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Depression, Capitalism and Radical Care

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Abstract

This article examines depression as both an inevitable feature of, and a construct produced within, contemporary Western society, shaped by the forces of late capitalism and neoliberal ideology. Building on Mark Fisher's call to politicise depression, it engages with Marxist, critical mental health, and anti-psychiatry scholarship to argue that the definition and treatment of depression by the psy-professions serve the interests of the neoliberal agenda. Rather than viewing depression as an apolitical, individualised 'disorder', the article situates it as a deeply political phenomenon rooted in systemic conditions. At the same time, it acknowledges the undeniable reality of lived experiences of depression, which necessitate forms of care. The discussion explores alternatives to psychiatric 'treatment', highlighting the possibilities found in radical therapy and, more radically still, in the abolition of psychiatric hegemony in favour of transformative, collective forms of care.

Keywords: depression; medicalisation; capitalism; anti-psychiatry; radical care

Introduction

'Depression' is a pervasive and increasingly common mental health issue. While it is often treated as an individual medical issue, it is also a deeply political one, shaped by the oppressive forces of capitalism. This article argues that depression is a political issue caused by capitalism's alienation, structural violence and inherent dysfunction, and examines how contemporary therapeutic practice upholds capitalism, often failing to achieve its stated aims. The critical dissection of 'mental illness' and the tools used to treat it offers little hope for those currently experiencing depression under capitalism.

Mark Fisher's death perhaps provides the most obvious evidence for this, and offers an anecdote upon which this article is based. Fisher was a cultural critic and theorist, who coined the term 'capitalist realism' to describe how neoliberalism has foreclosed the possibility of systemic alternatives, leaving individuals trapped in a cycle of economic precarity, social isolation and mental distress (Fisher, 2009, 2018). Fisher resonated with his acutely personal and theoretical dissection of the structural causes behind depression and its treatment, as he argued that depression is not just a personal struggle but a systemic condition, exacerbated by market-driven policies that erode welfare support, privatise healthcare and force individuals to internalise failure as a personal deficiency rather than a product of their environment (Fisher, 2018). Fisher further noted that the psychiatric model of mental illness, rather than addressing these structural issues, often serves to depoliticise suffering—framing it as a chemical imbalance or personal flaw instead of a rational response to the conditions of late capitalism (Fisher, 2018).

Despite his deep understanding of the social and political explanations of mental illness, Fisher himself struggled with depression and ultimately took his own life (Turner, 2019). His death only reinforces the urgency of his argument: "The task of repoliticising mental illness is an urgent one" (Fisher, 2009, p. 37). In light of these arguments, it is possible to ask what is meant by 'mental healthcare'? If depression is tied to the conditions of capitalism, and therapy acts to support the capitalist agenda, what hope is there for those currently struggling with it?

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The following article will answer Fisher's call to repoliticise mental illness, not only by critically examining its causes but also by questioning the very nature of mental healthcare under capitalism. It explores how psychiatric hegemony, medicalisation and pharmaceutical interventions serve to individualise suffering while reinforcing the broader economic structures that create it. Drawing on Marxist and critical mental health scholarship, this article interrogates the role of mental healthcare as a form of social control, highlighting how therapy often operates within a neoliberal framework that prioritises productivity and self-management over collective healing. It then explores potential alternatives—such as radical therapy, community-based support networks, and the abolition of psychiatric authority—that seek to disrupt the neoliberal order and reclaim mental health as a site of resistance rather than compliance. By conceptualising depression not as a disorder to be cured but as a symptom of an exploitative system, this article argues for a radical reimagining of care—one grounded in collective struggle and solidarity.

Defining depression and its impact

The very term depression is not without inherent bias, characterised by a Western biomedical lens and with a very traceable history (Greenberg, 2010). Before the rise of psychiatry, melancholia and unhappiness were conceptualised very differently from the modern view of depression (Kendler, 2020). The nineteenth century saw the rise of psychiatry and its legitimatisation by medical knowledge (Castel, 1983). The categorisation of madness as a disease was fundamental to securing psychiatric hegemony, as "the link with medicine provides the essential lifeline of respectability and trust" (Ingleby, 1983, p. 165). The medicalisation of unhappiness—the root of today's treatment of depression—rose on the nineteenth century wave of 'magic bullet medicine', or the idea that you could develop a drug for a particular molecular target and kill the disease (Greenberg, 2010).

However, this assertion of medical hegemony by psychiatry has no scientific basis, as even recent reviews have concluded that "no biological sign has ever been found for any 'mental disorder'", and correspondingly, there is "no known physiological aetiology" (Burstow, 2015, p. 75). Rather, psychiatric diagnosis can be understood as a form of moral and political control. British psychiatrist Joanna Moncrieff (2010, p. 371, as cited in Cohen, 2016) posits that a "psychiatric diagnosis can be understood as functioning as a political device, in the sense that it legitimates a particular social response to aberrant behaviour of various sorts, but protects that response from any democratic challenge." This context of psychiatric hegemony provides vital background to both the definition of depression and its impact.

The diagnostic criteria for depression as known today was first established in the 1980 release of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III). The DSM-I (American Psychiatric Association, 1952) and DSM-II (American Psychiatric Association, 1968), the two manuals that preceded the DSM-III, attempted to understand underlying unconscious mechanisms and did not develop clear definitions of specific 'mental illnesses' (Horwitz, 2011). The 1970s saw the psychiatric profession entering a period of political and epistemological crisis, and the legitimacy of psychiatry was called into question as clear diagnostic categories underpinned medical authority (Cohen, 2016). The DSM-III emerged as a solution to boost scientific credibility by improving the 'reliability' of diagnostic categories. It revolutionised psychiatric classification, but its success was in changing the rhetoric of psychiatry rather than one of actual scientific progress (Cohen, 2016; Horwitz 2002; Kirk & Kutchins, 1992).

From the DSM-III to the latest DSM-V-TR, the definition of depression has remained largely the same, characterised by a persistent feeling of sadness or loss of interest or pleasure, accompanied by a range of emotional, cognitive, physical and behavioural symptoms that cause significant distress or impairment in social, occupational or other areas of functioning (American Psychiatric Association, 2022). This definition is one of clinical syndrome, where the symptoms constitute the 'disease' and no specific aetiology is required (or even exists). It is under this definition that the World Health Organization (2021) describes

depression as a "pandemic" that necessitates urgent attention, and identifies major depressive disorder as the leading cause of disability worldwide. The ramifications of this pandemic of depression can be grave, particularly among adolescents, as those with major depressive disorder are up to 30 times more prone to engage in suicidal behaviour (Stringaris, 2017).

In Aotearoa/New Zealand there were large declines in mental well-being from 2001 to 2019, particularly among youth. Representative cross-sectional youth health surveys of the Aotearoa/New Zealand secondary school population found that from 2001 to 2019 well-being decreased, depression symptoms increased, and past-year suicide thoughts and suicide attempts increased (Sutcliffe et al., 2023). Aotearoa/New Zealand's youth suicide rate for adolescents aged 15–19 years was reported to be the highest of 41 OECD/EU countries, and suicide was the third leading cause of death in children and youth (Peiris-John et al., 2024; Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi | Child and Youth Mortality Review Committee, 2021).

These alarming statistics are often accompanied in medical research by a cry for greater or better treatment; however, there are many critics of the diagnostic increase. Critics from within psychiatry have argued that the rise of the depression diagnosis can be attributed to a failure to distinguish everyday experiences of distress or 'normal' sadness (sadness with a clear cause), from pathological conditions or 'abnormal' sadness (sadness without an identifiable cause) (e.g. Durà-Vilà et al., 2013; I. Parker, 2007; Vilhelmsson, 2014). Although this particular argument is clearly lacking a deeper sociocultural analysis and critical dissection of psychiatric power (e.g., Brinkmann, 2016), potentially most problematic is the faith in psychiatric doctors to provide judgement over 'normal' and 'abnormal', or what may constitute a 'reasonable' cause.

Trends of increasing diagnosis of mental illlness also correspond to an increase in mental health service provision. For instance, in Australia, spending on state and territory specialised mental health services rose from AUD7.1 billion in 2018–2019 to AUD8.1 billion in 2022–2023 (an increase of more than 14% in just one year), with significant investments in public hospitals and community mental healthcare services (Australian Institute of Health and Welfare, 2024). Davies (2013) emphasises that although increasing mental illness diagnoses correspond with an increasing demand for psychiatric and psychological services, there remains limited review of and evidence for the validity and quality of these services.

This is of particular relevance in the context of late capitalist society, where psychology has become "an increasingly powerful component of ideology" (I. Parker, 2007, p. 1) and the psy-professions act to uphold the interests of the ruling class—notably to maximise profit by furthering the neoliberal agenda of individualising socioeconomic conditions (Cohen, 2016; Fisher, 2018).

This article takes the stance that depression should be viewed as a social and cultural phenomenon, not a biological or medical one. Hence, the use of the term *depression* throughout could also be replaced with either the 'diagnosis of depression' or 'sadness/distress/suffering/isolation oppression/despondency'.

Depression as a symptom of capitalism

Marx's critique of capitalism provides a useful starting point for understanding the political nature of depression. For Marx (1867), capitalism is inherently alienating, as it separates people from their work, their community, even from themselves and what it means it be human. This alienation can lead to a sense of powerlessness, hopelessness and disconnection from the world (Harvey, 2011). Marx further argued that capitalism is structurally violent, perpetuating exploitation and oppression of workers. The inherent contradictions of the capitalist system can instil a sense of anxiety, despair and hopelessness, which contributes to the development of depression.

Capitalism's inherent injury goes beyond alienation and structural violence. The capitalist system is structured to prioritise profits over human well-being, inevitably leading to economic instability, social inequality and environmental degradation (Ehrenreich, 2016). This constant pursuit of profit at the expense of the broader population and the environment generates social and economic tensions that contribute to the experience of depression. The relentless pursuit of economic growth, coupled with the resulting disparities and insecurities, fuels a sense of disillusionment, helplessness and despair among individuals. As Hedva (2016, p. 5) eloquently stated, "It is the world itself that is making and keeping us sick." And as Adorno (1951 p. 139) reflected, "Happiness is outmoded: uneconomic." This contributes to a sense of disillusionment and meaninglessness. Adorno also highlighted how the culture industry—as one example of a societal force—encourages people to internalise capitalist norms and values, such as competitiveness, individualism and efficiency, which can exacerbate feelings of worthlessness and inadequacy (Adorno, 1991).

Mark Fisher's concept of capitalist realism provides another useful framework for understanding the extent to which mental illness is normalised and individualised under capitalism. *Capitalist realism* refers to the idea that capitalism has become so dominant that "not only is capitalism the only viable political and economic system, but also that it is now impossible even to imagine a coherent alternative to it" (Fisher, 2009). This creates a condition where, according to Jameson, "It is easier to imagine the end of the world than it is to imagine the end of capitalism" (cited in Rooksby, 2012). This sense of inevitability contributes to despair, depression and apathy. Fisher expands on Jameson's work, contemplating the death of historicity in post-modern culture and how this contributes to capitalist realism (Fisher, 2009, p. 65). The sense that time is 'out of joint' distorts the horizons of possibility, leading to a sense of atemporality, or that we are 'stuck'. There are numerous methods by which this effect is cultivated, with Jameson's famous critique of pastiche and Baudrillard's work on hyperreality (Baudrillard, 1983; Jameson, 1991). Fisher, drawing on Derrida, notes that we are haunted by this absence of alternatives, which in itself constitutes a depressive shadow (Fisher, 2009). The space in which new structures may emerge and evolve is instead already occupied by old structures, trapped in time and refusing to decay.

The depressive nature of capitalism is exacerbated by neoliberal policy. David Harvey (2007) characterises neoliberalism as a system of political economy that ascribes normative value to market exchange. It represents a resurgence of classical liberal economics, which had been globally overshadowed by the Keynesian consensus from the 1930s to the late 1970s. Neoliberalism asserts that the most effective approach to maximising well-being involves a laissez-faire attitude towards markets, trade, and individual entrepreneurial freedom, accompanied by robust protection of private property rights.

The neoliberal agenda is supported by an ideological foundation rooted in "traditional values" and "personal responsibility" (Whyte & Wiegratz, 2016). The doctrine of personal responsibility serves to legitimise the tendency for the affluent to accumulate even greater wealth at the expense of the poor. The narrative implies that if you find yourself in poverty, it is solely your own fault, while those who are wealthy are lauded for their presumed hard work that supposedly earned them a life of luxury. This narrative operates insidiously, perpetuating the transformation of privilege into admiration, echoing past concepts of the divine right of kings. Wealth becomes its own justification; its presence and absence assuming a reality that overshadows the actions, needs and aspirations of those who find themselves subject to its influence.

The inherent contradiction between the economic principles of capital and the normative ideals of neoliberalism, which emphasise personal responsibility and market rationality, carries unsettling implications across various domains. As subjects of capital, we are coerced into accepting the status quo as the only viable way of life, with any potential change relying solely on individual action and personal responsibility. If we experience unhappiness, it is automatically attributed to our own shortcomings. If we encounter depression, the burden falls on us to alter our mindset, transform our situation, and enhance ourselves. Moreover, this belief system reinforces the notion that if we fail to bring about change, it is solely

due to personal inadequacy. This perspective overlooks the profound disparities in privilege and resources pervasive in our unjust society, placing unrealistic expectations on those already facing considerable struggles. Words like efficiency, viability and optimality that resound in neoclassical economic discourse are, in fact, value judgements. In this case, many of the assumptions of neoclassical economics such as free markets, atomised individuals and rational economic actors neatly disguise and normalise such inhuman behaviours such as individual short-term profit-seeking regardless of communal and collective cost. Human solidarity is foreclosed, as market exchange and its logic reifies human beings into the caricatures proposed by neoclassical economists (Chang, 2012; Piketty, 2013). That such normative economic thinking is encouraged by the billionaire class and large corporations is unsurprising.

In the face of all of this, it is vital to understand the historicity of the neoliberal era—that it did not always exist and, indeed, will not always exist. The neoliberal revolution—whose success was not a sure thing—was birthed from a specific set of social, political and economic circumstances (Harvey, 2007). The deindustrialisation and financialisation of the global north that followed on the heels of the post-colonial era, with the new forms of imperialism, of IMF loans and structural adjustment, has had devastating consequences on the mental health and well-being of the working class (Harvey, 2005; Hickel, 2017; Piketty, 2013). For Harvey (2006, 2007), this has resulted not in economic growth or prosperity, but ultimately a redistribution of wealth upwards and a restoration of class power, largely attributed to what Harvey calls accumulation by dispossession. Harvey (2006, 2007) argues that the reduction in the social wage, in various forms such as public services and pensions, combined with the privatisation and literal foreclosure of individual and communal property, concentrated into the hands of the capitalist class, has been one of the primary modes of this accumulation.

The devastating consequences of the defunding of social services, the enclosure of the commons, this accumulation by dispossession, parallels Marx's (1867, p. 669) observation of the prehistory of capitalism, of primitive accumulation, being "written in the annals of mankind in letters of blood and fire". Indeed, there are strong parallels to the primitive accumulation in the neoliberal era for the very reason that neoliberalism seeks to universalise and expand the market exchange of commodities. In the era of globalisation, other modes of production have been disrupted to conform to a narrow focus on the production of commodities for sale on the global market (Hickel, 2017). Entire geographical regions and communities are reduced to their ability to export certain, specific products. Human flourishing—well-being, happiness, contentment—once more becomes secondary to the contradiction between use and exchange value, as the commodity form dictates.

Conceptualising depression under capitalism

These insights into neoliberal capitalism depict how depression can be conceptualised as inextricable from late capitalism. Such critiques of our current socioeconomic and political system emphasise the limitations of current approaches to mental health, which are individualised, medicalised and fail to address the political roots of depression. Fisher (2009, p. 32) posits that we are in a period of late capitalism in which "mental health is increasingly medicalised and pathologised". The dominant medical model of mental health ignores or denies the possibility of social causation and instead emphasises a chemico-biological perspective, treating depression as an individualised illness (Cuijpers et al., 2020; Fisher, 2009, 2018).

This perspective is part of a longer history of attributing mental distress to personal deficiencies, whether biological or moral, rather than recognising its broader social and economic determinants. Historically, mental illness has long been attributed to personal failings, often tied to heredity, moral weakness or deficient personality traits. Catharine Coleborne (2009) highlights how, in the Australia/New Zealand context, colonial-era psychiatric institutions framed mental distress as an inherent flaw in individuals rather than a product of social or environmental conditions. This narrative persisted into the

twentieth century, with psychiatric discourse reinforcing ideas that those suffering from mental ill-health were biologically predisposed to instability, making them less fit for participation in society. Neoliberalism has revitalised these ideas in new forms, pushing an ideology of self-responsibility and resilience that demands individuals manage their distress privately, rather than recognising its systemic roots (Harvey, 2007). Within this framework, those struggling with depression are encouraged to 'fix themselves' through productivity, self-discipline and pharmaceutical intervention—further entrenching the capitalist imperative that suffering must not disrupt economic function. As Cohen (2016) argues, psychiatric discourse serves to depoliticise mental distress, shifting focus away from structural conditions and on to the individual, reinforcing neoliberal demands for self-regulation and adaptation rather than systemic change.

Hence, capitalism inflicts a double injury on those suffering from depression. First, it creates a social, political and economic environment that is inherently depressive (as explored above). Then, second, it individualises the illness and places responsibility on the individual rather than the system. It frames depression as a personal issue where, as Dubrofsky (2007, p. 266) highlights, "Social, political, and economic problems are turned into personal problems that can be solved by an individual who is willing to work on him or herself." As Cohen (2016, p. 87) remarks, "Psychiatric discourse seeks to both depoliticise the fundamental inequalities and structural failings of capitalism as individual coping problems while reinforcing the values of competition and self- improvement as common sense and taken for granted." The onus is placed on the individual. If only they had led a better and more active life, made different choices, or had a more positive outlook, then they would not be depressed. This narrative is enforced by psychologists, mentors, holistic coaches, therapists, influencers and motivational speakers worldwide, who proclaim that happiness is a matter of personal choice and responsibility (Cohen, 2016; Fisher, 2018). This creates a society where, as Fisher (2018) said, "Individuals will blame themselves rather than social structures, which … they have been induced into believing do not really exist." Capitalism, therefore, not only makes us feel miserable, but also compounds the distress by making us "feel bad about feeling bad" (Frantzen, 2019a).

Fisher (2009) argues that while it is acknowledged that all mental illnesses have neurological manifestations, this alone does not explain their causation. Even if depression, for example, is associated with low serotonin levels, it is crucial to understand why certain individuals experience low serotonin levels in the first place. As Rose (2007) argues, "Medicalisation might be the starting point of an analysis, a sign of the need for an analysis, but it should not be the conclusion of an analysis." This necessitates a social and political explanation that takes into account the broader structural factors that contribute to mental illness.

First it is worth considering why depression has been individualised. According to Fisher (2009), this shift in perspective from the social to the individual level is beneficial for capitalism in two ways. First, it reinforces the capitalist drive towards atomistic individualisation, attributing mental illness solely to brain chemistry and disregarding broader social and political factors. This individualisation serves the interests of capitalism by diverting attention from systemic issues and placing the burden of illness on the individual. And second, it fulfils the capitalist profit motive. As Cohen (2016, p. 33) states, "The social control of populations considered as deviant and labelled as 'mentally ill' by the psy-professions serves specific requirements of the market, whether this is through the profiteering from individual treatments, the expansion of professional services, or the reinforcement of work and family regimes in the name of appropriate treatment outcomes."

Furthermore, the individualisation of mental illness aligns with the modern nation-state's interest in maintaining social order by pathologising those who fail to conform to capitalist norms. Historically, the classification of mental illness has been deeply tied to ideas of 'usefulness'—a criterion that dictated who was deemed socially and economically valuable. As Foucault (1971) argues, the rise of psychiatric institutions was inseparable from broader disciplinary mechanisms that sought to regulate deviance and

reinforce capitalist labour structures. This can be seen in the asylum system, which, as Scull (1989) details, functioned as a form of social control, segregating those deemed 'unfit' for the labour market under the guise of medical treatment. Anti-psychiatrists Szasz (1997) and Goffman (2017) provide further critiques, highlighting how psychiatric labels serve to discipline and marginalise those who do not conform to dominant social expectations. In this sense, the modern framing of depression as an individual pathology continues a long history of medicalising deviance to sustain economic and political hierarchies.

Exploring care under capitalism

The institutionalisation and individualisation of distress and care has been a dominant feature of capitalism since its emergence. From the nineteenth century, Marx (1843) critiqued the role of the church, providing pastoral care to the proletariat. Marx's assessment of pastoral care was rooted in his broader critique of religion and its role in society under capitalism. Marx saw the church and pastoral care as part of the ideological apparatus that perpetuated the existing social order and justified the exploitation of the working class. He argued that religion, including the provision of pastoral care, served as a form of false consciousness that obscured the material conditions of inequality and suffering imposed by capitalist relations. In our present context, the church and other religious institutions remain an important source of pastoral care for many. For Marx, the fact that religion still serves this role is emblematic of the fact that the material conditions, namely the alienation, isolation and economic deprivation that characterise capitalist society, are still extant.

The niche that religion previously dominated in simultaneously providing pastoral care to the proletariat while justifying the current distribution of power in society, now includes more ostensibly secular institutions including neoclassical economics and psychiatric intervention. There are apparent parallels in mental healthcare and the church. Just as the church attributed societal ills to God's will, contemporary mental health discourse often attributes individual despair to brain chemistry or 'unhealed trauma' (Fisher, 2018). This shift reflects a change in the dominant explanations for suffering while still perpetuating a system of individualised blame and pathologisation.

Central to any consideration of modern therapeutic approaches is a class-based analysis of the political economy that underpins it. The epistemological basis of psychiatric knowledge is profoundly influenced by the economic base that it ultimately must uphold. The positivist approach that underpins the so-called 'hard sciences', often to the exclusion of other sources of knowledge, in which social dynamics and context are deemed irrelevant, fails completely to understand the subject of its analysis: the inherently social human being (Feyerabend, 2020; Foucault, 1978). This clear flaw in the positivist methodology as applied in psychiatric care is masked by the different standards of evidence and lived experience of the different classes of people responsible for psychiatric knowledge and those subject to it (Waitzkin, 1984). As Cohen (2016, p. 207) stated, "The class interests of the psy-professions closely align with the ruling elites."

If the determinants of poor mental health with regard to political economy are simply not experienced, understood or just ignored by those attempting to understand them, it should come as no surprise that such determinants do not feature in their analysis or proposed solutions. Waitzkin (2000, p. 37) echoes this analysis, stating that the way medicine is structured engenders "patterns of oppression that are antithetical to medicine's more humane purposes", and that "these patterns mirror and reproduce oppressive features of the wider society". Furthermore, the industry and business of psychiatric practice has a material interest in justifying its own existence, the interpellative role supporting an understanding of mental illness as not requiring political and economic solutions, but those based on pathology located in individuals.

In addition, the formation of psychiatric services and medications as commodities, to be subject of exchange on a market, creates internal to them the same contradiction that for Marx (1867) resides in all commodities: primarily, that they possess a use and exchange value, that these commodities become fetishised; that is, the social relations of people appear to take the form of isolated relations between objects, with the agency and attributes of humans seemingly transferred to those objects. The contradictions between the use and exchange values of mental health services and medications are numerous and varied, leading to many crises, as seen in other commodities. Most critically in this case is an accessibility and affordability crisis due to inelastic demand, combined with the form of these treatment modalities; that is, a focus on repeated prescriptions versus addressing root causes. Furthermore, the social relations behind the psychiatrist-patient dynamic become ossified and opaque behind the language of commodity exchange. A session with a psychiatrist is purchased, and thus mental health itself is commodified. The patient seeks to address their mental distress as inflicted upon them by alienated wage labour, by using the wages from said labour to purchase the commodity of their own mental well-being from the psychiatrist. The patient's dual natures as both a subject and creator of their environment and therefore self, are instead transferred and mystified in these commodities.

The perpetuation of traditional gender norms and roles during the twentieth century was closely intertwined with the industrialised labour sector, particularly in the post-war period, where atomic families relied on women's unpaid domestic labour and reproductive capabilities to sustain the workforce (Federici, 2004). However, the advent of the neoliberal era brought about substantial transformations, including deindustrialisation, which significantly altered the economic and material foundations that once rendered the nuclear family and women's domestic servitude economically viable. While the demand for free domestic labour and the production of compliant workers remains, the methods employed have shifted since the 1950s (Federici, 2004). Likewise, the emergence of the happiness culture represents a distinct mode of biopower and control, replacing more overt forms of violence and coercion such as ice pick lobotomies and electroconvulsive therapy, employed previously in psychiatry as tools of social control (Jack, 2023). This shift reflects a reconfiguration of power dynamics within society, as happiness becomes a new mechanism for shaping and regulating individual behaviour.

Foucault's (1978) concepts of disciplinary power and biopower provide a thorough analysis of how happiness acts as a form of social control. Disciplinary power involves creating individual subjects who self-regulate in the interests of power through panoptical surveillance, while biopower involves managing populations through the manipulation of biological knowledge. By associating bodies with biology, institutions such as medicine organise populations to be optimised and naturalised, with politico-moral discourses of 'good' and 'bad' superimposed upon scientific discourses of 'normal' and 'abnormal'. This creates a governable population through the use of scientific discourse of happiness as normal (Davies, 2015). Starhawk (1982, p. 5) contends: "Psychologists have constructed a myth—that somewhere there exists some state of health which is the norm, meaning that most people presumably are in that state, and those who are anxious, depressed, neurotic, distressed, or generally unhappy are deviant." Hedva (2016, p. 2) expands on this, suggesting you can "supplant the word 'psychologists' with 'white supremacy,' 'doctors,' 'your boss,' 'neoliberalism,' and 'heteronormativity'".

Davies (2015) traces the historical shift from happiness being a subjective, emotional experience to a quantifiable metric that can be marketed and manipulated. The neoliberal agenda concluded that happy workers are more productive workers, and as a result, happiness has become an economic tool—one that shapes individuals to align with market-driven expectations. This cultural myth of normalcy, wherein happiness is presented as the key to personal success and social worth, serves to perpetuate the self-regulating, competitive individual in the capitalist system. As Jack (2023) argues, "When positioned as an ideal, happiness reinforces the individualist logic of neoliberalism by necessitating and sustaining the consumerist drive which upholds it."

Psychiatry has diffused its knowledge and therapeutic techniques into social institutions such as the family and the workplace, creating subjects who function in the interests of said power without noticing that these are externally imposed. Psychiatry offers an ideal intermediary through which to pass this governmentality because its scientific discourse legitimises its claim to expertise on the individual and their emotions, making subjects understand these to be normal, natural desires. As Jack (2023) argues, "Psychiatry becomes useful because it claims the ability to provide happiness through its knowledge." Ultimately, the construction of happiness as a biologically normal individual state of being creates governed subjects who seek it out, seemingly in their own interest, making it a highly efficient means of government.

Pharmaceutical companies are perhaps one of the most obvious crisis points of the contradictions inherent to healthcare as a commodity. Scandals surrounding intellectual property rights with regard to drug patent repurchasing and resultant state-enforced monopoly rights, in situations of inelastic demand, occur with deadly and damning frequency. Pharmaceutical companies have a material interest in developing commodities that are to be used widely and long-term in a non-curative capacity. Markets and consumers are sought for these products, and cultivated where necessary. Unsurprisingly, pharmaceutical companies and psychiatrists both have significant material incentives—profiting from the desire for and prescription of psychiatric medication such as antidepressants (Whitaker & Cosgrove, 2015).

The evidence base for antidepressant use in mild to moderate depression and anxiety is mixed at best, with numerous adverse drug reactions (ADRs) and side effects common, yet they remain widely prescribed regardless—a state of affairs that is at odds with ostensibly evidence-based modern practice (Kendrick, 2021). The material, social and political roots of the contradictions and crises in understanding mental health as a commodity are reflected well in this relationship between pharmaceutical companies and psychiatry.

The potential for radical care

Despite critiquing religion and the suffering of the working class in the 1840s, Marx recognised that the church provided the only form of pastoral care for many. He emphasised that his critiques were not meant to deprive the proletariat of one of their only sources of care (in contrast with the young Hegelians of his time), but rather to understand its limitations and imagine a way to transform society so that such care would no longer be needed. Or in other words, that "criticism has plucked the imaginary flowers on the chain not in order that man shall continue to bear that chain without fantasy or consolation, but so that he shall throw off the chain and pluck the living flower" (Marx, 1843, p. 1). In that same fashion, this essay aims not to deprive those suffering from depression the potential of solidarity and care, but rather to critique the societal conditions that make clinical care necessary and provide hope for radical alternatives of care that depart from psychiatric hegemony.

Instead of individualising the problem of mental illness, it is imperative to start problematising the individualisation of mental illness (Frantzen, 2019b). Scholarly activism, queer theory, sad theory and the opportunity of radical models of care provide hope for reconceptualising depression as both a symptom and construct of late capitalism rather than an individualised disorder. Scholars differ in their ideas of what may constitute radical care. Some advocate a reconceptualisation of current approaches to therapy and the development of new psychologies (for example, see Burstow, 1992; Parker, 2022; Sipe, 1986; Smail, 2005) while others reject the psy-professions at large and call for collective action and community care (for example, see Cohen, 2016; Cvetkovich, 2012; Hari, 2018).

Many radical therapists propose therapeutic models that could help challenge the internalisation of capitalist values and constructs. Dr. Harriet Fraad (2020), an anti-capitalist feminist counsellor and podcast host, proposes that "you can really help clients by exploring both the personal and their social determinants that shape their reality and that need to be changed. You need to know what's going on, in order to change

it." Radical therapy would embrace a dialectical approach, and help a 'patient' contextualise their experiences within a capitalist system. It can act as a space to challenge neoliberal socialisation, connecting the personal with the political. Ian Parker (2022, p. 39) argues that "psychoanalysis is very good at showing how all of us buy into our oppression", and can be a useful tool for feminist, anti-colonial and anti-racist theory.

For example, radical therapists "would know that there is a lot more going on with a depressed woman than the internalisation of anger. They would analyse these feelings in terms of the mutually interconnected oppressions of race, class, and sex" in the context of depression being "not only common to this system but vital to its continued functioning" (Sipe, 1986, p. 73). Although "saying that capitalism is the problem does not help me get up in the morning" (Cvetkovich, 2012, p. 15), it may help connect those struggling with a broader community or engagement with political action. As Sipe (1986, p. 74) explains, "In seeing our psychological and social world as it really is, we can see real possibilities for its transformation."

One example of an alternative model to traditional psychotherapy can be found in *Power, Interest and Psychology*, where Smail (2005) presents the "psychology of distress". This approach acknowledges the fundamental humanity of the therapeutic relationship, viewing it as a source of solidarity rather than a mere tool for effecting change. Smail recognises the ongoing societal obligation to address the distress and suffering experienced by individuals in contemporary society. The psychology of distress operates through four key treatment themes: demystification, rescuing subjectivity, character rehabilitation, and environmental reinstatement. Despite critiquing the assumptions of psychotherapy, Smail paradoxically reconstructs a form of psychotherapeutic practice, albeit in a more palatable form. Notably, Smail does not address why extensively trained practitioners (psychologists/therapists/psychiatrists) are required to provide care for those in need. This alternative falls into a common trap, failing to challenge the dominance of professionalisation and the inherent bias of psychiatric hegemony.

Attempts to reconstruct therapy from within the professions often continue to serve a neoliberal agenda whereby "contemporary research is usually bereft of any problematising of the mental health system, the psy-professions, or the psychiatric discourse on which such professions lay claims to expertise" (Cohen, 2016, p. 27). Forms of radical therapy still struggle to overcome the inherent problems of the psy-professions (Sipe, 1986), namely the embrace of neoliberal ideology, the requirement of an elite class of professionals, and a history of abuse, oppression, and political suppression. It is for these reasons that some critical scholars call for the abolition of the psy-professions all together. Cohen (2016, p. 206) highlights the many "atrocities committed by the psy-professionals as part of their moral management", and Burstow (2015, p. 299) emphasises that "the institution of psychiatry must go".

The call for abolition poses an urgent question: Where would that leave those who are struggling under capitalism? Neoliberal society places the burden on the individual, and as examined, capitalism is in many ways inherently depressive. In some ways the psy-professions act to fill a hole in a society that has few alternatives of care. Radical therapy provides a reform to psychiatric discourse, and an intermediatory for care. However, as Burstow (2015, p. 230) outlines, "the problem runs deeper", so "even when [mental healthcare is] conducted in a sensitive way, it is inherent in the financialisation and commodification of help." This reform of radical care should thus be practised alongside broader social and political activism, and a shift towards entirely radical forms of care.

Anti-capitalist movements provide radical forms of care that reject entirely the hegemony of the psy-professions, and even their conceptualisation of depression. Federici's (2004) work on feminist and anti-capitalist movements highlights how collective action and resistance can challenge the oppressive structures of capitalism and create new possibilities for community and social change. The call for collective care and resistance is echoed throughout Cvetkovich's book *Depression: A Public Feeling* (2012) and Hedva's (2016) Sick Women Theory. Cvetkovich contends that "the most anti-capitalist protest is to care for another

and to care for yourself." This challenges the individualistic and profit-driven values of capitalism by emphasising the importance of interdependent social connections and a politics of care. She goes on to advocate developing "a radical kinship, an interdependent sociality, a politics of care".

By actively practising care as a political act, the potential arises to subvert the dominant logic of capitalism and its relentless pursuit of self-interest. This practice recognises the transformative potential of collective care, viewing it as a powerful means of building alternative modes of sociality that prioritise well-being, compassion and solidarity over the commodification of human relationships (Cvetkovich, 2012; Hedva, 2016). Segal (2023, p. 270) declares that "the radical notion of care, defined broadly to include all activities that enable human life to flourish, alongside the nurturing of non-human and planetary well-being, is quite distinct from benevolence or pity." Through acts of care and mutual support, individuals not only resist the alienating effects of capitalism but also create spaces for nurturing and sustaining communities that embody a more equitable and humane way of being (Frantzen, 2019a).

By challenging the capitalist-induced pathologisation of depression and embracing a more politicised approach, there is potential for a new narrative that prioritises the well-being of individuals over profit. Any form of anti-capitalist resistance, whether that be through radical kindship, collective action, protest or scholarly activism, must contend with the lived experience of a 'depressed' (or sad/oppressed/isolated/despondent) working class.

Conclusion

Depression is not just an individual issue but a political one. Capitalism causes and exacerbates mental illness through its alienating, structurally violent and inherently dysfunctional nature (Ehrenreich, 2016). As though this reality wasn't depressive enough, capitalist realism decimates opportunities for hope, limiting our imagination and understanding of alternatives to the current system.

Depression's very conceptualisation emerged from a capitalist profession. Psychiatric knowledge, under the guise of being objective and scientific, asserts a moral authority dictating what behaviour is normal, while acting to further powerful profit motives. Approaches to care emerging from these psy-professions serve neoliberal ideology, putting the onus for change onto the individual and reinforcing the status quo.

However, anti-capitalist movements offer examples of collective action and resistance that challenge the oppressive structures and create new possibilities for mental health and well-being. Radical therapy has emerged as a reform to traditional psychiatric hegemony, typically practised by Marxist therapists and focused on politicising or contextualising the individual rather than individualising the political. Although radical therapy still falls under the scope of the psy-professions, and thus fails to overcome inherent issues such as professionalisation, it offers an alternative for care that breaks away from neoliberal ideology.

Other critical mental health scholarship calls for the abolition of the psy-professions, and from this demand emerges radical care. Far from new, this notion of community, collectivism and kinship has been practised by activists, Indigenous communities and radical groups. This challenges the alienating forces of capitalism, focusing on building up communities centred around care, solidarity and resistance.

Although these alternatives of care currently exist only in small pockets, they provide hope and a framework for reconceptualising depression and our approaches to it. As Fisher (2009, p. 80) concludes, capitalist realism's "oppressive pervasiveness" gives even the slightest suggestion of alternative political or economic models an extraordinary potential to "puncture a hole in the drab screen of reaction ... transforming a situation where nothing is feasible into one where anything is conceivable once more".

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