on behavioural norms.

Sara Ahmed also highlights the importance of behavioural and affective understandings of mental health. In *The Promise of Happiness*, she describes what she calls “a happiness script” as a prescriptive assumption of what social dynamics will lead to happiness. If we refuse these dynamics, or cannot adhere to their standards, we are imagined to cause unhappiness or to inevitably inherit unhappiness. Ahmed gives the example of the “unhappy queer” and the “melancholic migrant” to illustrate the way that happiness scripts become normative: there is a discourse around the “happy couple” that is heterosexual, married,

² Many disability scholars have also challenged the objectivity of bodily health as well.

procreative, and stable; and there is also the discourse around diasporic communities or communities of colour as inherently unhappy. Two black women are therefore imagined to be automatically outside of this equation, unable to accomplish happiness because of their sexual orientation and race. We can easily see how socio-economic class, disability, and other social markers can also be barriers to happiness, within a model that reiterates a white, middle-class, able-bodied, heterosexual person as normal and happy. When behavioural norms around happiness are refused, and bad affect follows, this bad affect is often pathologised as “mental illness.” The result is that mental health is not necessarily about “objective” health, but about affective normativity, or what we imagine to be normative affect.

Normative Affect and Intersectional Identity

This normative affect, as Ahmed notes, is gendered and racialized. Women are more than twice as likely as men to be diagnosed with and prescribed medication for depression (Ussher 92). Michelle Lafrance argues that diagnosis of depression is often more about power than identifying objective neurological failings, as discourses of femininity are often connected with problematic or over-emotional narratives of distress that make women more likely to be seen as both “depressed” and “in distress” (Lafrance 141). However, viewing depression in a more intersectional light has been a more recent prospect, as theorists are only beginning to trace the discrepancies between depression’s effects (and affects) within gender, race, and class. For example, Anna Mollow demonstrates that although white women are more likely to be diagnosed with depression, women of colour have a much lower rate of diagnosis. She calls this lack of diagnosis a “double bind” for the depressive experience of women of colour:

[t]he enormous power that the psychiatric profession wields in modern Western societies creates a double bind, in which both diagnosis with a mental illness or, alternatively, the lack of such a diagnosis, brings with it serious negative social consequences for people experiencing emotional distress. (73)

While a diagnosis of depression for a white woman might mean increased surveillance, involuntary treatment, prescription of mood-altering drugs, and/or denunciation of negative affect in the form of alternative therapy, a woman of colour may not even receive a diagnosis, leaving feelings of distress to manifest as personal failings rather than a separable medical diagnosis.

Transgender people have also been both scrutinised by the medical community and pathologised as mentally ill. In many cases, trans people depend on the medical community for hormone treatment, surgery, and other modifications to their bodies, but must first prove that they are in mental, rather than physical, distress. The diagnosis of mental distress that they must prove has also changed in name and description over time, demonstrating the cultural and societal assumptions of gender also change (Johnson 804). For trans people—especially trans people of colour—body and mind are not so easily separated. Race can further complicate our understandings of gender, as race interacts with our normative understandings of gender performance. Austin Johnson, for example, writes about the way that the medical community shapes gender through diagnostic tools. By once again assuming what is cognitively normal, medical “experts” reiterate the normality of the gender binary in the body.

Another nuance involves the violence against intersex bodies. Many intersex people have experienced involuntary surgeries on their bodies to fit into the same gender binary. The legacy of colonialism impacts which bodies are seen to be properly gendered, and can have a large impact on early surgeries.³ If mental distress arises later in life because of the scars of these surgeries, these people are very unlikely to trust the medical community to treat their distress with apology, respect, or “help” (Orr). For both trans and intersex folks, the body and the mind are not so easily separable, especially in a medical context. Encouraging the public to be using terms like “mental illness” and even “mental health,” rather than more specific claims to psychological distress, or more broad terms that recognize the moral and behavioural implications of

³ Which genitals are imagined to be too big or too small often depend on the eroticisation or exoticisation of people of colour.

connecting “mental” and “health,” erases the many ways that the medical community has not been the best “help” for many who experience psychological distress.

Indigenous Community and Bell Let’s Talk

The medical community in Canada is tightly connected to ongoing colonial processes that claim to “help” Indigenous peoples as well. Hana Shafi notes that while the Bell Let’s Talk campaign promises “over a million dollars to grassroots organizations,” these grants are short-lived, as those who received a grant in 2015 cannot reapply until 2017, leaving their funding precarious (Shafi). While Bell proclaims its donations to be changing the lives of some Indigenous peoples, it might also be reiterating the unfounded colonial promises of support. A number of things are therefore taking place when mental health is placed within the medical model, those who can “talk” about mental health seem to be consistently white, and yet mental health organisations in “aboriginal communities” are still the recipients of thousands of dollars of grant money. If Indigenous mental health is somehow about “community” in ways that white-settler mental health is not, then why are Indigenous peoples absent from the ad campaigns? The ads cater to the young people who have access to internet spaces and the time to invest in free labour for the company’s gain. Indigenous communities become secondary to the needs of the company itself, who profits from particular kinds of mental health support.

In *Depression: a public feeling*, Cvetkovich highlights how colonialism is important in discussions about depression. Cvetkovich argues that racism, colonialism, and imperialist detachment from the land acts as a barrier to positive affect. The intergenerational trauma of colonialism has therefore undoubtedly affected Indigenous communities in Canada. Although the Truth and Reconciliation Commission (TRC) aims to act partly as an apology for the colonial violence that Canada has enacted against its Indigenous populations, including the residential school system that forced many Indigenous communities to lose their children, the very act of retelling their violent experiences has been traumatic for some Indigenous people.

Ahmed (2004) also writes about the performance of national apology as another act of colonialism. When a nation-state disavows personal guilt, it creates an undue pressure on Indigenous people to challenge their own oppression, rather than the oppressor recognising their own actions:

Reconciliation becomes, in this narrative, the reconciliation of indigenous individuals into the white nation, which is now cleansed through its expression of shame. As Fiona Nicoll (1998) has argued, reconciliation has a double meaning. It can suggest coming to terms with, but it can also refer to passivity, in which one seeks to make the other passive (to reconcile her to her fate). (35)

When reiterated colonial trauma is placed in the hands of the Indigenous communities, Indigenous pain is felt in real affective ways. Depression, as Cvetkovich argues, is a “public feeling,” especially in an Indigenous context, as historical traumas repeat feelings of abandonment, isolation, and abuse.

However, this reiterated trauma is complicated by the ways that First Nations, Métis, and Inuit peoples in Canada are often called mentally unhealthy in order to justify further colonial intervention. Sarah de Leeuw, Margo Greenwood, and Emilie Cameron argue that Canadian policies to address Indigenous “deviance” have led to more First Nations children being removed from their communities, and more institutional violence against Indigenous peoples in Canada (283). Many of these policies are shrouded in language of “addiction” and “mental illness” that cover the ways that these diagnoses are a colonial process. If Bell Let’s Talk were really interested in Indigenous mental health, it would be more invested in decolonial processes that might step back from naming Indigenous communities mentally unhealthy.

The Mental Health Crisis

While claiming to support real change for marginalized people in Canada, the Bell Let’s Talk campaign is part of a larger trend involving the perceived “crisis” or “epidemic” of mental health problems among

college and university students. For example, Alicia Flatt argues that there is a “crisis” of mental health in North American universities today; she points to six factors that exacerbate the mental health issues of young people, including academic pressure, financial burden, accessibility, gender, technology, and lifestyle (Flatt). The combination of more women enrolling in universities, the academic pressures that make up any university experience, as well as a constant access to technologies like smartphones and social media has led to more diagnoses on university campuses than ever before. She writes that Canadian universities are comparable to American ones with respect to the number of students who have mental health issues:

Waddel, Offord, & Sheppard (2002) found 13 to 18 percent of Canadian adolescents suffer from a mental disorder, and Canada has the third highest suicide rate among adolescents in the Organization for Economic Cooperation and Development (OECD) countries (Statistics Canada, 1998). Price, McLeod, Gleich, and Hand (2006) conducted a study to determine rates of depression among first-year students at Canadian institutions and found that, similar to the United States, 7 percent of men and 14 percent of women in first-year university met the criteria for a major depressive disorder.

According to Flatt, these statistics are partly because of the ways that these young people interact with technology; constant connectivity has led to “internet addiction” which can contribute to depression, anxiety, and psychosis diagnoses. Although many of the studies to which she points are within a wider field that has found contradictory results as to the connection between technology and mental health issues, the increasing academic interest in the correlation between technology and mental health also represents the ways that this “crisis” may be discursive. It is possible that the “crisis of mental health” and youth is part of a general moral panic around youth and technology use.

This panic around a mental health crisis in young people can be compared to another moral panic that has recently proliferated: that of cyberbullying. Although also difficult to define, cyberbullying has become a national rallying cry after the suicide of Amanda Todd, a teenager from British Columbia, whose cyberbullying had a large effect on her death. However, the Canadian conversation about cyberbullying often fails to examine the larger gendered structures in place that make cyberbullying a reality. Cyberbullying victims are often women whose sexuality online is made explicitly problematic. Amanda Todd, for example, was exploited online, as pictures of her naked torso were shared over the internet. Her peers called her names because of these pictures, not recognising that she shared these images because of blackmail.⁴ Amanda Todd’s brave viral video where she discusses her depression and anxiety because of the cyberbullying she experienced has been called a “cry for help” (Walrave 169) about her impending suicide, rather than a representation of hope. The conversation about Todd has often failed to invest in a more critical engagement with how youth use social media. Returning to Bell’s campaign: one of the campaign videos for 2017 featured a university student who shared that she “was a victim of cyberbullying attacks” and that she “wasn’t herself” in her feelings of depression, but through a friend was able to talk about it (“Bell Let’s Talk 2017: Alexis Lahorra Testimonial”). This simplistic portrayal of cyberbullying and depression positions negative affects as easy to “overcome,” repeating conceptions of both cyberbullying and mental health as individual, rather than part of larger gendered issues.

Disability scholars, including Alison Kafer, have critiqued advertising campaigns that centre on disabled people “overcoming” their disabilities. In *Feminist Queer Crip*, Kafer critically examines the advertisement campaign of Foundation for a Better Life (FBL), arguing that in emphasising individual achievement, FBL intentionally depoliticises disability. “Overcoming” one’s disability is therefore not about a collective or community-based approach to dismantling disabling structures but is instead about the strength of individual power. The focus on individuality takes away the responsibility of the state to fund public initiatives that would help disabled people, and the responsibility of the corporate body to accommodate or integrate disability measures. In many cases, the Bell campaign follows this trajectory exactly, as those with mental distress are encouraged to “take time off” of corporate work, showing that “mental illness” actually

⁴ Todd’s abuser has since been arrested and charged in The Netherlands. The 35-year-old man has also been connected to a number of other young girls whom he has presumably also forced to send him nude pictures (“Man charged in the Netherlands...”).

has no place in the corporate world. The individual must leave the capitalist structure in order to survive it; they must overcome their distress to continue as employees. In this way, employees who talk about how they have overcome their distress through time off are helping the corporate enterprise in two ways: glorifying the company for accommodating their mental health needs, while also keeping their mental distress out of the company work.

The conception of mental health according to the Bell Let's Talk campaign is thus deeply connected to neoliberal claims to mental wellness. Ann Cvetkovich argues that neoliberalism is politically exhausting, forcing many people to become submerged in negative affect through economic processes that are isolating and lonely. She argues that Lisa Duggan's conception of neoliberalism is helpful in describing the feelings of those who are publicly affected by the violence of capitalism:

Lisa Duggan suggests that neoliberal economic and social policy is characterised by the shrinking of the public sphere and that affective life is forced to bear an increasing burden as the state divests itself of responsibility for social welfare and affective life is confined to a privatised family. Depression can be seen as a category that manages and medicalises the affects associated with keeping up with corporate culture and the market economy, or with being completely neglected by it. (11-12)

In many of their campaign videos, Bell claims that individuals seeking time off from work should not be afraid to speak with their superiors. In this way, Bell seems to recognise the ways that “keeping up with corporate culture” can add to mental distress. However, because their campaign is largely a method of Corporate Social Responsibility, it upholds this corporate culture as worthwhile. One example is the 2016 campaign video that features five Bell employees who talk about the policies around mental health at Bell. Two of these employees talk about their experiences taking time off, one saying that she feels “stronger” having taken time off from work (“Why mental health matters to Bell”). These overcoming narratives highlight corporate policies as helpful to capitalist enterprise.

While Bell's campaign has pledged to “lead by example” by “adopting the voluntary Standard for Psychological Health and Safety in the Workplace” (“Our Initiatives”), Bell recently came under great criticism for one former employee's testimony about her mental health struggles. After Maria McLean shared her mental health struggles with her colleagues and gave her supervisor a doctor's note saying she would need to take two weeks' leave in order to adjust to new medication, she was fired. She was working for a Bell Media radio station, part of Bell Canada Enterprises (Weldon). Bell has therefore been exaggerating their mental health policies to promote and maintain the integrity of their brand. While their goals seem all-encompassing and uncontroversial, their practices, in reality, seem not to hold up to their promises. McLean's termination reinforces the claim that the Bell Let's Talk campaign is especially focussed on advertising and brand promotion.

Affective Labour and the Bell Let's Talk Campaign

This advertising and brand promotion is shared and supported by young people in affective ways. The ways that young people use social media for the Bell campaign is affective because of the social aspects of social media. For example, Rubin and McClelland conducted interviews with eight young queer women of colour in 2015, asking them how they navigate their queerness online. Focussing specifically on Facebook and whether they were “out” to their entire networked public⁵ was this study's main concern. Their results confirmed other studies that have shown social norms to be policed online through peer interactions (see for example, Westlake). What the researchers discovered was that Facebook can be stressful for young people whose sexual identity(s)⁶ might not be heterosexual, permanent, or public. The subjects went on to describe the specifics of their negative experiences on Facebook by pointing to self-disciplining practices

⁵ I use danah boyd's term “networked public” to describe the ways that social media platforms become “public” when users form their communities with other users.

⁶ The researchers intentionally use the term “sexual identity(s)” to “acknowledge the potential development of plural selves, particularly in online environments” (Rubin and McClelland 513).

that they perform because of the surveillance they felt by their peers. The stress they feel from concealing their queerness from their peers is exacerbated by the stress they feel from navigating their racial difference as well. For example, Jo, one of the subjects, discusses this by saying: “I am already out of place for being, like, one of the only African American students. I don’t want to also feel out of place for telling everyone that I am bisexual” (qtd. in Rubin and McClelland 518). Navigating the difficulty of this intersectional identity, being both “African American” and “bisexual” was especially poignant in a networked public that contained primarily white and straight people.

This example of how some young people find particular online spaces stressful demonstrates the affective labour that takes place online. In *The Digital Housewife*, Kylie Jarett argues that internet production depends on free exploited labour from internet users whose data is mined and used as capital. Jarett’s Marxist analysis of internet users constructs the position of the “Digital Housewife” whose exploited labour depends on an affective engagement with internet processes. Like the housewife before her, the Digital Housewife “works” online without recognition or pay, performing the duties of domesticity online. While Jarett acknowledges that the Digital Housewife’s duties are very different from domestic labour in the home, she nonetheless argues that both sets of “work,” in the home and in online spaces, are integral to capitalism today. In both cases, affective labour is at play, as the Digital Housewife must affectively engage with various networked publics in empathetic ways. While Marx calls the work of the proletariat “alienating,” Jarett claims that the alienating nature of online spaces is more complex. Just as housewives engage in a deeply connected way to those they care for, the Digital Housewife is deeply socially entangled with her “work.” Jarett argues that online spaces are often affective spaces that create community, in the same way that domestic labour creates the basis for community life in the home. The difficulty is how and who has access to the community processes involved in both forms of labour.

Similarly, in describing the genesis of the internet as a social space, Sharon Strover talks about two competing—or perhaps complementary—cultural discourses around internet use: moral panic and moral imperative. She writes that while the media of the 1990s propagated a discourse of panic around internet use as housing predators and acting as an addicting substance, American government policy was simultaneously subsidising a development of the “Information Highway” (144). Through this juxtaposition of cultural discourses around the internet, we can see how the internet was built up as a neoliberal space; despite being initially seen as democratic or emancipatory, state policy dictated its importance for a capital development that depends largely on the free labour of those who enjoy its “highways.”

Decades later, the legacy of these discourses lingers in popular perspectives on “the millennial,” the generation who grew up in a political era of online predators and information highways. Two things are largely connected to the millennial figure: social media and mental health issues. Often these themes are conflated; millennials are portrayed as “addicted” to the internet, their smartphones, or social media, and are often framed as anti-social or interested in trivial sociality. These millennials, who are now attending universities and colleges, have created a “crisis of mental health,” largely because of experiences online. If these experiences can indeed be called “affective labour,” then this mental health crisis is more about exploited labour than about internet addiction. In large part, the Bell Let’s Talk campaign depends on the position of the millennial as a social media user with a real stake in conversations involving mental health. If there exists a mental health crisis on university campuses, then it makes sense for university students to be interested in challenging stigma and funding research towards ending this crisis.

Conclusion

Bell’s initiative cleverly capitalises on youth through its focus on mental health and social media. By encouraging young people who already have a vested interest in mental health to share their experiences alongside the company name, Bell exploits the affective labour of these young people. Further, by encouraging this work to happen in an online setting, where particular bodies and voices are already marginalised because of their gender, race, and other differences, Bell is encouraging a specific kind of body to do the “talking.” Their campaign videos contain white celebrities who talk about their experiences

“helping” those with mental health issues, young white athletes who talk about their experiences with teammates who have mental health issues, and white Bell employees who have “overcome” their mental health issues in order to succeed in a corporate setting. If sexism, racism, colonialism, and other structures of oppression are connected to mental health, the focus on individual experiences may not be helpful to an overall discussion of mental health in Canada. It is clear from the campaign materials that young, white, affluent Canadians are being encouraged to talk about mental health only in ways that will not trouble the white middle class’s claim on networked publics, that will not encourage more public health spending, and that will not resist the psychiatric system. As long as these millennials are implicated in the mental health crisis, Bell can continue to profit from their labour through a campaign that pledges to “reduce stigma,” even if that reduction is only surface-level. The emotional investment of young people is crucial to Bell’s branding. Bell’s failure to address the intersectional implications of mental health is not coincidental; it is much easier to garner support for a capitalist enterprise through neoliberal conceptions of identity. If, as Cvetkovich argues, depression is connected to the feeling of capitalism, corporate claims to address mental health need to be continually scrutinised.

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